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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 79
6010.56-M
JUNE 8, 2012

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: MAIL DELIVERY QUALITY CODE (MDQC)

CONREQ: 15806

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change revises the referenced Manuals to require use of the Mail Delivery Quality Code (MDQC) when processing returned mail or verifying addresses. An updated MDQC will prevent mailings to the beneficiary such as enrollment cards and letters. The MDQC field automatically resets whenever the address is updated.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 69 and Feb 2008 TSM, Change No. 40.

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Director, Operations Division

ATTACHMENT(S): 58 PAGES
DISTRIBUTION: 6010.56-M

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Enrollment Processing

The contractor shall record all enrollments on Defense Enrollment Eligibility Reporting System (DEERS), as specified in the TRICARE Systems Manual (TSM), [Chapter 3](#).

The contractor shall develop and implement an enrollment plan to support contractor enrollment of beneficiaries. The contractor shall consult with the Regional Director (RD) and all Military Treatment Facility (MTF) Commanders where Prime is offered in developing the enrollment plan.

1.0 ENROLLMENT PROCESSING

1.1 The contractor shall use the TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form (one combined form) Department of Defense (DD) Form 2876, and the TRICARE Prime Disenrollment Form DD Form 2877. The contractor shall ensure aforementioned forms are readily available to potential enrollees. The contractor shall implement enrollment processes (which do not duplicate Government systems) that ensure success and assistance to all beneficiaries.

1.1.1 The contractor shall collect TRICARE Prime enrollment applications at the TRICARE Service Centers (TSCs) or other sites mutually agreed to by the contractor, RD, and the MTF Commander, by mail, or by other methods proposed by the contractor and accepted by the Government.

1.1.2 Enrollment applications must be signed by the sponsor, spouse or other legal guardian of the beneficiary. **A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the Beneficiary Web Enrollment (BWE) system. An Active Duty Service Member (ADSM) or Active Duty Family Member (ADFM) signature is not required to make enrollment changes using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#). A signature from an ADSM, although desired, is not required to complete Prime enrollment as enrollment in Prime is mandatory per the TRICARE Policy Manual (TPM), [Chapter 10, Section 2.1, paragraph 1.1](#).**

1.1.3 The contractor shall also accept and process TRICARE Prime enrollment applications via the BWE process.

1.2 The contractor shall provide beneficiaries who enroll full and fair disclosure of any restrictions on freedom of choice that apply to enrollees, including the Point of Service (POS) option and the consequences of failing to make enrollment fee payments on time.

1.3 Enrollment shall be on an individual or family basis. For newborns and adoptees, see the TPM, [Chapter 10, Section 3.1](#).

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 6, Section 1

Enrollment Processing

1.4 The contractor shall follow the specifications of the Memorandum of Understanding (MOU) with the appropriate MTF Commander and RD and any other instructions from the RD in performing and coordinating enrollment processing with the MTF, the appropriate RD, and DEERS.

1.5 The contractor shall record all Prime enrollments from a centralized contractor data entry point on the DEERS using a Government-furnished systems application, the DEERS Online Enrollment System (DOES). The equipment needed to run the DEERS desktop enrollment application shall be furnished by the Managed Care Support Contractor (MCSC) and shall meet technical specifications in the TSM, [Chapter 3](#).

1.5.1 MCSCs shall resend PCM Information Transfers (PITs) to MTFs when requested.

1.5.2 The MCSC shall submit required changes to the DEERS Support Office (DSO) as required.

1.6 At the time of enrollment processing, the contractor shall access DEERS to verify beneficiary eligibility and shall update the residential and mailing addresses and any other fields that they can update on DEERS.

1.6.1 If the enrollment form contains neither a residence address nor a mailing address, the contractor shall attempt to develop the enrollment form for a residence address. If it is determined the beneficiary does not have an established residence address or that the beneficiary's mailing address differs from the residence address, the contractor shall also develop the enrollment form for a mailing address. **If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.4, paragraph 1.3.1, Addresses.**

1.6.2 Enrollees may submit a temporary address (i.e., Post Office Box, Unit address, etc.), 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](#). Contractors shall not input temporary addresses not provided by the enrollee.

1.6.3 If the DEERS record does not contain an address, or if the application 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 by telephone within five calendar days, outlining the discrepant information and requesting that the beneficiary contact the military personnel information office.

1.7 Defense Manpower Data Center (DMDC)/DEERS shall print and mail the Universal TRICARE Beneficiary Cards directly to the enrollee at the residential mailing address specified on the enrollment application after receipt of the enrollment record. DMDC will also provide notification of PCM assignments for new enrollments, enrollment transfers, PCM changes, and the replacement of TRICARE Universal Beneficiary Cards. (See TSM, [Chapter 3, Section 1.4](#).) The return address on the envelope mailed by DMDC will be that of the appropriate MCSC. In the case of receiving returned mail, the MCSC shall develop a process to fulfill the delivery to the enrollee.

1.8 An enrollee must present both a TRICARE Prime identification card and a military identification card to a provider to demonstrate eligibility for TRICARE Prime program benefits.

2.0 ASSIGNMENT OF PCM

The contractor shall assign all enrollees a PCM by name (PCMBN) on DOES at the time of enrollment. This applies to beneficiaries assigned to Direct Care (DC) and civilian network PCMs.

2.1 All DC TRICARE Prime enrollees shall be enrolled to a Department of Defense (DoD) MTF Primary Care Location by the MCSCs. The contractor shall comply with the MTF Commander's specifications in the MTF MOU for which enrollees or categories of enrollees shall be assigned a DC PCM or offered a choice of civilian network PCMs.

2.1.1 The contractor shall enroll TRICARE Prime beneficiaries to the MTF until the capacity is optimized in accordance with the MTF Commander's determinations; TRICARE Prime beneficiaries who cannot be enrolled to the MTF will be enrolled to the contractor's network.

2.1.2 All active duty personnel not meeting the requirements for TRICARE Prime Remote (TPR) shall be enrolled to an MTF, not the contractor's network, regardless of capacities.

2.1.3 When a family member of a sponsor E-1 through E-4 requests a PCM in an MTF that offers TRICARE Prime for any beneficiary category other than active duty, that beneficiary must be assigned an MTF PCM unless capacity has been reached. If overall MTF capacity has not been reached, the MCSC shall request the MTF to shift capacity in DOES to the ADFM beneficiary category from another category if necessary to accommodate an E-1 - E-4 ADFM beneficiary's PCM assignment request.

2.2 MTFs will provide the MCSC a current listing of all Primary Care Locations with associated groups or a current listings of DC PCMs. The list(s) will be made available for the beneficiary's use for the initial selection or change of a PCM. The MCSC will provide guidance to the enrollee in selecting a Primary Care Location or PCM, as appropriate given MTF guidance in the MOU. Upon receipt of an inquiry from a DC enrollee in regards to the person's assigned PCM, the MCSC shall refer the beneficiary to the MTF to which the beneficiary is enrolled.

2.3 At the time of enrollment, the contractor is responsible for determining the appropriate enrollment Defense Medical Information System Identification (DMIS-ID) based on the regional and MTF MOUs, access standards and/or other specific Government guidance. The contractor shall assign each enrollee a PCMBN at the time of enrollment based on those PCMs available within DOES.

2.3.1 The contractor will attempt to assign the beneficiary to the PCM requested on the enrollment form if capacity is available. If the preferred PCM is not available, the contractor will use the default PCM for that DMIS.

2.3.2 If the enrollment form contains a gender or specialty preference, the MCSC will try to assign an appropriate PCM. If the gender or specialty is not available, the beneficiary will be enrolled to the default PCM for that DMIS.

2.3.3 If there is no PCM preference stated on the enrollment form, the contractor will use the default PCM for that DMIS.

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2.3.4 If there is no DC PCM available in the appropriate DMIS/MTF, nonactive duty beneficiaries may be enrolled to a civilian PCM, by following the procedures specified for such situations in the local MTF MOU.

2.3.5 If there is no PCM capacity in the MTF for an ADSM, then the MCSC will contact the MTF for instructions.

2.4 DOES reflects only those DC PCMs that the MTF has loaded onto the DEERS PCM Repository. Further, DOES will only display PCMs with available capacity for the specific beneficiary's category and age. The contractors cannot add, delete, or modify DC PCMs on the repository.

2.5 The contractor shall complete all panel PCM reassignments (batch) using a Government-provided systems application, PCM Reassignment System (PCMRS). Panel reassignments may be specified by the appropriate MTF Commander for a variety of reasons, including the rotation or deployment of DC PCMs. MCSCs should expect at least one-half of DC PCM assignments to change each year. These moves may be based on various factors of either the enrollment or the individual beneficiary, including:

- DMIS ID to DMIS ID
- PCM ID to PCM ID
- Health Care Delivery Program (HCDP)
- Sex of beneficiary
- Unit Identification Code (UIC) (active duty only)
- Age of beneficiary
- Sponsor Social Security Number (SSN) (for family moves)
- Name of beneficiary

2.6 MTFs may request PCM reassignment, including panel reassignments, in several ways, including telephone, e-mail or other electronic submissions. The most common method to request individual PCM reassignments is the telephone. The preferred method for panel reassignments is the batch staging application within PCMRS. Regardless of the submission method, the MTF must provide sufficient information identifying both the PCMs and beneficiaries involved in a move to allow the contractor to reasonably accomplish the move. Thereafter, the contractor shall complete each DC PCM reassignment, both individual and panel reassignment, within three working days of receiving all necessary information from the MTF.

2.7 PCM change requests submitted via any means other than BWE application by beneficiaries enrolled to the civilian network must be processed by the MCSC within three working days of receipt, with an effective date no later than (NLT) the third working day.

2.8 PCM change requests submitted to the MCSC via the BWE application by beneficiaries will be processed within six calendar days of receiving the requests, and the effective date will be the sixth calendar day after the request was submitted or the date requested by the beneficiary if over six days but less than 91 days.

3.0 ENROLLMENT PERIOD

3.1 Effective Date of Enrollment

The contractor shall support continuous open enrollment for all beneficiaries. Enrollment may occur any time during the contract period; however, all new enrollment periods shall coincide with the fiscal year. The contractor shall align any enrollment established based on an enrollment year period to the fiscal year upon the first renewal of the enrollment period.

3.1.1 The effective date of enrollment for ADSMs shall be the date the contractor receives the signed enrollment application. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system.

3.1.2 All other enrollment periods shall begin on the first day of the month following the month in which the enrollment application and any required enrollment fee payment are received by the contractor. If an application and fee are received after the 20th day of the month, enrollment will be on the first day of the second month after the month in which the contractor received the application. (This recurring principle is referred to as the 20th of the month rule.)

3.1.3 Enrollees who transfer enrollment continue with the same enrollment period. The enrollment transfer, however, is effective the date the gaining contractor receives a signed enrollment application or transfer application. See TPM, [Chapter 10, Sections 2.1 and 5.1](#) for information on Transitional Assistance Management Program (TAMP) and other changes in status. An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

3.2 Enrollment Expiration

3.2.1 NLT 30 calendar days before the expiration date of an enrollment, the contractor shall send the appropriate individual (sponsor, custodial parent, retiree, retiree family member, survivor or eligible former spouse, etc.) a written notification of the pending expiration and renewal of the TRICARE Prime enrollment and a bill for the enrollment fee, if applicable (since ADSMs must be enrolled but their family members need not be, there is no action required if an ADSM does not have enrolled family members). The bill shall offer all available payment options and methods. The contractor shall issue a delinquency notice to the appropriate individual 15 calendar days after the expiration date of the enrollment.

