



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

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TRICARE
MANAGEMENT ACTIVITY

PRD

CHANGE 46
7950.1-M
JULY 9, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE SYSTEMS MANUAL (TSM)

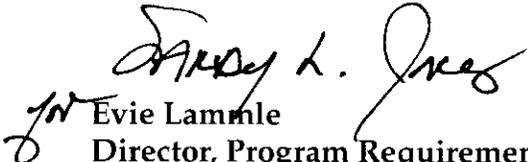
The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 7950.1-M, reissued August 2002.

CHANGE TITLE: MEDICARE PART D PROVISIONS

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change adds language specific to the
implementation of Medicare Part D.

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


Evie Lammle
Director, Program Requirements Division

ATTACHMENT(S): 23 PAGES
DISTRIBUTION: 7950.1-M

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

CHANGE 46
7950.1-M
JULY 9, 2007

REMOVE PAGE(S)

CHAPTER 2

Section 1.1, pages 7 through 14

Section 2.6, pages 7 through 17

Section 8.1, pages 1, 2, 27, and 28

INSERT PAGE(S)

Section 1.1, pages 7 through 13

Section 2.6, pages 7 through 18

Section 8.1, pages 1, 2, 27, and 28

TED RECORD NEGATIVE ADJUSTMENT (CONTINUED)

EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	500.00
Patient Cost-Share	0
Amount Paid	500.00
Covered Days	5
CANCELLATION TED RECORD	
Amount Billed	0
Amount Allowed	-500.00
Patient Cost-Share	0
Amount Paid	-500.00
Covered Days	-5
EFFECT AT TMA	
Amount Billed	500.00
Amount Allowed	0
Patient Cost-Share	0
Amount Paid	0
Covered Days	0

4.0. RESUBMISSION OF TED BATCH/VOUCHERS AND TED RECORDS

4.1. Batches/vouchers that fail any edits at the header record level will be rejected and returned to the contractor for correction. Header level rejections require the resubmission of the entire batch/voucher with the appropriate data corrections. The RESUBMISSION NUMBER must not be incremented from what was reported on the prior submission.

4.2. Institutional and Non-Institutional Records which fail only relational edits will be “provisionally” accepted on the TMA TED database, and returned to the contractor for correction. Provisionally accepted records must be corrected and resubmitted as an adjustment, in a new voucher/batch. Refer to [paragraph 3.0.](#) for requirements on correction of TED Records with provisional errors.

4.3. Institutional and Non-Institutional Records which fail validity edits will be rejected and returned to the contractor for correction and resubmission. All returned records which fail the validity edits within a **voucher** must be returned by the contractor at the same time and balance to the outstanding TOTAL AMOUNT PAID and number of outstanding records at TMA. All returned records which fail the validity edits within a **batch** must be returned by the contractor at the same time and balance to the outstanding number of records. Upon resubmission, the records will again be processed through the TMA editing system. Resubmission batch/vouchers are identified by the BATCH/VOUCHER RESUBMISSION NUMBER in the Header Record. Resubmission applies to all Institutional and Non-Institutional TED Records which have failed to pass the TMA validity edits, whether or not the TED Records incur relational edits as well.

4.4. TED record resubmissions must be reported using the TED RECORD INDICATOR reported on the initial or adjustment TED record, regardless of the number of times the TED record is resubmitted.

4.5. All data as reported on the initial or adjustment TED record must be resubmitted except for that data changed in order to correct the error(s).

4.6. If a TED record with TYPE OF SUBMISSION = 'I' (initial) is rejected for validity errors, report the correction TED record with TYPE OF SUBMISSION = 'R' (resubmission).

All other TED records rejected for validity errors must retain their original TYPE OF SUBMISSION code throughout the validity error resubmission process.

4.7. To liquidate or "clear" a voucher, both TOTAL AMOUNT PAID and the number of outstanding TED records must zero out. When a TED record passes editing (including provisionally accepted records), the TOTAL NUMBER OF RECORDS and the TOTAL AMOUNT PAID submitted on the original voucher are decremented on the TMA database by the corresponding amount. A voucher "clears" when both totals reach zero and the TMA database reflects no outstanding record or paid amounts.

