

## FIGURES

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**FIGURE 13-A-1 APPOINTMENT OF REPRESENTATIVE AND AUTHORIZATION TO DISCLOSE INFORMATION**

**(Reproduce Locally)**

### **SAMPLE FORMAT**

I appoint **(Print/Type Name and Address of Representative)** to act as my representative in connection with my appeal under [32 CFR 199.10](#), Appeal and Hearing Procedures, To avoid the possibility of a conflict of interest, I understand that an officer or employee of the United States, to include an employee or member of a Uniformed Service, an employee of a Uniformed Service legal office, an MTF Provider or a Health Benefits Advisor, is not eligible to serve as a representative. An exception to this is made when an employee of the United States or member of a Uniformed Service is representing an immediate family member.

I authorize the TRICARE Management Activity (TMA) to release to said representative, information related to my medical treatment, and if necessary, photocopies of any medical records which may be required for adjudication of my claim for TRICARE benefits.

I understand that the representative shall have the same authority as the party to the appeal and notice given to the representative shall constitute notice to the party.

This consent will expire upon the issuance of the final agency decision regarding my appeal; however, I reserve the right to withdraw this authorization at any time.

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**(Date)**

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**(Signature of Person Giving Consent)**

### **Prohibition on redisclosure:**

Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974 and other applicable Federal law.

FIGURE 13-A-2 APPEAL SUMMARY LOG, TMA FORM 607

APPEAL SUMMARY LOG									
PART I. TO BE COMPLETED BY MANAGED CARE SUPPORT CONTRACTOR									
APPEALING PARTY					CONTRACTOR'S CASE IDENTIFICATION NO.				
<input type="checkbox"/> PROVIDER <input type="checkbox"/> BENEFICIARY <input type="checkbox"/> REPRESENTATIVE					BENEFICIARY			DATE OF BIRTH	
APPEALING PARTY'S ADDRESS					<input type="checkbox"/> TRICARE PRIME ENROLLEE <input type="checkbox"/> TRICARE STANDARD		<input type="checkbox"/> TRICARE EXTRA		
SPONSOR		SPONSOR SSN			REPRESENTATIVE'S NAME (IF APPLICABLE)				
<input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> DECEASED					BENEFICIARY'S RELATIONSHIP TO SPONSOR				
PROVIDER'S INFORMATION (LIST ADDITIONAL PROVIDERS IN COMMENT SECTION)									
NAME(S) (ALL PROVIDERS)									
1.			<input type="checkbox"/> NON-NETWORK <input type="checkbox"/> NETWORK		BENEFICIARY HELD HARMLESS				
2.			<input type="checkbox"/> NON-NETWORK <input type="checkbox"/> NETWORK		<input type="checkbox"/> YES <input type="checkbox"/> NO				
3.			<input type="checkbox"/> NON-NETWORK <input type="checkbox"/> NETWORK		<input type="checkbox"/> YES <input type="checkbox"/> NO				
4.			<input type="checkbox"/> NON-NETWORK <input type="checkbox"/> NETWORK		<input type="checkbox"/> YES <input type="checkbox"/> NO				
5.			<input type="checkbox"/> NON-NETWORK <input type="checkbox"/> NETWORK		<input type="checkbox"/> YES <input type="checkbox"/> NO				
YES	NO	MEDICAL NECESSITY DETERMINATION			FACTUAL DETERMINATION				
<input type="checkbox"/>	<input type="checkbox"/>	PROPER APPEALING PARTY?			<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	BENEFICIARY ELIGIBILITY ESTABLISHED?			<input type="checkbox"/>				
<input type="checkbox"/>	<input type="checkbox"/>	DOUBLE COVERAGE? (IF YES, NAME OF OTHER PLAN)			_____				
<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID COVERAGE?			_____				
<input type="checkbox"/>	<input type="checkbox"/>	PARTICIPATING PROVIDER? (IF NON-NETWORK)			_____				
<input type="checkbox"/>	<input type="checkbox"/>	NONAVAILABILITY STATEMENT REQUIRED?			_____				
<input type="checkbox"/>	<input type="checkbox"/>	TIMELY FILED? (IF YES, DATE MAILED/RECEIVED)			_____				
<input type="checkbox"/>	<input type="checkbox"/>	WAIVER OF LIABILITY APPLICABLE?			_____				
AMOUNT IN DISPUTE DATA (IF ADDITIONAL CLAIMS, LIST ON ADDITIONAL SHEETS)									
<i>(See reverse for instructions)</i>									
Date of Service	(a) Initial Determination Date	(b) ICN(s) of Claims Appealed	(c) Billed Charges	(d) Allowable Charges	(e) Amount Denied	(f) Deductible Amount	AMOUNT PAID BY		
							(g) Other INS	(h) TRICARE	(i) Cost Share
Comments (Identify Service):									
Managed Care Support Contractor Point of Contact:									
PART II. TO BE COMPLETED BY NATIONAL QUALITY MONITOR CONTRACTOR (IF APPLICABLE)									
SECOND RECONSIDERATION DETERMINATION:									
YES	NO	PROPER APPEALING PARTY?							
<input type="checkbox"/>	<input type="checkbox"/>	TIMELY FILED? (IF YES, DATE MAILED/RECEIVED)			_____				
<input type="checkbox"/>	<input type="checkbox"/>	WAIVER OF LIABILITY APPLICABLE?			_____				
<input type="checkbox"/>	<input type="checkbox"/>	AMOUNT IN DISPUTE REMAINS \$300 OR MORE?			_____				
NQMC Point of Contact:									