3.2.2 The contractor shall automatically renew enrollments, including those for ADSMs, upon expiration unless the enrollee declines renewal, is no longer eligible for Prime enrollment, or fails to pay any required enrollment fee on a timely basis, including a 30 calendar day grace period beginning the first day following the last day of the enrollment period.

3.2.3 If the enrollee requests disenrollment during this grace period, the contractor shall disenroll the beneficiary effective retroactive to the enrollment period expiration date.

3.2.4 If an enrollee does not respond to the re-enrollment notification and fails to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the

enrollee has declined re-enrollment. The contractor shall disenroll the beneficiary retroactive to the enrollment expiration date.

3.2.5 ADSMs may not decline reenrollment nor may they request disenrollment.

3.2.6 DMDC sends written notification to the beneficiary of the disenrollment and the reason for the disenrollment within five business days of the disenrollment transaction.

3.3 Disenrollment

3.3.1 The contractor shall automatically disenroll beneficiaries when the appropriate enrollment fee payment is not received by the 30th calendar day following the enrollment period expiration date or the due date for the installment payment. The contractor shall set the disenrollment effective date retroactive to the annual renewal date or the payment due date, whichever applies. An appropriate enrollment fee payment includes the appropriate form of payment for the period the fee is intended to cover (i.e., monthly, quarterly, or annually).

3.3.2 Prior to processing a disenrollment for “non-payment of fees,” the MCSC or Uniformed Services Family Health Plan (USFHP) provider must reconcile their fee payment system against the fee totals in DEERS. Once the contractor confirms that the payment amounts match, the disenrollment may be entered in DOES.

3.3.3 The disenrolled beneficiary will be responsible for the deductible and cost-shares applicable under TRICARE Extra or Standard for any health care received during the 30 day grace period. In addition, the beneficiary shall be responsible for the cost of any services received during the 30 day grace period that may have been covered under TRICARE Prime but are not a benefit under TRICARE Extra or Standard, e.g., preventive care.

3.3.4 The contractor may suspend claims processing during the grace period to avoid the need to recoup overpayments.

3.3.5 See the TPM, [Chapter 10, Sections 2.1](#) and [3.1](#) for additional information on disenrollment.

3.4 Enrollment Lockout

3.4.1 The contractor shall “lockout” or deny re-enrollment for a period of 12 months from the effective date of disenrollment for the following beneficiaries:

- Retirees and/or their family members who voluntarily disenroll prior to their annual enrollment renewal date;
- ADFMs (E-5 and above) who change their enrollment status (i.e., from enrolled to disenrolled twice in a given year) for any reason during the enrollment year (October 1 to September 30) (refer to this chapter and TPM, [Chapter 10, Sections 2.1](#) and [3.1](#)); and
- Any beneficiary disenrolled for failure to pay required enrollment fees during a period of enrollment.

Note: The 12 month lockout provision does not apply to ADFMs whose sponsor's pay grade is E-1 through E-4.

3.4.2 Beneficiaries who decline re-enrollment during their annual renewal period are not subject to the 12 month enrollment lockout. At the end of an annual enrollment period, if the beneficiary declines to continue their enrollment and subsequently requests re-enrollment, a new enrollment form is required and the contractor shall process the request as a "new" enrollment. (If an enrollee did not respond to a re-enrollment notification and failed to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the enrollee declined re-enrollment.)

3.4.3 The contractor shall not grant waivers to the 12 month lockout provision. TRICARE Regional Office (TRO) Directors may grant waivers to the lockout provisions in extraordinary circumstances.

4.0 ENROLLMENT FEES

4.1 General

The contractor shall collect enrollment fee payments from TRICARE Prime enrollees as appropriate and shall report those fees, including any overpayments that are not refunded to the enrollee, to DEERS. (See the TSM, [Chapter 3](#).) The Prime enrollee may select one of the following three payment fee options (i.e., annual, quarterly, or monthly). In the event that there are insufficient funds to process a premium payment, the contractor may assess the account holder a fee of up to 20 U.S. dollars (\$20.00). The contractor shall provide commercial payment methods for Prime enrollment fees that best meet the needs of beneficiaries while conforming to the following ([paragraphs 4.1.1](#) through [4.1.3.7](#)):

4.1.1 Annual Payment Fee Option

An annual installment is collected in one lump sum. For initial enrollments, the contractor shall prorate the fee from the enrollment date to September 30. The contractor shall accept payment of the annual enrollment fee only by credit card (e.g., Visa/MasterCard). See [paragraph 3.3.1](#) for disenrollment information if the appropriate enrollment fee payment is not received.

4.1.2 Quarterly Payment Fee Option

Quarterly installments are equal to one-fourth (1/4) of the total annual fee amount. For initial enrollments, the contractor shall prorate the quarterly fee to cover the period until the next fiscal year quarter. (Fiscal quarters begin on January 1, April 1, July 1, and October 1.) The contractor shall collect quarterly fees thereafter. The contractor shall accept payment of the quarterly enrollment fee only by credit card (e.g., Visa/MasterCard). See [paragraph 3.3.1](#) for disenrollment information if the appropriate enrollment fee payment is not received.

4.1.3 Monthly Payment Fee Option

Monthly installments are equal to one-twelfth (1/12) of the total annual fee amount. Monthly enrollment fees must be paid-through an automated, recurring electronic payment either in the form of an allotment from retirement pay or through Electronic Funds Transfer (EFTs) from

the enrollee's designated financial institution (which may include a recurring credit or debit card charge). These are the only acceptable payment methods for the monthly payment option.

4.1.3.1 Enrollees who elect the monthly fee payment option must pay the first quarterly installment (i.e., the first three months) at the time the enrollment application is submitted to allow time for the allotment or EFT to be established. The contractor shall accept payment of the first quarterly installment by personal check, cashier's check, traveler's check, money order, or credit card (e.g., Visa/MasterCard).

4.1.3.2 The contractor shall initiate monthly allotments and EFTs and is responsible for obtaining and verifying the information necessary to do so.

4.1.3.3 The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT.

4.1.3.4 When an administrative issue arises that stops or prevents an automated monthly payment from being received by the contractor (e.g., incorrect or transposed number provided by the beneficiary, credit card expired, bank account closed, etc.), the contractor shall grant the enrollee 30 days to provide information for a new automated monthly payment method or the option to pay quarterly or annually. The contractor may accept payment by check during this 30 day period in order to preserve the beneficiary's Prime enrollment status.

4.1.3.5 Allotments from retired pay will be coordinated through the contractor with the Defense Finance and Accounting Service (DFAS), U.S. Coast Guard (USCG), or Public Health Service (PHS), as appropriate (see the TSM, [Chapter 1, Section 1.1, paragraph 11.10](#) for Payroll Allotment Interface Requirements). The contractor shall process all allotment requests submitted by beneficiaries.

4.1.3.6 The contractor shall also research all requests that have been rejected or not processed by DFAS, USCG, or PHS. If the contractor's research results in the positive application of the allotment action, the contractor shall resubmit the allotment request.

4.1.3.7 Within five business days, the contractor will notify the beneficiary of rejected allotment requests and issue an invoice to the beneficiary for any outstanding enrollment fees due. The contractor will respond to all beneficiary inquiries regarding allotments.

4.2 Member Category

The sponsor's member category on the effective date of the initial enrollment, as displayed in DOES, shall determine the requirement for an enrollment fee.

4.3 Unremarried Former Spouses (URFSs) and Children Residing with Them

4.3.1 URFSs became sponsors in their own right as of October 1, 2003. As such, they are enrolled under their own SSNs and pay an individual enrollment fee. URFS may not "sponsor" other family members and their fees may not be factored into any family fees associated with the former spouse/sponsor.

4.3.2 Children residing with the URFS and whose eligibility for benefits is based on the ex-spouse/former sponsor are identified under the ex-spouse/former sponsor's SSN on DEERS.

Likewise, they are enrolled under the ex-spouse/former sponsor and fees for these children shall be combined with other fees paid under the ex-spouse/former sponsor.

Example: A contractor would collect the individual enrollment fee for an URFS's enrollment under the URFS's own SSN. The contractor would also collect a family enrollment fee for any two or more eligible family members enrolled under the SSN of the ex-spouse/former sponsor. These enrollees might include the sponsor, any current spouse, and all eligible children, including those living with the URFS.

4.4 Medicare Part B Fee Waiver

Each Prime enrolled beneficiary under age 65, who maintains enrollment in Medicare Part B, is entitled to a waiver of an amount equivalent to the individual TRICARE Prime enrollment fee. Hence, individual enrollments for such beneficiaries will have the enrollment fee waived. A family enrollment in TRICARE Prime, where one family member is under age 65 and maintains enrollment in Medicare Part B, shall have one-half of the family enrollment fee waived; the remaining half must be paid. For a family enrollment where two or more family members are under age 65 and maintain enrollment in Medicare Part B, the family enrollment fee is waived regardless of the number of family members who are enrolled in addition to those entitled to Medicare Part B.

4.5 Survivors of Active Duty Deceased Sponsors and Medically Retired Uniformed Services Members and their Dependents

Effective Fiscal Year (FY) 2012, beneficiaries who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their dependents, shall have their Prime enrollment fees frozen at the rate in effect when classified and enrolled in a fee paying Prime plan. (This does not include TRICARE Young Adult (TYA) plans). Beneficiaries in these two categories who were enrolled in FY 2011 will continue paying the FY 2011 rate. The beneficiaries who become eligible in either category and enroll during FY 2012, or in any future fiscal year, shall have their fee frozen at the rate in effect at the time of enrollment in Prime. The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime. The fee for the dependent(s) of a medically retired Uniformed Services member shall not change if the dependent(s) is later re-classified a survivor.

4.6 Mid-Month Enrollees

The contractor shall collect any applicable enrollment fee from mid-month enrollees at the time of enrollment. However, there will be no enrollment fee collected for the days between the effective enrollment date and the determined enrollment date.

4.6.1 The effective enrollment date shall be the actual start date of the enrollment.

4.6.2 The determined enrollment date shall be established using the 20th of the month rule, as it is for initial enrollments.

Example: If the retirement date is May 27, the effective enrollment date will be May 27 and the determined enrollment date will be July 1. Fees will be charged for the period from July 1 forward; no fees will be assessed for the period from May 27 through June 30. Effective with enrollment fees that are to be applied to periods on or after October 1,

2012, DEERS will calculate the paid-through dates based on DEERS data and the enrollment fee amount collected and entered into DEERS by the contractor. Reference the TPM, [Chapter 10, Section 3.1](#).

4.7 Overpayment Of Enrollment Fees

4.7.1 Prior To October 1, 2012

If enrollment fees are overpaid at any point during an enrollment year, the contractor may credit the overpayment to any outstanding payments due. Such credits shall be reported on DEERS. If the overpayment of enrollment fees is not applied to outstanding payments due, the contractor shall refund any overpayments of \$1 or more to the enrollee. When TRICARE Prime enrollment changes from a family to an individual prior to annual renewal, the unused portion of the enrollment fee shall be prorated on a monthly basis and shall be applied toward a new enrollment period.