4.8. To liquidate or "clear" a batch, the number of outstanding records must zeroed out.

4.9. If TMA edits identify that the dollar amounts on the voucher are incorrect, the contractor must correct the related monetary data to balance to the AMOUNT PAID BY GOVERNMENT CONTRACTOR reported on the TED record. **Do not change the AMOUNT PAID BY THE GOVERNMENT CONTRACTOR on the TED record.** Correction of the payment error will be reflected through the contractor's processing and subsequent submission of the adjustment/cancellation TED record.

5.0. ASSIGNMENT OF TED RECORDS TO THE ACCRUAL FUND

5.1. All contractors that are **assigned appropriation specific** Automated Standard Application for Payment (ASAP) accounts (appropriated funds and accrual funds) shall **group TED records under the correct CLIN/ASAP Account Number using the BATCH/VOUCHER ASAP ACCOUNT NUMBER VALIDATION - ACCRUAL FUND CHECK edits specified in Chapter 2, Section 8.1.**

5.2. When ASAP accounts are assigned to a contractor, the government will specify the appropriate fund that the ASAP account shall be linked to. All claims grouped to the Accrual Fund shall **pass edit 1-000-01F (BATCH/VOUCHER ASAP ACCOUNT NUMBER VALIDATION - ACCRUAL FUND CHECK) for institutional claims OR edit 2-000-01F (BATCH/VOUCHER ASAP ACCOUNT NUMBER VALIDATION - ACCRUAL FUND CHECK) for non-institutional claims.** All claims that do not group with the Accrual Fund shall be grouped with the Appropriated Fund ASAP account.

6.0. BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER SELECTION CRITERIA FOR REGIONAL CONTRACTORS¹

The following process is only to be used by contractors submitting both financially underwritten **and** non-financially underwritten claims to TMA.

6.1. Batches

For all data submissions sent to TMA using the Batch process, the contractor shall zero fill the BATCH/VOUCHER ASAP Account Number.

6.2. Vouchers

For all data submissions sent to TMA using the Voucher process, the contractor must use one of the BATCH/VOUCHER CLIN/ASAP **Account** Numbers assigned to them by TMA, CRM in accordance with the TRICARE Operations Manual (TOM), [Chapter 3, Section 2](#). TMA, CRM shall assign two types of BATCH/VOUCHER CLIN/ASAP Account Numbers to the contractor's non-financially underwritten ASAP Accounts (formerly known as not-at-risk bank accounts) and financially underwritten CLIN Accounts. Financially underwritten CLIN Account Numbers are comprised of the contract CLIN plus the fiscal year (position 7) plus the Region (position 8). CLINs that are only four digits long will have 00 to fill positions 5 and 6 in this field. Non-financially underwritten ASAP Accounts are usually issued on a federal fiscal year basis by TMA, CRM. Financially underwritten CLIN ASAP Accounts are usually issued twice a year, at the change of each federal fiscal year and when an Option Period is exercised. The contractor should use the procedures outlined below in order to properly group claims under the correct BATCH/VOUCHER CLIN/ASAP Account Number.

6.2.1. Criteria For Selecting TMA Foreign Non-Financially Underwritten ASAP Accounts (South Contract Only)

All claims submitted using the foreign vouchering process (South Contract only) shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Numbers with a '3', '4', '5', or '6' in position 8. The BATCH/VOUCHER CLIN/ASAP Account Number with a '3' in position 8 shall be used for all appropriated fund foreign benefit payments - excluding Navy/Marine deployed claims covered by TRICARE Global Remote Overseas (**TGRO**). The BATCH/VOUCHER CLIN/ASAP Account Number with a '4' in position 8 shall be used for all Accrual/Trust fund foreign benefit payments. The BATCH/VOUCHER CLIN/ASAP Account Number with a '5' in position 8 shall be used for all Navy deployed claims covered by **TGRO**. The BATCH/VOUCHER CLIN/ASAP Account Number with a '6' in position 8 shall be used for all Marine deployed claims covered by **TGRO**.

¹ These guidelines apply only to the benefit CLINS, they DO NOT apply to the Administrative CLINs.