TMA FORM 607  
 REV. JAN. 98

**FIGURE 13-A-2 APPEAL SUMMARY LOG, TMA FORM 607 (CONTINUED)**

**PREPARATION OF AMOUNT IN DISPUTE DATA**

- a. Initial determination date ..... Enter date of the initial determination, which is usually the TRICARE Explanation of Benefits (EOB) date.
- b. ICN(s) of claims appealed ..... Enter the ICN of each claim being appealed.
- c. Billed charges ..... Enter total amount billed for this (these) claim(s).
- d. Allowable charges ..... Enter total allowable amount. For purposes of determining "amount in dispute," include the amount which would have been "allowable" if the service/supply denied would have been payable.
- e. Amount denied ..... Enter the amount of the "allowable charges," which were denied. Do not include any "allowable charge" reductions.
- f. Deductible amount ..... Enter amount of deductible, if any, applied to this (these) claim(s).
- g. Amount paid by other insurance ..... Enter amount of other insurance payment applicable.
- h. Amount paid by TRICARE ..... Enter amount actually paid by TRICARE on this (these) claim(s).
- i. Amount paid by cost share ..... Enter amount actually to be paid by the beneficiary/sponsor. If other insurance covers the entire cost share, enter Ø.

FIGURE 13-A-3 PROFESSIONAL QUALIFICATIONS, TMA FORM 780

Form Approved  
 OMB No: 0704-0313  
 Expires: 30 Sep 1992

<b>PROFESSIONAL QUALIFICATIONS                  MEDICAL/PEER REVIEWERS</b>			
<p>Public reporting burden for this collection of information is estimated to average 25 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0313), Washington, DC 20503</p>			
<b>Privacy Act Statement</b>			
<b>AUTHORITY:</b>	10 U.S.C. 1079, 1086 and 1092		
<b>PRINCIPAL PURPOSE:</b>	To solicit the professional qualifications of medical specialists and their credentials for Medical/Peer Reviewers positions. Individuals selected will review medical documentation contained in appeal or hearing case files.		
<b>ROUTINE USE:</b>	None.		
<b>DISCLOSURE:</b>	Voluntary		
<table border="1" style="width: 100%;"> <tr> <td style="width: 70%;">Physician's/Reviewer's Name:</td> <td style="width: 30%;">Year of Birth:</td> </tr> </table>		Physician's/Reviewer's Name:	Year of Birth:
Physician's/Reviewer's Name:	Year of Birth:		
Address:			
<b>Medical Education</b>			
State:	Year of Degree:		
School:	Year of License:		
American Specialty Boards:			
Specialties:			
Type of Practice:			
National Scientific Medical Societies:			

CHAMPUS Form 780  
 November 1990

Previous editions are obsolete



**FIGURE 13-A-4 LETTER TO PROPER APPEALING PARTY WHEN REVIEW HAS BEEN REQUESTED BY AN IMPROPER APPEALING PARTY**

An appeal in your behalf has been received from **(Name of Person who requested Appeal)**. Under **32 CFR 199.10**, **(Name of Person)**, is not an appropriate appealing party, and, consequently, the request cannot be accepted as an appeal.

The TRICARE case file does not indicate that you have appointed anyone as representative to act in your behalf. Therefore, if you wish to appeal you have the following options:

- a. Appeal in your behalf.
- b. Appoint a representative who may request an appeal in your behalf.