4.7.2 On Or After October 1, 2012

Effective with enrollment fees that are to be applied for coverage on or after October 1, 2012, the contractor shall update DEERS with the fee amount collected and DEERS will calculate the paid-through date and notify the contractor. DEERS will only extend the paid-through date to cover the current enrollment year, plus two future fiscal years. DEERS will store amounts that cannot cover one month's fees or amounts that extend the paid-through date beyond two fiscal years in the future as a credit. Additionally, funds applied that would move the paid-through date beyond the policy end date will be stored as a credit. (The exception is when Prime policies end mid-month; DEERS will set a paid-through date to the end of that month.) Also, if there is a 100% fee waiver with an end date that exceeds more than two fiscal years beyond the current enrollment year, the paid period can extend beyond the two fiscal years and any fee amounts sent to DEERS will be applied as a credit. The contractor shall refund any credit of \$1 or more on a current enrollment that extends beyond two fiscal years. The contractor shall update DEERS with any fee amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

4.8 The following reports will be provided to the contractor by DEERS to assist with identifying and correcting enrollment fee discrepancies. The contractor shall correct all accounts identified as discrepant. The contractor who is responsible for a beneficiary's current enrollment is responsible for resolving any over/under payments. For split enrollments, the reports will use the billing hierarchy to determine the responsible contractor.

4.8.1 Monthly Under Report (Prior To October 1, 2012)

Enrollment fees are considered delinquent and will show up on the Monthly Under Report when the paid-through date associated with a policy is greater than 60 days in the past. The Under Report will be provided on the first of each month. The contractor is required to analyze and correct all reported delinquencies within 30 days of the report's availability. The corrections may include synchronizing the fee data between the contractor's system and DEERS, correcting data discrepancies, and potentially terminating enrollments for failure to pay fees.

4.8.2 Monthly Over Report (Prior To October 1, 2012)

The Monthly Over Report will identify those policies where the paid amount is over the amount owed. Amount owed is based on the enrollment begin date, the paid-through date, any existing fee waivers, and DEERS data used to determine payment tiers (if applicable) and/or freezes of enrollment fees (premium override periods). The Over Report will be provided before the 10th business day of each month. The contractor is required to analyze and correct all reported accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary.

4.8.3 Quarterly Under Report (Prior To October 1, 2012)

The Quarterly Under Report will identify all terminated policies since the inception of the contract that have an associated paid-through date prior to the termination date. The Quarterly Report will be provided on the first day of the first month of the fiscal quarter (i.e., October 1, January 1, April 1, and July 1). The contractor shall correct all data discrepancies within 60 days of the report's availability.

4.8.4 Monthly Reports (On or After October 1, 2012)

4.8.4.1 DEERS will provide the following reports on a monthly basis:

- Current policies that are two months past due (paid period end date more than two months in the past)
- Any policies where the paid period end date exceeds the policy end date
- Policies where the paid period end date meets the policy end date but a credit exists
- Terminated policies where the paid period end date does not meet the policy end date

4.8.4.2 These reports will be provided before the 10th business day of each month. The contractor is required to analyze and correct all report accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary. For enrollment fee payments effective on or after October 1, 2012, the contractor shall update DEERS with any fee amount refunded within 30 calendar days.

5.0 ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4

5.1 When family members of E-1 through E-4 reside in a Prime Service Area (PSA) of an MTF offering TRICARE Prime, the family members will be encouraged to enroll in TRICARE Prime. Upon enrollment, they will choose or be assigned a PCM located in the MTF. Such family members may, however, specifically decline such enrollment without adverse consequences. The choice of whether to enroll in TRICARE Prime, or to decline enrollment is completely voluntary. Family members of E-1 through E-4 who decline enrollment or who enroll in Prime and subsequently

disenroll may re-enroll at any time. The completion of an enrollment application is a prerequisite for enrollment of such family members.

5.2 Enrollment processing and allowance of civilian PCM assignments will be in accordance with the Memorandum of Understanding between the contractor and the MTF.

5.3 The primary means of identification and subsequent referral for enrollment will occur during in-processing. These non-enrolled families may also be referred to the local TSC by the MTF, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers, and others.

5.4 The local TSC will provide enrollment information and support the family member in making an enrollment decision (i.e., to enroll in TRICARE Prime or to decline enrollment). The education of such potential enrollees shall specifically address the advantages of TRICARE Prime enrollment, including guaranteed access, the support of a PCM, etc. The contractor shall reinforce that enrollment is at no cost for family members of E-1 through E-4 and will give them the opportunity to select or be assigned an MTF PCM, to select a civilian PCM if permitted by applicable MOU, or to decline enrollment in TRICARE Prime.

5.5 The contractor shall also discuss the potential effective date of the enrollment, explaining that the actual effective date will depend upon the date the enrollment application is received, consistent with current TRICARE rules (i.e., the "20th of the month" rule). The effective date of enrollment shall be determined by the date the enrollment application is received by the MCSC. These enrollments and enrollment refusals should not be tracked, nor the enrollees identified differently than enrollments initiated through any other process, such as the MCSC's own marketing efforts.

5.6 Enrollment may be terminated at any time upon request of the enrollee, sponsor or other party as appropriate under existing enrollment/disenrollment procedures. Beneficiaries in this group may re-enroll at any time without restriction or penalty. However, such re-enrollments are subject to the 20th of the month rule.

5.7 Contractors are not required to screen TRICARE claims to determine whether it may be for treatment of a non-enrolled ADFM of E-1 through E-4 living in a PSA. Rather, they are to support the prompt and informed enrollment of such individuals when they have been identified by DoD in the course of such a person's interaction with the military health care system or personnel community and have been referred to the contractor for enrollment.

6.0 TRICARE ELIGIBILITY CHANGES/REFUNDS OF FEES

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

6.2 The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining to enroll in TRICARE Prime until such time as the enrollee loses his/her TRICARE eligibility. The beneficiary shall have the choice of paying the entire enrollment fee or paying the fees on a more frequent basis (e.g., monthly or quarterly). If the enrollee chooses to pay by installments, the contractor shall collect only those installments required to cover the period of eligibility. For enrollment fee payments effective on or after October 1, 2012, DEERS will calculate the paid-through date based on the enrollment fee amount collected and entered into DEERS by the contractor, which in this circumstance, should cover the period of the beneficiary's eligibility.

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Chapter 6, Section 1

Enrollment Processing

The contractor shall refund any overpayment of \$1 or more that DEERS does not use to extend the paid-through date to the policy end date (or the last day of the month in which a Prime policy ends). The contractor shall update DEERS with any fee amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

6.3 Contractors shall refund the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees and their families who have been recalled to active duty. Contractors shall calculate the refund using monthly prorating, and shall report such refunds to DEERS within 30 calendar days. If the reactivated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its PCM, if possible. Any enrollment/fiscal year catastrophic cap accumulations shall be applied to the new enrollment period. The contractor shall include an explanation for the premium refund.

6.4 The contractor shall refund enrollment fees for deceased enrollees upon receiving a written request from the remaining enrollee or the executor of the decedent's estate. The request must include a copy of the death certificate. Refunds shall be prorated on a monthly basis and apply both to individual plans where the sole enrollee is deceased and to the conversion of a family enrollment to an individual plan upon the death of one or more family members. For individual enrollments, the contractor shall refund remaining enrollment fees to the executor of the estate. For family enrollments that convert to individual plans, the contractor shall either credit the excess fees to the individual plan or refund them either to the remaining enrollee or to the executor of the decedent's estate, as appropriate. Enrollment fees for family enrollments of three or more members are not affected by the death of only one enrollee and no refunds shall be issued. The contractor shall update DEERS with any amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

6.5 The contractors shall refund the unused portion of the TRICARE Prime enrollment fee to TRICARE Prime enrollees who become eligible for Medicare Part A based upon disability, End Stage Renal Disease (ESRD) or upon attaining age 65, provided the beneficiary has Medicare Part B coverage. The contractor shall calculate the refund using monthly prorating. The contractor shall update DEERS with any amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

6.5.1 For Prime enrollees who become Medicare eligible upon attaining age 65 and who maintain Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts. The contractor shall utilize its files to substantiate any claim of overpayment.

6.5.2 For Prime enrollees who are under 65 years of age and become Medicare eligible due to disability or ESRD and who maintain Medicare Part B coverage, refunds are required for overpayments starting on the date the enrollee has Medicare Part B coverage. Beneficiaries must provide sufficient documentation to support the overpayment for a refund. The contractor shall supplement the beneficiary's documentation using DEERS and any available internal files, from the current and any prior contracts.

6.5.3 The contractors are not required to research their files to identify these individuals. If the contractor receives a refund request, then the contractor shall refund the unused portion of the enrollment fee determined to be an overpayment in accordance with policy. The contractor shall

update DEERS with any amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

6.5.4 Medicare eligible ADFMs age 65 and over are not required to have Medicare Part B to remain enrolled in TRICARE Prime. To maintain TRICARE coverage upon the sponsor's retirement, they must enroll in Medicare Part B during Medicare's Special Enrollment Period prior to their sponsor's retirement date. (The Special Enrollment Period is available anytime the sponsor is on active duty or within the first eight months of the sponsor's retirement. If they enroll in Part B after their sponsor's retirement date, they will have a break in TRICARE coverage.)

6.5.5 Medicare eligibles age 65 and over who are not entitled to premium-free Medicare Part A are not required to have Medicare Part B to remain enrolled in TRICARE Prime. Because they may become eligible for premium-free Medicare Part A at a later date, under their or their spouse's SSN, they should enroll in Medicare Part B when first eligible at age 65 to avoid the Medicare surcharge for late enrollment.

6.6 The contractor shall include full and complete information about the effects of changes in eligibility and rank in beneficiary education materials and briefings.

7.0 WOUNDED, ILL, AND INJURED (WII) ENROLLMENT CLASSIFICATION

The WII program provides a continuum of integrated care from the point of injury to the return to duty or transition to active citizenship for the Active Component (AC) or the Reserve Component (RC) service members who have been activated for more than 30 days. These AC/RC service members, referred to as ADSMs, have been injured or become ill while on active duty and will remain in an active duty status while receiving medical care or undergoing physical disability processing. WII programs vary in name according to Service. The Service shall determine member eligibility for enrollment into a WII program, as well as whether or not to utilize these enrollments.

To better manage this population, a secondary enrollment classification of HCDP Plan Coverage Codes, WII 415 and WII 416 were developed. The primary rules apply to the WII HCDP codes:

- ADSMs must be enrolled to a TRICARE Prime program prior to, or at the same time, as being enrolled into a WII 415 or WII 416 program.
- A member cannot be enrolled in WII 415 and WII 416 programs at the same time.
- WII 415 and WII 416 enrollments will terminate at the end of the member's active duty eligibility, when members transfer enrollment to another MTF, change of a plan code, or at the direction of the Service-specific WII entity.
- Any claims processed for WII 415/416 enrollees shall follow the rules associated with the primary HCDP Plan Coverage Code, such as TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Overseas Program (TOP) Prime, or TOP Prime Remote. All claims will process and pay under Supplemental Health Care Program (SHCP) rules. DEERS will not produce specific enrollment cards or letters for WII 415/416 enrollment.

WII 415/416 TRICARE Encounter Data (TED) records shall be coded with the WII 415/416

HCDP Plan Coverage Code; however, the Enrollment/Health Plan Code data element on the TED record shall reflect the appropriate value for the primary HCDP Plan Coverage Code. For example, a TED record for a WII 416 enrollee with primary enrollment to TPR would reflect the HCDP Plan Coverage Code of "416" but the Enrollment/Health Plan Code would be coded "W TPR Active Duty Service Member".

7.1 WII 415 - Wounded, Ill, And Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))

7.1.1 Service defined eligible ADSMs assigned to a WII 415 Program such as a MEDHOLD or WTU shall be enrolled to TRICARE Prime or TOP Prime prior to, or at the same time, as being enrolled into the WII 415. Members cannot be enrolled to the WII 415 without a concurrent TRICARE Prime or TOP Prime enrollment. Service appointed WII case managers as determined by the Services, will coordinate with the MTF to facilitate TRICARE Prime PCM assignments for WII 415 members. The contractor shall then assign a PCM in accordance with the MTF MOU and in coordination with the WII case manager. WII 415 enrollment will not run in conjunction with TAMP and members enrolled in TPR, or TOP Prime Remote are not eligible to enroll in the WII 415.

