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TRICARE  
MANAGEMENT ACTIVITY

OD

CHANGE 90  
6010.56-M  
DECEMBER 17, 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:** REMOVAL OF MAIL DELIVERY QUALITY CODE (MDQC)

**CONREQ:** 15806

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change removes all references to the MDQC.

**EFFECTIVE DATE:** Upon direction of the Contracting Officer.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 83, Feb 2008 TRM, Change No. 77, and Feb 2008 TSM, Change No. 45.

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DN: c=US, o=U.S. Government, ou=DoD,  
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Date: 2012.12.13 17:10:06 -0700

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**ATTACHMENT(S):** 52 PAGES  
**DISTRIBUTION:** 6010.56-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**CHANGE 90**  
**6010.56-M**  
**DECEMBER 17, 2012**

**REMOVE PAGE(S)**

**CHAPTER 6**

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**CHAPTER 8**

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**CHAPTER 24**

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**CHAPTER 25**

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**APPENDIX A**

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## Enrollment Processing

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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](#).

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#### Enrollment Processing

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**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.

**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

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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.

**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.

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**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 URS.

#### **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. 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 include an explanation to the beneficiary for the fee refund. The contractor shall update DEERS with any fee amount refunded within 30 calendar days.

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#### Enrollment Processing

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**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. The contractor shall include an explanation to the beneficiary for the fee refund. 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.

**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 contractor shall include an explanation to the beneficiary for the fee refund. The enrollee's 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.

**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.

**6.5.1** The contractor shall issue refunds to these beneficiaries upon receiving (1) a written request from the beneficiary (that includes a copy of their Medicare card) and either confirming their Part B enrollment in DEERS or in a previous Policy Notification Transaction (PNT), or (2) upon receipt of an unsolicited PNT noting a beneficiary's fee waiver update based on the Part B enrollment. DEERS generates a PNT when the Centers for Medicare and Medicaid Services (CMS) sends DEERS data indicating a Part B enrollment or disenrollment. Refunds are required for all payments that extend beyond the date the enrollee has Medicare Part B coverage, as calculated by DEERS. The contractor shall update DEERS with any amount refunded within 30 calendar days. The contractor shall include an explanation to the beneficiary for the fee refund. Effective October 1, 2012, if the fee waiver is a 100% waiver of the Prime enrollment fee, the contractor shall send a refund to the beneficiary. If the fee waiver is a 50% waiver of the Prime enrollment fee, DEERS will automatically calculate the overpayment and extend the paid through date for the policy, as appropriate; therefore, a refund may not be required unless a credit remains when the policy is paid in full.

**6.5.2** For Prime enrollees who become Medicare eligible 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 the PNTs received indicating a fee waiver based on Medicare to substantiate any claim of overpayment.

**6.5.3** 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.)

**6.5.4** 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.

## **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).

**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 **calendar** 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.

##### **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 calendar 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.

#### **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 pended, 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 BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)**

In addition to BE&SD functions specified throughout this chapter, the contractor shall perform BE&SD 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 BE&SD. 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 BE&SD 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 amount, payment date, date case was transferred to TMA OGC-AC and the date and amount of the deposit.

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**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. 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,
- 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 Signatures**

Beneficiary and host nation provider signatures.

### **6.6.2 Name and Address**

**6.6.2.1** Complete beneficiary and host nation provider name and address.

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

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

### 6.6.3 Diagnosis(es)

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

**6.6.3.2** Claims received for dates of service for outpatient services or dates of discharge for inpatient services prior to International Classification of Diseases, 10th Revision (ICD-10) implementation, with ICD-10 codes shall be converted to International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM) codes by the TOP contractor. Claims received for dates of service for outpatient services or dates of discharge for inpatient services on or after the date specified by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule as published in the **Federal Register**, with International Classification of Diseases, 9th Revision (ICD-9) or ICD-9-CM codes shall be converted to International Classification of Diseases, 10th Revision, Clinical Modifications (ICD-10-CM) codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraphs 4.0 and 5.0](#) regarding the use of ICD-9-CM **V** codes (factors influencing health status and contact with health services) and ICD-10-CM **Z** codes (factors influencing health status and contact with health services).

### 6.6.4 Procedures/Services/Supply/DME

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

**6.6.5** Claims received with a narrative description of services provided shall be coded by the TOP contractor with as accurate-coding as possible based upon the level of detail provided in the narrative description or as directed by the 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 for dates of service for outpatient services or dates of discharge for inpatient services prior to ICD-10 implementation, with International Classification of Diseases, 10th Revision (ICD-10) codes shall be converted to ICD-9 codes by the TOP contractor. Claims received for dates of discharge for inpatient services on or after the date specified by the CMS in the Final Rule as published in the **Federal Register**, with ICD-9 codes shall be converted to ICD-10 codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraph 4.0](#) regarding the use of **V** and **Z** codes.

#### 6.6.5.1 Inpatient Institutional Procedures

Inpatient institutional (i.e., hospital) claims received for claims received for dates of discharge for inpatient services prior to ICD-10 implementation, shall have the procedure narratives coded by the TOP contractor using ICD-9-CM, Volume 3 procedure codes. Inpatient institutional (i.e., hospital) claims received for dates of discharge for inpatient services on or after the date specified by the CMS in the Final Rule as published in the **Federal Register**, shall have the procedure narratives coded by the TOP contractor using ICD-10-Procedure Classification System (ICD-10-PCS) procedure codes.

#### **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. 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.

## TRICARE Operations Manual 6010.56-M, February 1, 2008

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#### Acronyms And Abbreviations

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JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee <sup>7</sup>
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
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
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
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

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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
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
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
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act

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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
MRS	Magnetic Resonance Spectroscopy
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

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NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
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

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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)
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

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#### Acronyms And Abbreviations

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OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OTCD	Ornithine Transcarbamylase Deficiency
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
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

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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
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
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

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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
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

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

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RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)

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SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier

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ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes

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TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M

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TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator

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US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation

**TRICARE Operations Manual 6010.56-M, February 1, 2008**

Appendix A

Acronyms And Abbreviations

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WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

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