6.2.2. Criteria For Selecting The TMA Domestic Non-Financially Underwritten ASAP Account (excludes claims that meet criteria specified under [paragraph 6.2.1.](#))

All domestic non-financially underwritten claims shall be submitted to TMA, CRM using the non-financially underwritten ASAP Account Number with a '1' in position 8. Exception: All Resource Sharing claims must follow the procedures as indicated in [paragraph 6.2.3.](#)

6.2.3. Criteria For Selecting Financially Underwritten CLINs (excludes claims that meet criteria specified under [paragraphs 6.2.1.](#) and [6.2.2.](#))

All financially underwritten benefit payments and all Resource Sharing claims must use the BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER containing the TMA Benefit CLIN (positions 1 through 6 of ASAP).

6.2.4. Criteria For Selecting BATCH/VOUCHER CLIN/ASAP Account Number Based On 'active' Dates (Fiscal Year **and Option Period)**

All BATCH/VOUCHER CLIN/ASAP Account Numbers assigned by TMA, CRM shall have an 'active' date range assigned. The BATCH/VOUCHER CLIN/ASAP Account Number's 'active' dates shall not overlap across Option Periods (CLIN type account numbers only) or Fiscal Year (ASAP **and** CLIN type account numbers). The BATCH/VOUCHER Date (0-030) is the field TMA shall use when editing for proper selection of BATCH/VOUCHER CLIN/ASAP Account Number based on date. All disbursements shall be made using a currently 'active' BATCH/VOUCHER CLIN/ASAP Account Number. All credits where reported disbursements did not occur (stale dated checks, voids, etc.) shall be credited back to the BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement. All collections (credits) of funds where the disbursement was originally reported using a CLIN Type BATCH/VOUCHER CLIN/ASAP Account Numbers shall be credited back to the BATCH/VOUCHER CLIN/ASAP Account Number originally used to report the disbursement. All collections (credits) of funds where the disbursement was originally reported to TMA using a ASAP Type BATCH/VOUCHER CLIN/ASAP Account Numbers (BATCH/VOUCHER CLIN/ASAP Account Number with a '1' or '3' or '4' or '5' or '6' in position 8) shall be credited to TMA using currently 'active' BATCH/VOUCHER CLIN/ASAP Account Number.

NOTE: These guidelines apply only to benefit CLINs. They DO NOT apply to administrative CLINs.

7.0. INTERIM INSTITUTIONAL PAYMENTS

In certain cases, providers can submit interim bills for institutional claims. All TED records for interim (interim or final) institutional bills must be submitted as an adjustment using the same ICN as the initial submission.

8.0. PROCESS FOR REPORTING RESOURCE SHARING AND CAPITATED TREATMENT ENCOUNTERS TO TMA

The following process is to be used by claims processors to submit data to TMA which relates to Resource Sharing or Capitated Treatment Encounters.

8.1. Special Processing Code

For Resource Sharing and/or Capitated claims/encounters, submit a TED record which includes the appropriate SPECIAL PROCESSING CODE, as defined in [Chapter 2, Section 2.8](#), for each patient encounter.

8.2. "Amount" Field Reporting

The "amount" fields must contain the following:

8.2.1. Amount Billed/Amount Billed By Procedure Code

The AMOUNT BILLED/AMOUNT BILLED BY PROCEDURE CODE fields shall be the amount (institutional or noninstitutional charges) that the capitated provider would charge a patient on a capitated basis. If a Resource Sharing provider is being reimbursed on a fee-for-service basis with negotiated/discounted rates, report these amounts.

8.2.2. Amount Allowed/Amount Allowed By Procedure Code

The AMOUNT ALLOWED/AMOUNT ALLOWED BY PROCEDURE CODE fields must contain the appropriate DRG or per diem for institutional services, the CHAMPUS Maximum Allowable Charge (CMAC) for noninstitutional services, or negotiated/discounted rates for both institutional and noninstitutional services.

8.2.3. Amount Paid By Government Contractor

The AMOUNT PAID BY GOVERNMENT CONTRACTOR field must equal the "lesser" of the amount allowed minus (PATIENT COST-SHARE plus AMOUNT APPLIED TOWARD DEDUCTIBLE) or AMOUNT ALLOWED minus amount of OHI. If the "Lesser" computed amount is negative, AMOUNT PAID BY GOVERNMENT CONTRACTOR must = \$0.00.