7.1.2 The Service-specific WII entity will stamp the front page of the DD Form 2876, enrollment application form, with WII 415 for new enrollments that begin after the DEERS implementation date. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

- WII 415 HCDP Plan Coverage Code
- WII 415 Enrollment Start Date (Contractors may change the DOES defaulted start date, which may or may not coincide with the Prime Enrollment Start Date. The start date can be changed up to 289 days in the past or 90 days into the future.)

7.1.3 WII 415 enrollments will be in conjunction with an MTF enrollment only, not to civilian network PCMs under TPR enrollment rules. DEERS will end WII 415 enrollments upon loss of member's active duty eligibility. WII 415 program enrollments will not be portable across programs or regions. The TOP contractor will enter WII 415 enrollments through DOES for outside the 50 United States and the District of Columbia.

7.1.4 The contractors shall accomplish the following functions based on receipt of notification from the Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- Contractors can request Policy Notification Transaction (PNT) resend
- Modify begin date
- Modify end date

7.1.5 Service WII entities will provide contractors with a list by name and SSN of those ADSMs currently assigned to their WII program at the time the program is implemented by DEERS. The

contractors shall enter these ADSMs into DOES as enrolled in WII 415 with a start date of the date of implementation, unless another date, up to 289 days in the past, is provided by the WII entity.

7.2 WII 416 - Wounded, Ill, And Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))

7.2.1 Service defined eligible ADSMs may be assigned to a WII 416 Program such as the Army's CBHCO and receive required medical care near the member's home. The service member shall be enrolled to TRICARE Prime, TPR, TOP Prime, or TOP Prime Remote prior to or at the same time as being enrolled into WII 416. Members cannot be enrolled to the WII 416 program without a concurrent Prime, TPR, TOP Prime, or TOP Prime Remote enrollment. Service appointed case managers will coordinate with the contractor or MTF to facilitate TRICARE Prime or TPR PCM assignments for eligible beneficiaries. The contractor shall then assign a PCM based on the MTF MOU and in coordination with the WII entity (e.g., CBHCO). WII 416 enrollments will not run in conjunction with TAMP.

7.2.2 The Service-specific WII Program will stamp the front page of the DD Form 2876, enrollment application form, with WII 416 for all new enrollments. The begin date will be the date the contractors receive the signed enrollment form. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

- WII 416 HCDP Plan Coverage Code
- WII 416 Enrollment Start Date (Date received by the contractor or the date indicated by the Service-specific WII Program which can be up to 289 days in the past, or 90 days in the future.)

An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

7.2.3 WII 416 enrollments can be in conjunction with an MTF, TPR, TOP Prime, or TOP Prime Remote enrollment. DEERS will end WII 416 enrollments upon loss of member's active duty eligibility. WII 416 program enrollments will not be portable across programs or regions.

7.2.4 The contractors shall accomplish the following functions based on receipt of notification from Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- Contractors can request PNT resend
- Modify begin date
- Modify end date

7.2.5 Service-specific WII entities will provide contractors with a list by name and SSN of those ADSMs currently participating in their WII program at the time the program is implemented by DMDC. The contractors shall enter these ADSMs into DOES as enrolled to WII 416 with a start date as the date of implementation, unless another date up to 289 days in the past is provided by the Service-specific WII program entities.

8.0 TRICARE POLICY FOR ACCESS TO CARE (ATC) AND PRIME SERVICE AREA (PSA) STANDARDS

8.1 Non-active duty beneficiaries in the Continental United States (CONUS) and Hawaii who reside more than 30 minutes travel time from their desired PCM must waive primary and specialty drive-time ATC standards. (Due to the unique health care delivery challenges in Alaska, the requirement to request a waiver for the drive-time access standard does not apply to beneficiaries in Alaska.) Before effecting an enrollment or portability transfer request, contractors shall ensure that the applicant has waived travel time ATC standards either by signing Sections V and VI of the DD Form 2876 enrollment application (this includes an electronic signature offered by and collected by the contractor) or by requesting enrollment through the BWE service (for both civilian and MTF PCMs). An approved waiver for a beneficiary residing less than 100 miles from their PCM will remain in effect until the beneficiary changes residence.

8.2 Contractors must estimate the travel time or distance between a beneficiary's residence to a PCM (either a civilian PCM or an MTF) using at least one web-based mapping program. The choice of the mapping program(s) is at the discretion of the contractor, but the contractor must use a consistent process to determine the driving distance for each enrollee applicant who may reside more than 30 minutes travel time from their PCM. The time or distance shall be computed between the enrollee's residence and the physical location of the PCM (including MTFs). It is not acceptable to use a geographic substitute, such as a geographic centroid.

8.3 Contractors (in conjunction with MTFs for MTF enrollees) are responsible for beneficiary drive-time waiver education and must ensure that beneficiaries who choose to waive these standards have a complete understanding of the rules associated with their enrollment and the travel time standards they are forfeiting. This includes educating beneficiaries who waive their ATC travel standards of the following:

- They should expect to travel more than 30 minutes for access to primary care (including urgent care) and possibly more than one hour for access to specialty care services.
- They will be held responsible for POS charges for care they seek that has not been referred by their PCM (or for MTF enrollees, by another MTF provider).
- They should consider whether any delay in accessing their enrollment site might aggravate their health status or delay receiving timely medical treatment.

8.4 Enrollment shall only be effected for beneficiaries who reside in the Region. If at any point during the enrollment period the contractor determines or is advised that a beneficiary's residential address is outside the Region, the contractor shall inform the beneficiary of the discrepant address situation. This notification shall occur when the discrepant information is known to the contractor (i.e., not wait until the end of the enrollment period). When there is a discrepant address situation, the contractor shall confirm with the beneficiary the correct address. If the beneficiary confirms

that a DEERS-recorded address is incorrect, the contractor shall request the beneficiary update DEERS with correct information (and assist as appropriate). If the contractor determines that the beneficiary resides outside the Region in which they are enrolled, the contractor shall inform the beneficiary no later than two months prior to expiration of the current enrollment period that enrollment will not be renewed to a Region in which they do not reside. The contractor shall provide information necessary for the beneficiary to contact the contractor for the region in which they do reside to request enrollment in that region.

8.5 MTF Enrollees

8.5.1 Non-active duty beneficiaries must reside within 30 minutes travel time from an MTF to which they desire to enroll. If a beneficiary desiring enrollment resides more than 30 minutes (but less than 100 miles) from the MTF, they may be enrolled so long as they waive primary and specialty ATC standards and the MTF Commander (or designee) approves the enrollment. (If the MOU includes zip codes or drive-time distances for which the MTF is willing to accept enrollments that are beyond a 30 minute drive, this constitutes approval. If not addressed in the MOU, the contractor shall submit each request to the MTF Commander (or designee) in a method that is outlined in the MOU.) The TRICARE Regional Office (TRO) Director may approve waiver requests from beneficiaries who desire to enroll to an MTF and who reside 100 miles or more from the MTF. In these cases, the MTF Commander must also be agreeable to the enrollment and have sufficient capacity and capability.

8.5.2 The contractor shall process all requests for enrollment to an MTF in accordance with the MOU between the MTF and the contractor. Enrollment guidelines in MOUs may include:

8.5.2.1 Zip codes and/or distances for which the MTF Commander is mandating enrollment to the MTF. These mandatory MTF enrollment areas must be within access standards (i.e., a 30 minute drive-time of the MTF) and can apply to all eligible beneficiaries or can be based on beneficiary category priorities for MTF access.

Note: Non-active duty TRICARE Prime applicants who reside more than 30 minutes travel time from an MTF must be afforded the opportunity to enroll with a civilian PCM if they live in a PSA.

8.5.2.2 Zip codes and/or distances for which the MTF Commander is willing to accept enrollment. This can include both areas within a 30 minute or less drive-time and over a 30 minute drive but within 100 miles. Any enrollment for a beneficiary with a drive of more than 30 minutes requires a signed waiver of access standards. If an enrollee applicant resides within a zip code previously determined to lie entirely within 30 minutes travel time from the MTF, the contractor need not compute the travel time for that applicant.

8.5.2.3 Whether or not the MTF Commander will consider a request for enrollment for 100 miles or greater. In determining whether or not the MTF Commander will consider a request for enrollment beyond 100 miles, the MTF Commander may use zip codes to designate those areas the MTF Commander will consider requests or will not consider requests.

8.5.3 The contractor shall notify the MTF Commander (or designee) when a beneficiary residing 100 miles or more from the MTF, but in the same Region, requests a new enrollment or portability transfer to the MTF. Such notification is not necessary if the MOU has already established that the MTF Commander will not accept enrollment of beneficiaries who reside 100 miles or more

from the MTF. The contractor shall make this notification by any mutually agreeable method specified in the MOU. The contractor shall not make the MTF enrollment effective unless notified by the MTF to do so.

8.5.3.1 The MTF Commander will notify the TRO Director of their desire to enroll a beneficiary who resides 100 miles or greater from the MTF and request approval for the enrollment. The TRO Director will make a determination on whether or not to approve or deny the request and notify the MTF Commander of their decision by a mutually agreeable method. The MTF Commander is responsible for notifying the contractor of all approved enrollment requests for beneficiaries who reside 100 miles or greater from the MTF. The contractor shall notify the beneficiary of the final decision.

8.5.3.2 Approved waivers for beneficiaries residing 100 miles or more from the MTF shall remain in effect until the beneficiary changes residence or unless the MTF Commander determines that they will no longer allow these enrollments. Even if a beneficiary has previously waived travel time standards, any MTF Commander may revise the MOU (following the MOU revision process) to state that enrollment of some or all current enrollees who reside 100 or more miles from the MTF are not to be renewed at the end of the enrollment period. The contractor shall inform such beneficiaries no later than two months prior to expiration of the current enrollment period that they are no longer qualified for renewal of enrollment to the MTF. Prior to notification, the contractor shall obtain the rationale for the change from the MTF to include in the notice to the beneficiary. The proposed notice shall be reviewed and concurred on by the TRO prior to being sent to the impacted beneficiaries. (The TRO will coordinate notices with the TRICARE Management Activity (TMA) Communication and Customer Service (C&CS) prior to approval.)

8.5.4 At any time during the enrollment period, if the contractor determines there is no signed travel time waiver on file for a current MTF enrollee who resides more than 30 minutes from the MTF, the contractor shall, at the next annual TRICARE Prime renewal point, require the beneficiary to waive the primary and specialty care ATC standards before the enrollment will be renewed. (This includes monitoring address changes received by the contractor from all sources.) The contractor shall notify the beneficiary of this waiver requirement no later than two months before expiration of the annual enrollment period. The language for all beneficiary notices shall be reviewed and concurred on by the TRO prior to being sent to beneficiaries. (The TRO will coordinate notices with TMA C&CS prior to approval.)

- Any notice to a beneficiary that is requesting they sign a waiver of access standards, denying their enrollment, or advising them they are not eligible for re-enrollment to an MTF, shall include information on any alternative options for enrollment. The notice must also advise the beneficiary of the option to participate in TRICARE Standard, Extra, or the USFHP where available.

8.5.5 For each approved enrollment to an MTF where the beneficiary has waived access standards (whether by DD Form 2876 or BWE), the contractor shall retain the enrollment request in a searchable electronic file until 24 months after the beneficiary is no longer enrolled to the MTF. The contractor shall provide the retained file to a successor contractor at the end of the final option period.

