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## Administration

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### 1.0 GENERAL

All TRICARE requirements regarding administration shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 1](#) for additional instructions regarding administration. Specific health care support services required for the performance of this contract are identified in this chapter, in the TPM, [Chapter 12](#), and the TOP contract.

### 2.0 CONTRACT ADMINISTRATION AND INSTRUCTIONS TO CONTRACTOR

**2.1** The provisions of [Chapter 1, Section 2](#) are applicable to the TOP. Additionally, the TOP contractor shall coordinate with the [Defense Health Agency \(DHA\)](#) Contracting Officer (CO), the appropriate [DHA](#) Contracting Officer Representative (COR), and the appropriate TRICARE Area Office (TAO) Director on any TOP policy or contractual issue that requires additional government clarification or assistance to resolve.

**2.2** The provisions of [Chapter 1, Section 2, paragraph 4.0](#) are superseded as described in [paragraphs 2.2.1](#) through [2.2.5](#).

**2.2.1** A 14 calendar day notice will be provided by the TMA Procurement Contracting Officer (PCO) for all meetings hosted by [DHA](#).

**2.2.2** The TOP contractor shall provide up to four contractor representatives at the Performance Readiness Validation briefing at [DHA](#).

**2.2.3** The TOP contractor shall provide at least two contractor representatives for transition briefings/meetings with each overseas Military Treatment Facility (MTF) and TAO. All briefings/meetings must be completed no later than 60 calendar days prior to the start of health care delivery.

**2.2.4** The TOP contractor shall provide annual representation at two contractor conferences (senior management level) at [DHA](#). The contractor shall also provide up to four contractor representatives at up to four additional meetings at the direction of the CO per contract year.

**2.2.5** The TOP contractor shall provide representation at [semiannual](#) TOP [operational](#) meetings to be held at [DHA Aurora](#) with TAO and [service](#) representation.

**2.2.6** The TOP contractor shall provide two contractor representatives at up to 18 additional meetings/site visits at the direction of the CO per option period.

### 3.0 TRICARE PROCESSING STANDARDS

See [Chapter 1, Section 3](#) for instructions regarding TRICARE processing standards.

**Note:** The standards for telephone inquiries apply to all toll-free lines supporting TOP contract customer service activities.

### 4.0 MANAGEMENT

The provisions of [Chapter 1, Section 4](#) are applicable to the TOP, except that the provisions of [Chapter 1, Section 4, paragraph 2.3](#) regarding zip code files are only applicable to Puerto Rico.

### 5.0 COMPLIANCE WITH FEDERAL STATUTES

See [Chapter 1, Section 5](#) for instructions regarding compliance with Federal statutes.

### 6.0 LEGAL MATTERS

See [Chapter 1, Section 6](#) for instructions regarding legal matters.

### 7.0 TRANSITIONS -- CONTRACT PHASE-IN

#### 7.1 Transition-In (Phase-In) Plan

The provisions of [Chapter 1, Section 7, paragraph 1.1](#) are applicable to the TOP. In addition to the start-up (transition-in/phase-in) plan, the contractor shall provide weekly status reports through the first 180 calendar days of the contract or as directed by the Government.

#### 7.2 Transition Specifications Meeting

See [Chapter 1, Section 7, paragraph 1.2](#) for instructions regarding transition specification meeting(s).

#### 7.3 Interface Meetings

The provisions of [Chapter 1, Section 7, paragraph 1.3](#) are applicable to the TOP.

#### 7.4 MTF/TAO Transition Briefings/Meetings

The contractor shall provide on-site transition briefings/meetings with all MTFs and TAOs per [paragraph 2.2.3](#). These briefings/meetings shall be targeted towards command suite/key leaders and their staff and shall encompass all key contract areas where collaboration between the contractor and the MTF/TAO will occur.

### 8.0 TRANSITIONS -- START-UP REQUIREMENTS

**8.1** See [Chapter 1, Section 7, paragraphs 2.1, 2.2, and 2.3](#) for instructions regarding start-up requirements. For purposes of TOP implementation, all references to TRICARE Prime in [paragraph 2.2](#) shall apply to TOP Prime and TOP Prime Remote.

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**8.2** See [Section 16](#) for instructions regarding [Statements of Responsibilities \(SORs\)](#). In addition to the [SOR](#) requirements in these referenced paragraphs, the TOP contractor shall also execute a [SOR](#) with each TAO Director No Later Than (NLT) 60 calendar days prior to the start of health care delivery, with copies to the PCO and the COR within 10 calendar days following [SOR](#) execution.

**8.3** See [Chapter 1, Section 7, paragraphs 2.5](#) and [2.6](#) for instructions regarding phase-in of TRICARE enrollment and transfer of enrollment files. For purposes of TOP implementation, all references to TRICARE Prime in these paragraphs shall apply to TOP Prime and TOP Prime Remote.

**8.4** The provisions of [Chapter 1, Section 7, paragraph 2.7](#) are not applicable to the TOP, since there are no enrollment fees associated with TOP Prime or TOP Prime Remote.

**8.5** See [Chapter 1, Section 7, paragraph 2.8](#) for instructions regarding Health Care Finder (HCF) phase-in.

**8.6** See [Chapter 1, Section 7, paragraph 2.9](#) for instructions regarding TRICARE Service Center (TSC) phase-in.

**Note:** Overseas TSCs are managed by the MTFs and are jointly staffed by MTF and TOP contractor personnel. The TOP contractor is responsible for providing on-site Beneficiary Service Representative (BSR) support in all TSC locations.

**8.7** All claims that fall within the scope of the TOP contract received on or after the start of health care delivery on the TOP contract shall be processed by the TOP contractor.

**Note:** Normal claims filing deadlines apply. See [Chapter 8, Section 3](#) and [Section 9, paragraph 3.0](#).

**8.8** The provisions of [Chapter 1, Section 7, paragraph 2.10](#) are applicable to the TOP, except that the provisions of [Chapter 1, Section 7, paragraph 2.10.4](#) are superseded by a requirement for the incoming contractor to cover non-obstetrical care for 90 days after the start of health care delivery under the incoming contract, in accordance with the outgoing contractor's existing practices and protocols, within the scope of the TRICARE program and applicable regulations or statutes. This transition period for prior authorizations and referrals is extended to one year for obstetrical care or any other condition for which a one-year authorization has been issued.

**8.9** See [Chapter 1, Section 7, paragraph 2.11](#) for instructions regarding contractor weekly status reporting.

**8.10** The provisions of [Chapter 1, Section 7, paragraph 2.12](#) are not applicable to the TOP. Instead, the TOP contractor shall prepare a mailing to the Resident Commissioners of Puerto Rico and the Northern Mariana Islands, and the Congressional representatives for American Samoa, Guam, and the U.S. Virgin Islands by the 45th calendar day prior to the start of health care delivery according to the specifications of the official transition schedule. This requirement supersedes the requirements outlined in [Chapter 1, Section 7, paragraph 2.12](#). The proposed mailing shall be submitted to the [DHA CO](#), [DHA COR](#), TAO Directors, and the [DHA Program Integration Office](#) for approval NLT 90 calendar days prior to the start of health care delivery. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

**8.11** See [Chapter 1, Section 7, paragraphs 2.13](#) and [2.14](#) for instructions regarding web-based services and applications and TRICARE Handbook mailings.

## **9.0 TRANSITIONS -- CONTRACT PHASE-OUT**

The provisions of [Chapter 1, Section 7, paragraph 3.0](#) are applicable to the TOP, except that the requirement in [paragraph 3.4](#) for the outgoing contractor to process claims and adjustment for 120 days following cessation of health care delivery is waived for the TOP. The outgoing contractor is only required to process claims and adjustments received during it's period of service delivery. Processing of all claims shall be completed within 180 calendar days following the start of the incoming contractor's services delivery.

- END -

## Financial Administration

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### 1.0 GENERAL

All TRICARE requirements regarding Financial Administration shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 3](#) for additional instructions.

### 2.0 PAYMENT POLICY

**2.1** Reimbursement of TOP beneficiary claims for overseas health care shall be based upon the lesser of billed charges, the negotiated reimbursement rate, or the government-established fee schedule. (See [Section 9](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 1, Sections 34](#) and [35](#) for additional guidelines). **Except for medical evacuations, claims for care in the U.S. commonwealths and territories** shall be reimbursed following stateside reimbursement guidelines. Philippines and Panama claims shall be reimbursed following government-established fee schedules, unless the TOP contractor has negotiated a lesser rate with a **purchased care sector** provider.

**2.2** Payment of Skilled Nursing Facility (SNF) claims from Puerto Rico and the U.S. territories (Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands) shall be processed as routine foreign claims and shall be subject to the Prospective Payment System (PPS), as required under Medicare in accordance with the Social Security Act. These SNFs will be subject to the same rules as applied to SNFs in the U.S. (see the TRM, [Chapter 8](#)). SNF care is not available in other TOP locations.

**2.2.1** TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard and TRICARE for Life (TFL) patients when TRICARE is the primary payer. The review required for the lower 18 Resource Utilization Groups (RUGs) for services prior to October 1, 2010, and the lower 14 RUGs for services on/after October 1, 2010, are a requirement for all TRICARE patients when TRICARE is primary (see TRM, [Chapter 8, Section 2, paragraph 4.3.16](#)). There will be no review for Standard or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

**2.2.2** Beneficiaries in the lower 18 or 14 RUGs depending on date of service do not automatically qualify for SNF coverage. These beneficiaries will be individually reviewed to determine whether they meet the criteria for skilled services and the need for skilled services (see the TRM, [Chapter 8, Section 2](#)). If these beneficiaries do not meet these criteria, the SNF PPS claim shall be denied.

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**2.2.3** The TOP contractor, at their own discretion, may collect Minimum Data Set (MDS) assessment data per the TRM, [Chapter 8, Section 2](#).

**2.3** The TOP contractor shall be responsible for entering into participation agreements with SNFs in Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

**2.3.1** The TOP contractor, at their own discretion, may conduct any data analysis to identify aberrant SNF PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG. The contractor shall also assist the TRICARE Area Office (TAO) Directors in obtaining/providing SNF data, for conducting any SNF PPS data analysis they deem necessary.

**2.4** Balance billing provisions do not apply to TOP beneficiary claims for care rendered in a foreign country and paid as billed, since there is no unpaid balance on these claims. Purchased care sector network providers, participating providers, and providers in U.S. commonwealths and territories are prohibited from balance billing.

**2.5** For health care rendered in Puerto Rico and in the U.S., reimbursement for all TOP beneficiary care shall follow the TRICARE payment policies except as outlined below.

**2.5.1** TOP ADSMs who have been required by the provider to make “up front” payment at the time services are rendered may submit a claim for reimbursement directly to the contractor. Normal TRICARE claims processing requirements apply (including any authorization requirements and the use of TRICARE-approved claims forms). If the claim is payable, the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim.

**2.5.2** In no case shall an ADSM be subjected to “balance billing” or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve, they shall pend the file and forward the issue to the appropriate TAO Director. The appropriate TAO Director will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the TAO Director has requested and has been granted a waiver from the COO, Defense Health Agency (DHA), or designee.

**2.5.3** Overseas drug claims shall be paid following the instructions in [Section 9](#) and the TRM, [Chapter 1, Section 15](#).

**2.5.4** Overseas ambulance service claims shall be paid following the instructions in [Section 7](#) and [Chapter 8, Section 1](#); [TPM, Chapter 8, Section 1.1](#), and [TRM, Chapter 1, Section 14](#).

**2.5.5** Payment may be made for ambulance services provided by commercial transport (see [Section 7](#) for additional processing instructions for these claims).

**2.5.6** The provisions of [Chapter 3, Section 2, paragraph 2.1](#) are applicable to the TOP except for the optional provisions of Electronic Funds Transfer (EFT) payments to TOP beneficiaries. The TOP contractor is required to make EFT payments to all TOP beneficiaries (upon beneficiary request) when the beneficiary requests payment to a U.S. bank account or other U.S. financial institution.

**2.5.7** The provisions of [Chapter 3, Section 2, paragraph 2.2](#) are not applicable to the TOP. The TOP contractor may not require purchased care sector providers who submit claims electronically

to accept an electronic remittance advice and to receive payment by Electronic Funds Transfer (EFT). These electronic processes are optional for **purchased care sector** providers since they may create a financial burden for the provider.

### 3.0 FINANCIAL ADMINISTRATION

**3.1** The TOP contractor shall follow the Financial Administration non-financially underwritten funds requirements in [Chapter 3](#) with the following exceptions:

**3.1.1** Foreign overseas drafts (local currency) and checks (U.S. currency) shall also reflect "TRICARE Overseas Program".

**3.1.2** Foreign overseas drafts shall also reflect information that indicates the draft is valid for 190 days and if reissue is required/necessary, the draft must be returned to the **TOP** contractor with a request for reissuance. The contractor shall issue drafts/checks for Germany claims which look like local German drafts/checks.

**3.2** The TRICARE Encounter Data (TED) for the overseas claims shall be reported on vouchers/batches according to the TRICARE Systems Manual (TSM), [Chapter 2](#) and as follows for remote sites:

**3.2.1** Active Duty Family Member (ADFM) and ADSM remote site claims, excluding health care claims for emergent/urgent care for Navy and Marine Corps ADSM who are either deployed and or deployed on liberty status in a remote site shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten foreign bank account. They shall be submitted like all other claims currently processed from that account.

**3.2.2** Navy deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The Automated Standard Application for Payment (ASAP) account on the voucher header will identify the voucher as Navy.

**3.2.3** Marine Corps deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The ASAP account on the voucher header will identify the voucher as Marine Corps.

**3.2.4** Claims for retirees and their eligible family members living in a remote site shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.2.4.1** Claims for care rendered in the United States or the District of Columbia to TOP ADSM, ADFM, retirees and their dependents living in a remote overseas site shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

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**3.3** For other than remote site claims:

**3.3.1** TOP eligible ADSM and ADFM claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.2** Claims for retirees and their eligible family members living overseas shall be submitted on vouchers and shall be paid from the current non-financially underwritten or TFL/accrual fund bank accounts. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.3** TOP Prime (ADSM and ADFM) and TOP Standard beneficiary stateside claims for health care shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.4** Overseas health care claims for stateside beneficiaries whose health care is normally provided under one of the three regional Managed Care Support Contracts (MCSCs) (i.e., beneficiaries enrolled or residing in the 50 United States or the District of Columbia, who receive care while traveling or visiting abroad) shall be processed by the TOP contractor. Claims for these beneficiaries shall be paid from the current non-financially underwritten bank account. This provision does not apply to beneficiaries who are enrolled to the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). Claims for these beneficiaries are processed by their respective contractor regardless of where the care is rendered.

**3.4** The TOP contractor shall:

**3.4.1** Provide TRICARE Overseas Currency reports identifying the gain or loss for the month reported to arrive by the 10th calendar day following the month reported. The reports for net gains/losses shall be sent in a electronic format to **DHA**, Attn: Finance and Accounting Branch, 16401 East Centretech Parkway, Aurora, CO 80011-9066.

**3.4.2** The TOP contractor shall calculate currency gains and losses resulting from payments made to host nations providers and/or beneficiaries in foreign countries. The gains and losses shall be computed based on the exchange rate in effect on the ending date of care. The difference between the cost of the foreign currency on the ending date of care and the contractor payment date shall be the gain or loss on the transaction. Payment shall be as follows for:

**3.4.2.1** Net Gain. For months that result in a net gain, the TOP contractor shall forward the report along with their check payable to the Department of Defense (DoD), **DHA**, for the gain from currency conversion.

**3.4.2.2** Net Loss. **DHA** will reimburse the TOP contractor for any losses incurred from currency conversion. The TRICARE Overseas Currency report shall be accompanied by a letter (invoice) requesting reimbursement for the loss incurred. This payment will not be subject to the Prompt Payment Act (FAR 32.9) as amended, therefore, payment by **DHA** will usually be made within five working days of receipt of the invoice and the TRICARE Overseas Currency report.

- END -

## Purchased Care Sector Providers

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### 1.0 GENERAL

TRICARE Overseas Program (TOP) health care services are provided by Military Treatment Facilities (MTFs) and **purchased care sector** network and non-network providers and institutions. All TRICARE requirements regarding Provider Certification/Credentialing and Network Development shall apply to the TOP unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP Contract"). See [Chapters 4](#) and [5](#) for additional instructions.

### 2.0 PURCHASED CARE SECTOR PROVIDER CERTIFICATION AND CREDENTIALING

**2.1** The TOP contractor will be responsible for provider certification oversight, and monitoring of provider/institution quality. The contractor shall use [Chapter 4](#), [32 CFR 199.6](#), and TPM, [Chapter 11](#) to the maximum extent possible for the certification of **purchased care sector** providers. The contractor is not required to follow TRICARE requirements for United States (U.S.) credentialing standards, except **when TRICARE requires the facility/agency to be Medicare certified** (e.g., home health, hospice, Skilled Nursing Facility (SNF) care). Also, Psychiatric Residential Treatment Centers (RTCs), Substance Use Disorder Rehabilitation Facilities (SUDRFs), and Psychiatric Partial Hospitalization Programs (PHPs) that are located in Puerto Rico require approval by the TRICARE Quality Monitoring Contractor (TQMC). Except for these services and facilities, the TOP contractor shall establish **purchased care sector** provider certification processes based on the accepted licensure and credentialing requirements for the host nation.

**Note:** Medicare certification for organ transplant centers is only required for transplants performed in the U.S., the District of Columbia, and U.S. territories where Medicare is available. See TPM [Chapter 12, Section 1.2](#).

**2.2** Refer to [paragraph 4.7](#) for additional certification requirements that have been established for **purchased care sector** providers in the Philippines. **Defense Health Agency (DHA)** may expand these additional certification requirements to other locations in the future.

### 3.0 NETWORK DEVELOPMENT

**3.1** The TOP contractor is responsible for developing and maintaining a complement of network and non-network **purchased care sector** providers to augment the existing capacity of the Direct Care (DC) system for Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFM) who are enrolled in TOP Prime, and to provide or arrange for primary and specialty care services for ADSMs and ADFMs who are enrolled in TOP Prime Remote.

**Note:** In remote overseas locations, the TOP contractor shall also establish dental provider networks for ADSMs in accordance with [Section 10](#).

**3.2** The TOP contractor shall establish signed provider agreements between network **purchased care sector** providers and the contractor.

**3.2.1** Network provider agreements shall include language indicating that the provider agrees to participate on claims for authorized services for TOP enrollees on a cashless, claimless basis.

**3.2.2** Network provider agreements must specify rates for ADSM medical records photocopying and postage, if applicable.

**Note:** "Cashless, claimless" is defined as a health care encounter that requires no up-front payment at the time of service, and the provider files the claim for the beneficiary.

**3.3** Networks will be sized to meet TOP-enrolled populations only. The TOP contractor may assist other beneficiaries (non-command sponsored ADFMs, retirees, retiree family members, etc.) upon request by identifying these **purchased care sector** providers as they will be credentialed and familiar with TRICARE, but networks will not be developed to accommodate non-TOP enrollees.

**3.4** In TOP Prime locations, MTF commanders shall identify the specialties needed in the network and will communicate this information on an ongoing basis to the TOP contractor per the process identified in the **Statements of Responsibilities (SORs)** (see [Section 16](#)).

**3.5** MTF capabilities and capacities may change frequently over the life of the contract without prior notice. The TOP contractor shall ensure that **purchased care sector** provider services can be adjusted as necessary to compensate for changes in MTF capabilities and capacities, when and where they occur over the life of the contract, including short notice of unanticipated facility expansion, provider deployment, downsizing, and/or closures.

**3.6** Network providers shall be able to communicate in English, both orally and in writing, or provide translation services at the time of service.

**3.7** The TOP contractor shall be responsible to enter into participation agreements with SNFs in Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands per the provisions of [Section 3](#).

#### **4.0 CONTRACTOR REQUIREMENTS - PURCHASED CARE SECTOR PROVIDERS**

**4.1** Reimbursement rates for **purchased care sector** providers may be negotiated by the contractor. **In locations where** the government has designated specific reimbursement rates or methodologies, **the contractor may not negotiate rates which exceed the government-directed rate**. Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 34](#) for additional instructions.

**4.2** The contractor shall provide ongoing **purchased care sector** provider education and support in accordance with [Section 11](#).

**4.3** The contractor shall have a Quality Oversight Plan for reviewing access and quality of care provided by **purchased care sector** providers. This plan shall incorporate customer comments and feedback regarding care from **purchased care sector** providers.

**4.4** The TOP contractor is required to assign provider numbers to **purchased care sector** providers, identify providers as network or non-network, and create and submit TRICARE Encounter Provider (TEPRV) records. Each provider shall be identified by a single provider number, with a sub-identifier for multiple service locations. Upon **the Government's** request, the contractor shall provide copies of licensure/certification information for **purchased care sector** providers.

**4.5** The TOP contractor shall deny claims from non-certified **purchased care sector** providers when **DHA** has directed that the country's **purchased care sector** providers must be specially certified in order to receive TRICARE payments. See **paragraph 4.7** for additional certification requirements.

**4.6** The provisions of **Chapter 5, Section 1, paragraph 1.3** regarding Telemental Health (TMH) are not applicable to the TOP contract.

**4.7** The TOP contractor is responsible for performing on-site verification and provider certification in the Philippines. At a minimum, this on-site verification shall confirm the physical existence of a facility/provider office, verify the credentials/licensure of the facility/provider, verify the adequacy of the facility/provider office, and verify the capability of the facility/provider office for providing the expected level and type of care. This requirement may be expanded to other locations upon Contracting Officer (CO) direction.

**4.7.1** The TOP contractor shall provide beneficiaries with easy access to both the approved Philippines demonstration provider listing and the certified provider listing via a user-friendly searchable World Wide Web (WWW) site and any other means established at the contractor's discretion. Information on the WWW site and any other electronic lists shall be current within the last 30 calendar days. At a minimum, the data base shall be searchable by provider location, provider name, and provider specialty (if available).

**4.7.2** If a claim is received for care rendered by a non-certified provider in the Philippines, the TOP contractor shall pend the claim and initiate on-site verification/provider certification action. Claims pended for this reason are excluded from normal claims processing cycle time standards. If the on-site verification/certification action is not completed within 90 calendar days, the TOP contractor shall deny claims based on lack of provider certification.

**4.7.3** The TOP contractor shall use the following guidelines for prioritizing certification of Philippine providers as follows:

**4.7.3.1** Reviewing new providers.

**4.7.3.2** Reviewing the TOP contractor's current certified provider files.

**4.7.3.3** Reviewing non-certified providers on claims which have been denied by the TOP contractor and the beneficiary/provider has followed-up on why the claim was denied.

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**4.7.3.4** Reviewing non-certified providers on claims which have been denied by the TOP contractor and the beneficiary/provider has NOT followed-up on why the claim was denied.

**4.7.4** Recertification of Philippine providers shall be performed by the TOP contractor every three years and shall follow the above process. DHA shall, as necessary, require the contractor to add additional overseas countries for purchased care sector provider certification. Upon direction of the government, the contractor shall follow the process outlined above for Philippines, to include prioritization of certification of new country providers.

**4.7.5** The TOP contractor shall deny claims submitted from non-certified or non-confirmed purchased care sector providers from the Philippines, advising the provider to contact the contractor for procedures on becoming certified.

**4.8** For the Philippines, prescription drugs may be cost-shared when dispensed by a certified retail pharmacy or hospital based pharmacy. The TOP contractor shall deny claims for prescription drugs obtained from a physician's office.

- END -

## TRICARE Overseas Program (TOP) Eligibility And Enrollment

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### 1.0 GENERAL

All TRICARE requirements regarding eligibility, enrollments, re-enrollments, disenrollments, and transfers shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 6](#); the TPM, [Chapter 10](#); and the TRICARE Systems Manual (TSM) for additional instructions.