9.0. PROCESS FOR REPORTING BLOOD CLOTTING FACTOR DATA TO TMA

The following process is to be used by claims processors to report claim-related data to TMA which contain charges for blood clotting factor.

9.1. Blood Clotting Factor

Data is to be reported on the Institutional TED record, even though they are to be reimbursed separately from the DRG methodology.

9.2. Calculation of Charge

Charges will be calculated in a two-step process, as described below.

9.2.1. First Step

The DRG-reimbursable hospital charges will be calculated in the normal way. All related financial data will be stored for later use (see below).

9.2.2. Second Step

The blood clotting factor financial data will be calculated based on the reimbursement methodology described in the TRICARE Policy Manual (TPM). All related financial data will be stored for later use. Revenue Code 0636 (Drugs Requiring Detailed Coding) is to be reported for blood clotting factor only. All other drugs are to be reported using the appropriate Revenue Codes in the 025X series.

9.2.2.1. The number to be coded in the UNITS OF SERVICE field is the number of units billed on the claim, not the number of payment units (which is 100 times the number of units billed).

9.2.2.2. The billed charges for blood clotting factor are to be reported in the TOTAL CHARGE BY REVENUE CODE field of the payment record.

NOTE: While blood clotting factor charges will be priced separately, the ADJUSTMENT DENIAL REASON CODE cannot indicate DRG non-reimbursables.

9.2.3. Data Reporting

From the two steps above, merge the financial data as follows, and enter them into the appropriate cost fields:

9.2.3.1. Amount Billed

This is the sum of all billed charges **including** those for blood clotting factor.

9.2.3.2. Amount Allowed

This is the sum of the two separate amounts allowed resulting from the calculations in Step 2 above.

9.2.3.3. Amount of OHI

This is the amount paid by other primary sources of reimbursement, if applicable.

9.2.3.4. Patient Cost-Share

Enter in the appropriate field based on the Category of Beneficiary:

9.2.3.4.1. Patient Cost-Share (For Other Than Active Duty Family Members (ADFMs)) |

This is the amount based on either 25% of the billed charges (including those for blood clotting factor) or the per diem amount times the number of days in the hospital stay.

9.2.3.4.2. Patient Cost-Share (For ADFMs) |

This is the amount based on the inpatient hospital daily rate times the number of days in the hospital stay.

9.2.3.4.3. Amount Paid By Government Contractor

This is the sum of the two separate amounts resulting from the calculations in Step 2 above.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.6

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

DATA ELEMENT DEFINITION

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) BEGIN REASON CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)		
	N	Not eligible for Medicare. Under age 65 this is the default value. At age 65 this indicates eligibility could not begin because the person did not have enough quarters of Social Security contributions to qualify. This value applies to Medicare Part A.
	P	Eligible for Medicare at or after 65 because of purchase. This value applies to Medicare Part A.
	R	Eligible for Medicare under age 65 because of end-stage renal disease. This value applies to Medicare Part A and Part B.
	V	Eligible for the Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA).
	W	Not applicable.
ALGORITHM N/A		
SUBORDINATE AND/OR GROUP ELEMENTS		
SUBORDINATE		GROUP
N/A		N/A

NOTES AND SPECIAL INSTRUCTIONS:

¹ If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

If person not on DEERS but claim is payable (i.e., government liability), report 'W' in this field.

NOTE: For Mail Order Pharmacy use the data element Medicare A Begin Reason Code from the DEERS inquiry/response to report this information. If the DEERS response does not contain an OGP BEGIN REASON CODE, report 'W' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE

RECORDS/LOCATOR NUMBERS

RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-131	1	Yes
Non-Institutional	2-191	Up to 99	Yes

PRIMARY PICTURE (FORMAT) One (1) alphanumeric character.

DEFINITION The code that represents what type of other government program the person has. Download field from DEERS.