8.5.6 When an enrollment request requires MTF Commander or TRO Director approval, any contractual requirements relating to processing timeliness for enrollment requests will begin when

the contractor has obtained direction from the MTF Commander or TRO Director regarding waiver approval or disapproval.

8.5.7 The contractor shall apprise the MTF Commander (or designee) of all enrollees to the MTF who have waived their ATC travel standards. The contractor shall separate the information into two categories, those who reside within 100 miles of the MTF and those who reside 100 miles or more from the MTF. This notification shall be by any mutually agreement means specified in the MOU between the contractor and the MTF Commander.

8.6 Civilian Enrollees

8.6.1 Within a PSA, the civilian network must have the capability and capacity to allow beneficiaries who reside in the PSA to enroll to a PCM within access standards. If a beneficiary who resides in the PSA requests enrollment to a specific PCM who is located more than a 30 minute drive from the beneficiary's residence, the contractor may allow the enrollment so long as the beneficiary waives travel time access standards. (Also, see [Chapter 5, Section 1.](#))

8.6.2 For new enrollments (including portability transfers), the contractor is not required to establish a network with the capability and capacity to grant enrollment to beneficiaries who reside outside a PSA. Requests for new enrollments to the civilian network from beneficiaries residing outside a PSA will be granted provided there is sufficient unused network capacity and capability to accommodate the enrollment and that the PSA civilian network PCM to be assigned is located less than 100 miles from the beneficiary's residence. Beneficiaries who reside outside the PSA and enroll in TRICARE Prime must waive their primary and specialty care travel time access standards. (The network shall have the capability and capacity to allow beneficiaries enrolled in TRICARE Prime, residing outside of PSAs, with a civilian network PCM prior to the beginning of Option Period One of the applicable regional Managed Care Support (MCS) contract to enroll to a PSA PCM provided the beneficiary resides less than 100 miles from an available network PCM in the PSA and waives both primary and specialty care travel time standards.)

8.6.3 Beneficiaries who reside outside the PSA and are 100 miles or greater from an available civilian network PCM in the PSA shall not be allowed to enroll in TRICARE Prime.

- END -

8.0 BENEFICIARY SIGNATURE WAIVER

8.1 Administrative Tolerance - Certain Ancillary Services

Claims for inpatient anesthesia, laboratory and other diagnostic services in the amount of \$50 or less, provided by physician specialists in anesthesiology, radiology, pathology, neurology and cardiology should not be returned for beneficiary signature unless required by state law or contractor corporate policy. Claims submitted by an institution when the claim is for those specific ancillary services cited above, should be included in this tolerance if the services were performed in an institution other than the institution in which the beneficiary is receiving inpatient care.

8.2 Beneficiary (Sponsor, Guardian Or Parent Moved) Unable To Locate

8.2.1 Requirements for a beneficiary's (sponsor, guardian or parent) signature should be waived in the following situations for claims received from non-network participating providers. The contractor should grant a waiver after the procedures described below have proven unsuccessful. If unable to obtain a signature because the beneficiary has moved and left no forwarding address, the contractor shall attempt to obtain the address by telephone or from internal files, or Defense Enrollment Eligibility Reporting System (DEERS). **If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.4, paragraph 1.3.1, Addresses.**

8.2.2 If a new address is obtained, the original claim should be returned to the beneficiary or sponsor with a request for signature. If the claim was submitted by a provider, a copy, with the diagnosis and any sensitive information deleted, shall be sent to the beneficiary or sponsor. If the signature is not obtained because the new address is still not valid and the patient cannot otherwise be located, the contractor should grant a signature waiver for a participating provider. Nonparticipating provider claims must be denied. However, if the address is valid, and the contractor knows, through the claim development process, that the beneficiary or sponsor does not wish to file a claim, the claim(s) must be denied whether or not the provider participates. If the contractor obtains a new address, this address cannot be released to the provider.

9.0 NETWORK PROVIDER SIGNATURE

Signature requirements for network providers are dependent upon the provisions of the agreement and administrative procedures established between the providers and the contractor.

10.0 NON-NETWORK PROVIDER SIGNATURE

The signature of the non-network provider, or an acceptable facsimile, is required on all participating claims. The provider's signature block Form Locator (FL) has been eliminated from the CMS 1450 UB-04. As a work around, the National Uniform Billing Committee (NUBC) has designated FL 80, "Remarks", as the location for the signature, if signature on file requirements do not apply to the claim. If a non-network participating claim does not contain an acceptable signature, return the claim. The provider's signature is also required to certify services rendered when a provider completes a nonparticipating claim for the beneficiary. If the provider does not sign, the contractor may contact the provider by telephone to verify the delivery of services or return the claim for

signature. A claimant may also attach an itemized bill on the letterhead/billhead of the provider verifying delivery of services.

10.1 Facsimile Or Representative Signature Authorization

In lieu of a provider's actual signature on a TRICARE claim, a facsimile signature or signature of a representative should be accepted if the contractor has on file a notarized authorization from the provider for use of a facsimile signature ([Addendum A, Figure 8.A-2](#)) or a notarized authorization or power of attorney for another person to sign on his or her behalf ([Addendum A, Figure 8.A-3](#)). The facsimile signature may be produced by a signature stamp or a block letter stamp, or it may be computer-generated, if the claim form is computer-generated. The authorized representative may sign using the provider's name followed by the representative's initials or using the representative's own signature followed by Power of Attorney (POA), or similar indication of the type of authorization granted by the provider.

10.2 Verification Of Provider Signature Authorization

In the absence of any indication to the contrary, contractors should assume the proper authorization is on file, validating through file checks, those claims containing facsimile and representatives' signatures which are included in their quality control audit, and program integrity samples. The contractor should remind providers of the requirement for current signature authorizations through at least annual notice in routine bulletins or newsletters and at other appropriate times when contacts are made. The contractor may return a claim with a request for the signature authorization when it is found that there is no authorization on file or it is out-of-date:

- Send a request to the provider advising of the need for authorization; and
- Set a utilization flag on the provider's file to stop further payment to the provider when the proper signature is not on the claim, pending receipt of the authorization.
- Advise the provider that if the authorization is not received, it will be necessary to deny the claim or to process it as a nonparticipating claim, depending on the information available to make a payment determination.
- Schedule a contractor representative visit to resolve any problem which may develop in the unlikely event a provider chooses not to cooperate.

10.3 Certification Of Source Of Care

Source of care certification is used to help determine the correct payee on the participating UB-92/UB-04 and the CMS 1500. The CMS 1450 UB-04 has eliminated the provider's signature block FL from the form. As a work around, the NUBC has designated FL 80, "Remarks", as the location for the signature, if signature on file requirements do not apply to the claim. Submission of the UB-04 claim form by an institution or provider certifies the institution or provider is complying with all the TRICARE certifications on the reverse of the claim. Provider signature on file requirements apply to the claims if not signed. If signed by the provider and the certification is unaltered, issue payment to that provider. If signed with alteration of the certification, issue payment to the beneficiary (parent/legal guardian of minor or incompetent). If unsigned and an itemized billing on the provider's letterhead is not attached, return the claim.

4.2 Changes in TRS Coverage

Once TRS coverage is in effect, TRS members, which include TRS-covered survivors, may request the following types of changes.

4.2.1 Type of Coverage Changes

A TRS member/survivor may change TRS type of coverage following procedure for a QLE specified in [paragraph 4.1.2](#) or procedures for open enrollment specified in [paragraph 4.1.3](#). The contractor shall follow procedures specified in [paragraph 5.5](#) for premium adjustments resulting from changes in coverage.

4.2.2 Addition Of Family Members to TRS Member and Family Coverage

TRS members/survivors may request to add eligible family members to an existing TRS member and family coverage plan at any time, once eligibility for the family is established. Eligibility is established by going to a military personnel office with RAPIDS capability to appropriately update DEERS. The effective date of coverage for the added family member(s) shall follow procedures specified in [paragraphs 4.1.2](#) or [4.1.3](#). The TRS request must be either received in the TSC or postmarked NLT 60 days after that date.

4.2.3 TRS Newborn/New Child Policy

4.2.3.1 A newborn/new child will be covered from the date of birth/custody only if, (a) the TRS member registers the newborn/new child in DEERS within 60 days of birth/custody, and (b) the TRS request is either received in the TSC or postmarked NLT 60 days after the date of birth/custody. The contractor shall handle claims associated with the newborn/new child as specified in [paragraph 6.2](#). The contractor shall make adjustments in premiums as specified in [paragraph 5.5](#).

4.2.3.2 TRS members who reside overseas may have difficulty in obtaining the documentation required to register a newborn/new child in DEERS. As with all other late submissions of enrollment requests, the member may submit a request for reconsideration to the appropriate TRICARE Regional Director (RD) (or their designee), or the TRICARE Area Office (TAO) Director consistent with [paragraph 4.5.1](#).

4.3 Processing

4.3.1 The contractor shall process all TRS transactions through DOES for members or survivors with a DEERS residential address in the contractor's region. The contractor shall process TRS requests received along with **the initial** premium payment ([see paragraph 4.1](#)) NLT **10 business** days after receipt.

4.3.2 If the contractor is unable to enroll the member/survivor in DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premium payment, or (e) the initial premium payment not being in the correct amount; the contractor shall return a copy of the original application and any incorrect premium payments to the member, within **10 business** days, with an explanation of what is needed for the contractor to accept the application for processing.

4.4 Termination of TRS Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 business days after the effective date of the termination or after receipt of a Policy Notification Transaction (PNT) notifying the contractor of a termination, whichever is later. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund. **If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.4, paragraph 1.3.1, Addresses.**

4.4.1 Loss of TRS Eligibility

The effective date of termination for a member covered under TRS shall be the effective date of the loss of their qualification for TRS coverage. The Selected Reserve member or their family members will not incur a lockout when coverage is terminated due to a loss of TRS eligibility.

4.4.1.1 Sponsor Loss of Eligibility

When a sponsor's eligibility is terminated at a date other than the anticipated end date, DEERS will send the contractor an unsolicited PNT advising the contractor of the terminated coverage. When a sponsor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage.

4.4.1.2 Individual Family Member or Survivor Loss of Eligibility

In the case of a family member or survivor losing eligibility in DEERS, DEERS will send the contractor an unsolicited PNT advising the contractor to terminate coverage for that individual. When an individual family member's or survivor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage. The contractor shall terminate coverage for the family member(s) or survivor(s) as appropriate.

4.4.2 Member or Survivor Gains Other TRICARE Coverage

No lockout shall be applied for termination due to the gain of other TRICARE coverage.

4.4.2.1 If a TRS member gains other TRICARE coverage for a period of 30 days or less, TRS coverage will continue unchanged.

4.4.2.2 If a TRS member or survivor gains other TRICARE coverage for a period of more than 30 days, DEERS will terminate TRS coverage in accordance with [paragraph 4.4.1.1](#). The contractor must be aware of the fact that DEERS may reflect ADSM and ADFM TRICARE coverage before the member actually reports for active duty.

4.4.2.3 If a TRS member gains other TRICARE coverage via a family member, the member and family members may terminate coverage under TRS without incurring a lockout.