### 2.0 ELIGIBILITY

**2.1** Eligibility for TRICARE is verified via the Defense Enrollment Eligibility Reporting System (DEERS). The DEERS record will indicate the dates of eligibility. Except for newborns, only those beneficiaries who are shown as eligible on DEERS will be enrolled or receive benefits under the TOP. If a beneficiary's date of birth is within 365 days of the contractor's query to DEERS, the contractor shall consider the newborn to be eligible for TRICARE benefits. In addition to DEERS eligibility, TOP Active Duty Family Members (ADFM)s are required to demonstrate Command Sponsorship to be eligible for TOP Prime and TOP Prime Remote enrollment unless a specific exception exists. The TOP contractor shall verify DEERS eligibility (and Command Sponsorship, where required) prior to enrolling beneficiaries into TOP.

**Note:** Family members of the Armed Forces of foreign North Atlantic Treaty Organization (NATO) or [Partnership for Peace \(PFP\)](#) nations are not eligible for the TOP.

### 3.0 ENROLLMENT PROCESSING

**3.1** TOP Prime and TOP Prime Remote are available to Active Duty Service Members (ADSM)s and certain ADFM)s in overseas locations as described below. These programs are similar, but not identical, to TRICARE Prime and TRICARE Prime Remote (TPR)/TRICARE Prime Remote for ADFM)s (TPRADM)s in the United States (U.S.). TOP Prime enrollees shall normally be enrolled to an Military Treatment Facility (MTF) Primary Care Manager (PCM), but enrollment to a [purchased care sector](#) PCM may be authorized when MTF capacity is reached. TOP Prime enrollment procedures shall be established in the [Statements of Responsibilities \(SORs\)](#) between the TOP contractor and the MTF Commander. TOP Prime Remote enrollees shall be enrolled to a remote Defense Medical Information System (DMIS) code with assignment to a [purchased care sector](#) PCM or to the TOP contractor, according to the specific regional enrollment procedures established in the [SORs](#) between the contractor and the TRICARE Area Office (TAO) Directors.

**3.2** Unless a specific exception exists, enrollment to TOP Prime or TOP Prime Remote is available only to ADSM)s who are permanently assigned overseas, and to ADFM)s who are Command Sponsored and accompanying their sponsor on his/her overseas tour, or on orders in an overseas

location (see [paragraph 5.1](#) for additional information regarding Command Sponsorship). This includes activated Reserve Component (RC) ADSMs who are on orders to an overseas location for more than 30 days, and their Command Sponsored ADFMs who accompany the RC member on his/her overseas tour or are on orders in an overseas location.

**3.3** Non-Command Sponsored ADFMs, retirees, and retiree family members are not eligible for TOP Prime or TOP Prime Remote enrollment in any overseas location. This long-standing limitation derives from the limited number and capacity of MTFs and staff in overseas locations, coupled with their mission-critical requirement to provide Prime coverage for ADSMs as their first priority, and to Command Sponsored ADFMs as their second priority. ADFMs who are not Command Sponsored or on military orders as described in this section will be covered by TOP Standard (see [Section 19](#)).

**3.4** Enrollment may occur at any time after TOP eligibility has been established, and normally remains effective during the overseas tour of the sponsor. Annual re-enrollment is not required for TOP Prime or TOP Prime Remote. Once enrolled, beneficiaries remain enrolled in these programs until they disenroll; transfer enrollment to another TRICARE region/program; lose eligibility for TRICARE, TOP Prime, or TPR; or until the 61st calendar day following the end of the overseas tour (see [paragraph 12.5](#)).

**3.5** The TOP contractor shall perform all enrollment-related activities for TOP Prime, TOP Prime Remote, TRICARE Plus, TRICARE Young Adult (TYA), TRICARE Reserve Select (TRS), and TRICARE Retired Reserve (TRR) in overseas locations. These activities include validation of eligibility, enrollment, re-enrollment, disenrollment, transfers, updating information in DEERS, clearing enrollment discrepancies, **assigning** or **changing** PCMs, collecting Other Health Insurance (OHI) information, and related enrollment functions. The contractor shall use the approved TRICARE enrollment request options for enrollment activities. Enrollment shall be accomplished within five working days of receipt of a complete TRICARE enrollment request.

**Note:** Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), **Philippines Phil Health**, and Australian Medicare, etc., are considered OHI.

**3.6** Enrollments for TOP Prime or TOP Prime Remote are effective on the date the enrollment request is received (and appropriate Command Sponsorship orders are received or attested to, when applicable), unless a retroactive enrollment has been authorized by the TAO Director or designee. For telephonic enrollments, the TOP contractor will collect the Military Sponsor's Order Number and date on the orders and document in the contractor's call notes. By providing the Order Number and date on the orders, the Sponsor and/or ADFM attests to command sponsorship. For TOP emergency cases that should be placed under immediate case management, TOP MTF commanders and/or the TAO Directors may approve exceptions on a case-by-case basis for retroactive TOP enrollment. Except for administrative errors, the effective date for retroactive enrollments shall not be earlier than the first day of the month that the application is submitted (see the TPM, [Chapter 10, Section 2.1](#)).

- An official signed enrollment request includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) a verbal consent provided via telephone and documented in the contractor's call notes. A signature is not required to make enrollment changes by phone as long as the verbal request is documented. A signature from an ADSM is never required to complete Prime enrollment as enrollment in Prime is mandatory per TPM, [Chapter 10, Section 2.1, paragraph 1.1](#).

**3.7** The contractor shall follow guidance from the TAO Directors and the MTFs regarding PCM assignment when enrolling beneficiaries into TOP Prime. The MTF enrollment area encompasses a 40-mile radius or a one-hour drive time from the MTF. TOP Prime Remote beneficiaries will be enrolled to the appropriate DMIS code for the beneficiary's remote overseas location. TOP Prime Remote enrollees in Canada will follow guidance applicable to the U.S. and Canada Reciprocal Health Care Agreement, and may be assigned to a Canadian Forces Health Facility for their primary care.

**3.8** Newborns/adoptees **in all overseas locations** are deemed to be enrolled for **120** days following birth/adoption when one other family member, to include the sponsor, is enrolled in TOP Prime/TOP Prime Remote. Parents of newborns/adoptees are required to take specific action to enroll the newborn/adoptee within 60 calendar days of birth/adoption. For newborns and newly adopted children who are deemed enrolled, Point of Service (POS) cost-sharing does not apply through the deemed enrollment period, or until an enrollment decision is made by a responsible representative, whichever is earlier. If the newborn or adoptee is formally enrolled in TOP Prime or TOP Prime Remote within the **120-day** period, the date of enrollment will be the date the enrollment request is received per [paragraph 3.6](#). If the newborn/adoptee is not formally enrolled during the **120-day** period, the newborn/adoptee will revert to TRICARE Standard effective the **121st** day, unless the deemed enrollment period has been waived.

**Note:** Newborns/adoptees of RC members who are called to active duty for more than 30 consecutive days are eligible for TOP/TRICARE benefits the same as other TRICARE eligible beneficiaries.

**3.9** The provisions of [Chapter 6, Section 1](#) and the TPM, [Chapter 10, Section 2.1](#) regarding Prime enrollment fees shall not apply to TOP Prime or TOP Prime Remote. There are no enrollment fees associated with TOP Prime or TOP Prime Remote.

#### **4.0 ENROLLMENT POLICY FOR ADSMs**

**4.1** Except as described in [paragraph 4.2](#), all ADSMs who are permanently assigned to an overseas duty location must be enrolled into the TOP program that is available in their area. This includes RC ADSMs who are called to active duty for more than 30 consecutive days with a final assignment to an overseas duty station.

**4.2** ADSMs assigned to operational forces with assigned organic medical assets may be enrolled to an operational forces' DMIS ID affiliated with its "Parent" DMIS. This includes activated RC members on duty in combatant theaters of operation with existing or imbedded organic medical treatment and support capabilities for health care. Enrollment to a Service or Region-specific operational forces' DMIS for all ADSMs should occur prior to deployment.

**4.3** **Since a signature from an ADSM is never required to complete Prime enrollment, the TOP contractor shall accept enrollment spreadsheets (with all applicable information) as a valid process for enrolling ADSMs into TOP Prime or TOP Prime Remote.**

#### **5.0 ENROLLMENT POLICY FOR ADFMs**

**5.1** ADFMs who have Permanent Change of Station (PCS) orders to accompany the sponsor overseas or service-funded orders to relocate overseas without the sponsor are eligible for TOP

Prime or TOP Prime Remote enrollment. In order to enroll in these programs, ADFMs must meet the definition of Command Sponsorship in the Joint Federal Travel Regulation (JFTR), Volume I, Appendix A (available at <https://www.defensetravel.dod.mil/Docs/perdiem/JTR.pdf>) unless one of the following exceptions exists:

**5.1.1** If the ADSM and his/her Command Sponsored ADFM(s) are enrolled in TOP Prime or TOP Prime Remote, and the sponsor is reassigned on unaccompanied PCS orders to a location that does not permit Command Sponsored family members, the family member(s) may retain their TOP enrollment for a period based on the length of the sponsor's unaccompanied orders (but not to exceed two years). In order to retain TOP enrollment in this situation, the family member(s) must continue to be Command Sponsored and may not relocate elsewhere during the sponsor's PCS move.

**5.1.2** If the ADFM(s) are authorized to relocate to an overseas location per the sponsor's PCS orders in accordance with JFTR U5222, or per Noncombatant Evacuation Orders without the sponsor, then the ADFM(s) are eligible for enrollment in the appropriate TOP program consistent with their orders.

**5.1.3** If the ADFM(s) resided in an overseas location prior to the activation/mobilization of a RC sponsor, then the ADFM(s) are eligible for enrollment in the appropriate TOP program based on the residential mailing address of the sponsor prior to activation/mobilization. The ADFM(s) must have had the same overseas residential address as the sponsor at the time of activation/mobilization.

**5.1.4** If the ADFM(s) are currently enrolled in TOP Prime or TOP Prime Remote, and the family has a newborn or adopts a child, then the new family member will be eligible to enroll in the same TOP program.

**5.1.5** If the ADFMs are eligible for Transitional Survivor benefits (see Enrollment Policy for Transitional Survivors below).

**5.2** ADFMs who choose to reside overseas but are not Command Sponsored as defined in the JFTR, and who do not meet any of the exceptions listed above, are not eligible for enrollment in TOP Prime or TOP Prime Remote. These ADFMs are eligible for TRICARE Standard, TRICARE Plus (where available) or MTF care on a space-available basis only. **ADFM's may not retain Prime enrollment to a stateside Managed Care Support Contract (MCSC) while residing overseas.**

**5.3** Eligibility for TOP enrollment normally requires the family to be accompanied by the sponsor; therefore, a family member cannot relocate within the overseas region, relocate to another overseas region, or relocate from a overseas location to an overseas location and transfer enrollment except as specified under the exceptions in this section.

**5.4** The TOP contractor shall verify that all of the above requirements are met (including DEERS eligibility check and validation of Command Sponsorship/military orders, if required) prior to enrolling an ADFM into TOP Prime or TOP Prime Remote.

**5.5** The process for identifying ADFMs who are Command Sponsored may vary by Service. This is a Service personnel decision and as such, these processes may change over the life of the contract. The TOP contractor may accept any current, valid method of identifying Command Sponsorship to

meet the TOP enrollment requirements (e.g., Navy ADFMs who are not listed on the sponsor's orders, but who are in receipt of a letter from the Navy Personnel Services Division (PSD)).

**5.6** ADFMs may request enrollment to an MTF that is not located at the sponsor's assigned installation; however, only requests for enrollment within the same TAO region as the sponsor's assigned location will be considered. All ADFM enrollments are subject to the MTF's enrollment/empanelment guidelines.

## **6.0 ENROLLMENT POLICY FOR TRANSITIONAL SURVIVORS**

The general provisions of TPM, [Chapter 10, Section 7.1](#) regarding Transitional Survivors shall apply to the TOP. Specific guidelines for Overseas Transitional Survivor benefits are listed below.

**6.1** TOP Prime/TOP Prime Remote enrollment policy provisions which require command sponsorship shall not apply to Transitional Survivors whose sponsors died on or after October 7, 2001.

**6.2** Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to remain in an overseas location are eligible for TOP Prime/TOP Prime Remote enrollment during the Transitional Survivor period, regardless of whether they remain at their original residence or relocate to another overseas location. These Transitional Survivors are also eligible for health care benefits under TRICARE Standard.

**6.3** Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to return to the United States from an overseas location are eligible for TRICARE Prime (in TRICARE Prime service areas) or TPRADFM (in remote locations) during the Transitional Survivor benefit period. These Transitional Survivors are also eligible for health care benefits under TRICARE Standard/Extra.

**6.4** Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to move from a stateside location to an overseas location are eligible for TOP Prime or TOP Prime Remote enrollment during the Transitional Survivor benefit period.

**6.5** Transitional Survivors whose sponsors died on or after October 7, 2001 are eligible for enrollment and claims reprocessing per TPM, [Chapter 10, Section 7.1](#). Transitional Survivors are also eligible for enrollment fee refunds (if applicable) per TPM, [Chapter 10, Section 7.1](#).

**6.6** If the Transitional Survivors are not enrolled in TOP Prime, the Transitional Survivor's priority for appointments at overseas MTFs will be the same as that of ADFMs who are not enrolled in TOP Prime.

**6.7** At the end of the Transitional Survivor period, survivors lose their eligibility for enrollment in TOP Prime/TOP Prime Remote (in overseas locations) and **TRICARE Prime**/TPRADFM (in remote locations) in the 50 United States and the District of Columbia.

## **7.0 ENROLLMENT PLAN**

The TOP contractor, in consultation with the TAO Directors and MTF Commanders, shall develop and implement a TOP enrollment plan. The TOP enrollment plan shall establish enrollment

goals and describe the methods to be used to accomplish these goals. The TOP enrollment plan shall be submitted to the **Defense Health Agency (DHA)** CO in accordance with the instructions in **Chapter 6, Section 1**. The TOP enrollment plan shall be submitted not less than 90 calendar days prior to the start of each health care delivery period. At a minimum, the TOP enrollment plan shall include the following:

**7.1** A description of the contractor's process for informing beneficiaries about the availability of TOP enrollment options (TOP Prime and TOP Prime Remote).

**7.2** A description of any unique conditions and resources which may impact enrollment activities by MTF area and TOP geographic region, along with a description of the contractor's plan for overcoming any potential barriers to effective and efficient enrollment of eligible beneficiaries.

**7.3** A description of the contractor's process for verification of eligibility prior to enrollment (including verification of command sponsorship status, when required for enrollment).

**7.4** A description of the contractor's process for enrollment of beneficiaries on the DEERS using an automated government-furnished systems application, including the contractor's process for ensuring that enrollment data remains up-to-date and accurate.

**7.5** A description of the contractor's process for providing continuous open enrollment for TOP Prime and TOP Prime Remote, automatic re-enrollment, and disenrollment as described in the TPM, **Chapter 10, Sections 2.1 and 3.1**. The contractor may propose multiple methods of enrollment; however the plan must include the opportunity for enrollment at TRICARE Service Centers (TSCs), at government-specified locations for arriving/deploying units (per **Section 11, paragraph 5.2**), via the TOP Point of Contact (POC) program, **by telephone**, and by mail.

**7.6** The TOP contractor shall provide TOP-enrolled beneficiaries with full and fair disclosure of any restrictions on freedom of choice that apply to TOP enrollees, including the POS option.

## **8.0 ASSIGNMENT OF PCM**

**8.1** **Unless the Government has approved enrollment to a purchased care sector PCM**, TOP Prime enrollees will be assigned to a PCM in a local Department of Defense (DoD) MTF. TOP Prime enrollees may not select an MTF Partnership Provider for a PCM.

**8.2** The MTFs will maintain current PCM lists and will make these lists available to the TOP contractor on a regular basis as determined in the **SORs**. MTF PCM lists should contain sufficient detail to facilitate new enrollments or PCM reassignments until capacity is optimized per MTF guidance.

**8.3** The TOP contractor shall assign TOP enrollees to a PCM at the time of enrollment via the Defense Online Eligibility and Enrollment System (DOES) per the **SOR**, access standards, and/or other specific government guidance. DOES will only display PCMs with available capacity. TOP Prime beneficiaries must enroll to an overseas DMIS with assignment to an MTF PCM. TOP Prime Remote beneficiaries must enroll to a civilian PCM, the contractor's call center(s), or a Canadian Forces Health Facility (in Canada). Appointments will be provided within the TRICARE Prime access standards.

**8.4** MTF Commanders may establish specific MTF enrollment/empanelment guidelines for their facilities. The TOP contractor shall enroll TOP Prime beneficiaries and assign PCMs according to these MTF guidelines. Upon receipt of a completed TRICARE enrollment request, the contractor shall attempt to enroll the beneficiary according to the identified preferences (e.g., specific provider, gender or specialty preference). If the beneficiary's PCM preferences are incompatible with MTF enrollment/empanelment guidelines, the beneficiary shall be enrolled according to MTF guidelines. If the preferred PCM is not available (no capacity), the contractor will use the default PCM for that MTF. If there is no PCM capacity in the MTF, the contractor shall contact the MTF for instructions.

**8.5** A significant number of MTF PCMs rotate or move each year. This will require the TOP contractor to move the enrollment panels associated with those PCMs. Through a government-provided application, the contractor shall perform batch PCM reassignments based on the parameters established by the MTF. Those parameters include DMIS ID to DMIS ID, PCM ID to PCM ID, Health Care Delivery Plan (HCDP), sex of beneficiary, Unit Identification Code (UIC) (active duty only), age of beneficiary, sponsor Social Security Number (SSN) (for family moves) and name of beneficiary. The contractor will perform MTF PCM reassignment moves within three working days of the effective date of the PCM's reassignment. The contractor will also perform PCM reassignment, as necessary, in response to **ADSM reassignment or turnover in purchased care sector** PCMs.

**8.6** The TOP contractor shall enroll TOP Prime Remote beneficiaries to the appropriate enrollment DMIS ID based on beneficiary location. The contractor shall list the name of the assigned remote location/site or the **purchased care sector** PCM, as appropriate.

## **9.0 ENROLLMENT PROCEDURES**

**9.1** No TRICARE-eligible beneficiary shall be denied enrollment or re-enrollment in, or be required to disenroll from, the TOP Prime/TOP Prime Remote program because of a prior or current medical condition.

**9.2** The TOP contractor shall be responsible for enrollment processing and for coordinating enrollment processing with the MTF, the appropriate TAO Director, and DEERS. The contractor shall enter enrollments into DEERS through the National Enrollment Database (NED) according to the provisions of the TSM, [Chapter 3](#). The contractor shall perform the following specific functions related to enrollment processing:

**9.2.1** The contractor shall collect TOP Prime enrollment requests at the TSCs or other sites mutually agreed to by the contractor, TAO Director, and the MTF Commander, or by mail, **telephone, Beneficiary Web Enrollment (BWE)**, or other secure means determined by the contractor. The contractor shall collect TOP Prime Remote service area enrollment requests by mail, **telephone**, or other secure means determined by the contractor.

**9.2.2** At the time of enrollment processing, the contractor shall access DEERS to verify eligibility of applicants and shall update the residential mailing address and any other fields for which they have update capability on DEERS. If the enrollment request does not contain a mailing address, the enrollment request should be developed for a mailing address. Enrollees may submit a temporary address (e.g., unit address) until a permanent address is established. Temporary addresses must be updated with the permanent address when provided to the contractor by the enrollee in

accordance with the TSM, [Chapter 3, Section 1.4](#). The contractor shall not input temporary addresses not provided by the enrollee. If the DEERS record does not contain an address, or if the enrollment request contains information different from that contained on DEERS in fields for which the contractor does not have update capability, the contractor shall contact the beneficiary within five calendar days outlining the discrepant information and requesting that the beneficiary contact their military personnel information office for assistance in updating the DEERS record.

**9.2.3** Unless the Government has waived the signature requirement, enrollment requests must be submitted by the sponsor, spouse, or other legal guardian of the beneficiary via one of the official enrollment request options (see [paragraph 3.6](#)).

**9.3** All TOP enrollees shall be issued enrollment cards per TSM, [Chapter 3, Section 1.4](#).

**9.4** TOP Prime/TOP Prime Remote enrollment may occur at any time during the period of TOP eligibility and shall remain effective until the enrollee transfers enrollment to another region, disenrolls, or becomes ineligible for TOP Prime/TOP Prime Remote or the TRICARE program.

**9.5** TOP Prime/TOP Prime Remote enrollment may be on an individual or family basis. Single enrollment may be changed to family at any time during the TOP enrollment period. A new TOP enrollment period shall be established for the family.

**9.6** Enrollment fees are not required for TOP Prime/TOP Prime Remote.

**9.7** ADSMs and ADFMs on PCS assignment in Canada (not at the request of the Canadian government) may enroll in TOP, but must pay up front for all health care and file a claim with the TOP contractor for reimbursement.

## **10.0 ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4**

**10.1** The provisions of [Chapter 6, Section 1](#) regarding enrollment of family members of E-1 through E-4 shall apply to the TOP, except that TOP Prime/TOP Prime Remote enrollment shall be effective the date that the enrollment is requested as long as it coincides with dates of eligibility.

**10.2** The provisions of [Chapter 6, Section 2](#) regarding enrollment portability shall apply to the TOP, except that stateside-enrolled retirees and retiree family members may not transfer Prime enrollment to an overseas location.

## **11.0 SPLIT ENROLLMENT**

The provisions of [Chapter 6, Section 3](#) regarding split enrollment shall apply to the TOP.

## **12.0 DISENROLLMENT**

**12.1** ADFMs shall be disenrolled from TOP Prime/TOP Prime Remote when:

- The enrollee requests disenrollment,
- The enrollee transfers enrollment to a new TRICARE region,
- The enrollee loses eligibility for TOP Prime or TOP Prime Remote,
- The enrollee loses TRICARE eligibility in DEERS, or

- The enrollee has not requested enrollment transfer/disenrollment within 60 calendar days following the end of the overseas tour.

**12.2** ADSMs shall be disenrolled from TOP Prime/TOP Prime Remote when:

- The enrollee transfers enrollment to a new TRICARE region,
- The enrollee loses TRICARE eligibility in DEERS, or
- The enrollee has not requested enrollment transfer/disenrollment within 60 calendar days following the end of the overseas tour.

**12.3** ADFMs who are enrolled in TOP Prime/TOP Prime Remote may disenroll at any time. They will not be permitted to make another enrollment until after a 12-month period if they have already changed their enrollment status from enrolled to disenrolled twice during the enrollment year (October 1 to September 30) for any reason. ADFMs with sponsors E-1 through E-4 are exempt from these enrollment lock-out provisions. See [Chapter 6, Section 1](#) for guidance regarding enrollment lock-outs.

**12.4** ADSMs cannot voluntarily disenroll from TOP Prime or TOP Prime Remote if they remain on permanent assignment in an overseas location where these programs are offered. ADSM enrollment in TOP Prime or TOP Prime Remote continues until they transfer enrollment to another TRICARE region/program or lose eligibility for TOP/TRICARE.

**12.5** TOP Prime/TOP Prime Remote enrollees must either transfer enrollment or disenroll within 60 calendar days of the end of the overseas tour when the ADSM departs to a new area of assignment. The TOP contractor shall provide continuing coverage until (1) the enrollment has been transferred to the new location, (2) the enrollee disenrolls, or (3) when enrollment transfer or disenrollment has not been requested by the TOP Prime/TPR enrollee by the 60th day. The TOP contractor will automatically disenroll the beneficiary on the 61st calendar day following the end date of the overseas tour. The ADFM TOP Prime/TPR beneficiary will revert to TRICARE Standard.