CODE/VALUE SPECIFICATIONS A Medicare Part A

NOTES AND SPECIAL INSTRUCTIONS:

Instructions to submit the TED OGP TYPE CODE:

1. If the DEERS response returns only one OGP TYPE CODE segment report the DEERS OGP TYPE CODE in the TED OGP TYPE CODE; **unless the DEERS response returns OGP TYPE CODE value 'D' then report 'H' in the TED OGP TYPE CODE.**
2. If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and "B" report a 'C' in the TED OGP TYPE CODE.
3. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and 'D' report a 'I' in the TED OGP TYPE CODE.**
4. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'B' and 'D' report a 'J' in the TED OGP TYPE CODE.**
5. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A', 'B', and 'D' report a 'L' in the TED OGP TYPE CODE.**
6. If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.
7. For Mail Order Pharmacy **and Retail Pharmacy, the Medicare Coverage Type Code from the DEERS inquiry/response should be reported in the TED OGP TYPE CODE.**

Contractors shall forward claims for beneficiaries who are age 65 or older to the TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC) when the DEERS response shows a Health Care Delivery Plan Code of 018, 020, 021, or 022, indicating TRICARE For Life or the response carries a Medicare Begin Reason Code of A, D, E, or R, indicating the patient has Medicare Part A.

Contractors shall forward claims for beneficiaries who are under 65 to the TDEFIC when the DEERS response carries a Medicare Begin Reason Code indicating the patient has Medicare Part A.

On receipt of the claim, the TDEFIC shall determine if a benefit exists. The forwarding regional MCSCs shall determine if a dual eligible benefit exists.

If person not on DEERS but claim is payable (i.e., government liability), report 'N' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (CONTINUED)

CODE/VALUE SPECIFICATIONS (CONTINUED)		
	B	Medicare Part B
	C	Medicare Part A & B
	H	Medicare Part D
	I	Medicare Part A & D
	J	Medicare Part B & D
	L	Medicare Part A, B, & D
	N	No Medicare
	V	CHAMPVA

NOTES AND SPECIAL INSTRUCTIONS:

Instructions to submit the TED OGP TYPE CODE:

1. If the DEERS response returns only one OGP TYPE CODE segment report the DEERS OGP TYPE CODE in the TED OGP TYPE CODE; **unless the DEERS response returns OGP TYPE CODE value 'D' then report 'H' in the TED OGP TYPE CODE.**
2. If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and "B" report a 'C' in the TED OGP TYPE CODE.
3. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and 'D' report a 'I' in the TED OGP TYPE CODE.**
4. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'B' and 'D' report a 'J' in the TED OGP TYPE CODE.**
5. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A', 'B', and 'D' report a 'L' in the TED OGP TYPE CODE.**
6. If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.
7. For Mail Order Pharmacy **and Retail Pharmacy, the Medicare Coverage Type Code from the DEERS inquiry/response should be reported in the TED OGP TYPE CODE.**

Contractors shall forward claims for beneficiaries who are age 65 or older to the TRICARE Dual Eligible Fiscal Intermediary Contractor (**TDEFIC**) when the DEERS response shows a Health Care Delivery Plan Code of 018, 020, 021, or 022, indicating TRICARE For Life or the response carries a Medicare Begin Reason Code of A, D, E, or R, indicating the patient has Medicare Part A.

Contractors shall forward claims for beneficiaries who are under 65 to the **TDEFIC** when the DEERS response carries a Medicare Begin Reason Code indicating the patient has Medicare Part A.

On receipt of the claim, the **TDEFIC** shall determine if a benefit exists. The forwarding regional MCSCs shall determine if a dual eligible benefit exists.

If person not on DEERS but claim is payable (i.e., government liability), report 'N' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: OTHER GOVERNMENT PROGRAM (OGP) TYPE CODE (CONTINUED)

ALGORITHM N/A

SUBORDINATE AND/OR GROUP ELEMENTS

SUBORDINATE	GROUP
N/A	N/A

NOTES AND SPECIAL INSTRUCTIONS:

Instructions to submit the TED OGP TYPE CODE:

1. If the DEERS response returns only one OGP TYPE CODE segment report the DEERS OGP TYPE CODE in the TED OGP TYPE CODE; **unless the DEERS response returns OGP TYPE CODE value 'D' then report 'H' in the TED OGP TYPE CODE.**
2. If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and "B" report a 'C' in the TED OGP TYPE CODE.
3. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A' and 'D' report a 'I' in the TED OGP TYPE CODE.**
4. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'B' and 'D' report a 'J' in the TED OGP TYPE CODE.**
5. **If the DEERS response returns multiple OGP TYPE CODE segments containing the values 'A', 'B', and 'D' report a 'L' in the TED OGP TYPE CODE.**
6. If the DEERS response does not returns a OGP TYPE CODE segment report 'N' in the TED OGP TYPE CODE.
7. For Mail Order Pharmacy **and Retail Pharmacy, the Medicare Coverage Type Code from the DEERS inquiry/response should be reported in the TED OGP TYPE CODE.**

Contractors shall forward claims for beneficiaries who are age 65 or older to the TRICARE Dual Eligible Fiscal Intermediary Contractor (**TDEFIC**) when the DEERS response shows a Health Care Delivery Plan Code of 018, 020, 021, or 022, indicating TRICARE For Life or the response carries a Medicare Begin Reason Code of A, D, E, or R, indicating the patient has Medicare Part A.

Contractors shall forward claims for beneficiaries who are under 65 to the **TDEFIC** when the DEERS response carries a Medicare Begin Reason Code indicating the patient has Medicare Part A.

On receipt of the claim, the **TDEFIC** shall determine if a benefit exists. The forwarding regional MCSCs shall determine if a dual eligible benefit exists.

If person not on DEERS but claim is payable (i.e., government liability), report 'N' in this field.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE			
RECORDS/LOCATOR NUMBERS			
RECORD NAME	LOCATOR#	OCCURRENCES	REQUIRED
Institutional	1-160	3	Yes ¹
Non-Institutional	2-095	3	Yes ¹
PRIMARY PICTURE (FORMAT)	Six (6) alphanumeric characters.		
DEFINITION	The group of three codes which indicate that certain questionable data has been identified and approved by the contractor and the normal editing and processing rules should be bypassed for this record.		
CODE/VALUE SPECIFICATIONS	11	Claims retained by the contractor for development (information not available from in-house sources). (Effective 02/01/2000)	

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

Clarification on use of Override Codes 'H1' and 'H2':

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.6

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	12	TPL claims requiring development. (Effective 02/01/2000)
	13	Government intervention claims - pending up to 60 calendar days. (Benefit Changes, CMAC updates, etc.) (Effective 02/01/2000)
	14	Claims requiring intervention by another contractor. (Effective 02/01/2000)
	15	Claims pending at government direction 60 calendar days and over. (Effective 02/01/2000)
	A	Patient is over 65. (Terminated 06/01/2003)

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

Clarification on use of Override Codes 'H1' and 'H2':

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Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 2.6

DATA REQUIREMENTS - INSTITUTIONAL/NON-INSTITUTIONAL RECORD DATA ELEMENTS (M - O)

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	B	Patient is a spouse under 12 years of age.
	C	Good faith claim; payment has been made.
	D	Patient is family member 21 years or older and over 18 for VA (over 18 for VA is no longer effective after 01/01/1996).
	E	Diagnosis is maternity; patient is under 12 years of age.
	F	Claim was filed after the filing deadline.
	G	Diagnosis/procedure code for female; sex indicates male.

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

Clarification on use of Override Codes 'H1' and 'H2':

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	H	Diagnosis/procedure code for male, sex indicates female.
	I	Patient is a former spouse under 34 years of age.
	J	Successive admission (patient is family member of an active duty sponsor and cost-share is based on both current and prior admission). (Institutional Only)
	K	Catastrophic loss protection limit reached, patient cost-share and deductible rules do not apply.
	M	NATO, Social Security Number not applicable.

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

Clarification on use of Override Codes 'H1' and 'H2':

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	N	Retrospective payment - Inpatient Mental Health (Institutional Only)
	P	Reserved (to be used only with TMA authorization)
	Q	Former Spouse with Pre-Existing Condition
	R	Person birth calendar date (patient) is not consistent with diagnosis/ procedure code age restricting; procedure performed due to medical necessity.