4.4.3 Failure to Make Payment

4.4.3.1 Failure to pay monthly premiums in accordance with the procedures in this chapter shall result in termination of coverage. The effective date of termination is the paid-through date. The contractor shall automatically terminate coverage of the TRS member, all covered family members and survivors, if the monthly premium payment is not received by the last day of the month following the due date for the monthly premium payment. After the last day of the month, the contractor shall terminate coverage with a termination effective date retroactive to the paid-through date. DMDC sends written notification to the beneficiary of the termination and the reason for the termination. Until the termination action is processed, the contractor may pend any claims received for health care furnished to the TRS member, family members, and/or survivors during the period for which premiums have yet to be paid, to avoid creating recoupment of health care costs for ineligible beneficiaries. The TRS member, family members, and/or survivors will be responsible for the cost of any health care received after the termination date following retroactive termination of coverage. If claims are not pended, the contractor shall initiate recoupment of health care costs following the procedures in [Chapter 11, Section 4](#).

4.4.3.2 A contractor shall apply a TRS purchase lockout for the RC member and/or family members and/or survivors whose coverage is terminated for failure to make a payment. The lockout shall be for a period of 12 months from the effective date of termination. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes notice of the 12 month lockout period.

4.4.4 Member/Survivor Request for Voluntary Termination

A contractor shall apply a TRS purchase lockout to all beneficiaries covered under the TRS plan for a period of 12 months from the effective date of terminations initiated by the TRS member or survivor.

4.4.4.1 Termination of Existing Plan(s)

The contractor shall accept requests for termination of coverage from TRS members at anytime. The effective date of termination is either (a) the last day of the month in which the request was postmarked or received in the TSC or (b) the last day of a future month as specified in the request given that the request was postmarked or received in the TSC in month preceding the requested month of termination. The contractor shall apply a TRS purchase lockout to all beneficiaries covered by the TRS plan for a period of 12 months from the effective date of terminations initiated by the TRS member or survivor. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes notice of the 12 month lockout period.

4.4.4.2 Termination of an Individual's Coverage

The contractor shall accept requests for termination of coverage for individual family members from TRS members at anytime. The effective date of termination is either (a) the last day of the month in which the request was postmarked or received in the TSC or (b) the last day of a future month as specified in the request, if the request was postmarked or received in the TSC in month preceding the requested month of termination. The contractor shall apply a TRS purchase lockout to individual family members or survivors whose TRS coverage was terminated upon request for a period of 12 months from the effective date of termination initiated by the TRS member or survivor. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes

notice of the 12 month lockout period.

4.4.4.3 Cancelled Eligibility and Enrollment

When the contractor receives a PNT for a cancelled enrollment, the contractor will generate a letter notifying the covered member of the cancellation and refund any unused portion of the premium payment. The contractor shall update DEERS with any premium amount refunded within 30 calendar days. No lockout shall be applied for a cancelled enrollment. The contractor shall include an explanation for the premium refund.

4.4.5 TRS Survivor Coverage Termination

If TRS coverage is continued as described in [paragraph 4.1.4.1](#) and the survivors do not wish to keep the coverage, the survivors must submit a request in writing, in accordance with procedures described in [paragraph 4.1.4.1](#), to be received by the contractor NLT 60 days after the date of death in order to terminate coverage retroactive to the day after the member's death. Alternatively, the survivor may request to terminate coverage in accordance with [paragraph 4.4.4](#). Otherwise, DEERS will terminate TRS survivor coverage six months after the date of the member's death. Refunds of premiums will be handled as specified in [paragraph 4.4](#).

4.5 Exceptions

4.5.1 Reconsiderations of Member's and Survivor's Actions

The contractor shall advise TRS members/survivors that all reconsideration requests for a refusal of a late submission of a request to enroll shall be submitted to the appropriate TRICARE RD or their designee or the TAO Director for determination. The TRICARE RD or their designee or the TAO Director will issue decisions within ten calendar days of receipt for all reconsideration requests. If changes are to be made to a member's/survivor's coverage as a result of a reconsideration determination, the TRICARE RD will send instructions to the contractor. The contractor shall carry out such instructions NLT 10 calendar days after receipt from the TRICARE RD or their designee or the TAO Director. The TRICARE RD, or their designee, or the TAO Director may authorize an "override" of information contained on DEERS, pending a system update, based on appropriate documentation regarding eligibility under the law, regulation and policy.

4.5.2 Administrative Issues

The TRICARE RD or their designee or the TAO Director will notify the contractor when the government determines that an administrative situation occurred that prevented a member's or survivor's request from being accepted for processing according to submission deadlines specified in this section.

5.0 PREMIUM BILLING AND COLLECTION

The contractor shall perform all premium and billing functions required for TRS. Members/survivors are responsible for all premium payments for the type of coverage elected (i.e., TRS member-only or TRS member and family). All applicable billing will be monthly; neither annual nor quarterly billings are authorized. Premium related transactions shall be reported through the enrollment fee payment interface (see the TSM, [Chapter 3, Section 1.4, paragraph 1.2.8.1](#)).

request is either received in the TSC or postmarked NLT 60 days after the date of birth/custody. The contractor shall handle claims associated with the child as specified in [paragraph 6.2](#). The contractor shall make adjustments in premiums as specified in [paragraph 5.5](#).

4.2.3.2 TRR members who reside overseas may have difficulty in obtaining the documentation required to register a newborn/new child in DEERS. As with all other late submissions of completed TRR request forms, the member may submit a request for reconsideration to the appropriate TRICARE Regional Director (RD) (or their designee), or the TRICARE Area Office (TAO) Director consistent with [paragraph 4.5.1](#).

4.3 Processing

4.3.1 The contractor shall process all TRR transactions through DOES for members or survivors with a DEERS residential address in the contractor's jurisdiction. The contractor shall process TRR requests received along with two months premium payment (as required) NLT 10 business days after receipt.

4.3.2 If the contractor is unable to enroll the member/survivor in DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premiums payment, or (e) an underpayment of the initial premium payment; the contractor shall return a copy of the original application and any premium payments to the member, within 10 business days, with an explanation of what is needed for the contractor to accept the application for processing.

4.4 Termination Of TRR Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 business days after the effective date of the termination or after receipt of a Policy Notification Transaction (PNT) notifying the contractor of a termination, whichever is later. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund. **If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.4, paragraph 1.3.1, Addresses.**

4.4.1 Loss of TRR Eligibility

The effective date of termination for a member or survivor covered under TRR shall be the effective date of the loss of his or her qualification for TRR coverage. No lockout shall be applied for termination due to loss of TRR eligibility.

4.4.1.1 Sponsor Loss of Eligibility

When a sponsor's eligibility is terminated at a date other than the anticipated end date, DEERS will send the contractor an unsolicited PNT advising the contractor of the terminated coverage. When a sponsor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage.

4.4.1.2 Individual Family Member or Survivor Loss of Eligibility

In the case of a family member or survivor losing eligibility in DEERS, DEERS will send the contractor an unsolicited PNT advising the contractor to terminate coverage for that individual. When an individual family member's or survivor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage. The contractor shall update the fee system based on the terminated coverage for the family member(s) or survivor(s) as appropriate.

4.4.2 Member Gains Other TRICARE Coverage

No lockout shall be applied for termination due to a gain of other TRICARE coverage.

4.4.2.1 If a TRR member gains other TRICARE coverage for a period of 30 days or less, TRR coverage will continue unchanged.

4.4.2.2 If a TRR member or survivor gains other TRICARE coverage for a period of more than 30 days; DEERS will terminate TRR coverage in accordance with [paragraph 4.4.1.1](#). The contractor must be aware of the fact that DEERS may reflect Active Duty Service Member (ADSM) and Active Duty Family Member (ADFM) TRICARE coverage before the service member actually reports for active duty.

4.4.2.3 If a TRR member gains other TRICARE coverage via a family member, the member and family members may terminate coverage under TRR without incurring a lockout.

4.4.3 Failure to Make Payment

4.4.3.1 Failure to pay monthly premiums in accordance with the procedures in this chapter shall result in termination of coverage. The effective date of termination is the paid-through date. The contractor shall automatically terminate coverage of the TRR member, all covered family members and survivors if the monthly premium payment is not received by the last day of the month following the due date for the monthly premium payment. After the last day of the month, the contractor shall terminate coverage with a termination effective date retroactive to the paid-through date. DMDC sends written notification to the beneficiary of the termination and the reason for the termination. Until the termination action is processed, the contractor may pend any claims received for health care furnished to the retired member, family members and/or survivors during the period for which premiums have yet to be paid, to avoid creating recoupment of health care costs for ineligible beneficiaries. The TRR member, family members and/or survivors will be responsible for the cost of any health care received after the termination date following retroactive termination of coverage. If claims are not pending, the contractor shall initiate recoupment of health care costs following the procedures in [Chapter 10, Section 4](#).

4.4.3.2 A contractor shall apply a TRR purchase lockout to the Retired Reserve member, family members, and/or survivors. The lockout shall be for a period of 12 months from the effective date of termination. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes notice of the 12 month lockout period.

4.4.4 Member/Survivor Request for Voluntary Termination

4.4.4.1 Termination of Existing Plan(s)

The contractor shall accept requests for termination of coverage from TRR members/survivors at anytime. The effective date of termination is either (a) the last day of the month in which the request was postmarked or received in the TSC or (b) the last day of a future month as specified in the request given that the request was postmarked or received in the TSC in the month preceding the requested month of termination. The contractor shall apply a TRR purchase lockout to all beneficiaries covered by the TRR plan for a period of 12 months from the effective date of terminations initiated by the TRR member or survivor. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes notice of the 12 month lockout period.

4.4.4.2 Termination of an Individual's Coverage

The contractor shall accept requests for termination of coverage for individual family members or survivors from TRR members/survivors at anytime. The effective date of termination is either (a) the last day of the month in which the request was postmarked or received in the TSC, or (b) the last day of a future month as specified in the request given that the request was postmarked or received in the TSC in month preceding the requested month of termination, or (c) as otherwise specified. The contractor shall apply a TRR purchase lockout to individual family members or survivors whose TRR coverage was terminated upon request for a period of 12 months from the effective date of terminations initiated by the TRR member or survivor. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes notice of the 12 month lockout period.

4.4.4.3 Cancelled Eligibility and Enrollment

When the contractor receives a PNT for a cancelled enrollment, the contractor will generate a letter notifying the covered member/survivor of the cancellation and refund any unused portion of the premium payment. The contractor shall update DEERS with any premium amount refunded within 30 calendar days. No lockout shall be applied for a cancelled enrollment. The contractor shall include an explanation for the premium refund.

4.4.5 TRR Survivor Coverage Termination

If TRR coverage is continued as described in [paragraph 4.1.4.1](#) and the survivors do not wish to keep the coverage, the survivors must submit a request in writing in accordance with procedures described in [paragraph 4.1.4.1](#) for receipt by the contractor NLT 60 days after the date of death in order to terminate coverage retroactive to the day after the member's death and no lockout is applied. Alternatively, the survivor may request to terminate coverage in accordance with [paragraph 4.4.4](#). Otherwise, DEERS will terminate TRR survivor coverage on the date on which the deceased member of the Retired Reserve would have attained age 60. Refunds of premiums will be handled as specified in [paragraph 4.4](#).

4.5 Exceptions

4.5.1 Reconsiderations of Member's and Survivor's Actions

The contractor shall advise TRR members/survivors that all reconsideration requests for a

(a) refusal of a late submission of a TRR request or (b) lockouts shall be submitted to the appropriate TRICARE RD or their designee or TAO Director for determination. The TRICARE RD or their designee or the TAO Director will issue decisions within 10 calendar days of receipt for all reconsideration requests. If changes are to be made to a member's/survivor's coverage as a result of a reconsideration determination, the TRICARE RD, or their designee or the TAO Director will send instructions to the contractor. The contractor shall carry out such instructions NLT 10 days after receipt from the TRICARE RD or their designee or TAO Director. The TRICARE RD or their designee, or the TAO Director may authorize an "override" of information contained on DEERS, pending a system update, based on appropriate documentation regarding eligibility under the law, regulation and policy.