### **13.0 TRICARE ELIGIBILITY CHANGES**

**13.1** Refer to the TPM, [Chapter 10, Section 3.1](#) for information on changes in eligibility.

**13.2** The TOP contractor shall include full and complete information about the effects of changes in eligibility and sponsor rank in beneficiary materials and briefings.

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## Medical Management

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### 1.0 GENERAL

All TRICARE requirements regarding Utilization Management (UM) and Quality Management (QM) shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 7](#) for additional instructions. Language in [Chapter 7](#) that has no direct application to the TOP contract does not apply (e.g., Diagnosis Related Group (DRG) validation reviews which are not applicable in any overseas location except Puerto Rico).

### 2.0 UTILIZATION MANAGEMENT

**2.1** The contractor shall establish a **Medical Management (MM)/UM Plan** for care received by TRICARE beneficiaries.

**2.1.1** The contractor's **MM/UM** plan shall recognize that the Military Treatment Facility (MTF) Primary Care Manager (PCM) retains clinical oversight for TOP Prime enrollees. As such, the enrolling MTF is responsible for **determining medical necessity and** issuing all **referrals** for TOP Prime enrollees, and for providing **UM and all** case management services for the MTF-enrolled population. The contractor is responsible for ensuring that MTF-issued **referrals and appropriate** authorizations are entered into all applicable contractor systems to ensure accurate, timely customer service and claims adjudication. **The contractor shall perform certain UM activities to assist the MTFs with the medical management of TOP Prime inpatients as described in paragraph 7.0.** The contractor is also responsible for providing notification of case to the MTF commander or designee whenever an MTF enrollee is admitted to an inpatient facility (including mental health admissions), regardless of location.

**Note:** **Newborns/adoptees who are deemed enrolled in TOP Prime (based on the sponsor's MTF enrollment) shall receive clinical oversight from the MTF.**

**2.1.2** The contractor shall be responsible for **determining medical necessity, conducting covered benefit reviews, and issuing** authorizations for specialty care for TOP Prime Remote enrollees and all Active Duty Service Members (ADSMs) who are on Temporary Duty/Temporary Additional Duty (TDY/TAD), in an authorized leave status, or deployed/deployed on liberty in a remote overseas location. The contractor shall provide notification of cases to the appropriate TRICARE Area Office (TAO) for reviews involving remote ADSM requests for specialty care, and whenever hospital admissions have occurred for any beneficiary not enrolled to a TOP MTF (including mental health admissions), regardless of location.

**Note:** Newborns/adoptees who are deemed enrolled in TOP Prime Remote (based on the sponsor's TOP Prime Remote enrollment) shall receive clinical oversight from the TOP contractor.

**2.1.3** The contractor shall also be responsible for review and authorization of urgent specialty care for beneficiaries enrolled to a stateside Managed Care Support Contractor (MCSC) who are traveling outside of the 50 United States and the District of Columbia.

**2.2** The MM/UM Plan shall recognize that network providers (except for TOP Partnership Providers) are the responsibility of the TOP contractor and the contractor shall ensure that any adverse finding related to purchased care sector provider care is forwarded within five calendar days of identification to the appropriate TAO.

**2.3** The MM/UM Plan shall include a process for identifying high utilization/high cost patients and locations.

**2.3.1** At a minimum, this process shall include the identification of patients exceeding the frequency and/or cost thresholds established in the TOP contract. These thresholds apply to all TOP beneficiaries, including TOP Prime, TOP Prime Remote, TOP Standard, and TOP TRICARE For Life (TFL).

**2.3.2** The TOP contractor shall review these claims for appropriateness of care, and shall propose interventions to reduce overutilization or contain costs whenever possible. Proposed interventions to cost and/or overutilization shall be forwarded to the government for review prior to contractor implementation.

**2.4** The MM/UM Plan shall integrate efforts to identify potential fraud/abuse. Any cases identified as possible fraud/abuse shall be referred directly and exclusively to the Defense Health Agency (DHA) Program Integrity (PI) Office in accordance with Section 14.

**2.5** The TOP contractor shall provide case management services as outlined in the contract with DHA. Specific case management processes shall be addressed in the Statements of Responsibilities (SORs) between the contractor, Military Treatment Facility (MTF) commanders and the TAO Directors.

**2.6** The TOP contractor shall closely monitor requests for inpatient care or medical evacuation services to ensure that services are medically necessary and appropriate for the patient's condition. Beneficiaries will not be assigned to a particular facility or medically evacuated to a particular geographic location based solely on personal preference, but will be transported to the closest medical facility capable of providing appropriate stabilization and/or treatment.

**2.7** Inpatient stays that exceed the standard Length-Of-Stay (LOS) for a local area in a host nation country or U.S. commonwealth/territory shall be identified and reviewed for medical necessity. Unless a different standard has been identified by the government, the contractor shall use best business practices to determine the standard LOS for a particular overseas location. Upon Government request, the TOP contractor shall provide supporting documentation related to LOS determinations.

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### 3.0 CONTRACTOR RELATIONSHIP WITH THE MILITARY HEALTH SYSTEM (MHS) TRICARE QUALITY MONITORING CONTRACTOR (TQMC)

The provisions of [Chapter 7, Section 3](#) do not apply to the TOP.

### 4.0 CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP)

The provisions of [Chapter 7, Section 4](#) are applicable to the TOP, except that the requirement for interface with the TQMC is waived for the TOP. The TQMC does not conduct regular, ongoing reviews to validate the appropriateness of the TOP contractor's quality of care and utilization review decisions; however, the TQMC may provide such reviews on a limited basis upon government request.

### 5.0 REFERRAL/AUTHORIZATION/HEALTH CARE FINDER REQUIREMENTS

**5.1** The TOP contractor shall develop procedures for processing referrals for TOP Prime and TOP Prime Remote enrollees in accordance with the TOP contract; [Chapter 8, Section 5](#); and this chapter. The TOP contractor shall conduct related authorization and Health Care Finder (HCF) activities. The MTF is responsible for conducting medical necessity reviews for TOP MTF enrollees and for determining that the requested care is not available in the MTF prior to forwarding the referral to the contractor.

**5.1.1** The contractor shall conduct covered benefit reviews to determine whether the referred care is a covered TRICARE benefit. Medical necessity notification to beneficiaries regarding covered benefit findings shall follow the provisions of [Chapter 8, Section 5](#). The contractor shall locate an appropriate network or non-network **purchased care sector** provider for all authorized care and shall provide the provider information to the beneficiary. Upon beneficiary request, the contractor shall assist with scheduling an appointment for the beneficiary. The contractor shall also implement guarantee of payment or other business process to ensure that TOP Prime and TOP Prime Remote beneficiaries have access to authorized care on a cashless, claimless basis.

**Note:** Although a referral/authorization is never required for emergency care, TRICARE Prime/TRICARE Prime Remote (TPR) ADFMs who require emergency care (including emergency medical evacuation, if medically necessary and appropriate) while traveling outside the 50 United States and the District of Columbia will be provided with emergency care on a cashless, claimless basis upon notification to the TOP contractor before the services are rendered (see [Sections 7](#) and [9](#)).

**5.2** The TOP contractor shall develop procedures for the identification and tracking of TOP enrollee claims submitted by a provider or a beneficiary without preauthorization/authorization.

**5.3** The TOP contractor is required to educate beneficiaries of preauthorization/authorization requirements and of the procedures for requesting preauthorization/authorization. In MTF locations, these beneficiary education efforts may be conducted in conjunction with MTF staff. **In remote locations, the contractor is responsible for all beneficiary education.** Although beneficiaries are required to obtain authorization for care prior to receiving payment for the care requiring TOP preauthorization/authorization, retroactive authorization may be requested following the care from the appropriate authority for issuing authorizations. **Specifically, TOP enrollees who seek urgent care from a purchased care sector without obtaining authorization will be required to contact their PCM within three business days so that a retroactive referral can be submitted.**

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Retroactive authorization requests will not be accepted by the TOP contractor after this initial time frame without higher level approval (TAO or TOPO). The contractor shall document preauthorization/authorizations according to current contract requirements.

**5.4** If medical review is required to determine medical necessity of a service rendered, the TOP contractor shall follow the requirements outlined in [Chapter 7, Section 1](#) related to medical review staff qualifications and review processes.

**5.5** The TOP preauthorization/authorization must be submitted with the claim or be available via internal contractor systems designated to interface with the claims processing system.

**5.6** The TOP contractor must maintain a preauthorization/authorization file.

**5.7** When necessary, clarification of discrepancies between authorization data and data on the claims shall be made by the TOP contractor with the appropriate authorizing authority.

**5.8** Except for obstetrical care or other long-term/chronic care authorizations, the TOP contractor shall consider authorizations valid for 90 days (i.e., date of service must be within 90 days of issue date). Authorizations may be granted for 365 days for obstetrical care, or for any other long-term/chronic conditions for which an extended care period is medically necessary and appropriate. Only services that are applicable to the care authorization shall be covered under the authorization (i.e., a care authorization for obstetrical care cannot be extended to cover specialty care that is unrelated to the pregnancy).

**5.9** Procedures for preauthorizations/authorizations for TOP beneficiaries for inpatient mental health care rendered in the 50 United States or the District of Columbia shall be developed between the TOP contractor and the overseas TAO Directors. The TOP contractor is responsible for authorizing/reviewing all stateside non-emergency inpatient mental health care (i.e., Residential Treatment Center (RTC), Substance Use Disorder Rehabilitation Facility (SUDRF), etc.) and outpatient mental health care sessions nine and above per fiscal year for TOP Prime/TOP Prime Remote ADFMs, regardless of where the care is rendered. To perform this requirement, the contractor shall at a minimum provide three 24-hour telephone lines: one stateside toll free, one commercial and one fax for overseas inpatient mental health review requirement, sample forms for use by the referring physician when requesting preauthorization/authorization for care, and a system for notification of the contractor when care has been authorized. Additionally, the TOP contractor shall:

**5.9.1** Inform the beneficiary/provider if a desired facility is not a TRICARE authorized facility and offer the beneficiary/provider a choice of alternative facilities and assist with identifying stateside facilities for referring providers.

**5.9.2** Upon request, either telephonically or by fax, from a referring provider, the contractor will initiate preauthorization prior to admission for non-emergency inpatient care, including TRC, SUDRF, Partial Hospitalization Program (PHP), etc. (Essentially, all admissions defined by TPM, [Chapter 1, Section 7.1](#), as requiring preauthorization). The TOP contractor will arrange ongoing utilization review, as indicated, for overseas beneficiaries admitted to any level of inpatient mental health care.

**5.9.3** The review determination must conclude in either authorization or denial of care. Review results must be faxed to the beneficiary/provider within 24 hours of the request. The review and denial process will follow, as applicable the processes outlined in [Chapter 7](#).

**5.9.4** The TOP contractor will provide an opportunity to discuss the proposed initial denial determination with the patient's attending physician AND referring physician (if different providers). The purpose of this discussion is to allow further explanation of the nature of the beneficiary's need for health care support services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of inpatient care. This is important in those beneficiaries designated to return overseas, where supporting alternative level of care is limited, as well as support for intensive outpatient treatment. If the referring provider does not agree with the denial determination, then the contractor will contact the appropriate overseas TAO **Medical Director** to discuss the case. The TAO Director will provide the schedule and contact information for all overseas TAO mental health advisors. The final decision on whether or not to issue a denial will be made by the TOP contractor.

**5.9.5** The TOP contractor will notify the referring provider if the patient is returning to ensure coordination of appropriate after-care arrangements, as well as facilitate discussion with the attending provider to ensure continuity of care is considered with the proposed after-care treatment plan.

**5.9.6** The TOP contractor will adhere to the appeals process outlined in [Section 13](#).

**5.10** The required data elements for MTF referrals prescribed in [Chapter 8, Section 5, paragraph 6.1](#) may be altered to accommodate the delivery of health care overseas with the permission of the government.

**Note:** Any alteration to the referral data elements prescribed in [Chapter 8, Section 5, paragraph 6.1](#) must be approved in writing by the **DHA CO** prior to implementation.

## **6.0 MEDICAL TRAVEL**

### **6.1 TOP Prime Enrollees and MTR-Referred Transient Beneficiaries**

If the TOP contractor's Health Care Finder determines that appropriate medical care is not available in the beneficiary's local service area, the TOP contractor shall provide Notification Of Case (NOC) to the appropriate MTF per the medical travel requirements of the Contract Data Requirements List (CDRL). The NOC shall identify the nearest purchased care sector provider or facility that can provide adequate specialty care. The TOP contractor shall issue a care authorization upon MTF request (as documented in the MTF's response to the NOC).

### **6.2 TOP Prime Remote and Self-Referred Transient Beneficiaries**

If the TOP contractor's Health Care Finder determines that appropriate medical care is not available in the beneficiary's local service area, the TOP contractor shall provide NOC to the appropriate TAO per the medical travel requirements of the CDRL. The NOC shall identify the nearest purchased care sector provider or facility that can provide adequate specialty care. The TOP contractor shall issue a care authorization upon TAO request (as documented in the TAO's response to the NOC).

## **7.0 CASE MANAGEMENT**

The TOP contractor shall establish and operate a case management program to identify and manage the health care of individuals with high-cost conditions or with specific diseases or conditions for which evidence-based clinical management. This program shall be available to all TOP beneficiaries (both enrolled and non-enrolled) except TRICARE-Medicare dual eligible beneficiaries who receive care in the Commonwealth of Puerto Rico, Guam, American Samoa, the Northern Marianas, and the U.S. Virgin Islands. MTFs retain primary responsibility for case management for MTF enrollees; however, the contractor shall assist the MTF by identifying MTF enrollees who might benefit from case management, and by coordinating care for these individuals with the MTF clinical staff as well as the **purchased care sector** provider staff. The contractor shall submit a Case Management Program and patient selection criteria and shall provide annual updates in accordance with the provisions of the TOP contract.

## **8.0 MEDICAL MANAGEMENT FOR TOP PRIME INPATIENTS**

The contractor is responsible for assisting the MTFs with the medical management to TOP Prime enrollees who are hospitalized in a purchased care sector facility (regardless of location). Based on the contractor's role as a PRO, their knowledge of TRICARE benefit policy, and their expertise regarding purchased sector health care, the contractor will perform concurrent review/continued stay reviews for all TOP Prime enrollees during the entire inpatient episode of care. These reviews shall assess the patient's continued need for treatment and the appropriateness of current and proposed treatment (including, but not limited to an assessment of the appropriateness of care setting). Based on these reviews, if changes to the treatment plan (as proposed by the inpatient facility) are indicated, the contractor shall intervene with the treating facility to make the appropriate changes. The contractor shall interface with the MTF PCM through the duration of the inpatient stay and shall provide status updates, discharge summaries, and follow-up care recommendations to the MTF. Upon discharge from the inpatient facility and transfer of the discharge summary/follow-up care recommendations, the contractor shall relinquish all medical management responsibilities to the MTF PCM.

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## Ambulance/Aeromedical Evacuation Services

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### 1.0 GENERAL

All TRICARE requirements regarding ambulance/aeromedical evacuation services shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [32 CFR 199.4](#) and the TPM, [Chapter 8, Section 1.1](#) for additional instruction.

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** The TOP contractor shall arrange for medically necessary ambulance/aeromedical evacuation services for TRICARE Overseas Program (TOP) Prime/TOP Prime Remote enrollees, Active Duty Service Members (ADSMs) who are deployed, in a temporary duty status, or in an authorized leave status in an overseas location, and all Active Duty Family Members (ADFM)s who require ambulance/aeromedical evacuation services while traveling outside of the 50 United States and the District of Columbia.

**Note:** Claims jurisdiction for ambulance/aeromedical evacuations is based on the patient's location, regardless of the patient's enrollment status or the origination or destination location of the ambulance/aeromedical evacuation service provider.

**2.1.1** When arranging for ambulance/aeromedical evacuation for the beneficiaries identified in [paragraph 2.1](#), the contractor shall determine beneficiary eligibility and enrollment status, prepare quote(s) for commercial movement options, and obtain signature authority and direction on evacuation destination from the appropriate Patient Movement Requirement Center (PMRC). Upon PMRC approval, the contractor shall authorize the services, arrange for medical records to accompany the patient, and coordinate the transfer with the receiving institution or provider. The appropriate TRICARE Area Office (TAO) shall be notified of all patient movements.

**2.1.2** For ADSM emergency medical evacuations (including ADSMs who are on temporary duty, in an authorized leave status, or deployed/deployed on liberty), the TOP contractor shall ensure that the ADSM's unit is aware of the medical evacuation. The TRICARE Area Office (TAO) shall be contacted for assistance if the member's unit information cannot be determined by the contractor.

**2.1.3** Except for normal TRICARE cost-shares, these beneficiaries shall not be responsible for any up-front payments for emergency ambulance service (to include aeromedical evacuation, when medically necessary and appropriate). The contractor shall establish business processes (e.g., Guarantee of Payment to purchased care sector ambulance provider) to ensure that these beneficiaries are not subjected to up-front payments in excess of normal TRICARE cost-shares.

**Note:** "Medical necessity" is defined in [32 CFR 199.2](#).

**2.2** Upon request, the TOP contractor shall facilitate medically necessary ambulance/aeromedical evacuation services for all TRICARE-eligible beneficiaries not identified in [paragraph 2.1](#) (regardless of enrollment location or residence) according to the processes identified in the TOP contract. When facilitating ambulance/aeromedical evacuation for these beneficiaries, the contractor shall identify ambulance/aeromedical evacuation resources that service the patient's location; however, the contractor is not required to schedule the evacuation, coordinate with the receiving institution or provider, obtain medical records, or establish business processes (e.g., Guarantee of Payment) to limit up-front payments for these beneficiaries.

**2.3** Since medical evacuations may involve transfers between TRICARE regions, the TOP contractor shall establish processes for coordinating medical evacuations with the stateside Managed Care Support Contractors (MCSCs). The TOP contractor shall also work cooperatively with the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor to provide customer service support, and to facilitate the medically necessary evacuation of TRICARE dual-eligible beneficiaries back to the United States.

**2.4** The TOP contractor shall ensure that ambulance/aeromedical evacuation services can be accomplished in an expeditious manner that is appropriate and responsive to the beneficiary's medical condition. The contractor may establish a dedicated unit for responding to such requests, or may augment existing service units. Contractor staff must be available for ambulance/aeromedical evacuation assistance 24 hours per day, seven days per week, 365 days per year. Ambulance/aeromedical evacuation telephone assistance must be available without toll charges to the beneficiary, regardless of their location.

**2.5** The TOP contractor shall maximize the use of military medical transport services before considering other options. If military medical transport services are not available (or if services cannot be provided in a timely manner that is appropriate for the patient's medical condition) **and the appropriate Patient Movement Requirements Center (PMRC) has approved commercial movement**, the contractor shall attempt to arrange services through the most economical commercial resource that is capable of providing appropriate services within the required time frame. Private, chartered evacuation services will only be used as a last resort when all other options have been exhausted. The contractor shall document their rationale and selection process for any commercial and/or private, chartered evacuation services. If multiple resources are identified that are capable of providing the needed services, the contractor shall select the resource that represents the best value to the government. Upon request, the contractor shall provide Defense Health Agency (DHA) with documentation supporting their rationale and selection process.

**2.6** Upon transfer to a facility for stabilization and care, the TOP contractor shall coordinate with the appropriate MTF (for TOP Prime enrollees) or TAO (for TOP Prime Remote enrollees) to advise of the patient's transfer and to provide further assistance as appropriate.

**2.7** The TOP contractor shall comply with the provisions of TPM, [Chapter 8, Section 1.1](#), except that the TOP contractor shall utilize the coding requirements identified for ambulance charges but is not required to develop claims for diagnosis or transfer information for ambulance services received overseas. The TOP contractor shall utilize the diagnosis if provided, or may use available in-house methods such as claims history when processing the claim. If a diagnosis is not provided and

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there are no claim attachments or other claims for the Episode of Care (EOC) from which a diagnosis can be determined, the claim shall be processed using an unlisted diagnosis.

**2.8** Medical evacuation charges that are determined to be a TRICARE benefit may be bundled on one claim and coded appropriately as a medical evacuation charge. If this simplified billing approach is adopted, all related documentation (including, but not limited to original invoices, supporting documents, and Explanation of Benefits (EOB)) related to the evacuation must be made available to the Government upon request for further review.

**2.9** The Ambulance Fee Schedule (AFS) reimbursement methodology (TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 14](#)) applies only to ground ambulance services in Puerto Rico. The AFS does not apply to air ambulance transport (aeromedical evacuations) covered under the TOP for Puerto Rico. Air ambulance transport (aeromedical evacuations) covered under the TOP, including Puerto Rico shall be reimbursed as billed charges.

- END -



## Claims Processing Procedures

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### 1.0 GENERAL

**1.1** All TRICARE requirements regarding claims processing shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP Contract"). See [Chapter 8](#) for additional instructions.

**1.2** The provisions of [Chapter 8, Section 1, paragraph 1.0](#) are applicable to the TOP.

**1.3** The provisions of [Chapter 8, Section 1, paragraph 2.1](#) are applicable to the TOP. Additionally, a designated TOP Point of Contact (POC) may submit claims in accordance with [Section 12](#).

**1.4** The provisions of [Chapter 8, Section 1, paragraph 2.2](#) are not applicable to the TOP, except in U.S. territories where Medicaid is available.

**1.5** The provisions of [Chapter 8, Section 1, paragraph 2.3](#) are applicable the TOP; however, region or country-specific requirements regarding third party payments or payment addresses may be established by Defense Health Agency (DHA) at any time to prevent or reduce fraud.

**Note:** Benefit payment checks and Explanation Of Benefits (EOB) to Philippine providers (and other nation's providers as determined by the government) shall be mailed to the place of service identified on the claim. This policy applies even if the provider uses a Third Party Administrator (TPA). No provider payments may be sent to any other address. The government may discontinue TPA payments to other countries or specific agencies if it is determined that significant fraud is occurring on a regular basis.

**1.6** Acceptable claim forms are identified in [Chapter 8, Section 1, paragraph 3.1](#). Additionally the TOP contractor may accept any other claim form or alternative documentation as long as these methods provide sufficient data to facilitate claims processing and TRICARE Encounter Data (TED) submission.

**1.7** The provisions of [Chapter 8, Section 1, paragraph 4.0](#) are applicable to the TOP.

**1.8** The contractor's claims processing procedures shall integrate efforts to prevent and identify fraud/abuse.

### 2.0 JURISDICTION

**2.1** In the early stages of TOP claims review, the TOP contractor shall determine whether claims received are within its contractual jurisdiction using the criteria below. TOP jurisdiction for health

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care and remote Active Duty Service Member (ADSM) dental care is identified in the TOP contract with DHA.

**2.2** Services rendered onboard a commercial ship while outside U.S. territorial waters are the responsibility of the TOP contractor. Claims for services provided on a commercial ship that is outside the territorial waters of the United States (U.S.) are to be processed as foreign claims regardless of the provider's home address. If the provider is certified within the U.S., reimbursement for the claim is to be based on the provider's home address. If the provider is not certified within the U.S., reimbursement will follow the procedures for foreign claims. This does not include health care for enrolled ADSM on a **military** ship at sea or on a **military** ship at home port.

**2.3** The provisions of [Chapter 8, Section 2, paragraphs 1.0 and 2.0](#) are superseded as described in [paragraphs 2.3.1 through 2.3.9](#).

**2.3.1** When a beneficiary is enrolled in TOP Prime or TOP Prime Remote, the TOP contractor shall process all health care claims for the enrollee, regardless of where the enrollee receives services. The contractor shall also process dental care claims for remote overseas ADSMs per the provisions of [Section 10](#). Referral/authorization rules apply.