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

Clarification on use of Override Codes 'H1' and 'H2':

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	S	Zip code override to be used when: <ol style="list-style-type: none"> 1. A beneficiary has moved out of a region and the contractor is still responsible for the care claimed; or 2. If a beneficiary resides in a region different from the region they are enrolled in, but are within the same contract jurisdiction.
	U	Beneficiary indemnification payment

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

Clarification on use of Override Codes 'H1' and 'H2':

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	V	Active Duty Family Member (ADFM), services provided in TRICARE Europe, Pacific or Latin America & Canada including the Caribbean Basin. (Effective 06/28/1996)
	Y	Newborn in mother's room without nursery charges. (Institutional Only)
	Z	Enhanced benefit
	H1 ²	Benefit payment made using incorrect BATCH/VOUCHER ASAP Number, contractor error.

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

Clarification on use of Override Codes 'H1' and 'H2':

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

DATA ELEMENT DEFINITION

ELEMENT NAME: OVERRIDE CODE (CONTINUED)		
CODE/VALUE SPECIFICATIONS (CONTINUED)	H2 ²	Benefit payment made using incorrect BATCH/VOUCHER ASAP Number, Government caused error.
	NC	Non-Certified Providers (does not include sanctioned/suspended providers) (Effective 08/01/2003)
ALGORITHM N/A		
SUBORDINATE AND/OR GROUP ELEMENTS		
SUBORDINATE	GROUP	
N/A	PROCESSING INFORMATION	

NOTES AND SPECIAL INSTRUCTIONS:

¹ Required if override code is applicable to override TMA edit checking. Each occurrence is two characters, left justify and blank fill each. Can report 1 to 3 codes, do not duplicate.

Override codes 'H1' and 'H2' are only valid for [Chapter 2, Section 8.1](#) edits. Override codes 'H1' and 'H2' are to be submitted on adjustment TED records only to allow financial edit errors to clear when payment is made from the wrong Batch/Voucher ASAP Account Number.

Clarification on use of Override Codes 'H1' and 'H2':

Failure to group TED records under the correct voucher header impairs the government's ability to ensure adequate funding is available to meet government payment obligations. The funding availability validation is performed on initial submissions only based on amounts reported in the voucher header, therefore it is imperative that contractors group claims (benefit costs) under the correct BATCH/VOUCHER CLIN/ASAP Account Number on the Initial Submission.

Many of the Financial Edits in [Chapter 2, Section 8.1](#) try to validate that the detail records contained under a voucher header are correctly reported and it is possible that the data contained on the detail TED record cannot be corrected to match BATCH/VOUCHER CLIN/ASAP Account Number. Moving a TED record from one header to another would require a cancellation and resubmission of the TED record. The contractor shall not cancel and resubmit claims to correct any [Chapter 2, Section 8.1](#) edit errors that can be bypassed if Override Codes 'H1' or 'H2' can be used. Since no further funding validation is performed after the Initial submission, correcting the header error would serve no purpose. The codes 'H1' and 'H2' have been established to facilitate the correction of header errors on Initial submissions. Use of Override Codes 'H1' and 'H2' shall be monitored by TMA, CRM.

Use of Override Code 'H2':

Contractor must have prior government approval specific to error condition before code 'H2' can be used on TED records, usage will be monitored by TMA, CRM.

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL (1-000)	
VALIDITY EDITS	
NONE	
RELATIONAL EDITS	
1-000-01F	<ul style="list-style-type: none"> BATCH/VOUCHER ASAP ACCOUNT NUMBER VALIDATION - ACCRUAL FUND CHECK
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR H2 BENEFIT PAYMENT USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER GOVERNMENT CAUSED ERROR
OR CONTRACT NUMBER =	MDA906-03-C-0015 (TDEFIC)
OR TYPE OF SUBMISSION =	D COMPLETE DENIAL OR O ZERO PAYMENT TED RECORD DUE TO 100% OHI
THEN BYPASS THIS EDIT	
ELSE IF HCDP PLAN COVERAGE CODE =	000 NO HEALTH CARE COVERAGE PLAN OR 121 CHCBP STANDARD - INDIVIDUAL COVERAGE OR 122 CHCBP EXTRA - FAMILY COVERAGE OR 401 TRS TIER 1 MEMBER-ONLY OR 402 TRS TIER 1 MEMBER AND FAMILY OR 405 TRS TIER 2 MEMBER-ONLY OR 406 TRS TIER 2 MEMBER AND FAMILY OR 407 TRS TIER 3 MEMBER-ONLY OR 408 TRS TIER 3 MEMBER AND FAMILY OR 409 TRS SURVIVOR CONTINUING INDIVIDUAL COVERAGE OR 410 TRS SURVIVOR CONTINUING FAMILY COVERAGE OR 411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR 412 TRS SURVIVOR NEW FAMILY COVERAGE OR