4.5.2 Administrative Issues

The TRICARE RD, or their designee or TAO Director will notify the contractor when the government determines that an administrative situation occurred that prevented a retired member's or survivor's request from being accepted for processing according to submission deadlines specified in this section.

5.0 PREMIUM BILLING AND COLLECTION

The contractor shall perform all premium and billing functions required for TRR. Retired Reserve members or survivors are responsible for all premium payments for the type of coverage elected (i.e., TRR member-only or TRR member-and-family). All applicable billing will be monthly; neither annual nor quarterly billings are authorized. Premium-related transactions shall be reported through the enrollment fee payment interface (see the TSM, [Chapter 3, Section 1.4, paragraph 1.2.8.1](#)).

5.1 Jurisdiction For Premium Billing And Collection

5.1.1 The particular contractor servicing the address for the TRR member or survivor shall perform premium billing and collection functions for the TRR member/survivor. The contractor shall identify the financially responsible individual for survivor plans from the survivors actually covered by TRR in descending order of precedence:

- Spouse
- Oldest Enrolled Child (or Legal Guardian as applicable)

5.1.2 As part of each applicable monthly bill, the contractor shall provide the opportunity for the TRR member/financially responsible survivor to submit a change of address to the servicing contractor. At any time the servicing contractor notices that a new residential address is in the servicing area of another TRICARE contractor, the contractor shall initiate the actions necessary in DOES to transfer premium collection and other applicable administrative services to the new servicing contractor. The jurisdiction shall be based on the TRR member's or financially responsible survivor's reported new address. Any TRR member/financially responsible survivor may transfer regions at any time. The gaining contractor shall perform the premium collections for overdue and future payments.

5.1.3 All unsolicited PNTs for TRR members/survivors will be evaluated to determine if residential address changes require a transfer of premium collection and other applicable

administrative services to another contractor for servicing. If a transfer is indicated, the contractor will follow requirements specified in [paragraph 5.1.2](#).

5.2 Issuance Of Bills

All applicable bills for premium payments shall be issued on the 10th calendar day of each month, or the next business day, for the following month. All direct bills shall be for full month premiums and/or prorated amounts, if applicable, and shall reflect a due date of the last day of each billing month. Bills shall reflect all payments received through no less than the fifth day of the month. The following statement will appear on all bills: Retired Reserve members (but not survivors) eligible for a health plan under 5 USC 89, the FEHBP, do not qualify for TRR and must submit a request to terminate TRR coverage.

5.3 Premium Collection

The contractor shall credit the TRR member or survivor for premium payments received. All bills shall specify that the premium payment is due for receipt by the contractor NLT the last calendar day of the current month for the following month of coverage. In the case of a start date of coverage at anytime other than the first of a month, the first bill generated by the contractor shall include the prorated amount on a daily basis necessary to synchronize billing to the first of the month. The daily prorated amount shall be equal to 1/30th of the appropriate premium (rounded to the penny) regardless of how many days are actually in the month. The amount of the initial premium payment due may be printed on the prescribed form. For TRR coverage, effective on or after October 1, 2012, DEERS will automatically prorate the premium due for the mid-month enrollments from the effective date of coverage to the end of that first enrollment month, e.g., from the 18th of the month to the 31st.

5.3.1 The contractor shall accept payments by personal check, cashier's check, money order, credit/debit card (i.e., Visa/MasterCard), and Electronic Funds Transfer (EFT). (Effective January 1, 2013, all premium payments (after the initial payment required in [paragraph 4.1](#)) must be made by either recurring EFT or Recurring Credit/Debit Card (RCC) (i.e., Visa/MasterCard).) An EFT payment or a RCC payment shall be processed within the first five business days of the month of coverage. The contractor shall not generate monthly bills on or after January 1, 2013, except when having to correct a problem establishing or maintaining the EFT or RCC payment. The contractor shall advise member/survivors at the time of EFT/RCC election that an insufficient-funds fee of up to \$20 United States (US) may be assessed, if sufficient funds are not available.

5.3.2 The contractor shall be responsible for initiating EFTs and automatic credit/debit card payments with the member's/survivor's financial institution upon request, or when required, to do so by the TRR member/survivor.

5.3.3 The contractor shall directly bill the TRR member/survivor when a problem occurs in initially setting up the EFT or credit card payments when there are insufficient funds to process a monthly EFT. The contractor may apply a fee of up to \$20 US for insufficient funds. The contractor shall include notice of the fee of up to \$20 US when billing the member/survivor. If the contractor is unable to obtain the requested premium payment from the TRR member's/survivor's account for any reason after an EFT or recurring credit card payment is established, the TRR member/survivor will be responsible for paying the overdue premiums and any insufficient-funds fee by means of direct billing.

5.3.4 Premium payments shall be made payable to the contractor servicing the member's or survivor's coverage as specified in [paragraph 5.1](#).

5.4 Annual Premium Adjustment

5.4.1 Contractors shall include advance notification of any annual premium adjustments on the October, November and December monthly bills. (The October notification may not include the actual premium rates for the new year.) The notification shall include the new amount for member-only and member-and-family coverage. For those members/survivors not receiving a monthly bill, the contractor shall issue a notice advising the member/survivor of the adjusted premium amount at the same time the payment is collected in October, November, and December bills are mailed and shall initiate all actions required to allow the continuation of the EFT transaction or credit/debit card payment with the adjusted premium amount.

5.4.2 For premium adjustments that go into effect at any time other than January the first, the government will provide instructions about notification of members/survivors.

5.5 Premium Adjustments From Changes Associated With QLEs

5.5.1 When a QLE is processed that changes the premium, the effective date of the premium change shall be the date of the QLE.

5.5.2 If the change from a QLE results in an increase in the premium, the contractor shall adjust the next bill or electronic payment, to include any underpaid amount (prorated to the day as specified in [paragraph 5.3](#)), to the effective date of the change.

5.5.3 If the change from a QLE results in a decrease in the premium, the contractor shall retain any overpaid amount and apply it to subsequent bills or electronic payments until all of the overpayment is exhausted.

5.6 Terminations

The contractor shall initiate the process to refund any premium amounts applied for coverage after the date of termination as specified in [paragraph 4.4](#).

5.7 Online Transactions

In addition to requirements specified in [paragraph 5.0](#) and its subordinate paragraphs, the contractor may provide online capability for TRR members/survivors to conduct business related to premium collection and other applicable administrative services through secure access to the contractor's web site.

6.0 CLAIMS PROCESSING

6.1 The contractor shall process TRR claims under established TRICARE Standard and TRICARE Extra retiree cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRR.

6.2 The contractor shall pend all claims for health care provided to a newborn/new child of a TRR member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRR member has an unregistered newborn/new child, the contractor shall notify the TRR member of the requirement to register the new child in DEERS and submit a request form for the newborn/new child NLT 60 days after birth/custody. When the member completes the process specified in [paragraph 4.2.3.1](#), the contractor shall process any claims associated with the child's health care. If the member fails to complete the process as specified in [paragraph 4.2.3.1](#), the contractor shall deny any claims associated with the child's health care.

6.3 Premium payments made for TRR shall not be applied to the fiscal year deductible or catastrophic cap limit.

6.4 Non-Availability Statement (NAS) requirements shall apply to TRR members, family members, and survivors in the same manner as for retirees under TRICARE Standard/Extra.

6.5 If a Retired Reserve member purchases TRR during the same calendar year that the member had a TRICARE Reserve Select plan in effect, the catastrophic cap, deductibles and cost shares shall not be recalculated.

6.6 Medicare is the primary payer for TRICARE beneficiaries who have Medicare eligibility. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in the [Chapter 20, Section 3](#). The MCSCs shall follow procedures established in the TRICARE Reimbursement Manual (TRM) ([Chapter 4, Section 4](#)) regarding dual-eligibles' claims processing.

6.7 If the contractor receives a PNT notifying them of a retroactive TRR disenrollment the contractor shall initiate recoupment of claims paid if appropriate as specified in [Chapter 10](#).

6.8 If at anytime the contractor discovers that the Retired Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD or their designee or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRR eligibility. If any other actions are to be taken by the contractor as a result of this discovery, the TRICARE RD or their designee or TAO Director will send instructions to the contractor.

7.0 COMMUNICATIONS AND CUSTOMER SERVICE (C&CS)

In addition to C&CS functions specified throughout this chapter, the contractor shall perform C&CS functions to the same extent as they do for TRICARE Standard and TRICARE Extra.

7.1 Customer Education

7.1.1 Materials (i.e., public notices, flyers, informational brochures, web site etc.) will be developed and distributed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), Office of C&CS. The contractor shall distribute all informational materials associated with the TRR program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRR handbook and other information materials may be obtained through the usual TMA C&CS process.

7.1.2 Upon start of coverage under TRR each contractor shall mail one copy of the TRR handbook to each TRR member/survivor with TRR member-only coverage and one copy to the household of each TRR member/survivor with TRR member-and-family coverage. The member/survivor's servicing contractor shall send additional handbooks upon request, such as when covered family members live in different locations (split locations).

7.2 Customer Service

The contractor shall provide all customer service support in a manner equivalent to that provided TRICARE Standard beneficiaries. When the contractor receives an inquiry involving TRR eligibility or qualifications, the contractor shall refer the individual to the appropriate RC.

8.0 ANALYSIS AND REPORTING

TRR workload shall be included, but not separately identified, in all reports.

9.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED

9.1 Claims Reporting

The contractor shall report TRR program claims according to [Chapter 3](#). The contractor shall process payments on a non-financially underwritten basis for the health care costs incurred for each TRR claim processed to completion according to the provisions of [Chapter 3](#).

9.2 Fiduciary Responsibilities

9.2.1 The contractor shall act as a fiduciary for all funds acquired from TRR premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All premium collections received by the contractor shall be maintained in accordance with these procedures.

9.2.2 Either a separate non-interest bearing account shall be established for the collection and disbursement of TRR premiums or the account used for TRICARE Reserve Select (TRS) premium collections shall be used for TRR premiums as well. The contractor shall deposit premium collections to the established account within one business day of receipt.

9.2.3 The contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified government account as directed by the TMA Contract Resource Management (CRM) Finance and Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the TMA CRM F&AO, by e-mail, within one business day of the deposit, specifying the date and amount of the deposit as well as its purpose (i.e. TRR premiums). Premiums for TRS and TRR may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been transferred to TMA Office of General Counsel-Appeals, Hearings & Claims collection Division (OGC-AC) shall be wire-transferred separately. The contractor shall notify TMA CRM F&AO and TMA OGC-AC by e-mail within one business day of the day of deposit, specifying the sponsor name, sponsor Social Security Number (SSN) (last four digits), payment

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amount, payment date, date case was transferred to TMA OGC-AC and the date and amount of the deposit.

9.2.4 The contractor shall maintain a system for tracking and reporting premium billings, collections, and starts of coverage. The system is subject to government review and approval.

9.2.5 The contractor shall electronically submit monthly reports of premium activity supporting the wire transfer of dollars to the Contracting Officer (CO).

- END -

form (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 turnover in host nation 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 host nation 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 applications at the TSCs or other sites mutually agreed to by the contractor, TAO Director, and the MTF Commander, or by mail or other secure means determined by the contractor. The contractor shall collect TOP Prime Remote service area applications by mail 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 form does not contain a mailing address, the enrollment form should be developed for a mailing address. **If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.4, paragraph 1.3.1, Addresses.** 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 application 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 Enrollment applications must be signed by the sponsor, spouse, or other legal guardian of the beneficiary. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#). A signature from an ADSM, although desired, is not required to complete Prime enrollment as enrollment in Prime is mandatory per TPM, [Chapter 10, Section 2.1, paragraph 1.1](#).