If you intend to appeal in your own behalf or through a duly-appointed representative, the appeal must be received within 20 days of the date of this letter or by the appeal deadline set forth in the initial determination notice (whichever is later).

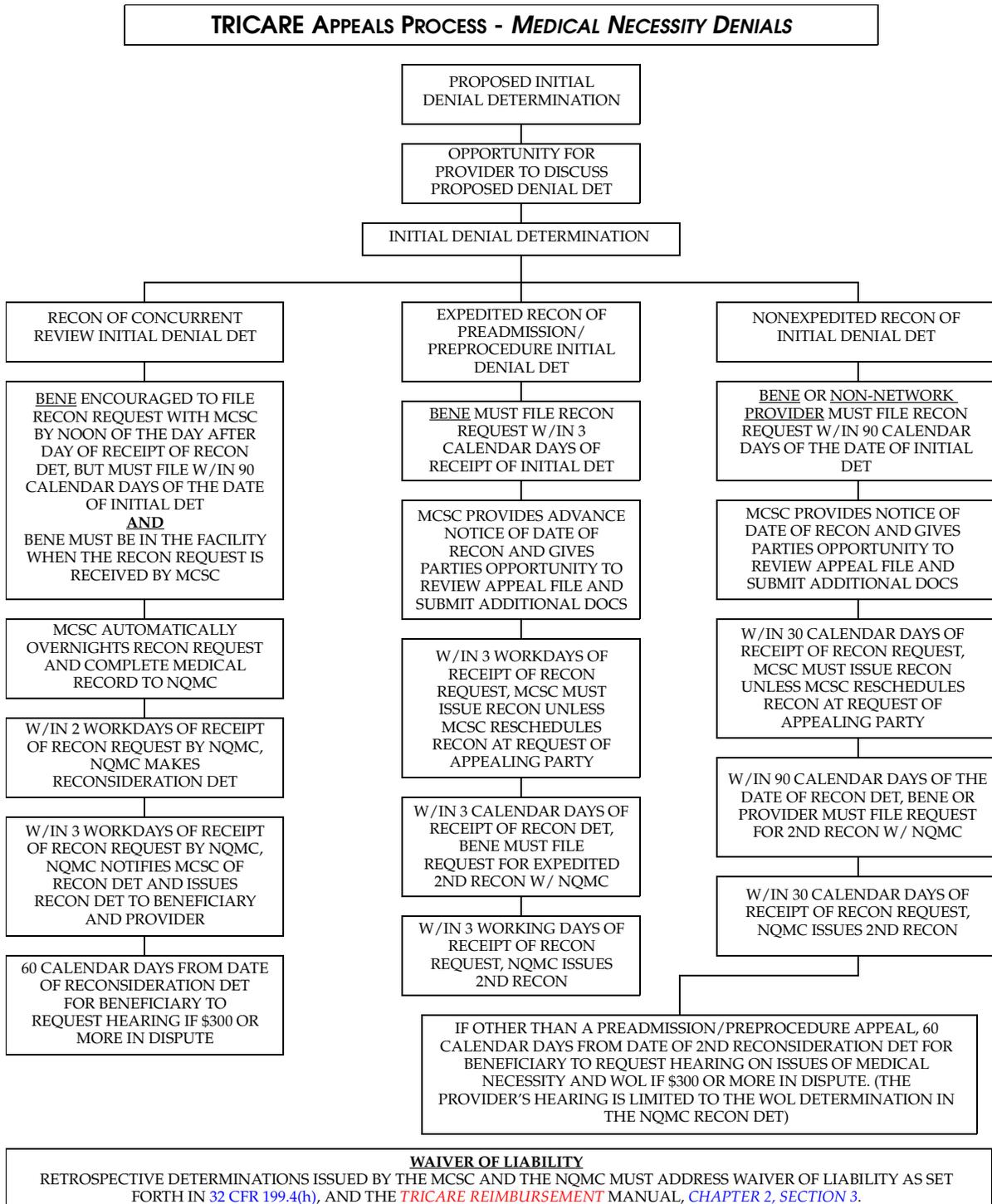
An Appointment of Representative form is enclosed for your convenience should you wish to appoint a representative. Your correspondence should be addressed to:

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

Signature

cc:  
**Improper Appealing Party**

**FIGURE 13-A-5 TRICARE APPEALS PROCESS - MEDICAL NECESSITY DENIALS**



**FIGURE 13-A-6 TRICARE APPEALS PROCESS - FACTUAL DETERMINATIONS**

