

## Figures

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

**(Provider Name)**

**(Provider Street Address)**

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

Dear **(Provider Name)**:

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

This letter notifies you that sixty (60) days from the date on this letter, overseas pharmacy claims must comply with TRICARE requirements for a National Drug Coding (NDC). Claims must include correct and complete NDC coding, whether submitted electronically or using standard claim forms. Drug claims received for processing for dates of service on or after **(Date 60 days from the Date on this Letter)** that do not have applicable NDC coding will be returned.

Additionally, effective sixty (60) days from date on this letter, **(Date)**, overseas pharmacy claims submitted will be processed in accordance with the reimbursement formulas for TRICARE claims in the United States which is Blue book rates plus \$3.00 administration fee. Should you have any questions regarding this requirement, please write me at **(Contractor Mailing Address)**.

Sincerely,

**(Contractor Name)**

**(Contractor Title)**

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



**OVERSEAS**

(Sample Philippine Contractor Provider Certification Request Letter)

Dear Provider:

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

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

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

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

Sincerely,

**(Contractor's Name)**

**FIGURE 24.30-3 ATTESTATION**

**ATTESTATION**

I \_\_\_\_\_ certify that I personally provided the services listed on the attached TRICARE claim I signed and dated (**Date Signed**) to (**Patient's Name**), a TRICARE Beneficiary. I further certify that the amount billed for these services is the amount I routinely charge the general public, Governmental, and other health plans and health insurers for these services.

I understand that TRICARE beneficiaries are required, by law, to pay their cost-share and deductible and that I will collect the required cost-share and deductible from the beneficiary listed on the claim or another individual or entity on behalf of the beneficiary. I further understand that by accepting the TRICARE payment, I am accepting the TRICARE determined allowable charge plus the beneficiary's cost-share and deductible as payment in full and that I will not bill or collect any amounts in excess of the TRICARE allowable charge. This does not prohibit me from billing for any non-covered services.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

- END -