**2.3.2** Claims for Active Duty Family Members (ADFM) (including Reserve Component (RC) ADFMs whose sponsors have been activated for more than 30 days), retirees, and retiree family members whose care is normally provided under one of the three regional Managed Care Support Contracts (MCSCs) (i.e., beneficiaries enrolled or residing in the 50 United States and the District of Columbia) who receive Civilian Health Care (CHC) while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary resides or is enrolled. Referral/authorization and Point Of Service (POS) rules apply for TRICARE Prime/TRICARE Prime Remote (TPR) enrollees.

**Note:** This provision does not apply to beneficiaries who are enrolled in the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). Claims for these beneficiaries are processed by their respective contractor regardless of where the care is rendered.

**2.3.3** Claims for ADSMs residing in the 50 United States and the District of Columbia (including RC ADSMs activated for more than 30 days) who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in an overseas location shall be processed by the TOP contractor, regardless of where the ADSMs resides or is enrolled. Referral/authorization rules apply.

**2.3.4** Claims for TOP-enrolled ADSMs (including RC ADSMs activated for more than 30 days) on a **military** ship or with an overseas home port shall not be processed by the member's military unit. These claims shall be processed by the TOP contractor.

**2.3.5** Initial and follow-on Line Of Duty (LOD) claims for RC ADSMs on orders for 30 consecutive days or less, who are injured while traveling to or from annual training or while performing their annual training who receive civilian medical care overseas, shall have their claims processed by the TOP contractor **upon verification of LOD status**. MMSO will **validate LOD status for RC ADSMs** in the U.S. Virgin Islands.

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**2.3.6** The TOP contractor shall process claims for Durable Equipment (DE) and Durable Medical Equipment (DME) (otherwise coverable by TRICARE) that is purchased/ordered by TOP-eligible beneficiaries in an overseas area from a stateside provider (i.e., internet, etc.).

**2.3.7** For inpatient claims that are paid under the Diagnosis Related Group (DRG)-based payment system, the TOP contractor, on the date of admission, shall process and pay the entire DRG claim, including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short stay outlier cases, and for professional claims that are date-driven, the contractor shall process and pay the claims.

**2.3.8** When a beneficiary's enrollment changes from one TRICARE region to another during a hospital stay that will be paid under the DRG-based payment system, the contractor with jurisdiction on the date of admission shall process and pay the entire DRG claim, including cost outliers.

**2.3.9** For information on portability claims for relocating TOP Prime/TOP Prime Remote enrollees, refer to [Chapter 6, Section 2](#).

**2.4** The provisions of [Chapter 8, Section 2, paragraphs 6.0, 6.1, 6.2, and 6.3](#) are applicable to the TOP.

**2.5** The provisions of [Chapter 8, Section 2, paragraph 6.4](#) and [Chapter 19, Section 4](#) are applicable to the TOP for U.S. citizens who are practicing outside the U.S.

**2.6** The provisions of [Chapter 8, Section 2, paragraphs 6.5, 6.6, 6.7, 7.1, 7.2, 8.1, 8.2, and 8.3](#) are applicable to the TOP.

**2.7** Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4, paragraph 5.0](#) for jurisdictional guidance regarding health care claims for work-related illness or injury, which is covered under a Worker's Compensation Program.

**2.8** The provisions of [Chapter 8, Section 2, paragraph 5.0](#) are applicable to the TOP in those locations where the TRICARE Pharmacy (TPharm) contractor has established services (the U.S. territories of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands). The TOP contractor cannot process pharmacy claims from these locations except for pharmacy that is part of an emergency room visit or inpatient treatment. Any prescriptions from this care that are not provided at time of treatment for inpatient/emergency care, shall be required to be submitted through the TPharm contractor. Copays will apply.

**2.9** The TOP contractor shall forward all retail pharmacy claims to the TPharm contractor within 72 hours of identifying it as being out-of-jurisdiction. In all other overseas locations, the contractor shall process claims from host nation retail pharmacies and providers.

**2.10** Non-enrolled ADFMs (Standard), retirees or their family members residing overseas obtaining prescription from an overseas host nation pharmacy shall submit their claims to the TOP contractor. TRICARE Standard cost-share/**deductible** provisions will apply. **The provisions of TRICARE Reimbursement Manual (TRM), Chapter 2, Addendum B regarding the mandatory collection of pharmacy copayment amounts at the time of service are waived for foreign providers.**

### 3.0 CLAIMS FILING DEADLINE

The provisions of [Chapter 8, Section 3](#) are applicable to the TOP except that claims for services provided outside the 50 United States or the District of Columbia, the Commonwealth of Puerto Rico, or the possessions of the United States are considered to be filed in a timely manner if they are filed No Later Than (NLT) three years after the date the services were provided or three years from the date of discharge for an inpatient admission. The TOP contractor shall search their claims system and reprocess any such claims that denied for lack of timely filing, retroactive to December 30, 2008. The TOP contractor shall notify the Contracting Officer's Representative (COR) if they become aware of country-specific claims filing processes that are in conflict with this timely filing **deadline**. All other claims must be filed within one year according to the requirements listed in [Chapter 8, Section 3](#), unless an exception to the filing deadline has been granted. See [Chapter 1, Section 2, paragraph 5.0](#) for the timely filing waiver process.

### 4.0 SIGNATURE REQUIREMENTS

**4.1** The provisions of [Chapter 8, Section 4](#) are applicable to the TOP unless a different process has been directed by the DHA CO.

**4.2** The TOP contractor may, at its discretion, accept a thumbprint in lieu of a signature on a claim form, unless otherwise directed by the government.

**4.3** When directed by the DHA CO, the TOP contractor may not use signature on file and may not accept facsimile or thumbprint signatures on claims.

### 5.0 REFERRALS/PREAUTHORIZATIONS/AUTHORIZATIONS

The provisions of [Chapter 8, Section 5](#) are altered for the TOP by the requirements listed below.

#### 5.1 Referral/Preauthorization/Authorization Requirements for TOP Prime and TOP Prime Remote Enrollees

**5.1.1** Unless otherwise directed by the government, referrals/preauthorizations/authorizations are not required for emergency care, clinical preventive services, ancillary services, radiological diagnostics (excluding Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) scans), drugs, and services provided by a TOP Partnership Provider. Additionally, TOP Prime/TOP Prime Remote ADFMs may receive the first eight outpatient mental health sessions in a fiscal year without preauthorization. All other care that is provided to a TOP Prime/TOP Prime Remote-enrolled ADSM or ADFM by anyone other than their Primary Care Manager (PCM) requires authorization, regardless of where the care is rendered.

**5.1.2** Claims for ADSM care not authorized by the TOP contractor shall be pended for a review to make a determination regarding authorization. If the care is retroactively authorized **by the Government (including submission of an approved waiver for a non-covered service)**, then the contractor shall enter the authorization and process the claim for payment. If the contractor determines that the care was not authorized, the contractor shall deny the claim. Refer to [Section 26](#) for additional information.

**5.1.3** TOP ADSM claims for non-emergent care obtained in the 50 United States and the District of Columbia shall only be paid when accompanied by the appropriate payment authorization forms (SF 1034 or NAVMED 6320/10) or a referral with justification statement from the ADSM's Primary Care Manager (PCM).

**5.1.4** Claims for self-referred, non-emergency care for TOP Prime and TPR enrolled ADFMs shall process with POS deductibles and cost-shares **unless the appropriate TRICARE Area Office (TAO) or TRICARE Overseas Program Office (TOPO) has approved a retroactive authorization** (see [paragraph 5.4](#)).

## **5.2 Referral/Preauthorization/Authorization Requirements for all other TOP Beneficiaries**

**5.2.1** TRICARE-eligible beneficiaries residing in an overseas location who are not enrolled in TOP Prime/TOP Prime Remote typically do not need to obtain preauthorization/authorization for care. However, preauthorization reviews shall be performed for all care and procedures listed in [Chapter 7, Section 2](#).

**5.2.2** The TOP contractor may propose additional authorization reviews for non-enrolled TOP beneficiaries to the government.

## **5.3 Referral/Preauthorization/Authorization Requirements for Beneficiaries Who Reside in the 50 United States and the District of Columbia**

**5.3.1** TRICARE beneficiaries whose health care is normally provided under one of the three regional MCSCs who require care while traveling in an overseas location shall request any necessary preauthorizations/authorizations through the TOP contractor, regardless of where the beneficiary resides or is enrolled.

**Note:** This process does not apply to beneficiaries enrolled to the USFHP or the CHCBP.

**5.3.2** Effective for dates of service June 1, 2010, Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories must be preauthorized for Medicare/TRICARE dual eligible beneficiaries. The dual eligible contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer.

## **5.4 Point of Service (POS) Provisions**

**5.4.1** Unless specifically excluded by this section, all self-referred, non-emergency care provided to TOP Prime/TOP Prime Remote-enrolled ADFMs which is not either provided/referred by the beneficiary's PCM or specifically authorized shall be reimbursed under the POS option. This provision applies regardless of where the care is rendered. POS provisions also apply to the following stateside beneficiaries when traveling overseas: ADFMs, retirees, and retiree family members who are enrolled in TRICARE Prime, and ADFMs enrolled in TPR for ADFMs.

**5.4.2** POS cost-sharing only applies to TRICARE-covered services. Claims for services that are not a covered TRICARE benefit shall be denied.

**5.4.3** The TOP contractor shall adjust POS deductibles and cost-shares when TOP PCMs or Health Care Finders (HCFs) do not follow established referral/authorization procedures. For

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example, if the contractor processes a claim under the POS option because there was no evidence of a referral and/or an authorization, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the contractor shall adjust the claim and reverse the POS charges. The contractor need not identify past claims that may be eligible for POS adjustment; however, the contractor shall adjust these claims as they are brought to their attention.

**5.4.4** On a case-by-case basis, following stabilization of the patient, the TAO Director or MTF Commander may require an enrolled beneficiary to transfer to a TOP network facility or an MTF. The TAO Director or MTF Commander shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to a TOP network facility/MTF. If a beneficiary who is subject to TOP POS provisions elects to remain in the non-network facility after such notification, POS cost-sharing provisions will apply beginning 24 hours following the receipt of the written notice. Neither the TOP Director nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

**5.4.5** The following deductible and cost-sharing amounts apply to all TOP POS claims for health care support services:

- Enrollment year deductible for outpatient claims: \$300 per individual; \$600 per family. No deductible applies to inpatient services.
- Beneficiary cost-share for inpatient and outpatient claims: 50% of the allowable charge after the deductible has been met (deductible only applies to outpatient claims).
- POS deductible and cost-share amounts are not creditable to the enrollment/Fiscal Year (FY) catastrophic cap and they are not limited by the cap.
- POS deductible and cost-share amounts do not apply to claims for care received by newborns and newly adopted children who are deemed enrolled in TOP Prime or TOP Prime Remote.

**5.4.6** POS deductible and cost-share amounts do not apply if a TOP enrollee has Other Health Insurance (OHI) that provides primary coverage (i.e., the OHI must be primary under the provisions of the TRM, [Chapter 4, Section 1](#)). Evidence of OHI claims processing (including the exact amount paid on the claim) must be submitted with the TOP claim.

**5.4.7** EOB shall clearly indicate that a claim has been processed under the POS Option.

**5.4.8** POS is not applicable to ADSMs or to TOP non-enrollees.

**5.5** Extended Care Health Option (ECHO) benefits in overseas locations must be authorized by the **TOP contractor**. Refer to [Section 23](#) and the TPM, [Chapter 9](#) for additional guidance.

**5.6** Refer to [Section 10](#) for referral/preauthorization/authorization requirements for ADSM dental care in remote overseas locations.

## 6.0 CLAIM DEVELOPMENT

**6.1** Development of missing information shall be kept to a minimum. The TOP contractor shall use available in-house methods, contractor files, telephone, Defense Enrollment Eligibility Reporting System (DEERS), etc., to obtain incomplete or discrepant information. If this is unsuccessful, the contractor may return the claims to sender with a letter which indicates that the claims are being returned, the reason for return and requesting the required missing documentation. The contractor's system must identify the claim as returned, not denied. The government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits. The contractor shall review all claims to ensure TOP required information is provided prior to payment. For the Philippines, claims requiring development of missing or discrepant information, or those being developed for medical documentation, shall be pended for 90 days and are excluded from the claims processing standard.

**6.2** Claims may be filed by eligible TRICARE beneficiaries, TOP **purchased care sector** providers, TOP POCs, and TRICARE authorized providers in the 50 United States and the District of Columbia as allowed under TRICARE (see [Chapter 8, Section 1](#)). Providers may submit claims by fax if the TOP contractor provides a secure fax for claims receipt by the contractor.

**6.3** Confidentiality requirements for TOP are identical to TRICARE requirements outlined in [Chapter 8](#).

**6.4** As a guideline, all overseas claims shall be sent to the microcopy area, transferred to microcopy format, and returned to the contractor's claims processing unit No Later Than (NLT) the close of business the following working day of submission.

**6.5** The provisions of [Chapter 8, Section 9](#) are applicable to TOP.

**6.6** The following minimal information is required on each overseas claim prior to payment:

### 6.6.1 Signatures

Beneficiary and **purchased care sector** provider signatures (**signature on file is acceptable unless specifically prohibited by the Government**).

### 6.6.2 Name and Address

**6.6.2.1** Complete beneficiary and **purchased care sector** provider name and address.

**6.6.2.2** If an address is not available on the claim, obtain the address either from previously submitted claims, directly from the beneficiary/**purchased care sector** provider via phone, fax or e-mail, DEERS per [paragraph 6.11](#), or notify the TAO Director as appropriate.

**Note:** The TOP contractor shall accept APO/FPO for the beneficiary address.

### **6.6.3 Diagnosis(es)**

**6.6.3.1** A valid payable diagnosis. Prior to returning a claim that is missing a diagnosis, the TOP contractor shall research the patient's history and determine whether a diagnosis from a related claim can be applied.

**6.6.3.2** Claims received for dates of service for outpatient services or dates of discharge for inpatient services before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, with ICD-10 codes shall be converted to International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM) codes by the TOP contractor. Claims received for dates of service for outpatient services or dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation, with ICD-9 or ICD-9-CM codes shall be converted to ICD-10-CM codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraphs 4.0 and 5.0](#) regarding the use of ICD-9-CM **V** codes (factors influencing health status and contact with health services) and ICD-10-CM **Z** codes (factors influencing health status and contact with health services).

### **6.6.4 Procedures/Services/Supply/DME**

Identification of the procedure/service/supply/DME ordered, performed or prescribed, including the date ordered, performed or prescribed. The TOP contractor may use the date the claim form was signed as the specific date of service, if the service/purchase date/order date is not on the bill.

**6.6.5** Claims received with a narrative description of services provided shall be coded by the TOP contractor with as accurate-coding as possible based upon the level of detail provided in the narrative description or as directed by the DHA CO. The provisions of [paragraph 6.1](#) apply for narrative claims that cannot be accurately coded due to insufficient or vague information. Claims received for dates of service for outpatient services or dates of discharge for inpatient services before the mandated date, as directed by HHS, for ICD-10 implementation, with ICD-10 codes shall be converted to ICD-9 codes by the TOP contractor. Claims received for dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation, with ICD-9 codes shall be converted to ICD-10 codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraph 4.0](#) regarding the use of **V** and **Z** codes.

#### **6.6.5.1 Inpatient Institutional Procedures**

Inpatient institutional (i.e., hospital) claims received for claims received for dates of discharge for inpatient services before the mandated date, as directed by HHS, for ICD-10 implementation, shall have the procedure narratives coded by the TOP contractor using ICD-9-CM, Volume 3 procedure codes. Inpatient institutional (i.e., hospital) claims received for dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation, shall have the procedure narratives coded by the TOP contractor using ICD-10-Procedure Classification System (ICD-10-PCS) procedure codes.

#### **6.6.5.2 Outpatient Institutional Procedures and Professional Services**

Claims received for outpatient institutional (e.g., ambulance services, laboratory, Ambulatory Surgery Centers (ASCs), partial hospitalizations, outpatient hospital services) services

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and professional services shall be coded using Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT).

**6.6.6** Care authorizations (when required).

**6.6.7** Itemization of total charges. (Itemization of hospital room rates are not required on institutional claims).

**6.6.8** Proof of payment is required for all beneficiary submitted claims if the claim indicates that the beneficiary made payment to the provider or facility. **Acceptable documentation for demonstrating proof of payment includes, but is not limited to, canceled checks, bank or credit card statements, dated/itemized receipts from the provider/facility, etc. Due to cultural differences, there may be significant variation in provider processes for issuing receipts to the beneficiaries. Therefore,** the overseas claims processor shall use best business practices when determining if the documentation provided is acceptable for the country where the services were rendered.

**6.7** The TOP contractor shall return all claims for overseas pharmacy services submitted by high volume overseas providers without National Drug Code (NDC) coding (where required), unless the provider has been granted a waiver by the DHA CO as outlined below.

**6.8** Non-prescription (Over-The-Counter (OTC)) drugs are to be denied. This includes drugs that are considered OTC by U.S. standards, even when they require a prescription in a foreign country.

**6.9** The TOP contractor shall use a schedule of allowable charges based on the Average Wholesale Price (AWP) as a reference source for processing drug related TRICARE overseas claims.

**6.10** Claims for medications prescribed by a host-nation physician, and commonly used in the host-nation country, may be cost-shared **unless they are considered OTC by U.S. standards.**

**6.11** For the Philippines, prescription drugs may only be cost-shared when dispensed by a certified retail pharmacy or hospital-based pharmacy. The TOP contractor shall deny claims for prescription drugs dispensed by a physician's office. Certification requirements outlined in [Section 4, paragraph 4.7](#) apply.

**Note:** This does not apply to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

**6.12** Claims for DME involving lease/purchase shall always be developed for missing information.

**6.13** The TOP contractor shall use ECHO claims processing procedures outlined in TPM, [Chapter 9, Section 18.1](#), when processing ECHO overseas claims.

**6.14** The TOP contractor shall deny claims from non-certified or non-confirmed **purchased care sector** providers when the DHA CO has directed contractor certification/confirmation of the **purchased care sector** provider prior to payment.

**6.15** Requests for missing information shall be sent on the TOP contractor's TRICARE/TOP letterhead. When development is necessary in TRICARE Eurasia-Africa Region, the contractor shall include a special insert in German, Italian, Spanish, **Tagalog, Japanese, and Korean** which indicates

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what missing information is required to process the claim and includes the contractor's address for returning requested information.

**6.16** If the TOP contractor elects to develop for additional/missing information, and the request for additional information is not received/returned within 45 days, the contractor shall deny the claim.

**6.17** If the TOP contractor has no record of referral/authorization prior to denial/payment of the claim, the contractor will follow the TOP POS rules, if the service would otherwise be covered under TOP.

**6.18** The TOP contractor shall develop procedures for the identification and tracking of TOP enrollee claims submitted by either a **purchased care sector** designated or non-designated overseas **purchased care sector** provider without preauthorization/authorization. Upon receipt of a claim for a TOP-enrolled ADFM submitted by a **purchased care sector** designated or non-designated overseas **purchased care sector** provider without preauthorization/authorization, the contractor shall process the claims following POS payment procedures. For ADSM claims submitted by a **purchased care sector** provider without preauthorization/authorization, the contractor shall pend the claim for review prior to denying the claim.

**6.19** The TOP contractor must have an automated data system for eligibility, deductible and claims history data and must maintain on the automated data system all the necessary TOP data elements to ensure the ability to reproduce both TRICARE Encounter Data (TED) and EOB as outlined in [Chapter 8, Section 8](#), except for requiring overseas providers to use Health Care Procedure Coding System (HCPCS) to bill outpatient rehabilitation services, issue **provider** the Form 1099 and suppression of checks/drafts for less than \$1.00. The contractor is allowed to split claims to accommodate multiple invoice numbers in order to reference invoice numbers on EOB when necessary. Refer to [Chapter 8, Section 6](#) for additional requirements related to claims splitting.

**6.20** The TOP contractor shall not pay for pharmacy services obtained through the internet.

**6.21** The TOP contractor shall pay all TOP ADSM stateside claims as outlined in [Section 26](#).

**6.22** All claims must be submitted in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. Refer to [Section 28](#) for more information on HIPAA requirements.

**6.23** Electronic claims not accepted by the TOP contractor's Electronic Data Information (EDI) system/program shall be rejected.

**6.24** For all overseas claims, the TOP contractor shall create and submit TEDs following current guidelines in the TSM for TED development and submission. Claim information will be able to be accessed through the TRICARE Patient Encounter Processing and Reporting (PEPR) Purchased Care Detail Information System (PCDIS).

**6.25** The TOP contractor shall establish Utilization Management (UM) high dollar/frequency thresholds in accordance with [Section 6](#).

**6.26** Claims either denied as "beneficiary not eligible" or "found to be not eligible on DEERS" may be processed as a "good faith payment" when received from the DHA Beneficiary Education and

Support Division (BE&SD). The TAO Director shall work with the TOP contractor on claims issues related to good faith payment documentation (e.g., a completed claim form and other documentation as required by [Chapter 10, Sections 3 and 4](#)).

**6.27** The provisions of [Chapter 8, Section 6, paragraph 11.0](#) shall apply to the TOP.

**6.28** The Claims Auditing Software requirements outlined in the TRM, [Chapter 1, Section 3](#) do not apply to TOP claims; however, the TOP contractor shall implement an internal process for identifying upcoding, unbundling, etc. on coded claims.

## **7.0 APPLICATION OF DEDUCTIBLE AND COST-SHARING**

Application of TOP deductible and cost-sharing procedures shall follow the guidelines outlined in [Chapter 8, Section 7](#).

## **8.0 EOB VOUCHERS**

**8.1** The TOP contractor shall follow the EOB voucher requirements in [Chapter 8, Section 8](#), where applicable, with the following exceptions and additional requirements:

**8.1.1** The letterhead on all TOP EOB shall also reflect "TRICARE Overseas Program" and shall be annotated Prime or Standard.

**8.1.2** TOP EOB may be issued on regular stock, shall provide a message indicating the exchange rate used to determine payment and shall clearly indicate that "This is not a bill".

**8.1.3** TOP EOB shall include the toll-free number for beneficiary and provider assistance.

**8.1.4** TOP EOB for overseas enrolled ADSM claims shall be annotated "ACTIVE DUTY."

**8.1.5** For Point of Sale or Vendor pharmacy overseas claims, TOP EOB must have the name of the provider of service on the claim.

**8.1.6** For beneficiary submitted pharmacy claims, TOP EOB shall contain the name of the provider of service, if the information is available. If the information is not available, the EOB shall contain "your pharmacy" as the provider of service.

**8.1.7** The TOP contractor shall insert the provider's payment invoice numbers in the patient's account field on all provider EOBs, if available.

**8.1.8** The following EOB message shall be used on overseas claims rendered by non-network **purchased care sector** providers who are required to be certified, but have not been certified by the TOP contractor - "Your provider has not submitted documentation required to validate his/her training and/or licensure for designation as an authorized TRICARE provider".

**8.1.9** When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

**8.1.10** The TOP contractor may utilize secure electronic EOB delivery to beneficiaries unless mail/courier delivery has been requested by the beneficiary.

## **9.0 DUPLICATE PAYMENT PREVENTION.**

**9.1** The TOP contractor shall follow the duplicate payment prevention requirements outlined in [Chapter 8, Section 9](#).

**9.2** The TOP contractor shall ensure that business processes are established which require appropriate system and/or supervisory controls to prevent erroneous manual overrides when reviewing potential duplicate payments.

## **10.0 DOUBLE COVERAGE**

**10.1** TOP claims require double coverage review as outlined in the TRM, [Chapter 4](#).

**10.2** Beneficiary/provider disagreements regarding the contractor's determination shall be coordinated through the overseas TAO Director for resolution with the contractor.

**10.3** Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI. National Health Insurance (NHI) plans do not always provide EOBs to assist in the adjudication of TRICARE claims. If a beneficiary has attempted unsuccessfully to obtain an EOB from their NHI plan, they may submit a beneficiary attestation and an itemized claim checklist (approved by DHA) with their claim. The TOP contractor shall waive the requirement for an EOB from the NHI plan when accompanied by the DHA-approved document.

**Note:** If the Japanese insurance points are not clearly indicated on the claim/bill, the TOP contractor shall contact the submitter or the appropriate TOP POC for assistance in determining the Japanese insurance points prior to processing the claim.

## **11.0 THIRD PARTY LIABILITY (TPL)**

The TOP contractor shall reimburse TOP claims suspected of TPL and then develop for TPL information. Upon receipt of the information, the contractor shall refer claims/documentation to the appropriate Judge Advocate General (JAG) office, as outlined in the [Chapter 10](#).

## **12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS**

When processing TOP claims, the TOP contractor shall follow the reimbursement payment guidelines outlined in the TRM, [Chapter 1, Section 34](#) and the cost-sharing and deductible policies outlined in the TRM, [Chapter 2, Section 1](#), and shall:

**12.1** Reimburse claims for host nation services/charges for care rendered to TOP eligible beneficiaries which is generally considered host nation practice and incidental to covered services, but which would not typically be covered under TRICARE. An example of such services may be, charges from host nation ambulance companies for driving host nation physicians to accidents or private residences, or the manner in which services are rendered and considered the standard of care in a host nation country, such as rehabilitation services received in an inpatient setting.

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**12.2** Reimburse claims at the lesser of the billed amount, the negotiated reimbursement rate, or the CHAMPUS Maximum Allowable Charge (CMAC) or the government established fee schedules (TRM, Chapter 1, Sections 34 and 35), unless a different reimbursement rate has been established as described in TPM, Chapter 12, Section 1.3.

**Note:** Government established fee schedules (per TRM, Chapter 1, Sections 34 and 35) are only applicable to retirees or their eligible family members or Standard ADFMs.

**12.3** Not reimburse for host nation care/services specifically excluded under TRICARE.

**12.4** Not reimburse for host nation care/services provided in the Philippines unless all of the certification requirements listed in Section 14 have been met.

**12.5** Not reimburse for administrative charges billed separately on claims, except for individual administrative charges as determined by the government. The contractor shall reimburse these charges only in instances when the fee is billed concurrently with the corresponding health care services. If a bill is received for these charges without a corresponding health care service, the charges should be denied.

**12.6** Determine exchange rates as follow:

**12.6.1** Use the exchange rate in effect on the ending date that services were received unless evidence of OHI and then the TOP contractor shall use the exchange rate of the primary insurer, not the rate based on the last date of service to determine the TOP payment amount, and/or;

**12.6.2** Use the ending dates of the last service to determine exchange rates for multiple services.

**12.6.3** Use the exchange rate in paragraph 12.6.1 to determine deductible and copayment amounts, if applicable, and to determine the amount to be paid in foreign currency.

**12.6.4** Overseas drafts/checks and EOBs. Upon completion of processing, checks (payable in U.S. dollars) shall be created by the TOP contractor within 48 hours, after Contract Resource Management (CRM) approval. Drafts (payable in foreign currency units) shall be created by the TOP contractor within 96 hours following CRM approval, unless a different process has been authorized by DHA. Payments that need to be converted to a foreign currency shall be calculated based on the exchange rate in effect on the last date of service listed on the EOB. Drafts/checks shall be matched with the appropriate EOB, and mailed to the beneficiary/sponsor/purchased care sector provider/ POC as applicable.

**Note:** Drafts for certain foreign currency units may require purchase from a bank location other than the one normally used by the TOP contractor (out of state or out of country). Currency units that must be purchased from an alternate bank (out of state or out of country) may take up to 10 business days for the draft to be returned and matched up with the EOB.

**12.7** The TOP contractor shall convert lump sum payments instead of line items to minimize conversion problems.

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**12.8** Provider claims for all overseas locations (excluding claims from Korean providers) will be paid by foreign currency/drafts. Drafts may not be changed to a U.S. dollar check after the contractor has issued a foreign draft. Claims from Korean providers will be paid in U.S. dollars.

**12.9** Foreign overseas drafts (in local currency) are good for 190 days and may be cashed at any time, unless a different process has been established by DHA. U.S. dollar checks are good for 120 days unless a different process has been established by DHA. The provisions of [Chapter 3, Section 4](#) regarding staledated, voided, or returned checks/Electronic Funds Transfers (EFTs) are applicable to the TOP.

**12.10** TOP claims submitted by a beneficiary shall be paid in U.S. dollars, unless there is a beneficiary request on the claim at the time of submission for payment in a foreign currency. The TOP contractor may reissue the payment in U.S. dollars if a request is subsequently received from the beneficiary and the foreign draft is included in the request or the payment has staledated, or if directed by the appropriate DHA COR.

**12.11** Payment to Germany, Belgium, Finland, France, Greece, Ireland, Italy, Luxemburg, Netherlands, Austria, Portugal, Spain, Cyprus, and Malta shall be made in Euros. As other countries transition to Euro, the TOP contractor shall also switch to Euros.

**12.12** The contractor shall issue drafts/checks for German claims which look like German drafts/checks.

**Note:** In order for TRICARE drafts/checks to look like German drafts/checks, a German address must be used. The TOP contractor may use a corporate address in Germany or the TAO Eurasia-Africa address for this purpose.

**12.13** U.S. licensed Partnership providers claims for treating patients shall be paid based upon signed agreements. Refer to [Section 29](#) for additional information related to the Partnership Program.

**12.14** The contractor shall pay all beneficiary-submitted claims for TRICARE covered drugs dispensed by a U.S. embassy health clinic to the beneficiary. The contractor is not to make payments directly to the embassy health clinic.

**12.15** Professional services rendered by a U.S. embassy health clinic are not covered by TRICARE/TOP. These services are covered under International Cooperative Administrative Support Services (ICASS) agreements. Embassy providers (acting as PCMs) may refer TOP enrollees to purchased care sector providers, these claims shall be processed per TOP policy and procedures.

**12.16** Claims for drugs or diagnostic/ancillary services purchased overseas shall be reimbursed by the TOP contractor following applicable deductible/cost-share policies.

**12.17** In emergency situations, the requirement for Medicare certification for facilities in U.S. commonwealths and territories may be waived. After a review of the facts, the contractor may cost-share otherwise covered services or supplies rendered in an emergency situation by an unauthorized provider to the beneficiary, or on behalf of the beneficiary, to the beneficiary's appointed payee, guardian, or parent in accordance with TPM, [Chapter 11, Section 4.2](#) and TRM, [Chapter 1, Section 29](#).

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**12.18** The contractor shall mail the drafts/checks and EOB to **purchased care sector** providers unless the claim indicates payment should be made to the beneficiary. In conformity with banking requirements, the drafts/checks shall contain the contractor's address. Drafts and EOBs shall be mailed using U.S. postage. Additionally, payments/checks may be made to network providers, with an Embassy address.

**12.19** Benefit payment checks and EOBs to Philippine providers, and other nations' providers as directed by the DHA CO, shall be mailed to the place of service identified on the claim. No provider checks or EOBs for Philippine providers, and other nations' providers as directed by the DHA CO may be sent to any other address.

**12.20** Inpatient and outpatient claims for TRICARE overseas eligible beneficiaries, including ADSM claims, are to be processed/paid as indicated below:

**12.20.1** The TPharm contractor shall allow TOP ADSM to use the TPharm retail pharmacy network under the same contract requirements as other Military Health System (MHS) eligible beneficiaries (see TPM, [Chapter 8, Section 9.1](#)).

**12.20.2** The TPharm contractor shall allow TOP enrolled ADFM beneficiaries to use their stateside retail pharmacy network under the same contract requirements as other MHS eligibles (see TPM, [Chapter 8, Section 9.1](#)).

**12.20.3** The TOP contractor shall process claims for overseas health care received by TRICARE beneficiaries enrolled to or residing in a stateside MCSC's region following the guidelines outlined in this chapter. Payment shall be made from applicable bank accounts and shall be based on billed charges unless a lower reimbursement rate has been established by the government or the contractor.

**12.21** EFT payments. Upon **purchased care sector** provider request, the TRICARE Overseas health care support contractor shall provide EFT payment to a U.S. or overseas bank on a weekly basis. Bank charges incurred by the provider for EFT payment shall be the responsibility of the provider. Upon beneficiary request, EFT payments to a U.S. bank may be provided. Bank charges associated with beneficiary EFT payments shall be the responsibility of the beneficiary.

**12.22** The TOP contractor shall process **90%** of all retained and adjustment TOP claims to completion within **30** calendar days from the date of receipt. Claims pending per government direction are excluded from this standard. However, the number of excluded claims must be reported on the Overseas Weekly/Monthly Workload/Cycletime Aging report. 100% of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days from the date of receipt, unless the CO specifically directs the contractor to continue pending a claim or group of claims.

**12.23** Correspondence pending due to stop payment orders, check tracers on foreign banks and conversion on currency. This correspondence is excluded from the routine 45 calendar day correspondence standard and the priority 10 calendar day correspondence standard. However, the number of excluded routine and priority correspondence must be reported on the Overseas Monthly Workload/Cycletime Aging report.

**12.24** The TOP contractor is authorized to pay Value Added Tax (VAT) included on German health care claims for all beneficiary categories.

**12.25** Fees for transplant donor searches in Germany may be reimbursed on a global flat fee basis since the German government does not permit health care facilities to itemize such charges.

**12.26** Itemized fees for supplies that are related or incidental to inpatient treatment (e.g., hospital gowns) may be reimbursed if similar supplies would be covered under reimbursement methodologies used within the U.S. The TOP contractor shall implement internal management controls to ensure that payments are reasonable and customary for the location.

### **13.0 CLAIMS ADJUSTMENT AND RECOUPMENT**

**13.1** The TOP contractor shall follow the adjustment requirements in [Chapter 10](#) except for the requirements related to financially underwritten funds.

**13.2** The TOP contractor shall follow the recoupment requirements in [Chapter 10](#) for non-financially underwritten funds, except for providers. The contractor shall use the following procedures for **purchased care sector** provider recoupments. Recoupment actions shall be conducted in a manner that is considered culturally appropriate for the **purchased care sector** provider's country. The contractor shall:

**13.2.1** Send an initial demand letter.

**13.2.2** Send a second demand letter at 90 days.

**13.2.3** Send a final demand letter at 120 days.

**13.2.4** Refer the case to DHA at 240 days, if the case is over \$600.00, and if under \$600.00 the case shall remain open for an additional four months and then shall be written off at 360 days.

**13.3** Recoupment letters (i.e., the initial letter, the 90 day second request and the 120 day final demand letter) shall be modified to delete references to U.S. law. Invoice numbers shall be provided on all recoupment letters. The TOP contractor shall include language in the recoupment letter requesting that refunds be returned/provided in the exact amount requested.

**13.4** Provider recoupment letters sent to Germany, Italy, Spain, **Japan, and Korea** shall be written in the respective language.

**13.5** The TOP contractor may hand write the dollar amount and the **purchased care sector** provider's name and address, on all recoupment letters.

**13.6** If the recoupment action is the result of an inappropriately processed claim by the TOP contractor, recoupment is the responsibility of the contractor, not the beneficiary/provider.

**13.7** The TOP contractor shall have a TOP bank account capable of receiving/accepting wire transfers for **purchased care sector** provider recoupment/overpayment returns. The TOP contractor shall accept the amount received as payment against the amount owed. Any fees associated with the wire transfer will be the responsibility of the payer/provider.

**14.0 DUPLICATE PAYMENT PREVENTION**

The provisions of [Chapter 8, Section 9](#) are applicable to the TOP.

- END -



## Active Duty Dental Care In Remote Overseas Locations

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### 1.0 GENERAL

All TRICARE requirements regarding active duty dental care shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract").

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** The TOP contractor shall arrange and provide access to dental care on a cashless, claimless basis to TOP Prime Remote enrolled Active Duty Service Members (ADSMs), except for ADSMs located in U.S. territories (including Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands). This includes routine, urgent, and emergent dental care services, including dental transportation/evacuation when medically necessary and appropriate. The contractor shall also arrange and provide access to urgent and emergent dental care services (including dental transportation/evacuation when medically necessary and appropriate) to non-enrolled ADSMs who require urgent or emergent dental care services while on Temporary Additional Duty /Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in a remote overseas location.

**Note:** "Cashless, claimless" refers to an encounter with a provider who collects only normal TRICARE copayments at the time of service and agrees to file the claim for the beneficiary.

**2.2** The TOP contractor shall establish a network of host nation dental providers who have been evaluated and determined to meet international hygiene and clinical practice standards. Upon beneficiary request, the contractor will also provide information to any TRICARE beneficiary regarding dental network providers; however, the contractor is not required to establish dental networks to support Active Duty Family Members (ADFM)s, retirees, or retiree family members **in any overseas location**.

**2.3** The TOP contractor's Call Center(s) shall provide assistance regarding ADSM dental care 24 hours per day, seven days per week, 365 days per year.

**2.4** ADSMs in remote overseas locations shall contact the TOP contractor's Call Center to schedule routine care under \$750. Treatment plans that exceed \$750 per episode or \$1,500 per calendar year require prior authorization and approval from the **Defense Health Agency (DHA) Dental Program Office** even if the dental visits are considered "routine care". The contractor shall assist ADSMs in submitting treatment plans for TAO review.

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### Chapter 24, Section 10

#### Active Duty Dental Care In Remote Overseas Locations

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**2.5** The TOP contractor shall ensure that the following documentation is provided to the TAO for all pre-authorization reviews: radiographs and diagnosis, treatment plan, estimated time required for care, probable cost, and projected length of tour of duty at the patient's present duty station.

**2.6** All ADSM orthodontic service requests shall be forwarded to the **DHA Dental Program Office** for review and authorization, regardless of treatment cost.

**2.7** ADSMs who seek dental service without coordinating their care through the TOP contractor may be required to pay up-front at the time services are rendered. The ADSM shall be responsible for submitting claims for reimbursement. Dental care claims that lack proper authorization (where required) shall be denied. The **DHA Dental Program Office** may provide a retroactive authorization for dental care services when appropriate.

**2.8** Prior authorizations are not required for emergency dental care services. However, ADSMs shall be encouraged to contact the contractor's Call Center for assistance with obtaining emergency dental care whenever possible. This shall ensure that services can be provided on a cashless, claimless basis for covered services from a qualified dental provider.

**2.9** Dental claims may be submitted by TOP Points of Contact (POCs) on behalf of remote ADSMs in accordance with [Section 12](#).

**2.10** Reserve component members who are on orders for less than 30 days may not appear eligible in DEERS. Claims submitted for these beneficiaries must be accompanied by proof of eligibility in order to adjudicate the claim.

**2.11** Claims will be accepted without Current Dental Terminology (CDT) procedure codes and will be manually coded by the TOP contractor based on narratives provided.

**2.12** Host nation dental providers will not be required to indicate dental readiness classification on the claim form.

**2.13** Payment for remote overseas active duty dental care shall be at billed charges, unless a different process has been identified by the government.

**2.14** Normal TRICARE foreign currency rules apply.

**2.15** Upon beneficiary request, the TOP contractor shall assist the ADSM in locating an appropriate dental provider and making dental appointments.

**2.16** The government will provide the TOP contractor with a Dental Overseas Benefit Brochure/ Handout explaining local requirements. This material shall be incorporated into all applicable beneficiary education briefings and mailings.

**2.17** At the discretion of the TOP contractor, dental emergencies that cannot be adequately addressed through the contractor's dental network may be treated as medical cases and shall interface with the medical management program (e.g., if an ADSM resides in a remote area where there are no dental providers, they may be referred to a host nation medical provider for pain management pending travel to an area with a qualified dentist).

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**2.18** The TOP contractor shall prepare and submit a quarterly report for TOP ADSM dental care per [Section 15](#).

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## Beneficiary Education And Support Division (BE&SD)

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### 1.0 GENERAL

**1.1** All TRICARE requirements regarding BE&SD shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 11](#) for additional instructions.

**1.2** Per Department of Defense Instruction (DoDI 6010.21 ("TRICARE Marketing Policy") dated December 18, 2001, TRICARE marketing materials developed by contractors must be coordinated with appropriate Regional Director (RD) and approved by [Defense Health Agency \(DHA\)](#). For the TOP contract, this coordination includes the TRICARE Area Office (TAO) Directors [and the TRICARE Overseas Program Office \(TOPO\)](#). Coordination of local administrative changes is at the local discretion of Military Treatment Facilities (MTFs).

### 2.0 TRICARE SERVICE CENTERS (TSCs)

#### 2.1 Location, Operations, And Staffing

**2.1.1** TSCs are jointly staffed by MTF personnel and TOP contractor personnel. TSCs in the MTFs shall be staffed at a minimum, Monday - Friday (except holidays recognized by the installation) during the administrative hours of the MTF.

**2.1.2** [The TOP contractor shall provide Beneficiary Service Representatives \(BSRs\) on a full-time basis at each location as designated in the contract. BSRs shall be qualified to perform enrollments/disenrollments/Primary Care Manager \(PCM\) changes; perform registrations in Composite Health Care System \(CHCS\) \(as required to support TRICARE enrollments\) and update patient information in CHCS and DEERS; resolve PCM Information Transfer \(PIT\) discrepancies; assist beneficiaries with TRICARE benefit/coverage or claims questions; assist beneficiaries with debt collection issues; and provide TRICARE briefings as requested by the MTF. The TOP contractor shall provide sufficient BSR staffing to accomplish all work in a timely manner; however, at least one full-time BSR will be assigned to each location regardless of actual workload unless the Government has specifically authorized part-time coverage. The TOP contractor shall advise the Government of any locations where the workload does not justify full-time BSR coverage. The TOP contractor shall implement appropriate business processes to provide full-time TSC coverage if the assigned BSR\(s\) are unavailable due to planned or unplanned absences \(e.g., illness, leave, personal emergencies, etc.\) for more than two consecutive business days. Local processes for managing short-term BSR absences \(up to two consecutive business days\) shall be addressed in the \[Statement of Responsibilities \\(SOR\\)\]\(#\) between the affected MTF commander\(s\) and the TOP contractor.](#)

**2.1.3** The TSC shall meet the standards in [Chapter 1, Section 3](#), as applicable.

## 2.2 TSC Functions

**2.2.1** The contractor shall **provide overseas TSCs with Beneficiary Service Representative (BSR) support** to provide all Military Health System (MHS) beneficiaries with information and services as specified below. The contractor shall ensure eligibility for care and enrollment status of beneficiaries before making any arrangements for medical services. (Eligibility for the non-active duty patients is determined by the MTF per [Section 26, paragraph 2.4.4.](#)) TSCs shall have an interface with the automated claims processing and enrollment systems to support the functions of the TSC No Later Than (NLT) 30 calendar days prior to the start of the health care delivery.

**2.2.2** The contractor shall provide all MHS beneficiaries with **information regarding** TOP Prime and TOP Prime Remote enrollment information, access to and referral for care, information on the Point of Service (POS) option, information (including on-line access to the claims processing system for information about the status of a claim), assist beneficiaries with claim problems when the TOP contractor is responsible for processing the claim and continuity-of-care services to all MHS beneficiaries including, but not limited to, active duty personnel, dependents of active duty personnel, retirees and their dependents, survivors, Medicare-eligible beneficiaries and all other categories of individuals eligible to receive MHS services. TSCs shall have a fully operational, on-line interface with the automated claims processing and enrollment systems to support the functions of the TSC NLT 30 calendar days prior to the start of the health care delivery and shall maintain that interface through the life of the contract. The activities of the TSC shall include:

### 2.2.2.1 MHS Beneficiary Information

**The TOP contractor** shall provide personal assistance to all MHS beneficiaries seeking information about TRICARE Prime, TRICARE Standard, and TRICARE For Life (TFL). The TOP contractor shall ensure that the TSCs are supplied with enrollment and educational information for TRICARE Prime and TRICARE Standard, dual-eligible program and claims submission information, Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA), TRICARE dental programs and all other relevant materials. Through the **BSRs and Call Centers**, the TOP contractor shall establish mechanisms to advise beneficiaries of care options, including the POS option, and services offered.

### 2.2.2.2 BSR Interface With MTFs

**BSRs** shall act as the focal point for providing information, referral, and assistance to beneficiaries seeking **claims assistance or** access to TRICARE services. **BSRs** shall maintain day-to-day liaison with MTF **staff** to promote MTF optimization and ensure effective performance of the access, referral, information, and continuity of care functions.

### 2.2.2.3 Enrollment

**BSRs and contractor Call Center** staff shall provide personal assistance to eligible beneficiaries, electing to enroll or disenroll, and permanently assigned active duty personnel enrolling in TRICARE Prime. The **TOP contractor** shall provide assistance to all MHS beneficiaries, including active duty, Medicare eligibles, and others, in understanding program requirements, by answering questions, adhering to MTF Commanders' and **TAO Director's** determinations for Primary Care Manager (PCM) assignment, and following grievance and inquiry procedures in accordance with this manual.

#### 2.2.2.4 Providers

The TOP contractor shall maintain an up-to-date online provider search tool for all providers and facilities in the contractor's network in accordance with Chapter 11, Section 4. A copy of the most current list will be maintained by each BSR for TSC use. MTF commanders, TAO and TOPO staff, and MHS beneficiaries shall be granted access to these lists on an as-needed basis. Contractor staff shall provide lists of Direct Care (DC) PCMs to MHS beneficiaries when required for PCM selection, if these lists are provided to the contractor by the MTF.

#### 2.2.2.5 Claims

Contractor staff in the TSCs shall assist all TRICARE beneficiaries with all claims issues when the TOP contractor is responsible for processing the claim. When the TOP contractor is not responsible for processing the claim, the contractor staff in the TSC shall assist the beneficiary in identifying and contacting the organization that is responsible for processing the claim.

#### 2.2.2.6 TRICARE Dental Plans

Contractor staff in the TSCs shall provide general information on eligibility for the TRICARE Dental Plans (Active Duty Dental Program (ADDP), TRICARE Dental Program (TDP), and TRICARE Retired Dental Program (TRDP)) and how to obtain dental plan information from the appropriate dental contractor. The beneficiaries shall be referred to the appropriate dental contractor for additional information.

### 2.3 Creating And Updating Department of Defense (DoD) Self-Service Logon (DS Logon) Accounts

DoD affiliates and Department of Veterans Affairs (DVA) affiliates qualify for a DS Logon account. A DS Logon is a secure, self-service logon ID that allows DoD/DVA affiliates to access certain web sites using a single username and password. DoD/DVA affiliates are DoD sponsors, spouses (regardless of age), and dependents (18 and older), and retirees and veterans who have an active affiliation in the Defense Enrollment Eligibility Reporting System (DEERS), which includes Reserve Component (RC) sponsors (including all subcomponents such as the Selected Reserve, Retired Reserve, Individual Ready Reserve (IRR), and Standby Reserve) along with their spouses, and dependents (18 and older). The DoD Self-Service Access Station (DS Access Station) is an online web application developed by the Defense Manpower Data Center (DMDC) for the purpose of creating DS Logon account requests on behalf of DoD/DVA affiliates. When a beneficiary inquiry concerns the DS Logon, the contractor shall refer the caller to the DoD MyAccessCenter application help section at <https://myaccess.dmdc.osd.mil/>.

#### 2.3.1 DS Access Station

Upon request by DoD/DVA affiliates, TSC personnel shall use the DS Access Station and perform In-Person Proofing (IPP) to generate requests for DMDC to create and update DS Logon accounts following instructions specified in the current version of the DS Logon - Access Station User Guide. DS Access Station is currently available at <https://www.dmdc.osd.mil/appj/dsaccessstation/>. The contractor shall request DS Access Station user authorization for TSC personnel from DMDC through the contractor's DEERS site security manager. A copy of the current DS Logon - Access Station User Guide will be provided upon request.

## **2.3.2 DS Logon Account Levels**

Two account levels of DS Logon access are available to DoD/DVA affiliates, each with progressing security features and each with a different user-authentication procedure:

### **2.3.2.1 Basic Account (Level 1)**

This is an entry level user account established online that only provides limited view access to the user's personal information that the user has provided online. This level of account is provided to individuals who have registered online at the eBenefits web site (<http://www.ebenefits.va.gov>) without being in-person proofed. Many applications will not allow access with a Basic (Level 1) Account.

### **2.3.2.2 Premium Account (Level 2)**

This account is given to a DoD/DVA affiliate who has self-registered using their Common Access Card (CAC) or Defense Financing and Accounting Service (DFAS)/myPay Login ID or who has completed an IPP process with designated representatives such as TSC personnel. To provide enhanced security to the user's personal information, access to most applications including TRICARE-related applications require a Premium (Level 2) Account.

## **2.3.3 Generating DS Logon Requests**

**2.3.3.1** Before generating a request for a Premium Account, TSC personnel shall determine if the requestor has an existing Basic Account. If they do, TSC personnel shall follow DS Logon user guide instructions to generate a request to upgrade the Basic Account to a Premium Account. Upon successful completion of an upgrade, the Premium Account is immediately available for use.

**2.3.3.2** If a Premium Account is created outright rather than being upgraded from a Basic Account, the Premium Account will not be effective and available for use until the requestor receives a letter in postal mail from DMDC and follows the instructions in the letter before the specified deadline to activate the Premium Account. If the requestor does not have an existing Basic Account, TSC personnel shall inform the requestor of the advantages of establishing a Basic Account and provide the requestor with the procedures for obtaining a Basic Account. If the requestor does not wish to create a Basic Account first, TSC personnel shall proceed with the procedures for a new DS Logon request.

## **2.3.4 DS Access Station Users and Confidentiality**

Only users authorized by the DMDC may access the DS Access Station and perform IPP. Furthermore, only authorized DS Access Station users may view any documents presented for IPP or be informed in any way of information available in the DS Access Station. Every authorized user must safeguard the confidentiality of such information at all times to comply with the Privacy Act of 1974. The contractor shall return all documents presented for IPP to the requester and shall not retain any documents. The contractor shall not make photocopies or any other images of documents presented for IPP.

### 3.0 HEALTH CARE FINDER (HCF) SERVICES

**3.1** TOP HCF functions are performed by TOP contractor personnel located in the TSCs or in contractor-operated call center(s). The TOP contractor shall offer call center operations to support HCF services via toll-free lines 24 hours per day, seven days per week, 365 days per year.

**Note:** The contractor must also offer claims assistance via toll-free lines seven days per week, 365 days per year, between the hours of 2:00 AM and 7:00 PM Central Standard Time (CST). These service hours for claims assistance apply even if claims assistance is provided via the contractor's call center(s).

**3.1.1** HCFs are responsible for facilitating access to **purchased care sector** provider care (including, but not limited to primary care, specialty care, mental health care, ancillary services, Durable Medical Equipment (DME), and pharmacy services), and for authorizing certain health care services. Additionally, HCFs shall inform beneficiaries of access mechanisms, referral procedures, and rules regarding use of network/non-network providers. They shall also improve patient continuity of care by establishing mechanisms to facilitate necessary consultations, follow-up appointments and the sharing of medical records. TOP HCFs will serve all MHS beneficiaries in the region, regardless of their enrollment status. This includes dual-eligible beneficiaries and beneficiaries residing or enrolled in the 50 United States and the District of Columbia who may require assistance when accessing care in an overseas location.

**3.1.2** For MTF enrollees, the specialty care referral process includes a covered benefit review; entering appropriate authorizations into the contractor's system; locating a qualified network or non-network host nation provider to provide the care on a cashless, claimless basis; providing the beneficiary with a written care authorization and the host nation provider's information; and assisting the beneficiary with establishing an appointment with the host nation provider (upon beneficiary request). The contractor shall also provide information to MTF personnel regarding the status of specialty care referrals and shall work cooperatively with the MTF to assist in obtaining consult results from host nation providers; however, the contractor is not responsible for tracking receipt of consult results.

**3.1.3** For TOP Prime Remote enrollees, the specialty care referral process includes a medical necessity review; a covered benefit review; entering appropriate authorizations into the contractor's system; locating a qualified network or non-network **purchased care sector** provider to provide the care on a cashless, claimless basis; providing the beneficiary with a written care authorization and the **purchased care sector** provider's information; and assisting the beneficiary with establishing an appointment with the **purchased care sector** provider (upon beneficiary request). This process is also applicable to Active Duty Service Members (ADSMs) who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), in an authorized leave status, or deployed/ deployed on liberty in a remote overseas location, and to TRICARE Prime/TRICARE Prime Remote (TPR) enrollees who require urgent specialty care while traveling outside the 50 United States and the District of Columbia.

**Note:** This process applies to all TOP Prime Remote enrollees, regardless of the status/location of the referring provider or health unit.

**3.1.4** Beneficiaries enrolled to the Uniformed Services Family Health Plan (USFHP) and the Continued Health Care Benefit Program (CHCBP) must follow the requirements of those programs when obtaining overseas care.

**3.2** The TOP HCF is responsible for the following functions:

**3.2.1 Referral Assistance for TOP Beneficiaries**

The TOP contractor (working in concert with the MTF Commander) is required to ensure optimal use of MTFs and to foster coordination of all care delivered in the civilian sector and care referred to and from the MTF. The TOP HCF is the primary mechanism for achieving these objectives. The referral services of the TOP HCF are primarily to ensure access to care for enrolled beneficiaries, but the TOP HCF is also available to assist non-enrollees in finding network/non-network **purchased care sector** providers. For TOP Prime/TOP Prime Remote enrollees, the referral is generally initiated by the beneficiary's PCM. The PCM or beneficiary contacts the TOP HCF for assistance in locating an appropriate **purchased care sector** provider and to obtain authorization for the care (see [Sections 17](#) and [18](#) for additional information on HCF referral assistance).

**3.2.2 Referral Assistance for Beneficiaries Enrolled or Residing in the 50 United States and the District of Columbia**

The TOP contractor shall provide referral assistance for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. These referrals will generally be initiated by the beneficiary, a **purchased care sector** provider, or an overseas MTF provider. Emergency care never requires preauthorization; however, ADFMs enrolled to TRICARE Prime/TPR may receive urgent and emergency health care services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation per [Section 7](#)) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor. The TOP contractor shall implement guarantee of payment or other business processes to ensure that ADFMs enrolled to TRICARE Prime/TPR may receive urgent or emergency medical services on a cashless, claimless basis upon beneficiary request.

**Note:** Routine care will not be authorized for traveling TRICARE Prime/TPR enrollees overseas.

**3.2.3 Authorizations**

**3.2.3.1** The TOP HCF will authorize care for TPR enrollees; for ADSMs who are on TAD/TDY, in an authorized leave status, or deployed, deployed on liberty in a remote overseas location, and for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. The contractor shall also ensure that MTF-issued authorizations are entered into all applicable contractor systems. Non-emergent specialty health care received from a **purchased care sector** provider must be authorized if benefits are to be paid as TOP Prime/TPR.

**3.2.3.2** Care subject to a PCM referral/authorization/Non-Availability Statement (NAS) may receive a clinical review and authorization by the HCF or other designee.

**3.2.4** If an ADFM TOP Prime/TOP Prime Remote enrollee receives care that was not authorized, the care may be covered under the TOP POS option, with POS deductibles and cost-shares. POS

provisions also apply to TRICARE Prime/TPR enrollees who receive non-emergency care outside the 50 United States and the District of Columbia without obtaining prior authorization from the TOP contractor. The care must also be otherwise coverable under TRICARE or the claim shall be denied.

**3.2.5** ADSM care that was not referred and authorized **will** be denied unless it is retroactively authorized by the appropriate service **and Director, DHA. This includes obtaining an approved waiver for any non-covered service.** POS does not apply to ADSMs.

#### **4.0 CUSTOMER SERVICE RESPONSIBILITIES**

TOP customer support shall be provided to **TOPO** and TAO staffs, TOP **purchased care sector** providers, TOP beneficiaries, designated POCs, TOP MTF staffs including Health Benefit Advisors (HBAs)/Beneficiary Counseling and Assistance Coordinators (BCACs)/Debt Collection Assistance Officers (DCAOs), stateside TRICARE Regional Offices (TROs), stateside Managed Care Support Contractors (MCSCs), stateside TRICARE beneficiaries traveling overseas, and **DHA**. TOP contractor customer support service shall include the following:

**4.1** The TOP contractor shall secure at a minimum one dedicated post office box for the receipt of all claims and correspondence from foreign locations per overseas region.

**4.2** The TOP contractor shall identify a specific individual and an alternate to assist the **TOPO**, TAO Directors, **DHA**, BCACs and stateside claims processing contractors with the resolution of TOP issues. Issues which cannot be successfully resolved shall be referred to the TOP Contracting Officer's Representative (COR).

**4.3** The TOP contractor shall identify a specific individual and an alternate to assist DCAOs with the resolution of TOP beneficiary debt collection issues.

**4.4** The TOP contractor shall be responsible for establishing and operating a dedicated TRICARE overseas claims/correspondence processing department with a dedicated staff. This department and staff shall be under the direction of a supervisor, who shall function as the contractor's POC for TRICARE overseas claims and related operational and support services. The contractor's department for TRICARE overseas claims shall include at a minimum the following functions/requirements:

**4.4.1** The TOP contractor shall provide toll-free telephone service for claims assistance to TOP beneficiaries and providers seven days a week, 365 days a year, between the hours of 2:00 AM and 7:00 PM CST. Toll-free services must be available from any stateside or overseas location.

**4.4.2** The TOP contractor shall have the ability to translate claims submitted in a foreign language and write in German, Italian, Japanese, Korean, Tagalog (Filipino) and Spanish, or shall have the ability to obtain such translation or writing.

**4.4.3** The TOP contractor shall provide on-line read only access to their claims processing system to the **TOPO**, each TOP TAO Director, and the **DHA** technical representative for TOP claims.

**4.4.4** The TOP contractor shall provide a secure, user-friendly internet portal for receipt of customer claims status inquiries and access to claims status information (to include the ability to view and print Explanation of Benefits (EOBs)).

**4.4.5** The TOP contractor is required to provide, upon **Government** request, documentation of claims for auditing purposes.

**4.5** The TOP contractor is required to assist traveling TOP beneficiaries to ensure beneficiary access/receipt of urgent or emergent care in the 50 United States and the District of Columbia. The contractor shall also assist beneficiaries residing or enrolled in the United States or the District of Columbia who require urgent or emergent care while traveling overseas. ADFMs who are enrolled to TRICARE Prime or TPR may receive emergency medical services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor.

**4.6** The contractor shall refer beneficiary, provider, HBAs, and congressional inquiries not related to claims status to **DHA** Chief, BE&SD.

## **5.0 BENEFICIARY SERVICES**

**5.1** The TOP contractor shall achieve the highest level of beneficiary satisfaction possible in the overseas environment. This shall be accomplished by developing qualified **purchased care sector** provider networks (complemented by non-network **purchased care sector** providers as necessary), ensuring timely access to host nation care, providing TOP information/education/training to beneficiaries and **purchased care sector** providers, and processing claims in a timely, accurate manner.

**5.2** In addition to the beneficiary education requirements outlined in **Chapter 11, Sections 1 and 2**, the TOP contractor may be required to conduct beneficiary education/enrollment activities for arriving/deploying units in accordance with the enrollment protocols established in the **SORs** between the TOP contractor and the MTFs.

**5.3** The TOP contractor shall maintain up-to-date lists of **purchased care sector** network providers, and shall make this information available at all TOP TSCs and via web-based access. Web-based network provider listings shall include information regarding authorization requirements that are applicable to TOP enrollees.

**5.4** The TOP contractor's beneficiary education **activities and materials shall include information for** TOP beneficiaries regarding care received in the 50 United States and the District of Columbia. At a minimum, this process shall include information regarding referrals/authorizations while stateside, TOP POS policy, and the recommended process for accessing care while stateside. TOP beneficiaries traveling stateside shall be encouraged to utilize MTF care whenever possible. If MTF care is not available, beneficiaries should be encouraged to seek care from a network provider before obtaining care from a non-network provider.

**5.5** The requirement for a quarterly three-day TRICARE training course, as outlined in **Chapter 11, Section 2, paragraph 1.1**, is superseded for the TOP contractor by a requirement for a total of nine three-day TRICARE training courses per contract option period (two per option period within the TRICARE Eurasia-Africa area; two within the TRICARE Pacific area; two within the TRICARE Latin America/Canada (TLAC) area; and three additional courses that may occur in any stateside or overseas location at the direction of the Contracting Officer (CO)).

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**Note:** Only the frequency requirements of [Chapter 11, Section 2, paragraph 1.1](#) are superseded; all other requirements of the referenced paragraph apply to the TOP contractor.

**5.6** The requirement for mailing TRICARE handbooks, as outlined in [Chapter 11, Section 1, paragraph 4.1](#), is superseded for the TOP contractor by a requirement for “on-demand” processes for distributing TRICARE handbooks upon beneficiary request (including, at a minimum, web-based requests, telephone requests, and on-site requests at a TSC).

#### **6.0 PROVIDER SERVICES**

**6.1** The TOP contractor shall ensure that all **purchased care sector** network providers and their support staff have sufficient understanding of the applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner that promotes beneficiary satisfaction.

**6.2** The TOP contractor shall have the responsibility for developing and delivering TRICARE Program information to **purchased care sector** providers. The contractor shall determine the requirements for printed products and will develop and deliver these products after obtaining approval from the government. The information in these products will generally be determined by the contractor based on their understanding of the needs of their network providers; however, the government may mandate the inclusion of certain topics or information.

**6.3** Provider education materials shall include information regarding claims processing procedures, claims submission deadlines, and normal claims processing time lines.

**6.4** The government shall ensure provider satisfaction with contractor-provided information by conducting random satisfaction surveys of select network providers.

#### **7.0 GRIEVANCES AND GRIEVANCE PROCESSING**

The TOP contractor shall process all grievances related to contractor personnel or contractor actions. The contractor shall also process all grievances related to network or non-network **purchased care sector** providers or institutions, with a copy provided to the **DHA** COR and the appropriate TAO.

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## TRICARE Overseas Program (TOP) Point Of Contact (POC) Program

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### 1.0 GENERAL

The TRICARE Overseas Program (TOP) Point of Contact (POC) Program is a liaison service that assists remote site beneficiaries by facilitating timely TRICARE claims filing and payment. As needed, the TOP POC Program shall assist with coordinating the return travel for Active Duty Service Members (ADSMs) and TRICARE Prime enrolled Active Duty Family Members (ADFMs) after a medical evacuation. The TOP POC program was established in 1991 and continues to be successful because of the ongoing oversight and support by the Uniformed Services Branches.

### 2.0 POC DESIGNATION

**2.1** Designated TOP POCs are established by the Uniformed Services, the Defense Intelligence Agency (DIA), the Defense Security Assistance Agency (DSAA), or other organizations as established by the government, with final approval by the TRICARE Area Office (TAO) Directors.

**2.2** Requests for POC designation shall be submitted in writing by the Commanding Officer of a military organizational unit or location, Defense Attache Offices (DAOs), and Security Assistant Organizations (SAOs) to the appropriate TAO Director. Requests for POC designation should include the POC's name, anticipated date of transfer/reassignment from the unit or location 24-hour commercial fax number, 24-hour commercial phone number, e-mail address, and a valid and secure mailing address for pouch mail. The request should indicate whether the individual is being designated as the primary POC or alternate POC (if any), along with the names of other POCs in the organization. The request should also indicate whether the POC will be replacing a previously designated POC who is scheduled for reassignment or transfer. POC designation is generally limited to one primary POC and one or two alternate POCs per organization. If more than two alternate POCs are desired, the organization must submit additional justification with the request.

**2.3** Upon receipt of a written request for POC designation, the TAO Director will review the nomination for approval. After approval has been granted, the TAO Director will notify the TOP contractor of the POC designation. This notification must be in writing and may be sent electronically or faxed to the contractor, with a copy to the POC's organization, the **Defense Health Agency (DHA)** Contracting Officer Representative (COR), and the **DHA** technical expert for overseas claims.

**2.4** POC designations are not Uniformed Service-specific, nor is designation limited to a specific beneficiary category (e.g., ADSM) or a specific TRICARE benefit category (e.g., medical, pharmacy, maternity, etc.).

**2.5** POC organizations are responsible for providing updated POC information to TAO Directors and the TOP contractor as needed. Information updates for designated primary/alternate POCs must be provided in a timely manner to avoid possible delays in claims processing. Updates to POC's commercial fax/phone numbers, e-mail address, and mailing address shall be e-mailed directly to the appropriate TAO Director as soon as the change occurs.

**2.6** Primary and alternate POCs are responsible for notifying the appropriate TAO Director in writing of any pending reassignments or transfers. This written notification should indicate the POC's projected date of departure, the names of any remaining POCs in the organization, and whether a new POC will be designated as a replacement. If a new POC will be designated, the POC's organization should request designation as outlined in [paragraph 2.2](#).

### **3.0 GOVERNMENT RESPONSIBILITIES**

**3.1** POCs shall assist TRICARE beneficiaries (including ADSMs) with the timely completion and filing of TOP claim forms. POCs shall secure and safeguard Protected Health Information (PHI), Personally Identifiable Information, and Sensitive Information for TRICARE beneficiaries in accordance with Department of Defense (DoD) 5400.11-R, "Department of Defense Privacy Program", May 14, 2007 and DoD Instruction 8500.2, "Information Assurance Implementation", February 6, 2003.

**3.2** Under no circumstance will a POC sign as a claimant for any beneficiary's claim other than the POC's personal claim.

**3.3** As needed, the POCs shall assist ADSMs and Prime enrolled ADFMs with coordinating their return travel after a medical evacuation and hospital discharge with the ADSM or ADFM service representative. This shall include making the necessary phone calls and sending e-mails to assist with the return travel. The POCs will assist to the extent possible using the existing personnel. The Services' commands are still responsible for arranging and funding the return travel.

**3.4** Each TAO office shall develop and distribute a region-specific POC Program booklet outlining specific POC duties and responsibilities. Each TAO office shall also develop and implement region-specific POC training. POC booklets and training materials shall include instructions regarding the security requirements identified in [paragraph 3.1](#) and other relevant security instructions. POCs shall use the current version of their region's POC booklet (and any additional training materials and sessions) as a guide in the performance of their POC duties.

**3.5** Questions regarding specific POC duties and responsibilities shall be addressed to the appropriate TAO office for resolution.

### **4.0 TOP CONTRACTOR RESPONSIBILITIES**

The TOP contractor shall:

**4.1** Maintain a current listing of POCs, in coordination with the TAO offices.

**4.2** Assist **DHA** staff, TAO staff, POCs, Uniformed Services, TRICARE beneficiaries, and **purchased care sector** providers with information on the completion and filing of TRICARE claims.

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**4.3** Provide a dedicated P.O. Box, dedicated fax number, and dedicated e-mail address for the receipt of TOP claims and correspondence from all designated POCs. The fax number must be able to receive data 24 hours a day, seven days a week.

**4.4** Develop procedures for the coordination, control, tracking, and processing of health care claims that are submitted by POCs in accordance with established standards for the protection of health information. This includes, but is not limited to, microcopying/imaging of claims upon receipt, storage/maintenance of the claim and all related correspondence, verification of beneficiary eligibility for TRICARE benefits, development of claims for missing information, processing of claims, and issuance of foreign drafts/U.S. dollar checks/Explanation of Benefits (EOB).

**4.5** Contact the appropriate POC (via phone, fax or e-mail) when additional information is needed to process a claim submitted by that POC. The TOP contractor shall pend the claim for 14 calendar days following POC notification. If the requested information is not received by the contractor by the Close Of Business (COB) on the 14th calendar day following POC notification, the contractor shall deny the claim.

**4.6** Accept only faxed claims/inquiries/information faxed by an officially designated primary or alternate POC. Electronic mail may also be used for TOP inquiries/information, subject to all applicable privacy rules.

**4.7** Report POC inquiries (including fax, e-mail, and letters) as routine correspondence as outlined in [Chapter 1, Section 3](#).

**4.8** Pay all beneficiary-submitted claims for TRICARE covered drugs dispensed by a U.S. embassy health clinic to the beneficiary. The contractor shall not make payments directly to an embassy health clinic.

**4.9** Professional services rendered by a U.S. embassy health clinic are not covered by TRICARE/TOP. Those services are covered under International Cooperative Administrative Support Services (ICASS) agreements. Embassy providers (acting as Primary Care Managers (PCMs)) may refer TOP enrollees to **purchased care sector** providers; these claims shall be processed per TOP policy and procedures.

**4.10** Use priority pouch mail to mail foreign drafts/U.S. dollar checks/EOBs for claims submitted via POCs. Priority pouch mail must be sent to the appropriate POC's location, unless a single point of dispersal for all payments has been established for that country. In those locations where a single point of dispersal has been established for all payments for that country, the TOP contractor shall batch payments/EOBs by country and mail the payments/EOBs in pouches to the designated point of dispersal at least once every five working days. Payments and EOBs that are placed in pouch mail shall be placed in sealed separate envelopes by individual beneficiary/**purchased care sector** provider for POC distribution. Pouch mail shall normally be sent via overnight mail delivery; however, if overnight mail service is not available or is not timely in a foreign location, the contractor shall use the most expeditious means available.

**4.11** Report unresolved claims problems or issues between the POC and the contractor to the TAO Director and the **DHA** COR.

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**Note 1:** Under no circumstance will any payment be made payable to a POC other than the POC's personal claim. POCs are not authorized to sign as a claimant for any beneficiary's claim other than the POC's personal claim.

**Note 2:** POCs also assist TRICARE Dental Program (TDP) beneficiaries with the submission of dental claims. POC responsibilities for TDP claims are described in the POC Program booklet. The TOP contractor is not responsible for processing dental claims, except for adjunctive dental services as identified in the TRICARE Policy Manual (TPM), [Chapter 8, Section 13.1](#) and remote ADSM claims in accordance with [Section 10](#). POC-submitted TDP claims that are misdirected to the TOP contractor shall be returned to the appropriate POC.

**4.12** Follow the inquiry process outlined in this section for POC requests for claims status update and for POC requests for changes to mail, fax numbers, etc.

**4.13** Upon receipt of a POC inquiry and once the inquiry is completed, fax the response back to the person identified as the POC. The TOP contractor shall follow the faxed POC inquiry with a phone call, if necessary.

- END -

## Program Integrity

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### 1.0 GENERAL

All TRICARE requirements regarding program integrity shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 13](#) for additional instructions.

**1.1** In addition to the requirements outlined in [Chapter 13](#), the Government may implement additional requirements as necessary to prevent or detect fraud in overseas locations.

**Note:** TRICARE guidance regarding anti-fraud programs at Military Treatment Facilities (MTFs) is contained in Department of Defense Instruction (DoDI) 5505.12 (October 19, 2006). This instruction is located at: <http://www.dtic.mil/whs/directives/corres/pdf/550512p.pdf>.

**1.2** The TRICARE Area Office (TAO) Directors shall report possible fraudulent or abuse practices by a TOP beneficiary/[purchased care sector](#) provider to the TOP contractor, the appropriate [Defense Health Agency \(DHA\)](#) Contracting Officer's Representative (COR), and the [DHA](#), Chief, Program Integrity Branch, including requests for the contractor to flag or watch providers suspected of fraud and abuse.

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** The TOP contractor is required to notify the [DHA](#) Program Integrity Office (PI) in writing of any new or ongoing fraud and abuse issues.

**2.2** In cases involving check fraud, the TOP contractor is not required to reissue checks until the investigation is finalized, fraud has been determined, and the contractor has received the money back from the investigating bank.

**2.3** Upon direction from [DHA](#), the contractor shall discontinue payments to Third Party Administrators (TPAs) in countries or specific agencies where significant fraud is occurring on a regular basis.

- END -



## Audits, Inspections, Reports, And Plans

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### 1.0 GENERAL

All TRICARE requirements regarding audits, inspections, reports, and plans shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 14](#) for additional instructions.

### 2.0 AUDITS AND INSPECTIONS

**2.1** The TOP contractor shall comply with the provisions of [Chapter 14, Section 1](#) regarding audits and inspections.

**2.2** The TRICARE Overseas Currency reports, and the claims supporting them, are subject to audit by [Defense Health Agency \(DHA\)](#) or other authorized Government auditors as part of any financial audit.

**2.3** The claims auditing software requirements outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 3](#) do not apply to TOP claims.

### 3.0 REPORTS AND PLANS

**3.1** All TOP reports and plans shall be submitted to [DHA](#) in accordance with the process identified in [Chapter 14, Section 2](#), unless a different method of submission is identified in the Contract Data Requirement Lists (CDRLs), DD Forms 1423, incorporated into the contract.

**3.2** Reports must be sortable by all fields and by TOP Region/TRICARE Area Office (TAO) unless a different format is specified by the government.

**3.3** All reports and plans shall be titled as listed in the TOP contract CDRLs.

**3.4** All reports and plans shall contain the contact information for contractor personnel who were involved in preparation of the report/plan, and who can be contacted if questions arise.

**3.5** All reports and plans shall contain a legend for abbreviations or other terms used in the report.

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**3.6** All TRICARE requirements regarding Health Insurance Portability and Accountability Act of 1996 (HIPAA) and privacy of Individually Identifiable Health Information (IIHI) shall apply to TOP reports and plans.

- END -

## TRICARE Area Office (TAO) Director/Military Treatment Facility (MTF) And Contractor Interfaces

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### 1.0 GENERAL

All TRICARE requirements regarding government/contractor interfaces shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 15](#) for additional instructions.

### 2.0 GOVERNMENT/CONTRACTOR RESPONSIBILITIES

**2.1** The Memorandum of Understanding (MOU) requirements outlined in [Chapter 15, Section 1](#) are **superseded for the TOP by a requirement for annual Statements of Responsibilities (SORs)**. The TOP contractor shall enter into a **SOR** with each TRICARE Area Office (TAO) Director to address region-specific issues and procedures, and with each Military Treatment Facility (MTF) commander to address local issues and procedures. MTFs with oversight/control of subordinate military clinics (a parent/child Defense Medical Information System (DMIS) relationship) shall be addressed in a single **SOR** between the parent MTF and the contractor. The model **SOR in Section J of the TOP contract** may be used as a guide for the development of TOP **SORs**, or any other MOU format may be adopted as long as all required components are addressed and the format is mutually acceptable to the Government and the TOP contractor.

**2.2** **SORs should be reviewed and approved annually; however, minor updates (e.g., telephone number changes) should be annotated as changes occur.** Beginning with Option Period 2, **SORs** may be re-executed by the development of a cover sheet which identifies any changes in processes/staff since the previous **SOR** was signed. This cover sheet (with appropriate signatures) along with any updated/revised attachments, will be accepted as a properly re-executed **SOR** when submitted with the original **SOR**. **Re-executed MOUs must be completed (and approved) no later than 30 calendar days prior to the start of each new option period.**

**2.3** **SORs** shall identify MTF hours/days of operation, to include any holiday or training days, and other unique issues regarding MTF operation (e.g., inclement weather procedures). The MTFs shall ensure that the **SOR** is updated as **such** changes occur.

**2.4** **SORs** shall include a process for ongoing, regular communication between TAOs, MTFs, and the contractor regarding anticipated changes that may affect health care delivery for TOP beneficiaries (e.g., deployments, increase/decrease in MTF capacity and capabilities, change in troop strength/number of command sponsored family member billets, etc.).

**2.5** The provisions of [Chapter 15, Sections 2 and 3](#) are not applicable to the TOP.

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**2.6** The TOP contractor shall immediately notify the TAO Directors and TRICARE Overseas Program Office (TOPO) of any changes to telephone and/or fax numbers for contractor facilities or key personnel.

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## TRICARE Overseas Program (TOP) Prime Program

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### 1.0 GENERAL

**1.1** TRICARE Overseas Program (TOP) Prime is available to Active Duty Service Members (ADSMs) (including Reserve Component (RC) members activated for more than 30 days) who are on permanent assignment overseas in a location serviced by a Military Treatment Facility (MTF), Command-Sponsored Active Duty Family Members (ADFM), accompanying the sponsor or on service orders, and certain transitional survivors and Transitional Assistance Management Program (TAMP)-eligible beneficiaries according to the eligibility and enrollment provisions of [Section 5](#). TOP Prime offers enrollees access to a Primary Care Manager (PCM), clinical preventative services, and specialty services.

**Note:** Command Sponsorship is defined in the Joint Federal Travel Regulations (JFTR), Volume I, Appendix A at <https://www.defensetravel.dod.mil/Docs/perdiem/JTR.pdf>.

**1.2** TOP Prime has no enrollment fees, and deductibles and cost-shares are waived except for TOP Prime ADFMs who receive care under the Point of Service (POC) option, or who obtain pharmacy services in the 50 United States, the District of Columbia, or United States (U.S.) territories where the TRICARE Pharmacy (TPharm) contractor has established a retail pharmacy network. Waiver of copayment and deductibles under TOP Prime is subject to review/updating based on enrollment status.

**1.3** Under TOP Prime, annual catastrophic caps are calculated on fiscal years. The enrollment year shall coincide with the fiscal year. Since deductibles and cost-shares are waived for TOP Prime enrollees, this policy will apply only to TOP Prime enrollees who incur out-of-pocket expenses as described above.

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** TOP Prime enrollees shall select or have assigned to them PCMs according to guidelines established by the MTF Commander, TRICARE Area Office (TAO) Director, or designee. TOP Prime enrollment to a **purchased care sector** PCM may only occur when all available capacity in the MTF has been reached. The TOP PCM:

**2.1.1** May be an individual professional provider (not a Partnership Provider) in an overseas MTF, other military treatment site, or other health care delivery arrangement that is part of the MTF. MTF PCMs may be organized into teams for the purpose of ensuring patient continuity and accountability in the event that the individual's assigned PCM is absent or unavailable.

**2.1.2** May be a **purchased care sector** primary care provider (internist, family practitioner, pediatrician, general practitioner, obstetrician/gynecologist, physician assistant, nurse practitioner, or certified nurse midwife) when determined by the TOP contractor to meet governing country

rules and licensure requirements. See [Section 14](#) for additional provider certification requirements in the Philippines.

**2.1.3** May also act as a Health Care Finder (HCF), when dual responsibility is necessary, as determined by the MTF commander or TAO Director.

**2.2** A TOP Prime enrollee must seek all his or her primary health care from the TOP PCM with the exception of care listed in [Section 8](#). If the TOP PCM is unable to provide the care, the TOP PCM is responsible for referring the enrollee to another primary care provider.

**2.3** TOP Prime enrollees must obtain appropriate referral/authorization for any non-emergency care rendered by anyone other than the beneficiary's PCM or another MTF provider. This provision applies regardless of where the care is rendered. **MTFs may submit requests for retroactive authorizations up to three business days after the care was rendered. After three business days, the TAO Directors and/or Chief, TRICARE Overseas Program Office (TOPO), may direct retroactive authorizations on a case-by-case basis.** TOP Prime enrollees who need urgent care while traveling stateside may contact the TOP contractor's call center(s) for appropriate authorization. Routine care is generally not authorized while a TOP Prime enrollee is traveling out of their enrollment region; however, exceptions may be made for unusual circumstances on a case-by-case basis with PCM referral and appropriate **written justification from the referring MTF**. Emergency care does not require prior authorization; however, the beneficiary should contact their PCM and the TOP contractor as soon as possible to arrange any necessary follow-up care.

**2.4** Failure to obtain a TOP PCM referral/authorization when one is required for care may result in the service being paid under TOP Point of Service (POS) procedures for an Active Duty Family Member (ADFM) with a deductible and cost-shares for outpatient services and cost-shares for inpatient services.

**2.5** The TOP PCM is responsible for notifying the TOP HCF that a referral is being made/ requested. The TOP HCF will assist the TOP Prime enrollee and other beneficiaries in locating an MTF or network or non-network provider to provide the care, and to assist in scheduling an appointment upon request. The HCF will conduct a benefit determination review and provide authorization for service for which the referral was made. If the contractor has no record of referral/ authorization, prior to denial/payment, the contractor will follow the TOP POS rules, assuming the service would otherwise be covered under the provisions of TRICARE Standard.

**2.6** TOP MTF PCMs may be delegated authority by the TOP MTF Commander to authorize referrals within the MTF. All referrals/authorizations to civilian **purchased care sector** providers and all referrals/authorization made by a TOP designated **purchased care sector** PCM must be made through the TOP HCF and must receive an authorization.

**2.7** The TOP contractor shall ensure that all authorized services for TOP Prime enrollees are provided on a cashless, claimless basis. The contractor shall implement guarantee of payment or other business arrangements to ensure that TOP Prime enrollees are not required to pay up front at the time services are rendered by a **purchased care sector** provider.

**2.8** Cashless, claimless provisions do not apply to self-referred care that would normally require authorization.

**2.9** MTFs have right of first refusal for any specialty care provided to TOP Prime enrollees. In all overseas locations except Puerto Rico, right of first refusal is the responsibility of the referring MTF and refers to an internal review process to determine whether specialty care can or cannot be provided by the direct care system based on MTF capability and capacity. Submission of an MTF referral shall signify that the referring MTF has determined that the care cannot be provided by the direct care system within the TRICARE access standards. In Puerto Rico, right of first referral is defined as providing the local MTF with an opportunity to review each referral from a purchased care sector PCM to determine if the MTF has the capability and capacity to provide the care. Specific language regarding this process shall be incorporated into each Statement of Responsibility (SOR) with all MTFs with Puerto Rico.

**2.10** For TOP Prime enrollees who are traveling in the 50 United States or the District of Columbia, the TOP contractor will direct TOP beneficiaries to utilize stateside MTFs whenever possible. If MTF care is unavailable, beneficiaries will be provided with information regarding the nearest available network provider(s) who can assist the beneficiary. Non-network providers should only be used when MTF or network care is not available.

### **3.0 POS OPTION**

**3.1** TOP Prime-enrolled ADFMs are required to follow established referral/authorization procedures prior to obtaining specialty care to avoid the application of POS cost-shares and deductibles. This includes all self-referred, non-emergency outpatient specialty medical services (including outpatient mental health services) and all inpatient care (including inpatient mental health care), except for ancillary services, drugs, services provided by a TOP Partnership Provider, and the first eight outpatient mental health visits in a fiscal year. TOP Prime ADFMs who self-refer to a civilian provider other than their PCM shall have their claims processed as POS.

**3.2** POS cost-shares and deductibles shall not apply to claims for care received by newborns/adoptees during the deemed enrollment period.

**3.3** There are no NAS requirements for TOP Prime enrollees. This requirement is replaced by a care authorization from the PCM.

**3.4** Self-referred, non-emergency, specialty, or inpatient care provided to a TOP Prime enrollee by a network or non-network purchased care sector provider, which is not either provided/referred by the beneficiary's PCM or specifically authorized may be reimbursed only under the TOP Prime POS option if it is a benefit under TRICARE Standard. Services which are not a TRICARE benefit shall be denied.

**3.5** POS cost-sharing and deductible amounts do not apply if a TOP Prime enrollee has Other Health Insurance (OHI) that provides primary coverage. The OHI must be primary under the provisions of the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 1](#), and documentation that the other insurance processed the claim and the exact amount paid must be submitted with the TOP claim. TRICARE OHI provisions apply for this type of claim.

**3.6** The POS option does not apply to ADSM overseas/stateside care.

**3.7** The TOP contractor shall adjust TOP Prime copayments when TOP PCMs or HCFs do not follow established referral/authorization procedures. For example, if the contractor processes a

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claim without evidence of an authorization and/or a referral under POS provisions, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the contractor shall adjust the claim under TOP Prime provisions. The contractor need not identify past claims, however, the contractor shall adjust these claims as they are brought to their attention.

**3.8** On a case-by-case basis, following stabilization of the patient, the MTF Commander may require a TOP Prime beneficiary to transfer to a TOP network facility or the MTF. The MTF Commander shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to a TOP network facility/MTF. If a TOP Prime-enrolled ADFM elects to remain in a non-network facility following notification of an impending transfer to another facility, TOP POS cost-sharing will begin 24 hours following receipt of the written notice. The MTF Commander may not require a transfer until such time as the transfer is deemed medically safe.

**3.9** The following deductible and cost-share amounts apply to all TOP Prime POS claims for health care services:

**3.9.1** Enrollment year deductible for outpatient claims (no deductible applies to inpatient services): \$300 per individual; \$600 per family.

**3.9.2** Beneficiary cost-share for inpatient and outpatient claims: 50% of the allowable charge after the deductible has been met (deductible only applies to outpatient claims).

**3.9.3** POS deductible and cost-share amounts are NOT creditable to the enrollment/fiscal year catastrophic cap and they are not limited by the cap.

**3.9.4** POS deductible and cost-sharing do not apply to the claims for care received by certain newborn and newly adopted children during the deemed enrollment period. See [Section 6](#) for additional guidance regarding deemed enrollment for newborns/adoptees.

- END -

## TRICARE Overseas Program (TOP) Prime Remote Program

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### 1.0 GENERAL

**1.1** TRICARE Overseas Program (TOP) Prime Remote is available to Active Duty Service Members (ADSMs) (including Reserve Component (RC) members activated for more than 30 days) on permanent assignment to a remote overseas location, Command-Sponsored Active Duty Family Members (ADFMs) accompanying their sponsor in the remote location or on Service orders, and certain transitional survivors according to the eligibility and enrollment provisions of [Section 5](#). TOP Prime Remote offers enrollees access to a Primary Care Manager (PCM), clinical preventative services, and specialty services. The TOP contractor, working in concert with **purchased care sector** providers and the TRICARE Area Offices (TAOs), has primary responsibility for ensuring that TOP Prime Remote enrollees receive appropriate services and support to facilitate access to the TOP benefit in remote overseas locations.

**Note:** Command Sponsorship is defined in the Joint Federal Travel Regulations (JFTR), Volume I, Appendix A at <https://www.defensetravel.dod.mil/Docs/perdiem/JTR.pdf>.

**1.2** TOP Prime Remote has no enrollment fees, and deductibles and cost-shares are waived except for TOP Prime Remote ADFMs who receive care under the Point of Service (POS) option, or who obtain pharmacy services in the 50 United States, the District of Columbia, and United States (U.S.) territories where the TRICARE Pharmacy (TPharm) has established a retail pharmacy network. Waiver of copayment and deductibles under TOP Prime Remote is subject to review/updating based on enrollment status.

**1.3** Under TOP Prime Remote, annual catastrophic caps are calculated on fiscal years. The enrollment year shall coincide with the fiscal year. Since deductibles and cost-shares are waived for TOP Prime Remote enrollees, this policy will apply only to TOP Prime Remote enrollees who incur out-of-pocket expenses as described above.

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** TOP Prime Remote enrollees shall select or have assigned to them Primary Care Managers (PCMs) according to guidelines established by the TAO Director, or designee.

**2.1.1** **TOP** PCMs may be an individual professional provider (not a Partnership Provider), an overseas treatment site, or other health care delivery arrangement. For the purposes of referral management and authorization for TOP Prime Remote episodes of care, the TOP contractor's call center(s) are considered PCMs.

**2.1.2** **TOP PCMs** may be an internist, family practitioner, pediatrician, general practitioner, obstetrician/gynecologist, physician assistant, nurse practitioner, or certified nurse midwives when determined by the TOP contractor to meet governing country rules and licensure.

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**2.1.3** May also act as a Health Care Finder (HCF), when dual responsibility is necessary, as determined by the TAO Director.

**2.2** A TOP Prime Remote enrollee must seek all his or her primary health care from the TOP PCM with the exception of care listed in [Section 8](#). If the TOP PCM is unable to provide the care, the TOP PCM is responsible for referring the enrollee to another primary care provider.

**2.3** TOP Prime Remote enrollees must obtain appropriate referral/authorization for any non-emergency care rendered by anyone other than the beneficiary's PCM. This provision applies regardless of where the care is rendered. TAO Directors may direct retroactive authorizations on a case-by-case basis. TOP Prime Remote or TAO enrollees who need urgent care while traveling stateside should contact the TOP contractor's call center(s) for appropriate authorization. Routine care is generally not authorized while a TOP Prime Remote enrollee is traveling out of their enrollment region. **The TOP contractor shall fully document the justification for authorizing routine out-of-area care.** Emergency care does not require prior authorization; however, the beneficiary should contact their PCM and the contractor as soon as possible to obtain authorization for any necessary follow-up care.

**2.4** Failure to obtain a TOP PCM referral/authorization when one is required for care may result in the service being paid under TOP POS procedures for an Active Duty Family Member (ADFM) with a deductible and cost-shares for outpatient services and cost-shares for inpatient services.

**2.5** The TOP PCM is responsible for notifying the TOP HCF that a referral is being made/requested. The TOP HCF will assist the TOP Prime Remote enrollee and other beneficiaries in locating an Military Treatment Facility (MTF) or **purchased care sector** network or non-network provider to provide the care, and will assist in scheduling an appointment **with a purchased care sector provider** upon request. The HCF will conduct a benefit determination review and provide authorization for service for which the referral was made. If the contractor has no record of referral/authorization, prior to denial/payment, the claims processing contractor will follow the TOP POS rules, assuming the service would otherwise be covered under the provisions of TRICARE Standard.

**2.6** All referrals made by a TOP designated **purchased care sector** PCM must be made through the TOP HCF and must receive an authorization.

**2.7** The TOP contractor shall ensure that all authorized services for TOP Prime Remote enrollees are provided on a cashless, claimless basis. The contractor shall implement guarantee of payment or other business arrangements to ensure that TOP Prime Remote enrollees are not required to pay up front at the time services are rendered by a **purchased care sector** provider.

**2.8** Cashless, claimless provisions do not apply to self-referred care that would normally require an authorization.

**2.9** For TOP Prime Remote enrollees who are traveling stateside, the TOP contractor will **direct** TOP beneficiaries to utilize stateside MTFs whenever possible. **If MTF care is unavailable, beneficiaries will be provided with information regarding the nearest available network provider(s) who can assist the beneficiary. Non-network providers should only be used when MTF or network care is not possible.**

### 3.0 POINT OF SERVICE (POS) OPTION

**3.1** TOP Prime Remote-enrolled ADFMs are required to follow established referral/authorization procedures prior to obtaining specialty care to avoid the application of POS cost-shares and deductibles. This includes all self-referred, non-emergency outpatient specialty medical services (including outpatient mental health services) and all inpatient care (including inpatient mental health care), except for ancillary services, drugs, services provided by a TOP Partnership Provider, and the first eight outpatient mental health visits in a fiscal year. TOP Prime Remote ADFMs who self-refer to a civilian provider other than their PCM shall have their claims processed as POS.

**3.2** POS cost-shares and deductibles shall not apply to claims for care received by newborns/adoptees during the deemed enrollment period.

**3.3** There are no Non-Availability Statement (NAS) requirements for TOP Prime Remote enrollees. This requirement is replaced by a care authorization from the TOP contractor or other appropriate authority.

**3.4** Self-referred, non-emergency, specialty, or inpatient care provided to a TOP Prime Remote ADFM enrollee by a network or non-network **purchased care sector** provider, which is not either provided/referred by the beneficiary's PCM or specifically authorized may be reimbursed only under the TOP Prime Remote POS option if it is a benefit under TRICARE. Services which are not a TRICARE benefit shall be denied.

**3.5** POS cost-sharing and deductible amounts do not apply if a TOP Prime Remote ADFM enrollee has Other Health Insurance (OHI) that provides primary coverage. The OHI must be primary under the provisions of the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 1](#), and documentation that the other insurance processed the claim and the exact amount paid must be submitted with the TOP claim. TRICARE OHI provisions apply for this type of claim.

**3.6** The POS option does not apply to ADSM overseas/stateside care.

**3.7** The TOP contractor shall adjust TOP Prime Remote copayments when TOP PCMs or HCFs do not follow established referral/authorization procedures. For example, if the contractor processes a claim without evidence of an authorization and/or a referral under POS provisions, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the **TOP** contractor shall adjust the claim under TOP Prime Remote provisions. The contractor need not identify past claims, however, the contractor shall adjust these claims as they are brought to their attention.

**3.8** On a case-by-case basis, following stabilization of the patient, the TAO Director may require a TOP Prime Remote beneficiary to transfer to a TOP network facility or the MTF. The TOP TAO Director shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to a TOP network facility/MTF. If a TOP Prime Remote-enrolled ADFM elects to remain in a non-network facility after being notified of an impending transfer to another facility, TOP POS cost-sharing will begin 24-hours following receipt of the written notice. The TAO Director may not require a transfer until such time as the transfer is deemed medically safe.

**3.9** The following deductible and cost-share amounts apply to all TOP Prime Remote POS claims for health care services:

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**3.9.1** Enrollment year deductible for outpatient claims (no deductible applies to inpatient services): \$300 per individual; \$600 per family.

**3.9.2** Beneficiary cost-share for inpatient and outpatient claims: 50% of the allowable charge after the deductible has been met (deductible only applies to outpatient claims).

**3.9.3** POS deductible and cost-share amounts are NOT creditable to the enrollment/fiscal year catastrophic cap and they are not limited by the cap.

**3.9.4** POS deductible and cost-sharing do not apply to the claims for care received by certain newborn and newly adopted children during the deemed enrollment period. See [Section 5](#) for additional guidance regarding deemed enrollment for newborns/adoptees.

- END -

## TRICARE Overseas Program (TOP) Standard

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### 1.0 GENERAL

**1.1** All TRICARE requirements regarding TRICARE Standard shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract").

**1.2** TOP Standard is identical to TRICARE Standard in the United States with benefits, deductibles, and cost-shares unchanged. Beneficiaries residing overseas may be required to pay up front and file a claim for reimbursement.

**1.3** TRICARE requirements regarding TRICARE Extra are not applicable to the TOP contract. TRICARE Extra is not available overseas.

### 2.0 ELIGIBILITY

TRICARE-eligible Active Duty Family Members (ADFM), retirees, and retiree family members are eligible for TOP Standard in all overseas locations. The TOP contractor shall verify beneficiary eligibility via the Defense Enrollment Eligibility Reporting System (DEERS) in accordance with the provisions of [Section 5](#).

### 3.0 CONTRACTOR RESPONSIBILITIES

**3.1** The TOP contractor shall process claims and provide claims assistance for TRICARE Standard beneficiaries who reside in an overseas location (regardless of where the care was rendered), and for TRICARE Standard beneficiaries residing in the United States and the District of Columbia who receive health care services in an overseas location. This includes claims for prescriptions unless these claims are otherwise covered under the TRICARE Pharmacy (TPharm) contract.

**3.2** The TOP contractor is not required to develop **purchased care sector** provider networks to support the TOP Standard beneficiary population.

**3.3** The TOP contractor is not required to provide health care services on a cashless, claimless basis for TOP Standard beneficiaries, or for TRICARE Standard beneficiaries residing in the United States and the District of Columbia who receive health care services in an overseas location.

**3.4** The TOP contractor is not required to make appointments with **purchased care sector** providers for TOP Standard beneficiaries, or for TRICARE Standard beneficiaries residing in the United States and the District of Columbia who receive health care services in an overseas location. However, upon beneficiary request, the contractor shall provide the name, telephone number, and

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address of network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic area.

- END -

## TRICARE Overseas Program (TOP) TRICARE For Life (TFL)

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### 1.0 GENERAL

**1.1** The TRICARE Overseas Program (TOP) TRICARE For Life (TFL) program provides health care administration and claims processing for individuals with dual eligibility under both Medicare and TRICARE who receive care in locations where Medicare is not available.

**1.2** The provisions of [Chapter 20](#) regarding TFL are applicable to beneficiaries residing in locations where Medicare is available. These areas include the 50 United States, the District of Columbia, and the U.S. territories of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

### 2.0 JURISDICTION

**2.1** Dual eligible beneficiaries are covered under TOP TFL if they receive care in a location where Medicare is not available. TOP TFL benefits, cost-shares, and deductibles are identical to TOP Standard.

**2.2** Dual eligible beneficiaries residing in Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands are not covered under TOP TFL. These beneficiaries receive TRICARE coverage under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) according to the provisions of [Chapter 20](#).

**2.3** **Claims for** services rendered on board a commercial ship are the responsibility of the TDEFIC contractor if the care was rendered in the territorial waters adjoining the land areas of the United States. **Claims for** services rendered on board ship while outside U.S. territorial waters are the responsibility of the TOP contractor.

### 3.0 CONTRACTOR RESPONSIBILITIES

**3.1** The TOP contractor shall provide administration and claims processing services for the TOP TFL program.

**3.2** TOP TFL has the same cost-shares and deductibles as TOP Standard.

**3.3** TOP TFL has the same requirements for referrals or prior authorizations as TOP Standard. All TOP requirements regarding provider certification apply.

**3.4** The TOP contractor is not required to develop **purchased care sector** provider networks to support the TOP TFL beneficiary population.

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**3.5** The TOP contractor is not required to provide health care on a cashless, claimless basis for TOP TFL beneficiaries.

**3.6** The TOP contractor is not required to make appointments with **purchased care sector** providers for TOP TFL beneficiaries. However, upon beneficiary request, the contractor shall provide the beneficiary with the name, telephone number, and address of network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic region.

**Note:** See [Section 9, paragraph 5.3.2](#) for requirements **relating to** skilled nursing care received in the U.S. and U.S. territories.

- END -

## TRICARE Reserve Select (TRS) And TRICARE Retired Reserve (TRR)

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### 1.0 GENERAL

All TRICARE requirements regarding TRICARE Reserve Select (TRS) and TRICARE Retired Reserve (TRR) shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), Chapter 12; or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See Chapter 22, Sections 1 and 2 for additional instructions. For purposes of TOP implementation, all references to TRICARE Prime in this section shall apply to TOP Prime and TOP Prime Remote, and all references to TRICARE Regional Offices (TROs) shall apply to TRICARE Area Offices (TAOs).

### 2.0 ELIGIBILITY

2.1 The TOP contractor shall provide TRS and TRR information and enrollment/disenrollment assistance to Reserve Component (RC) members, retired reserve members, and eligible family members who reside in overseas locations outside the 50 United States and the District of Columbia.

### 3.0 ENROLLMENT

3.1 The TOP contractor shall process TRS and TRR enrollment applications and collect premium payments for TRS/TRR enrollment.

3.2 TRS and TRR enrollees will receive a member card reflecting their overseas region of enrollment (TRICARE Eurasia-Africa, TRICARE Pacific, or TRICARE Latin America/Canada (TLAC)).

3.3 The TOP contractor shall process claims for TRS and TRR members enrolled overseas (regardless of where the care was rendered), and for TRS and TRR members enrolled in the 50 United States and the District of Columbia who receive health care services in an overseas location. This includes claims for prescriptions unless these claims are otherwise covered by the TRICARE Pharmacy (TPharm) contract. TOP TRS and TRR claims shall be processed as TOP Standard since TRS and TRR members are not eligible for TOP Prime or TOP Prime Remote.

3.4 The TOP contractor is not required to develop purchased care sector provider networks to support the TRS or TRR beneficiary population.

3.5 The TOP contractor is not required to provide Guarantee of Payment or implement other business processes to provide TRS or TRR enrollees with cashless, claimless service.

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**3.6** The TOP contractor is not required to make appointments with **purchased care sector** providers for TRS **or TRR** enrollees. However, upon beneficiary request, the contractor shall provide the enrollee with the name, telephone number, and address of network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic area.

- END -

## TRICARE Plus

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### 1.0 GENERAL

**1.1** TRICARE Plus is a service-directed primary care enrollment program that is available at selected Military Treatment Facilities (MTFs). Local MTF commanders determine whether TRICARE Plus shall be offered based on their facility's capacities, capabilities, and mission.

**1.2** All TRICARE requirements regarding TRICARE Plus shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 6, Section 4](#) for additional instructions.

### 2.0 ELIGIBILITY

Active Duty Family Members (ADFMs) in overseas locations may enroll in TRICARE Plus (where available) regardless of whether they are Command Sponsored. See [Chapter 6, Section 4](#) for additional instructions regarding TRICARE Plus eligibility.

### 3.0 ENROLLMENT

**3.1** All beneficiary inquiries regarding TRICARE Plus enrollment/disenrollment shall be directed to the TOP contractor's toll-free number or, based on the [Statement of Responsibilities \(SOR\)](#) with each MTF Commander, to the designated MTF Point of Contact (POC) for TRICARE Plus. This shall include questions about TRICARE Plus, general questions about enrollment/disenrollment, providing enrollment/disenrollment forms, providing information about the availability of TRICARE Plus at a particular MTF, the extent of coverage available and not available through TRICARE Plus, the selection of individual primary care coordinators, or confirmation of enrollment/disenrollment.

**3.2** MTFs are responsible for approving or disapproving requests for TRICARE Plus enrollment and for managing Primary Care Clinic capacity for TRICARE Plus enrollment. The MTF is responsible for ensuring that TRICARE Plus enrollment forms are complete with validated eligibility through the Defense Enrollment Eligibility Reporting System (DEERS). The MTFs shall send all completed and approved TRICARE Plus enrollment/disenrollment forms to the TOP contractor no less frequently than weekly.

**3.3** The TOP contractor is responsible for ensuring that all TRICARE Plus enrollments are entered through the Defense Online Enrollment System (DOES). The contractor shall return incomplete forms or any application for which enrollment/disenrollment cannot be effected, for any reason other than internal contractor systems or process problems, to the MTF for completion/correction. The contractor shall make no effort to correct or complete any TRICARE Plus enrollment/disenrollment application.

**3.4** TOP Prime and TOP Prime Remote cannot be used in conjunction with TRICARE Plus. Enrollment in TRICARE Plus will necessitate disenrollment from TOP Prime or TOP Prime Remote.

**3.5** TRICARE Plus enrollment to an overseas MTF is effective on the date the enrollment application is approved by the MTF.

#### **4.0 DISENROLLMENT**

**4.1** All beneficiary inquiries regarding TRICARE Plus disenrollment shall be directed to the appropriate location in accordance with [paragraph 3.1](#). Beneficiaries may disenroll from TRICARE Plus at any time. TRICARE Plus disenrollment is effective on the date the disenrollment application is approved by the MTF. Disenrollment forms will be sent to the TOP contractor no less frequently than weekly. The contractor shall process disenrollments in accordance with [paragraph 3.3](#).

#### **5.0 PURCHASED CARE SECTOR PROVIDER SERVICES**

**5.1** TRICARE Plus is an MTF primary care access program, not a health plan. TRICARE Plus has no impact on care received from civilian providers. Claims for care rendered to **TRICARE-eligible** TRICARE Plus enrollees by civilian providers will be processed as TRICARE Standard. This includes care rendered by **purchased care sector** providers overseas or civilian providers in the United States and the District of Columbia.

**5.2** The TOP contractor is not required to develop host **purchased care sector** provider networks to support the TRICARE Plus beneficiary population.

**5.3** The TOP contractor is not required to provide Guarantee of Payment to **purchased care sector** providers or institutions for TRICARE Plus enrollees.

**5.4** The TOP contractor is not required to make appointments with **purchased care sector** providers for TRICARE Plus enrollees. However, upon beneficiary request, the contractor shall provide the beneficiary with the name, telephone number, and address of network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic location.

- END -

## Continued Health Care Benefit Program (CHCBP)

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### 1.0 GENERAL

All TRICARE requirements regarding the Continued Health Care Benefit Program (CHCBP) shall apply to the TRICARE Overseas Program (TOP) unless specifically waived or superseded by the provisions of this section or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See the TRICARE Policy Manual (TPM), [Chapter 10, Section 4.1](#) for additional instructions.

### 2.0 ELIGIBILITY AND ENROLLMENT

**2.1** CHCBP enrollees in overseas locations are not eligible for enrollment in TOP Prime or TOP Prime Remote.

**2.2** CHCBP enrollees in overseas locations cannot use the TRICARE Extra program, regardless of whether they receive care from a network **purchased care sector** provider. TRICARE Extra is not available in any overseas location. CHCBP claims in overseas locations are processed as Standard by the CHCBP contractor.

### 3.0 CONTRACTOR RESPONSIBILITIES

**3.1** The TOP contractor is not required to develop **purchased care sector** provider networks to support the CHCBP beneficiary population.

**3.2** The TOP contractor is not required to provide Guarantee of Payment to **or implement other business processes to provide** CHCBP enrollees **with cashless, claimless care**.

**3.3** The TOP contractor is not required to make appointments with **purchased care sector** providers for CHCBP enrollees. However, upon beneficiary request, the contractor shall provide CHCBP enrollees with the name, telephone number, and address of network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic location.

**3.4** The TOP contractor shall provide general CHCBP program information and enrollment forms upon request.

- END -



## TRICARE Overseas Program (TOP) Supplemental Health Care Program (SHCP)

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### 1.0 GENERAL

**1.1** All TRICARE requirements regarding the Supplemental Health Care Program (SHCP) shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section, TRICARE Policy Manual (TPM), [Chapter 12](#), or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP Contract"). See [Chapter 17](#) for additional instructions.

**1.2** Uniformed service members in an active duty status of greater than 30 days (also known as Active Duty Service Members (ADSMs)) who are on permanent or official duty assignment in a location outside the 50 United States and the District of Columbia must enroll in TRICARE Overseas Program (TOP) Prime or TOP Prime Remote. ADSMs in a temporary duty status and enrolled elsewhere should not transfer their enrollment to TOP Prime or TOP Prime Remote unless it is medically appropriate and will not cause enrollment eligibility disruption to family members' enrollment status. ADSMs are not CHAMPUS-eligible and do not have the option to use TRICARE Standard or the Point of Service (POS) option under TOP Prime or TOP Prime Remote. Uniformed service members who would normally receive care from a **purchased care sector** provider may be directed to transfer their care to a Military Treatment Facility (MTF). This applies to ADSMs and uniformed service members not in active duty status (Reserve Component (RC) members under Line of Duty (LOD) care). These controls ensure the maintenance of required fitness-for-duty oversight for TOP uniformed service members. Refer to [Section 9](#) for claims processing instructions.

### 2.0 CONTRACTOR RESPONSIBILITIES

**2.1** ADSMs who are enrolled in TOP Prime shall follow the procedures outlined in [Chapter 17](#) for MTF-enrolled ADSMs, except that any references to the Military Medical Support Office (MMSO) should be replaced by a reference to the appropriate regional TRICARE Area Office (TAO) in all overseas locations except the U.S. Virgin Islands concerning Line of Duty Determinations and except for care delivered under the National Department of Defense (DoD)/Department of Veteran Affairs (DVA) Memorandum of Agreement (MOA) authorization requirements. See [paragraph 2.4.3](#) for National DoD/DVA MOA authorization requirements. ADSMs who are enrolled in TOP Prime Remote must seek authorization from the TOP contractor for all non-emergent specialty and inpatient care. ADSMs not enrolled in TOP who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status outside the 50 United States and the District of Columbia shall follow referral/authorization guidelines for TOP Prime Remote enrollees.

**2.2** If an ADSM seeks host nation care without appropriate authorization, they put themselves at financial risk for claims payment. They are also at risk for potential compromise of medical

readiness posture, flight status, or disability benefits, and they may be subject to disciplinary action for disregarding service-specific policy. Lost work time may be charged as ordinary leave.

**2.3** The TOP contractor shall ensure a benefit review is done on each SHCP referral and authorization. The TOP contractor shall return deferred-to-network referrals for non-covered services with an explanation of why it was denied. The TOP contractor shall not issue an authorization unless they obtain a copy of an approved waiver. The contractor shall deny all claims for TRICARE non-covered health care services. (Reference Health Affairs (HA) Policy 12-002 "Use of Supplemental Health Care Program Funds for Non-Covered TRICARE Health Care Services and the Waiver Process for Active Duty Service Members").

**2.3.1** If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy and no **Defense Health Agency (DHA)** approved waiver is provided, the contractor shall decline to file an authorization and shall deny any received claims accordingly. If the request was received as an MTF referral, the contractor shall notify the MTF (and enrolled MTF if different from the submitting MTF) of the declined authorization with explanation of the reason. If the request was received as a referral from a civilian provider (for a remote Service member/non-enrolled Service member), the contractor shall notify the civilian provider and the remote Service member/non-enrolled Service member of the declined authorization with explanation of the reason. The notification to a civilian provider and the remote Service member/non-enrolled Service member shall explain the waiver process and provide contact information for the applicable Uniformed Services Headquarters Point of Contact (POC)/Service Project Officers as listed in [Chapter 17, Addendum A, paragraph 2.0](#). No notification to the SPOC is required.

**2.3.2** TRICARE benefits may not be extended for complications resulting from non-covered surgeries and treatments performed outside the MTF for a Service member without an approved waiver. If the treatment is a non-covered TRICARE benefit, any follow-on care, including care for complications, will not be covered by TRICARE once the Service member separates from active duty or retires ([32 CFR 199.4\(e\)\(9\)](#); TPM, [Chapter 4, Sections 1.1 and 1.2](#)). The Services will provide appropriate counseling that such follow-on care is the member's personal financial responsibility upon separation or retirement.

**2.4** The provisions of [Chapter 17](#) are changed for the TOP as follows:

**2.4.1** The provisions of [Chapter 17, Section 2, paragraph 2.0](#) (Uniformed Services Family Health Plan (USFHP)) are not applicable to the TOP contract. USFHP services are not available outside the 50 United States and the District of Columbia.

**2.4.2** Except for the claims for ADSM care provided under the National DoD/DVA MOA, the provisions of [Chapter 17, Section 3, paragraph 1.2.1](#) regarding the timeline for review of SHCP claims by overseas MTFs is extended to 10 calendar days. ADSM claims for covered benefits submitted to the TOP contractor for which an authorization is not on file are to be pended for a determination of whether the care should be authorized. The claim shall be pended and the MTF of enrollment shall be notified that an authorization determination should be accomplished and returned to the TOP contractor within 10 calendar days. If the TOP contractor does not receive the MTF's response within 10 calendar days, the contractor shall move the claim back into active processing within one business day and shall process the claim as if the MTF had authorized the care. Claims authorized due to a lack of response by the MTF shall be considered as "Referred Care", but the contractor must be able to distinguish these claims from MTF-authorized claims. Claims

pending under the provisions of this section shall be considered to be excluded claims for the purposes of calculating and reporting claims processing cycle time performance.

**2.4.3** The provisions of [Chapter 17, Section 2, paragraph 3.1](#) regarding claims for care provided under the National DoD/DVA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), Blind Rehabilitation, and Polytrauma are applicable to the TOP and shall be processed in accordance with [Chapter 17, Section 2, paragraph 3.1.3](#). Such care will be authorized by the MMSO for ADSMs under this MOA.

**2.4.4** The provisions of [Section 6, paragraph 5.0](#) and [Chapter 8, Section 5](#) apply to TOP SHCP referrals. Additionally, when MTFs submit a referral request for purchased care services for a non-AD sub-population beneficiary eligible for SHCP, the MTF shall utilize the required data elements identified in [Chapter 8, Section 5, paragraph 6.1](#) and shall annotate the referral with "SHCP" in line item 12, "Review Comment". This will ensure that SHCP claims for eligible non-AD sub-population beneficiaries are properly adjudicated.

**Note:** Circumstances where supplemental funds may be used to reimburse for care rendered by non-governmental health care providers to non-active duty patients are limited to those where a MTF provider orders the needed health care services from civilian sources for a patient, and the MTF provider maintains full clinical responsibility for the episode of care. This means that the patient is not disengaged from the MTF that is providing the care. See [Chapter 17, Section 1, paragraph 1.1](#).

**2.5** When an ADSM leaves a remote TOP assignment as a result of Permanent Change of Station (PCS) or other service-related change of duty status, the following applies in support of medical record accumulation:

**2.5.1** For ADSMs leaving remote TOP assignment in Puerto Rico, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to ADSMs within 30 calendar days of the ADSM's request for the records. The ADSM may also request copies of medical care documentation (specialty care visits and discharge summaries) on an ongoing, EOC basis.

**2.5.2** For ADSMs leaving remote TOP assignments from all overseas areas other than Puerto Rico, ADSMs in those locations should request medical records from the **purchased care sector** provider(s) who provided health care services during the ADSM's tour of duty. These ADSMs may also request copies of medical care documentation (specialty care visits and discharge summaries) on an ongoing, EOC basis.

**2.5.3** Records provided by **purchased care sector** providers in languages other than English may be submitted to the TOP contractor for translation into English according to the terms of the contract.

**2.5.4** Network **purchased care sector** providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Non-network **purchased care sector** providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges unless the government has directed a lower reimbursement rate. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no

TRICARE Overseas Program (TOP) Supplemental Health Care Program (SHCP)

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out-of-pocket expenses. All providers and/or ADSMs must submit a claim form, with the charges clearly identified, to the contractor for reimbursement.

**2.5.5** The provisions of Chapter 17, Section 3, paragraph 1.1.8 are not applicable to the TOP. SHCP funds may not be used to pay for overseas purchased sector care for foreign military members or their families. The TOP contractor shall deny any MTF referrals and claims for such care.

**Note:** The purpose of copying medical records is to assist the ADSM in maintaining accurate and current medical documentation. The contractor shall not make payment to a purchased care sector provider who photocopies medical records to support the adjudication of a claim.

**2.6 Provision of Respite Care For The Benefit of Seriously Ill or Injured Active Duty Members**

**2.6.1** The provisions of Chapter 17, Section 3 and the TRICARE Systems Manual (TSM), Chapter 2, Sections 2.8 and 6.4 regarding respite care for seriously ill or injured ADSMs are applicable in locations outside the 50 United States and the District of Columbia where TRICARE-authorized Home Health Agencies (HHAs) have been established.

**2.6.2** The respite care benefit is applicable to ADSMs enrolled to TOP Prime, TOP Prime Remote, and to any ADSM referred by an overseas MTF or TAO.

**2.6.3** All normal ADSM authorization and case management requirements for the TOP apply to the ADSM respite care benefit.

- END -

## Figures

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### FIGURE 24.30-1 OVERSEAS PHARMACY PROVIDER NOTICE LETTER (SAMPLE)

**(Provider Name)**

**(Provider Street Address)**

**(Provider City, State and Zip Code)**

Dear **(Provider Name)**:

The Department of Defense, through **Defense Health Agency (DHA)**, is responsible for appropriate cost containment for services provided to TRICARE beneficiaries. One particular area of concern has been the costs billed for prescription drugs. In an effort to establish a Uniformed Military Services drug benefit and claim processing requirement for all TRICARE eligibles, the Deputy Director, **DHA**, has determined that pharmacy claims submitted for services outside the United States must be reimbursed in accordance with the reimbursement formulas for TRICARE United States (U.S.) claims as established under the Code of Federal Regulations.

This letter notifies you that effective sixty (60) days from date on this letter, **(Date)**, overseas pharmacy claims submitted will be processed in accordance with the reimbursement formulas for TRICARE claims in the United States which are from a schedule of allowable charges based on the Average Wholesale Price (AWP) rates plus \$3.00 administration fee. Should you have any questions regarding this requirement, please write me at **(Contractor Mailing Address)**.

Sincerely,

**(Contractor Name)**

**(Contractor Title)**

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**FIGURE 24.30-2 TOP CONTRACTOR PROVIDER CERTIFICATION REQUEST LETTER**



**OVERSEAS**

(Sample Philippine Contractor Provider Certification Request Letter)

Dear Provider:

**(TOP Contractor Name)**, your TRICARE claims processor has received a claim for services provided by you.

You are not currently listed with us as a TRICARE authorized/credentialed provider. To complete processing of your claim, you must request to be an authorized/credentialed TRICARE provider. So that we may complete the processing of your claim, please complete the attached TRICARE Provider Application including copies of your current license(s). Unless we receive the requested license(s)/credentials the claim will be denied.

Please return the completed application with copies of your license(s)/credentials to:

**(Contractor's Name and Address)**

Sincerely,

**(Contractor's Name)**

- END -

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### Appendix A

#### Acronyms And Abbreviations

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LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPA	Licensed Psychological Associate
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
LVSD	Left Ventricular Systolic Dysfunction
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MAP	MYH-Associated Polyposis
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board

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### Appendix A

#### Acronyms And Abbreviations

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MGIB	Montgomery GI Bill
MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MM	Medical Management
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMR	Mismatch Repair
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPC	Medical Payments Coverage
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft® Multiple Sclerosis
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command

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### Appendix A

#### Acronyms And Abbreviations

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MSI	Microsatellite Instability
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MSS	Medical Social Services
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
MYH	mutY homolog
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACHA	National Automated Clearing House Association
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCCN	National Comprehensive Cancer Network
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System

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### Appendix A

#### Acronyms And Abbreviations

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NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLDA	Nursery and Labor/Delivery Adjustment
NLT	No Later Than
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions

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#### Acronyms And Abbreviations

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OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office for Civil Rights Optical Character Recognition
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
<b>OIT</b>	<b>Oral Immunotherapy</b>
OLT	Orthotopic Liver Transplantation
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OTCD	Ornithine Transcarbamylase Deficiency
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics

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P&CL	Privacy & Civil Liberties [Office]
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAS	Privacy Act Statement
PAT	Performance Assessment Tracking
PATH Intl	Professional Association of Therapeutic Horsemanship International
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMH	Patient-Centered Medical Home
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Pelvic Congestion Syndrome Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository

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PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFPP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
PGD	Preimplantation Genetic Diagnosis
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PII	Personally Identifiable Information
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
<b>PMRC</b>	<b>Patient Movement Requirement Center</b>
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction

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POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSF	Provider Specific File
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time

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PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QABA	Qualified Applied Behavior Analysis
QASP	Qualified Autism Services Practitioner
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
RBT	Registered Behavior Technician
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
Rddb	Reportable Disease Database

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REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHA	Records Holding Area
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RIA	Radioimmunoassay
RM	Records Management
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation Specified Authorization Staff (formerly Service Point of Contact (SPOC))
SAT	Service Assist Team
SAVR	Surgical Aortic Valve Replacement

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SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SLP	Speech-Language Pathology
SMC	System Management Center
SME	Subject Matter Expert
SMHC	Supervised Mental Health Counselor
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number

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SOR	Statement of Reasons <b>Statement of Responsibilities</b> System of Records
SORN	System of Records Notice
SP	Special Publication
SPA	Simple Power Analysis
SPC	Special Processing Code
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUD	Substance Use Disorder
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVP	State Vaccine Program State Vaccine Program entity
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAH	Total Artificial Heart
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office

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TAVR	Transcatheter Aortic Valve Replacement
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDR	Total Disc Replacement
TDRL	Temporary Disability Retired List
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
THP	TRICARE Health Plan
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health

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TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TN	Termination Notice
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TP	Treatment Plan
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select

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TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
US-CERT	United States-Computer Emergency Readiness Team
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office(r)

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USCYBERCOM	United States Cyber Command
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VBP	Value-Based Purchasing
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WDR	Written Determination Report
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network

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WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

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