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 on the date that the application is signed 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,

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- 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.

- END -

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.

6.2 Claims may be filed by eligible TRICARE beneficiaries, TOP host nation 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 Beneficiary and host nation provider signatures.

6.6.2 Complete beneficiary and host nation provider name and address.

6.6.3 If an address is not available on the claim, obtain the address either from previously submitted claims, directly from the beneficiary/host nation provider via phone, fax or e-mail, [DEERS per paragraph 6.11](#), or notify the TAO Director as appropriate. **If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.4, paragraph 1.3.1, Addresses.**

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

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

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6.6.5 Identification of the 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.

6.6.6 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 TMA CO. The provisions of [paragraph 6.1](#) apply for narrative claims that cannot be accurately coded due to insufficient or vague information. Claims received with International Classification of Diseases, 10th Revision (ICD-10) codes shall be converted to International Classification of Diseases, 9th Revision (ICD-9) codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraph 4.0](#) regarding the use of "V" codes.

6.6.7 Care authorizations (when required).

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

6.6.9 Proof of payment is required for all beneficiary submitted claims if the claim indicates that the beneficiary made payment to the provider or facility. 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 TMA 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.

6.11 The TOP contractor shall use \$3,000 as the overseas pharmacy service drug tolerance. A limited waiver to the NDC coding and payment requirements (where required) may be granted for overseas claims for pharmaceuticals submitted from low volume/small overseas pharmacy providers or TRICARE eligible beneficiaries from the Philippines, Panama, and Costa Rica and any other country designated by TMA, when it would create an undue hardship on a beneficiary. High volume providers who provide pharmaceuticals in the Philippines, Panama, and Costa Rica (and any other country designated by TMA) would not qualify for the limited waiver. See [Section 14](#) for specific NDC coding and payment requirements.

6.12 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 14](#) apply.

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

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

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

6.15 The TOP contractor shall deny claims from non-certified or non-confirmed host nation providers when the TMA CO has directed contractor certification/confirmation of the host nation provider prior to payment.

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

6.17 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.

6.18 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.

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

6.20 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's 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.

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

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6.22 The TOP contractor shall pay all non-emergency and emergency civilian/medical surgical and dental claims for TRICARE Eurasia-Africa, TLAC, and Pacific ADSM health care even when not a TRICARE covered benefit when the claim is:

6.22.1 Submitted by the MTF or other military command personnel, or by a designated POC; and

6.22.2 Accompanied by a completed and signed TRICARE claim form; and

6.22.3 Accompanied by either a Standard Form (SF) 1034, a Standard Form 1035 continuation sheet, a Naval Medical (NAVMED) Form 6320/10 (these forms shall be considered an authorization for payment), or a referral from the ADSM's PCM or designee; and

6.22.4 DEERS verification indicates the TRICARE Eurasia-Africa, TLAC, and Pacific ADSM was on Active Duty (AD) at the time the services were rendered.

Note: The SF 1034, SF 1035 continuation sheet or NAVMED 6320/10 must be signed by the submitting military command. If a patient signature is not present on the claim form, the military command must submit a letter of explanation with the unsigned claim form prior to payment.

6.23 Upon payment for a TOP enrolled ADSM overseas claim, a copy of the EOB and, when applicable, the SF 1034 or SF 1035 or NAVMED 6320/10 shall also be manually submitted to the MTF, or MTF command personnel, or a designated POC.

6.24 Emergency submitted non-remote ADSM claims for health care received overseas/stateside not meeting TPM, [Chapter 2, Section 4.1](#) policy on emergency department services shall be denied explaining the reason of denial and advising resubmission with proper forms by the appropriate MTF, etc.

6.25 The TOP contractor shall deny non-remote TRICARE Eurasia-Africa, TLAC, and Pacific ADSM claims for health care received overseas when any one of the administrative items are missing. Upon denial, the contractor shall instruct the non-remote TRICARE Eurasia-Africa, TLAC, and TRICARE Pacific ADSM/host nation provider to contact the local MTF or other military command personnel, for assistance in proper claim submission and in obtaining missing documentation. Copies of EOB and claims denied as DEERS ineligible or not submitted by an MTF shall be electronically forwarded to the appropriate overseas TAO Director for further action.

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

6.27 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.

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

6.29 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).

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

6.31 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 TMA Beneficiary and Provider Services (BPS). 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](#)).

6.32 The provisions of [Chapter 8, Section 6, paragraph 10.0](#) shall apply to the TOP.

6.33 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 host nation 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.

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 TMA) with their claim. The TOP contractor shall waive the requirement for an EOB from the NHI plan when accompanied by the TMA-approved documentation.

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, etc.

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12.2 Reimburse claims at the lesser of the billed amount, the negotiated reimbursement rate, 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](#).

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 TMA. 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/host nation 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.

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 TMA. U.S. dollar checks are good for 120

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days unless a different process has been established by TMA. 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 payment may not be changed to U.S. dollars after the foreign draft has been issued.

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 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 host nation 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 Not honor any draft request for currency change, except when directed by the appropriate TMA COR, once a foreign currency draft has been issued by the TOP contractor and the draft has been returned with the request.

12.18 Shall mail the drafts/checks and EOB to host nation 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 EOB to Philippine providers, and other nations' providers as directed by the TMA CO, shall be mailed to the place of service identified on the claim. No provider for Philippine providers, and other nations' providers as directed by the TMA CO may be sent to any other address.

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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 Provider requests for EFT payment. Upon host nation 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.

12.22 The TOP contractor shall process 85% of all retained and adjustment TOP claims to completion within 21 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 host nation provider recoupments. Recoupment actions shall be conducted in a manner that is considered culturally appropriate for the host nation 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 TMA 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, and Spain, shall be written in the respective language.

13.5 The TOP contractor may hand write the dollar amount and the host nation 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 from TRICARE Eurasia-Africa overseas for host nation 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 -

4.1.2 Continuation Coverage

A young adult dependent may purchase TYA coverage with an effective date immediately following the termination of coverage under another TRICARE program, including the CHCBP. The TYA application required by [paragraph 4.1](#) along with an initial payment (see [paragraph 4.1](#)) of premiums, must either be received in the TSC, entered into the BWE application, or postmarked NLT 30 days following termination of coverage. See [paragraph 10.0](#) and the TRICARE Policy Manual (TPM), [Chapter 10, Section 4.1](#), for information regarding termination of CHCBP coverage and refund of CHCBP premiums. If the young adult dependent does not meet the requirement for continuation or retroactive coverage, the application will be processed as a new application. If the young adult dependent does not meet the requirement for continuation or retroactive coverage, the application will be processed as an open enrollment application.

4.1.3 Retroactive TYA Standard/Extra Coverage

A qualified young adult dependent may elect retroactive TYA Standard/Extra coverage effective as of January 1, 2011, if the dependent was eligible as of that date. If retroactive coverage is elected, TYA Standard/Extra premiums must be paid for the time period between January 1, 2011, and the date of the election, along with at least the initial payment (see [paragraph 4.1](#)) of prospective premiums, or as eligible. If retroactive coverage is requested but the young adult dependent was not eligible for TYA Standard/Extra coverage on January 1, 2011, then the date the young adult dependent became eligible for TYA Standard/Extra coverage shall be used as the coverage effective date. Premiums are to be prorated as necessary for the time period between the coverage effective date and the date of election, which includes at least the initial months of prospective coverage, or as eligible. No purchase of retroactive coverage may take place after September 30, 2011. Retroactive coverage is limited to the TYA Standard/Extra benefit only. See [paragraph 10.0](#) and the TPM, [Chapter 10, Section 4.1](#), for information regarding termination of CHCBP coverage and refund of CHCBP premiums.

4.1.4 Changing Coverage Within Same Contractor

4.1.4.1 Upon receipt of an application, qualified dependents already enrolled in a TYA plan and who are current in their premium payments may elect to change to another TYA plan for which the qualified dependent is eligible based on the sponsor's eligibility and the geographic location of the qualified young adult dependent. Changes in coverage are effective following the application processing time frames listed in [paragraph 4.1.1](#).

4.1.4.2 If the premium amount changes, the contractor will adjust future premiums by applying any overages to future TYA premium payments, and adjusting the Electronic Funds Transfer/Recurring Credit/Debit Charge (EFT/RCC) payments so the young adult dependent is not over or undercharged for the coverage requested.

4.1.5 Transfer of Coverage to Another Contractor

Young adult dependents desiring to transfer TYA coverage to another contractor must submit a new application to the desired contractor. Transfer of TYA coverage to another contractor is only permitted if the young adult dependent is current with their premiums. The gaining contractor shall process transfer requests within 10 calendar days.

4.2 Processing

4.2.1 The contractor shall process all TYA transactions through Web DOES for young adult dependents with a residential address as indicated by the TYA purchaser on the TYA application in the contractor's jurisdiction. The contractor shall process TYA requests received along with at least an initial payment (see [paragraph 4.1](#)) (as required) NLT 10 calendar days after receipt.

4.2.2 The contractor shall assign Primary Care Managers (PCMs) to purchasers of TYA Prime coverage per [Chapter 6](#).

4.2.3 If the contractor is unable to enroll the young adult dependent in Web DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premiums payment, or (e) an underpayment of the initial premium payment; the contractor shall provide notification to the young adult dependent, initiated within 10 calendar days of receipt of the application, with an explanation of what is needed for the contractor to accept the application for processing and return any premium amounts if appropriate.

4.3 Termination Of TYA Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 calendar days after the effective date of the termination or after receipt of a Policy Notification Transaction (PNT) notifying the young adult dependent's contractor of a termination, whichever is later. Premium refunds, to include an explanation of the premium refund, will be sent to young adult dependent's residential address unless an alternate mailing address has been provided. **If the contractor uses DEERS to determine an address and it is determined that the mailing address is invalid, it shall not be used. Invalid addresses are noted by an updated Mail Delivery Quality Code (MDQC), which indicates that mail is undeliverable to that address. See the TSM, Chapter 3, Section 1.4, paragraph 1.3.1, Addresses.** The contractor shall also update DEERS with any premium amount refunded within 30 calendar days.

4.3.1 Loss Of TYA Qualification

At any time a young adult dependent ceases to meet all eligibility qualifications, coverage under the TYA program shall terminate. This could be due to the sponsor's losing eligibility for care. The effective date of termination shall be the date upon which the young adult dependent ceased to meet any of the prerequisite qualifications. If a subsequent change in circumstances occurs such as losing eligibility for an eligible employer-sponsored plan, the young adult dependent may qualify again to purchase coverage under the TYA program. Young adult dependents who age out of TYA at age 26 may be eligible to purchase CHCBP coverage (see [TPM, Chapter 10, Section 4.1](#)).

4.3.1.1 Change in Sponsor Status

4.3.1.1.1 A change in sponsor status (active to retired; active duty to the Reserve Component (RC), etc.), may require the young adult dependent's coverage to be transferred to another TYA coverage plan or cause TYA coverage to be terminated.

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Acronyms And Abbreviations

KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
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
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
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
MDQC	Mail Delivery Quality Code

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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
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
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
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMSO	Military Medical Support Office
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
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

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MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
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
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
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
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
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility

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NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHHD	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
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
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)

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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 of Civil Rights
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
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
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking

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PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
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
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	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
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
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PPPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information

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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
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
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
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
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

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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
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
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
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