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

**ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - INSTITUTIONAL
(1-000) (CONTINUED)**

	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE
OR ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	AA	CHCBP EXTRA - FAMILY COVERAGE OR
	SR	SHCP REFERRED CARE
OR SPECIAL PROCESSING CODE =	AR	SHCP MTF REFERRED CARE
OR HCC MEMBER CATEGORY CODE =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD ACTIVE > 30 DAYS; AGR CODE A - OR
	J	ACADEMY STUDENT, NOT OCS OR
	N	NATIONAL GUARD NOT ACTIVE OR < 31 DAYS OR
	S	RESERVE MEMBER ACTIVE > 30 DAYS OR
	T	FOREIGN MILITARY OR
	V	RESERVE MEMBER NOT ACTIVE OR < 31 DAYS OR
	Y	SERVICE AFFILIATES (ROTC, MERCHANT MARINE)
AND HCC MEMBER RELATIONSHIP CODE =	A	SELF
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
ELSE IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A	MEDICARE PART A OR
	C	MEDICARE PART A & B OR
	H	MEDICARE PART D OR
	I	MEDICARE PART A & D OR
	L	MEDICARE PART A, B, & D
AND OTHER GOVERNMENT PROGRAM BEGIN REASON CODE ≠	N	NOT ELIGIBLE FOR MEDICARE
AND HCDP PLAN COVERAGE CODE =	004	DIRECT CARE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	005	TRICARE STANDARD FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL (2-000) (CONTINUED)

OR SPECIAL PROCESSING CODE =	AR	SHCP MTF REFERRED CARE
OR HCC MEMBER CATEGORY CODE =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD ACTIVE > 30 DAYS; AGR CODE A-H OR
	J	ACADEMY STUDENT, NOT OCS OR
	N	NATIONAL GUARD NOT ACTIVE OR <31 DAYS OR
	S	RESERVE MEMBER ACTIVE > 30 DAYS OR
	T	FOREIGN MILITARY OR
	V	RESERVE MEMBER NOT ACTIVE OR < 31 DAYS OR
	Y	SERVICE AFFILIATES (ROTC, MERCHANT MARINE)
AND HCC MEMBER RELATIONSHIP CODE =	A	SELF
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
ELSE IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A	MEDICARE PART A OR
	C	MEDICARE PART A & B OR
	H	MEDICARE PART D OR
	I	MEDICARE PART A & D OR
	L	MEDICARE PART A, B, & D
AND OTHER GOVERNMENT PROGRAM BEGIN REASON CODE ≠	N	NOT ELIGIBLE FOR MEDICARE
AND HCDP PLAN COVERAGE CODE =	004	DIRECT CARE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	005	TRICARE STANDARD FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	010	TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSOR OR
	014	DIRECT CARE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	015	TRICARE STANDARD FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

**ELEMENT NAME: BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER - NON-INSTITUTIONAL
(2-000) (CONTINUED)**

016	DIRECT CARE FOR SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS OR
017	TRICARE STANDARD FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
020	TFL FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
021	TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
022	TFL FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
023	TFL FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
024	DIRECT CARE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
110	TRICARE PRIME FOR INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
111	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
114	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
115	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
131	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
132	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
133	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
134	TRICARE PRIME INDIVIDUAL COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
135	TRICARE PRIME FAMILY COVERAGE FOR TRANSITIONAL SURVIVORS OF GUARD/ RESERVE DECEASED SPONSORS OR
136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR