



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

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TRICARE
MANAGEMENT ACTIVITY

PCSIB

CHANGE 83
7950.1-M
AUGUST 17, 2010

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE SYSTEMS MANUAL (TSM), AUGUST 2002**

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

CHANGE TITLE: NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) 2010, SECTION 705,
TRICARE RETIRED RESERVE

CONREQ: 15016

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Section 705 of the NDAA for Fiscal Year (FY) 2010 allows certain members of the retired reserve who are qualified for a non-regular retirement, but are not yet age 60 ("gray-area" retirees), to purchase TRICARE Standard coverage.

EFFECTIVE DATE: October 1, 2010.

IMPLEMENTATION DATE: September 1, 2010.

This change is made in conjunction with Aug 2002 TOM, Change No. 100.



Jack Arendale
Chief, Purchased Care Systems
Integration Branch

ATTACHMENT(S): 42 PAGES
DISTRIBUTION: 7950.1-M

CHANGE 83
7950.1-M
AUGUST 17, 2010

REMOVE PAGE(S)

CHAPTER 2

Section 5.1, pages 7 and 8

Section 5.2, pages 7, 8, 31, 32

Section 6.3, pages 15 and 16

Section 6.4, pages 7 - 10, 15 - 18

Section 8.1, pages 1 - 10, 25 - 32

Addendum M, pages 5 and 6

CHAPTER 3

Section 1.3, pages 11 - 16

INSERT PAGE(S)

Section 5.1, pages 7 and 8

Section 5.2, pages 7, 8, 31, 32

Section 6.3, pages 15 and 16

Section 6.4, pages 7 - 10, 15 - 18

Section 8.1, pages 1 - 10, 25 - 32

Addendum M, pages 5 and 6

Section 1.3, page 11 - 16

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CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

**ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (SPONSOR)
(1-066) (CONTINUED)**

		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
		411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
		412	TRS SURVIVOR NEW FAMILY COVERAGE OR
		413	TRS MEMBER-ONLY COVERAGE OR
		414	TRS MEMBER AND FAMILY COVERAGE OR
		418	TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE OR
		419	TRR MEMBER AND FAMILY COVERAGE OR
		420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
		421	TRR SURVIVOR FAMILY COVERAGE
1-066-02R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
		G	NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
		J	ACADEMY STUDENT OR
		P	TAMP MEMBER OR
		S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
1-066-03R	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN ONE OCCURRENCE OF OVERRIDE CODE =	M	NATO

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CHAPTER 2, SECTION 5.1

INSTITUTIONAL EDIT REQUIREMENTS (ELN 000 - 099)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER RELATIONSHIP CODE (1-070)

VALIDITY EDITS

1-070-01V MUST BE A VALID HCC MEMBER RELATIONSHIP CODE (REFER TO [CHAPTER 2, SECTION 2.5](#))

RELATIONAL EDITS

1-070-01R IF PATIENT AGE¹ < 17
 THEN HCC MEMBER RELATIONSHIP CODE ≠ A SELF

1-070-02R IF PATIENT AGE¹ < 12
 THEN HCC MEMBER RELATIONSHIP CODE ≠ B SPOUSE **OR**
 G SURVIVING SPOUSE
 UNLESS ONE OCCURRENCE OF
 OVERRIDE CODE = B PATIENT IS A SPOUSE UNDER 12 YEARS OF AGE

1-070-03R IF PATIENT AGE¹ ≥ 21
 AND PERSON BIRTH CALENDAR DATE (PATIENT) ≠ 19111111
 THEN HCC MEMBER RELATIONSHIP CODE MUST ≠ C CHILD OR STEPCHILD **OR**
 D PRE-ADOPTIVE CHILD **OR**
 E WARD (COURT ORDERED)
 UNLESS ONE OCCURRENCE OF
 OVERRIDE CODE = D PATIENT IS FAMILY MEMBER 21 YEARS OF AGE OR OLDER

1-070-04R IF PATIENT AGE¹ < 34
 THEN HCC MEMBER RELATIONSHIP CODE ≠ H FORMER SPOUSE (20/20/20) **OR**
 I FORMER SPOUSE (20/20/15) **OR**
 J FORMER SPOUSE (10/20/10) **OR**
 K FORMER SPOUSE (TRANSITIONAL ASSISTANCE (COMPOSITE))
 AND HCC MEMBER CATEGORY CODE ≠ W FORMER SPOUSE
 UNLESS ONE OCCURRENCE OF
 OVERRIDE CODE = I PATIENT IS A FOMER SPOUSE UNDER 34 YEARS OF AGE

1-070-05R IF HCC MEMBER CATEGORY CODE = T FOREIGN MILITARY MEMBER
 AND HCC MEMBER RELATIONSHIP CODE ≠ A SELF
 THEN HCC MEMBER RELATIONSHIP CODE MUST = B SPOUSE **OR**

¹ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND BEGIN DATE OF CARE.

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)	
	410 TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412 TRS SURVIVOR NEW FAMILY COVERAGE OR
	413 TRS MEMBER-ONLY COVERAGE OR
	414 TRS MEMBER AND FAMILY COVERAGE OR
	418 TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE OR
	419 TRR MEMBER AND FAMILY COVERAGE OR
	420 TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421 TRR SURVIVOR FAMILY COVERAGE
THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	T TRICARE STANDARD OR
	V TRICARE EXTRA OR
	FE TFL - EXTRA OR
	FS TFL - STANDARD OR
	PS TSRx OR
	SR SHCP-REFERRED CARE
1-111-02R	IF HCDP PLAN COVERAGE CODE =
	401 TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410 TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412 TRS SURVIVOR NEW FAMILY COVERAGE OR
	413 TRS MEMBER-ONLY COVERAGE OR
	414 TRS MEMBER AND FAMILY COVERAGE OR
	418 TRR MEMBER-ONLY COVERAGE OR

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (1-111)

		419	TRR MEMBER AND FAMILY COVERAGE OR
		420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
		421	TRR SURVIVOR FAMILY COVERAGE
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =	PF	ECHO
1-111-03R	IF HCDP PLAN COVERAGE CODE =	417	TRANSITIONAL CARE FOR SERVICE-RELATED CONDITIONS (TCSRC)
	THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	X	FOREIGN ADSM OR
		SR	SHCP - REFERRED CARE

ELEMENT NAME: REGION INDICATOR (1-112)

VALIDITY EDITS

1-112-01V	MUST BE VALID REGION INDICATOR (REFER TO SECTION 2.8)		
1-112-02V	IF TYPE OF SUBMISSION ≠	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
		E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND REGION INDICATOR =	NC	NORTH CONTRACT OR
		SC	SOUTH CONTRACT OR
		WC	WEST CONTRACT
	THEN ADJUSTMENT KEY MUST =	0	BATCH OR
		5	VOUCHER

RELATIONAL EDITS

NONE

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (CONTINUED)			
	AND TYPE OF INSTITUTION =	10	GENERAL MEDICAL AND SURGICAL
	THEN END DATE OF CARE MUST BE ≥ 10/01/2001		
	AND ENROLLMENT/ HEALTH PLAN CODE MUST =	FE	TFL - EXTRA OR
		FS	TFL - STANDARD
1-185-38R	<ul style="list-style-type: none"> SPECIAL PROCESSING CODE 'V' IS USED FOR CARE PROVIDED WITHIN NORMAL LIMITS - WHILE SPECIAL PROCESSING CODE "W" IS USED FOR CARE OVER AND ABOVE THOSE NORMAL LIMITS 		
	IF BEGIN DATE OF CARE IS ≥ 12/28/2001		
	AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	CT	CCTP
	THEN AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	V	FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR OR
		W	NON-FINANCIALLY UNDERWRITTEN PAYMENT BY FINANCIALLY UNDERWRITTEN CLAIMS PROCESSOR
1-185-39R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	PF	ECHO
	THEN HCDP PLAN COVERAGE CODE MUST ≠	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
		402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
		405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
		406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
		407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
		408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
		409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
		410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR

¹ AS STATED IN SECTION 2.8 OR BLANK.
² PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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CHAPTER 2, SECTION 5.2

INSTITUTIONAL EDIT REQUIREMENTS (ELN 100 - 199)

ELEMENT NAME: SPECIAL PROCESSING CODE (1-185) (CONTINUED)

	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRR MEMBER-ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE

1-185-49R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AU AUTISM DEMONSTRATION
 THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/2008
 AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST = PF ECHO
 AND PATIENT AGE² MUST BE ≥ 18 MONTHS

1-185-50R IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = 49 HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/REPLACEMENT OF DEVICE DURING WARRANTY PERIOD OR
 50 HOSPITAL REIMBURSEMENT REDUCED BY MANUFACTURER CREDIT/RECALLED DEVICE

THEN DRG NUMBER MUST EQUAL A DRG SUBJECT TO THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT [HTTP://WWW.TRICARE.MIL/DRGRATES/](http://www.tricare.mil/drgrates/)

AND DATE OF ADMISSION MUST BE ≥ THE DRG EFFECTIVE DATE AND ≤ THE DRG TERMINATION DATE AS PER THE REPLACEMENT DEVICE POLICY POSTED ON TRICARE'S DRG WEB PAGE AT [HTTP://WWW.TRICARE.MIL/DRGRATES/](http://www.tricare.mil/drgrates/)

¹ AS STATED IN SECTION 2.8 OR BLANK.
² PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (1-186)

VALIDITY EDITS

1-186-01V MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE LISTING IN SECTION 2.5.

RELATIONAL EDITS

NONE

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (2-285) (CONTINUED)	
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409 TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410 TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411 TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412 TRS SURVIVOR NEW FAMILY COVERAGE OR
	413 TRS MEMBER-ONLY COVERAGE OR
	414 TRS MEMBER AND FAMILY COVERAGE OR
	418 TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE OR
	419 TRR MEMBER AND FAMILY COVERAGE OR
	420 TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421 TRR SURVIVOR FAMILY COVERAGE
2-285-02R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = PF ECHO
	THEN HHC MEMBER CATEGORY CODE MUST = A ACTIVE DUTY OR
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J ACADEMY STUDENT OR
	P TAMP MEMBER OR
	S RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE)
2-285-03R	IF TYPE OF SERVICE (FIRST POSITION) = A AMBULATORY SURGERY COST-SHARED AS INPATIENT
	THEN HCC MEMBER CATEGORY CODE MUST = A ACTIVE DUTY OR
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J ACADEMY STUDENT OR
	N NATIONAL GUARD MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR

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CHAPTER 2, SECTION 6.3

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 200 - 299)

ELEMENT NAME: HEALTH CARE COVERAGE (HCC) MEMBER CATEGORY CODE (2-285) (CONTINUED)

	P	TRANSITIONAL ASSISTANCE MANAGEMENT PROGRAM (TAMP) MEMBER OR
	S	RESERVE MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE MEMBER (NOT ON ACTIVE DUTY OR ON ACTIVE DUTY FOR 30 DAYS OR LESS) OR
	Z	UNKNOWN

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = 0

2-285-04R	IF TYPE OF SERVICE (SECOND POSITION) =	C	AMBULATORY SURGERY
	THEN HCC MEMBER CATEGORY CODE MUST =	D	DISABLED AMERICAN VETERAN OR
		F	FORMER MEMBER OR
		H	MEDAL OF HONOR RECIPIENT OR
		R	RETIRED OR
		W	FORMER SPOUSE OR
		Z	UNKNOWN

UNLESS AMOUNT ALLOWED BY PROCEDURE CODE = 0

2-285-05R	IF HCC MEMBER CATEGORY CODE =	T	FOREIGN MILITARY MEMBER
	THEN ONE OCCURRENCE OF OVERRIDE CODE =	M	NATO

ELEMENT NAME: PAY GRADE CODE (SPONSOR) (2-291)

VALIDITY EDITS

2-291-01V	MUST BE A VALID PAY GRADE CODE (SPONSOR) (REFER TO SECTION 2.7)
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RELATIONAL EDITS

NONE

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)

VALIDITY EDITS

2-301-01V MUST BE A VALID HCDP PLAN COVERAGE CODE LISTED IN **ADDENDUM M**.

2-301-02V IF FILING DATE ≥ 09/01/2007

AND HCDP PLAN COVERAGE
CODE =

109 TRICARE USFHP DIRECT CARE COVERAGE
FOR ADFMS **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**

118 TRICARE USFHP DIRECT CARE INDIVIDUAL
COVERAGE FOR RETIRED SPONSORS AND
FAMILY MEMBERS **OR**

119 TRICARE USFHP DIRECT CARE FAMILY
COVERAGE FOR RETIRED SPONSORS AND
FAMILY MEMBERS **OR**

133 TRICARE USFHP DIRECT CARE INDIVIDUAL
COVERAGE FOR TRANSITIONAL
SURVIVORS OF ACTIVE DUTY DECEASED
SPONSORS **OR**

138 TRICARE USFHP DIRECT CARE INDIVIDUAL
COVERAGE FOR SURVIVORS OF GUARD/
RESERVE DECEASED SPONSORS **OR**

139 TRICARE USFHP DIRECT CARE FAMILY
COVERAGE FOR SURVIVORS OF GUARD/
RESERVE DECEASED SPONSORS

**THEN THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT ALLOWED
BY PROCEDURE CODE MUST = ZERO**

RELATIONAL EDITS

2-301-01R IF HCDP PLAN COVERAGE
CODE =

401 TRS TIER 1 MEMBER-ONLY COVERAGE
(CONTINGENCY OPERATIONS) **OR**

402 TRS TIER 1 MEMBER AND FAMILY
COVERAGE (CONTINGENCY OPERATIONS)
OR

405 TRS TIER 2 MEMBER-ONLY COVERAGE
(CERTIFIED QUALIFICATIONS) **OR**

406 TRS TIER 2 MEMBER AND FAMILY
COVERAGE (CERTIFIED QUALIFICATIONS)
OR

407 TRS TIER 3 MEMBER-ONLY COVERAGE
(SERVICE AGREEMENT) **OR**

408 TRS TIER 3 MEMBER AND FAMILY
COVERAGE (SERVICE AGREEMENT) **OR**

409 TRS SURVIVOR CONTINUING WITH
INDIVIDUAL COVERAGE **OR**

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)

	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRICARE RETIRED RESERVE (TRR) MEMBER-ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
THEN ENROLLMENT/ HEALTH PLAN CODE MUST =	T	TRICARE STANDARD OR
	V	TRICARE EXTRA OR
	FE	TFL - EXTRA OR
	FS	TFL - STANDARD OR
	PS	TSRx OR
	SR	SHCP-REFERRED CARE
2-301-02R	IF HCDP PLAN COVERAGE CODE =	
	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRR MEMBER-ONLY COVERAGE OR

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) PLAN COVERAGE CODE (2-301)	
	419 TRR MEMBER AND FAMILY COVERAGE OR
	420 TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421 TRR SURVIVOR FAMILY COVERAGE
	THEN NO OCCURRENCE OF SPECIAL PROCESSING CODE CAN =
	PF ECHO
2-301-03R	IF HCDP PLAN COVERAGE CODE =
	417 TRANSITIONAL CARE FOR SERVICE-RELATED CONDITIONS (TCSRC)
	THEN ENROLLMENT/HEALTH PLAN CODE MUST =
	X FOREIGN ADSM OR
	SR SHCP - REFERRED CARE

ELEMENT NAME: REGION INDICATOR (2-303)	
VALIDITY EDITS	
2-303-01V	MUST BE A VALID REGION INDICATOR (REFER TO SECTION 2.8)
2-303-02V	IF TYPE OF SUBMISSION ≠
	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
	AND REGION INDICATOR =
	NC NORTH CONTRACT OR
	SC SOUTH CONTRACT OR
	WC WEST CONTRACT
	THEN ADJUSTMENT KEY MUST =
	0 BATCH OR
	5 VOUCHER
RELATIONAL EDITS	
	NONE

TRICARE SYSTEMS MANUAL 7950.1-M, AUGUST 1, 2002

CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305)

VALIDITY EDITS

2-305-01V	OCCURRENCE NUMBER 1--MUST BE A VALID SPECIAL PROCESSING CODE ¹
2-305-02V	OCCURRENCE NUMBER 2--MUST BE A VALID SPECIAL PROCESSING CODE ¹
2-305-03V	OCCURRENCE NUMBER 3--MUST BE A VALID SPECIAL PROCESSING CODE ¹
2-305-04V	OCCURRENCE NUMBER 4--MUST BE A VALID SPECIAL PROCESSING CODE ¹
2-305-05V	A VALUE CANNOT BE CODED MORE THAN ONCE (EXCEPT BLANK).
2-305-06V	SPECIAL PROCESSING CODE OCCURRENCES MUST BE LEFT JUSTIFIED.
2-305-07V	<ul style="list-style-type: none"> • SHCP REFERRED/NON-REFERRED
	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	AN SHCP - NON-MTF-REFERRED CARE OR
	AR SHCP - REFERRED CARE
	THEN BEGIN DATE OF CARE MUST BE < 06/01/2004
2-305-08V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	GF TPR FOR ELIGIBLE ADFM RESIDING WITH A TPR ELIGIBLE ADSM
	THEN BEGIN DATE OF CARE MUST BE < 09/01/2002
2-305-09V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	U BRAC PHARMACY
	THEN BEGIN DATE OF CARE MUST BE < 04/01/2001
2-305-10V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	MN TSP - NON-NETWORK OR
	MS TSP - NETWORK
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2001
2-305-11V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	SN TSS - NON-NETWORK OR
	SS TSS - NETWORK
	THEN BEGIN DATE OF CARE MUST BE < 12/31/2002
2-305-13V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PD PHARMACY REDESIGN PILOT PROGRAM
	THEN BEGIN DATE OF CARE MUST BE < 04/01/2001
2-305-14V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	ST SPECIALIZED TREATMENT
	THEN BEGIN DATE OF CARE MUST BE < 10/01/2004
2-305-15V	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	WR MENTAL HEALTH WRAPAROUND DEMONSTRATION
	THEN BEGIN DATE OF CARE MUST BE < 06/30/2001

RELATIONAL EDITS

2-305-02R	IF CA/NAS EXCEPTION REASON =	6	RESOURCE SHARING
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¹ AS STATED IN SECTION 2.8 OR BLANK

² CPT ONLY © 2006 AMERICAN MEDICAL ASSOCIATION (OR SUCH OTHER DATE OF PUBLICATION OF CPT). ALL RIGHTS RESERVED.

³ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)	
31	CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED OR
32	OUR RECORDS INDICATE THAT THIS DEPENDENT IS NOT AN ELIGIBLE DEPENDENT AS DEFINED OR
33	CLAIM DENIED. INSURED HAS NO DEPENDENT COVERAGE OR
34	CLAIM DENIED. INSURED HAS NO COVERAGE FOR NEWBORNS OR
62	PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED, PRE-CERTIFICATION/AUTHORIZATION OR
141	CLAIM ADJUSTMENT BECAUSE THE CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE
2-305-29R	<ul style="list-style-type: none"> SPECIAL PROCESSING CODE "V" IS USED FOR CARE PROVIDED WITHIN NORMAL LIMITS - WHILE SPECIAL PROCESSING CODE "W" IS USED FOR CARE OVER AND ABOVE THOSE NORMAL LIMITS
	IF BEGIN DATE OF CARE IS \geq 12/28/2001
	AND ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	CT CCTP
	THEN AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =
	V FINANCIALLY UNDERWRITTEN PAYMENT BY CLAIMS PROCESSOR OR
	W NON-FINANCIALLY UNDERWRITTEN PAYMENT BY FINANCIALLY UNDERWRITTEN CLAIMS PROCESSOR
2-305-30R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =
	PF ECHO
	THEN HCDP PLAN COVERAGE CODE MUST \neq
	401 TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR

¹ AS STATED IN SECTION 2.8 OR BLANK

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³ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)

	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRR MEMBER-ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
2-305-31R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = AU AUTISM DEMONSTRATION	
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/15/2008	
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST = PF ECHO	
	AND PATIENT AGE ³ MUST BE ≥ 18 MONTHS	
2-305-32R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = RB RESPITE BENEFIT FOR ADMSs	
	THEN BEGIN DATE OF CARE MUST BE ≥ 01/01/2008	
	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST = AD FOREIGN ACTIVE DUTY CLAIMS OR	
	GU ADMS ENROLLED IN TPR OR	
	SE SHCP - TRICARE ELIGIBLE	
2-305-35R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = DE TDRL PHYSICAL EXAMS	
	THEN BEGIN DATE OF CARE MUST BE ≥ 03/30/2009	
	AND ENROLLMENT/HEALTH PLAN CODE MUST = SR SHCP REFERRED CARE	

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³ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: SPECIAL PROCESSING CODE (2-305) (CONTINUED)

	AND AT LEAST ONE OTHER OCCURRENCE OF SPECIAL PROCESSING CODE MUST =	SE	SHCP - TRICARE ELIGIBLE
2-305-36R	IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE =	EF	TRICARE RESERVE AND NATIONAL GUARD FAMILY MEMBER BENEFITS
	THEN BEGIN DATE OF CARE MUST BE ≥ 11/01/2009		
	AND ENROLLMENT/HEALTH PLAN CODE MUST =	T	TRICARE STANDARD PROGRAM OR
		V	TRICARE EXTRA
	AND HCDP SPECIAL ENTITLEMENT CODE MUST =	02	NOBLE EAGLE PARTICIPATION SPECIAL ENTITLEMENT OR
		03	ENDURING FREEDOM PARTICIPATION SPECIAL ENTITLEMENT
	AND AMOUNT APPLIED TOWARD DEDUCTIBLE MUST = ZERO		

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³ PATIENT AGE IS CALCULATED BASED ON PERSON BIRTH CALENDAR DATE (PATIENT) AND CARE DATES.

ELEMENT NAME: HEALTH CARE DELIVERY PROGRAM (HCDP) SPECIAL ENTITLEMENT CODE (2-306)

VALIDITY EDITS

2-306-01V	MUST BE A VALID HCDP SPECIAL ENTITLEMENT CODE LISTING IN SECTION 2.5
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RELATIONAL EDITS

NONE

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CHAPTER 2, SECTION 6.4

NON-INSTITUTIONAL EDIT REQUIREMENTS (ELN 300 - 399)

ELEMENT NAME: CA/NAS NUMBER (2-310)

VALIDITY EDITS

2-310-01V IF CA/NAS NUMBER IS NOT BLANK THEN MUST BE 1 TO 11 OR 1 TO 15 ALPHANUMERIC CHARACTERS.

RELATIONAL EDITS

NO ERROR IF TYPE OF SUBMISSION = C COMPLETE CANCELLATION OR
D COMPLETE DENIAL

THEN BYPASS ALL CA/NAS NUMBER RELATIONAL EDITING.

NO ERROR IF BEGIN DATE OF CARE IS OLDER THAN 6 YEARS

THEN DO NOT CHECK IF ZIP CODE IS IN CATCHMENT AREA

NO ERROR IF ANY OCCURRENCE OF SPECIAL PROCESSING CODE = R MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NOT A MEDICARE BENEFIT) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR

T MEDICARE/TRICARE DUAL ENTITLEMENT (SECOND PAYOR) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR

AN SHCP - NON-MTF-REFERRED CARE OR

AR SHCP - REFERRED CARE OR

CE SHCP - COMPREHENSIVE CLINICAL EVALUATION PROGRAM OR

PF ECHO

RS MEDICARE/TRICARE DUAL ENTITLEMENT (FIRST PAYOR-NO TRICARE PROVIDER CERTIFICATION, i.e., MEDICARE BENEFITS HAVE BEEN EXHAUSTED) AND BEGIN DATE OF CARE ≥ 10/01/2001 OR

SC SHCP - NON-TRICARE ELIGIBLE OR

SE SHCP - TRICARE ELIGIBLE OR

SM SHCP - EMERGENCY OR

ST SPECIALIZED TREATMENT OR

WR MENTAL HEALTH WRAP AROUND

THEN BYPASS ALL CA/NAS NUMBER EDITING.

NO ERROR IF ENROLLMENT/HEALTH PLAN CODE = U TRICARE PRIME, CIVILIAN PCM OR

W TPR ADSM - USA OR

X FOREIGN ADSM OR

Y CHCBP - STANDARD OR

Z TRICARE PRIME, MTF/PCM OR

AA CHCBP - EXTRA OR

BB TSP OR

FE TFL - EXTRA OR

FS TFL - STANDARD OR

¹ CATCHMENT AREA DETERMINATION IS BASED ON BEGIN DATE OF CARE.

² MTF IS A 40 MILES CATCHMENT AREA.

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 ≠	MDA906-02-C-0013 (TMOP) OR MDA906-03-C-0009 (WEST) OR MDA906-03-C-0010 (SOUTH) OR MDA906-03-C-0011 (NORTH) OR MDA906-03-C-0019 (TRRx)
OR AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO	
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 403 TOBACCO CESSATION DEMONSTRATION PROGRAM OR 404 WEIGHT MANAGEMENT DEMONSTRATION PROGRAM 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

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

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

	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
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRICARE RETIRED RESERVE (TRR) MEMBER- ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
OR ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	AA	CHCBP EXTRA - FAMILY COVERAGE OR
	SN	SHCP NON-REFERRED CARE OR
	SR	SHCP REFERRED CARE
OR SPECIAL PROCESSING CODE =	AN	SHCP NON-MTF REFERRED CARE OR
	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

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CHAPTER 2, SECTION 8.1

FINANCIAL EDIT REQUIREMENTS

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

ELSE IF OTHER GOVERNMENT PROGRAM TYPE CODE =	A	MEDICARE PART A OR
	C	MEDICARE PART A & B 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
	016	DIRECT CARE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	017	TRICARE STANDARD FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	021	TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	023	TFL FOR 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
	136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	137	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	138	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	143	TRICARE PLUS COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR

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FINANCIAL EDIT REQUIREMENTS

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

	144	TRICARE PLUS WITH CHC COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	148	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	149	TRICARE PLUS COVERAGE WITH CHC FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	151	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
OR HCC MEMBER CATEGORY CODE =	F	FORMER MEMBER OR
	H	MEDAL OF HONOR RECIPIENT OR
	R	RETIRED OR
	W	FORMER SPOUSE
THEN BATCH/VOUCHER ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST =	TF	TRUST/ACCRUAL FUND
ELSE BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
1-000-02F		• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - NORTH CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVT CONTRACTOR (TOTAL) = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC
AND CONTRACT NUMBER =		MDA906-03-C-0011 (NORTH)

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FINANCIAL EDIT REQUIREMENTS

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

AND BEGIN DATE OF CARE ≥ 09/01/2004

THEN SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR
	AU	AUTISM DEMONSTRATION OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR ENROLLMENT/ HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000	CARE DELIVERED TO INELIGIBLES OR
	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRR MEMBER-ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR

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FINANCIAL EDIT REQUIREMENTS

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

	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
1-000-03F		• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - SOUTH CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVT CONTRACTOR (TOTAL) = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC
AND CONTRACT NUMBER =		MDA906-03-C-0010 (SOUTH)
AND BEGIN DATE OF CARE ≥ 11/01/2004		
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	Y	CHCBP OR
	AA	CHCBP - EXTRA OR
	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000	CARE DELIVERED TO INELIGIBLES OR
	121	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	122	CHCBP EXTRA - FAMILY COVERAGE OR
	401	TRS TIER 1 MEMBER-ONLY COVERAGE OR
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR

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FINANCIAL EDIT REQUIREMENTS

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

	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRR MEMBER-ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
OR SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR
	AU	AUTISM DEMONSTRATION OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN

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FINANCIAL EDIT REQUIREMENTS

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

1-000-04F	• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - WEST CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVT CONTRACTOR (TOTAL) = ZERO	
THEN BYPASS THIS EDIT	
ELSE IF BATCH/VOUCHER CLIN/ ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD TRICARE DOMESTIC
AND CONTRACT NUMBER =	MDA906-03-C-0009 (WEST)
AND BEGIN DATE OF CARE ≥ 10/01/2004	
THEN SPECIAL PROCESSING CODE MUST =	AR SHCP - REFERRED CARE OR
	AU AUTISM DEMONSTRATION OR
	CL CLINICAL TRIALS OR
	CM INDIVIDUAL CASE MANAGEMENT OR
	CT CUSTODIAL CARE
OR ENROLLMENT/ HEALTH PLAN CODE =	SR SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000 CARE DELIVERED TO INELIGIBLES OR
	401 TRS TIER 1 MEMBER-ONLY COVERAGE OR
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR

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FINANCIAL EDIT REQUIREMENTS

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

409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
412	TRS SURVIVOR NEW FAMILY COVERAGE OR
413	TRS MEMBER-ONLY COVERAGE OR
414	TRS MEMBER AND FAMILY COVERAGE OR
418	TRR MEMBER-ONLY COVERAGE OR
419	TRR MEMBER AND FAMILY COVERAGE OR
420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
421	TRR SURVIVOR FAMILY COVERAGE
OR PATIENT ZIP CODE IS IN ALASKA	
OR PCM DMIS ID STATE = ALASKA	
OR HCC MEMBER CATEGORY CODE MUST =	
A	ACTIVE DUTY OR
G	NATIONAL GUARD > 30 DAYS OR
J	ACADEMY STUDENT OR
N	NATIONAL GUARD < 30 DAYS OR
S	RESERVE > 30 DAYS OR
T	FOREIGN MILITARY MEMBER OR
V	RESERVE < 30 DAYS OR
Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	
A	SELF OR
Z	UNKNOWN

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FINANCIAL EDIT REQUIREMENTS

ELEMENT NAME: SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) (1-060)

VALIDITY EDITS

REFER TO [SECTION 5.1](#)

RELATIONAL EDITS

1-060-01F	• FOREIGN EDITS [ACTIVE DUTY SERVICE MEMBER]
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR AMOUNT PAID BY GOVERNMENT CONTRACTOR (TOTAL) = ZERO	
THEN BYPASS THIS EDIT	
ELSE IF HEADER TYPE INDICATOR =	5 VOUCHER HEADER NON-ADMIN CLAIM RATE-ELIGIBLE OR
	6 VOUCHER HEADER ADMIN CLAIM RATE- ELIGIBLE
AND ENROLLMENT/HEALTH PLAN CODE =	X FOREIGN ADSM
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION IN THE TMA DATABASE MUST =	TF TRICARE FOREIGN
AND SERVICE BRANCH CLASSIFICATION CODE (SPONSOR) MUST =	A ARMY OR
	C COAST GUARD OR
	F AIR FORCE OR
	H PUBLIC HEALTH SERVICE OR
	M MARINES OR
	N NAVY OR
	O NOAA OR
	Z NOT PROVIDED FROM DEERS
AND HCC MEMBER CATEGORY CODE MUST =	A ACTIVE DUTY OR
	G NATIONAL GUARD MEMBER (MOBILIZED OR ON ACTIVE DUTY FOR 31 DAYS OR MORE) OR
	J ACADEMY STUDENT OR

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

	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRR MEMBER-ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
OR ENROLLMENT/HEALTH PLAN CODE =	Y	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	AA	CHCBP EXTRA - FAMILY COVERAGE OR
	SN	SHCP NON-MTF REFERRED CARE OR
	SR	SHCP REFERRED CARE
OR SPECIAL PROCESSING CODE =	AN	SHCP NON-MTF REFERRED CARE OR
	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
	I	MEDICARE PART A & D OR
	L	MEDICARE PART A, B, & D
AND OTHER GOVERNMENT PROGRAM BEGIN REASON CODE ≠	N	NOT ELIGIBLE FOR MEDICARE

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

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
	016	DIRECT CARE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	017	TRICARE STANDARD FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	021	TFL FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	023	TFL FOR 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
	136	TRICARE PRIME INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	137	TRICARE PRIME FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	138	TRICARE USFHP DIRECT CARE INDIVIDUAL COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	139	TRICARE USFHP DIRECT CARE FAMILY COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	143	TRICARE PLUS COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR
	144	TRICARE PLUS WITH CHC COVERAGE FOR SURVIVORS OF ACTIVE DUTY DECEASED SPONSORS OR

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

	148	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	149	TRICARE PLUS COVERAGE WITH CHC COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS OR
	151	TRICARE PLUS COVERAGE FOR SURVIVORS OF GUARD/RESERVE DECEASED SPONSORS
OR HCC MEMBER CATEGORY CODE =	F	FORMER MEMBER OR
	H	MEDAL OF HONOR RECIPIENT OR
	R	RETIRED OR
	W	FORMER SPOUSE
THEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST =	TF	TRUST/ACCRUAL FUND
ELSE BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER APPROPRIATION TYPE FOUND IN CORAMS MUST ≠	TF	TRUST/ACCRUAL FUND
2-000-02F		• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - NORTH CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVT CONTRACTOR BY PROCEDURE CODE = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC)
AND CONTRACT NUMBER =		MDA906-03-C-0011 (NORTH)
AND BEGIN DATE OF CARE ≥ 09/01/2004		
THEN SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR
	AU	AUTISM DEMONSTRATION OR

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

	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR ENROLLMENT/ HEALTH PLAN CODE =	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000	CARE DELIVERED TO INELIGIBLES OR
	401	TRS TIER 1 MEMBER-ONLY COVERAGE (CONTINGENCY OPERATIONS) OR
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRR MEMBER-ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR

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

	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN
2-000-03F		• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - SOUTH CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2	BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B	ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E	COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVT CONTRACTOR BY PROCEDURE CODE = ZERO		
THEN BYPASS THIS EDIT		
ELSE IF BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD	TRICARE DOMESTIC)
AND CONTRACT NUMBER =		MDA906-03-C-0010 (SOUTH)
AND BEGIN DATE OF CARE ≥ 11/01/2004		
THEN ENROLLMENT CODE/HEALTH PLAN CODE MUST =	Y	CHCBP OR
	AA	CHCBP - EXTRA OR
	SR	SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000	CARE DELIVERED TO INELIGIBLES OR
	121	CHCBP STANDARD - INDIVIDUAL COVERAGE OR
	122	CHCBP EXTRA - FAMILY COVERAGE OR
	401	TRS TIER 1 MEMBER-ONLY COVERAGE OR
	402	TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405	TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406	TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR

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

	407	TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408	TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR
	409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
	410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
	411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
	412	TRS SURVIVOR NEW FAMILY COVERAGE OR
	413	TRS MEMBER-ONLY COVERAGE OR
	414	TRS MEMBER AND FAMILY COVERAGE OR
	418	TRR MEMBER-ONLY COVERAGE OR
	419	TRR MEMBER AND FAMILY COVERAGE OR
	420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
	421	TRR SURVIVOR FAMILY COVERAGE
OR SPECIAL PROCESSING CODE MUST =	AR	SHCP - REFERRED CARE OR
	AU	AUTISM DEMONSTRATION OR
	CL	CLINICAL TRIALS OR
	CM	INDIVIDUAL CASE MANAGEMENT OR
	CT	CUSTODIAL CARE
OR HCC MEMBER CATEGORY CODE MUST =	A	ACTIVE DUTY OR
	G	NATIONAL GUARD > 30 DAYS OR
	J	ACADEMY STUDENT OR
	N	NATIONAL GUARD < 30 DAYS OR
	S	RESERVE > 30 DAYS OR
	T	FOREIGN MILITARY MEMBER OR
	V	RESERVE < 30 DAYS OR
	Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	A	SELF OR
	Z	UNKNOWN

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FINANCIAL EDIT REQUIREMENTS

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

2-000-04F	• NON-FINANCIALLY UNDERWRITTEN BATCH/VOUCHER CLIN/ASAP ACCOUNT NUMBER VALIDATION - WEST CONTRACT
IF ANY OCCURRENCE OF OVERRIDE CODE =	H1 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, CONTRACTOR ERROR OR
	H2 BENEFIT PAYMENT MADE USING INCORRECT BATCH/VOUCHER CLIN/ASAP NUMBER, GOVERNMENT CAUSED ERROR
OR TYPE OF SUBMISSION =	B ADJUSTMENT TO NON-TED RECORD (HCSR) DATA OR
	E COMPLETE CANCELLATION OF NON-TED RECORD (HCSR) DATA
OR THE TOTAL OF ALL OCCURRENCES/LINE ITEMS OF AMOUNT PAID BY GOVT CONTRACTOR BY PROCEDURE CODE = ZERO	
THEN BYPASS THIS EDIT	
ELSE IF BATCH/VOUCHER CLIN/ ASAP ACCOUNT NUMBER ASAP DESCRIPTION FOUND IN CORAMS =	TD TRICARE DOMESTIC)
AND CONTRACT NUMBER =	MDA906-03-C-0009 (WEST)
AND BEGIN DATE OF CARE ≥ 10/01/2004	
THEN SPECIAL PROCESSING CODE MUST =	AR SHCP - REFERRED CARE OR
	AU AUTISM DEMONSTRATION OR
	CL CLINICAL TRIALS OR
	CM INDIVIDUAL CASE MANAGEMENT OR
	CT CUSTODIAL CARE
OR ENROLLMENT/ HEALTH PLAN CODE =	SR SHCP - REFERRED CARE
OR HCDP PLAN COVERAGE CODE MUST =	000 CARE DELIVERED TO INELIGIBLES OR
	401 TRS TIER 1 MEMBER-ONLY COVERAGE OR
	402 TRS TIER 1 MEMBER AND FAMILY COVERAGE (CONTINGENCY OPERATIONS) OR
	405 TRS TIER 2 MEMBER-ONLY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	406 TRS TIER 2 MEMBER AND FAMILY COVERAGE (CERTIFIED QUALIFICATIONS) OR
	407 TRS TIER 3 MEMBER-ONLY COVERAGE (SERVICE AGREEMENT) OR
	408 TRS TIER 3 MEMBER AND FAMILY COVERAGE (SERVICE AGREEMENT) OR

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

409	TRS SURVIVOR CONTINUING WITH INDIVIDUAL COVERAGE OR
410	TRS SURVIVOR CONTINUING WITH FAMILY COVERAGE OR
411	TRS SURVIVOR NEW INDIVIDUAL COVERAGE OR
412	TRS SURVIVOR NEW FAMILY COVERAGE OR
413	TRS MEMBER-ONLY COVERAGE OR
414	TRS MEMBER AND FAMILY COVERAGE OR
418	TRR MEMBER-ONLY COVERAGE OR
419	TRR MEMBER AND FAMILY COVERAGE OR
420	TRR SURVIVOR INDIVIDUAL COVERAGE OR
421	TRR SURVIVOR FAMILY COVERAGE
OR PATIENT ZIP CODE IS IN ALASKA	
OR PCM DMIS ID STATE = ALASKA	
OR HCC MEMBER CATEGORY CODE MUST =	
A	ACTIVE DUTY OR
G	NATIONAL GUARD > 30 DAYS OR
J	ACADEMY STUDENT OR
N	NATIONAL GUARD < 30 DAYS OR
S	RESERVE > 30 DAYS OR
T	FOREIGN MILITARY MEMBER OR
V	RESERVE < 30 DAYS OR
Z	UNKNOWN
AND HCC MEMBER RELATIONSHIP CODE MUST =	
A	SELF OR
Z	UNKNOWN

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CHAPTER 2, ADDENDUM M

DATA REQUIREMENTS - HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE VALUES

VALID VALUE	DESCRIPTION
214	TRICARE Dental Plan Individual Coverage for Active Guard/Reserve (AGR) Family Members
215	TRICARE Dental Plan Family Coverage for Active Guard/Reserve (AGR) Family Members
216	TRICARE Dental Plan Individual Remote Coverage for Active Guard/Reserve (AGR) Family Members
217	TRICARE Dental Plan Family Remote Coverage for Active Guard/Reserve (AGR) Family Members
218	TRICARE Dental Plan Individual Coverage for Survivors of Active Guard/Reserve (AGR) Family Members
219	TRICARE Dental Plan Family Coverage for Survivors of Active Guard/Reserve (AGR) Family Members
220	TRICARE Dental Plan for Mobilization-Asset Individual Ready Reserve (IRR) Sponsors
221	TRICARE Dental Plan Individual Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Member
222	TRICARE Dental Plan Family Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
223	TRICARE Dental Plan Individual Remote Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
224	TRICARE Dental Plan Family Remote Coverage for Mobilization-Asset Individual Ready Reserve (IRR) Family Members
225	TRICARE Dental Plan Individual Coverage for Survivors of Mobilization-Asset Individual Ready Reserve (IRR) Deceased Sponsors
226	TRICARE Dental Plan Family Coverage for Survivors of Mobilization-Asset Individual Ready Reserve (IRR) Deceased Sponsors
227	TRICARE Dental Plan for Non-Mobilization-Asset Individual Ready Reserve (IRR) Sponsors
228	TRICARE Dental Plan Individual Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
229	TRICARE Dental Plan Family Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
230	TRICARE Dental Plan Individual Remote Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
231	TRICARE Dental Plan Family Remote Coverage for Non-Mobilization-Asset Individual Ready Reserve (IRR) Family Members
301	BRAC Pharmacy
302	Pharmacy Redesign Pilot Project (PRPP)
400	TRICARE Extended Care Health Option (ECHO) Program

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CHAPTER 2, ADDENDUM M

DATA REQUIREMENTS - HEALTH CARE DELIVERY PROGRAM PLAN COVERAGE CODE VALUES

VALID VALUE	DESCRIPTION
401	TRICARE Reserve Select Tier 1 Member-Only Coverage (Contingency Operations)
402	TRICARE Reserve Select Tier 1 Member and Family Coverage (Contingency Operations)
403	Tobacco Cessation Demonstration Program
404	Weight Management Demonstration Program
405	TRICARE Reserve Select Tier 2 Member-Only Coverage (Certified Qualifications)
406	TRICARE Reserve Select Tier 2 Member and Family Coverage (Certified Qualifications)
407	TRICARE Reserve Select Tier 3 Member-Only Coverage (Service Agreement)
408	TRICARE Reserve Select Tier 3 Member and Family Coverage (Service Agreement)
409	TRICARE Reserve Select Survivor Continuing with Individual Coverage
410	TRICARE Reserve Select Survivor Continuing with Family Coverage
411	TRICARE Reserve Select Survivor New Individual Coverage
412	TRICARE Reserve Select Survivor New Family Coverage
413	TRICARE Reserve Select Member-Only Coverage
414	TRICARE Reserve Select Member and Family Coverage
415	Wounded, Ill, and Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))
416	Wounded, Ill, and Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))
417	Transitional Care For Service-Related Conditions (TCSRC)
418	TRICARE Retired Reserve Member-Only Coverage
419	TRICARE Retired Reserve Member and Family Coverage
420	TRICARE Retired Reserve Survivor Individual Coverage
421	TRICARE Retired Reserve Survivor Family Coverage
602	Direct Care and TRICARE Mail Order Pharmacy (TMOP) and Retail Pharmacies
603	Direct Care Only
999	Unverified Newborn

PCM. Since in some locations PCMs are not available, **ADFM**s may be enrolled in TPR without a PCM assignment.

There is a Point of Service (POS) option under this program. TRICARE utilization review and utilization management requirements do apply to this program.

6.1.2.5. Health Care Plan: TRICARE Plus

The TRICARE Plus program is a **DC**-based program that became effective October 1, 2001. Enrolled beneficiaries must be eligible for DC, and may or may not have an entitlement to **CHC**. There are two types of TRICARE Plus coverage to differentiate between those beneficiaries with a CHC entitlement and those without. Coverage is at the individual level. There are no family policies. A family may have more than one individual policy, with each family member holding an individual policy.

6.1.2.6. Health Care Plan: USFHP

The USFHP is a TRICARE program for major medical health care, preventive care, and medically necessary care including prescription drug coverage. The USFHP is currently composed of civilian health care facilities contracted by the DoD to provide health care through the USFHP. USFHP enrollees are enrolled into the TRICARE Prime coverage plans with a USFHP PCM **Network Provider Type Option Code of 'U'**. The USFHP also covers beneficiaries age 65 and over that are Medicare-eligible, as well as dependent parent and parent-in-laws that have been grandfathered into the program. The beneficiaries are enrolled in separate USFHP plans for persons only having a DC entitlement. (See [Chapter 3, Addendum C for HCDP and PCM Network Provider Type Codes.](#))

6.1.2.7. Health Care Plan: TRICARE Senior Prime (TSP)

This coverage plan is referenced for historical purposes only.

Beneficiaries who were eligible for DC as well as Medicare may have chosen to enroll into the **TSP** coverage plan demonstration. Enrollees in this program selected a PCM in a participating MTF and were enrolled for the longevity of the program, which ended on December 31, 2001. Enrollment fees did not apply to this program. **TSP** did not offer a family coverage option, but allowed more than one individual plan for a family.

6.1.2.8. Health Care Plan: FEHBP Demonstration Project

The **NDAA** FY 1999 directed the DoD and the Office of Personnel Management (OPM) to develop a demonstration project to allow Medicare eligible military retirees age 65 and over, their family members, certain unremarried former spouses of military members or former members, and family members of deceased military members or former members to enroll into an FEHBP coverage plan for their health care.

The FEHBP demonstration project lasts three years at ten demonstration sites. Health care coverage began January 1, 2000 and ends December 31, 2002. Enrollment is managed through the FEHBP Demonstration Project Information Processing Center. The eligibility criteria and program requirements are beyond the scope of this document.

MCSCs do not perform enrollments for FEHBP.

6.1.2.9. Health Care Plan: CHCBP

The CHCBP is optional coverage to which beneficiaries may subscribe for a specified period (not to exceed 36 months) after the sponsor's entitlement to DoD benefits ends. Enrollment into the CHCBP program is performed by the CHCBP enrollment contractor. Details of this program are beyond the scope of this document (see the TPM, [Chapter 10, Section 4.1](#)).

6.1.2.10. Health Care Plan: TRICARE Reserve Select (TRS) Program

The TRS program is optional coverage to which Reserve Component (RC) members may subscribe when they commit to continued service in the Selected Reserve after release from AD to which the member was called or ordered for a period of more than 30 days on or after September 11, 2001, under one of the activation authorities in Section 101(a)(13)(B) of Title 10, U.S. Code and have served continuous for 90 days or more pursuant to such call or order to AD unless such continuous service on AD is less than 90 days solely due to an injury, illness or disease incurred or aggravated while deployed. Beneficiaries enrolled in the TRS program are not entitled to care at the MTF and must pay a premium for coverage.

6.1.2.11. Health Care Plan: TRICARE Retired Reserve (TRR) Program

TRR is a premium-based TRICARE health plan available for purchase by qualified members of the Retired Reserve and qualified survivors that offers health coverage for Retired Reserve members and their eligible family members. The RCs will validate members' and survivors' qualifications to purchase TRR coverage and will identify qualified members/survivors in the DEERS. Beneficiaries enrolled in the TRR program are entitled to care at the MTF.

6.2. Special Health Care Programs

DEERS supports any special health care program mandated by the DoD. These special health care programs are programs into which a beneficiary can enroll or register, regardless of other assigned or enrolled health care coverage plans to which they are entitled.

The Program for Persons with Disabilities (PPPWD) has been expanded to include an extended home health care benefit. The name of the TRICARE PFPWD has been changed to TRICARE Extended Care Health Option (ECHO). ECHO beneficiaries must be ADFMs, have a qualifying condition, and be registered to receive ECHO benefits on DEERS. MCSCs and USFHP providers are required to review appropriate documentation, including registration documents, and ascertain that individuals are ECHO eligible. Once a determination that an individual is ECHO eligible, MCSCs and USFHP providers must register the individual on DEERS. Registration will be performed through a Government Furnished Equipment (GFE) application and will include entering at least the following information, 1) ECHO, as a Special Health Care Coverage Plan Code, and 2) Registration Start Date. (NOTE: If the Begin Date is not entered, DOES will enter a default date using the 20th of the month rule.) ECHO-related codes needed for claims processing purposes shall be

returned as a Special Health Care Program within the Health Care Coverage Claims Response. Contractors may also utilize the web-based General Inquiry of DEERS (GIQD) application to obtain ECHO coverage information. See the TPM and TRICARE Operations Manual (TOM) for details regarding this program.

7.0. IDENTIFICATION SCHEMA FOR ELECTRONIC DATA INTERCHANGE (EDI)

7.1. Primary And Secondary Identifiers

Identification of persons in the DEERS database is established via primary identifiers and secondary identifiers. A primary identifier must be unambiguous, so that information systems and software can process it without the need for intervention by users or artificial intelligence technology. Secondary identifiers can be ambiguous and must be processed by users who match these secondary identifiers to persons in the DEERS database. Because secondary identifiers are ambiguous, system users generally use more than one secondary identifier to minimize mistakes in the identification process. More information on primary and secondary identifiers is explained in the next section of this document.

7.2. Person Identification

Sources external to DEERS identify persons initially in the DEERS database using only secondary identifiers. DEERS is the definitive system for person identification. The secondary identifiers are:

- Sponsor's SSN
- First three characters of the last name
- DOB

If only the SSN is provided, duplicate records are often resolved manually and thus system-to-system identification cannot be done. The last name and DOB are used to resolve duplications when two or more individuals have the same SSN, and to correct inaccurate identification of persons caused by using only the SSN. Usually, a person may be positively identified by an end user by matching an SSN along with the first three characters of the last name and the DOB. Data for both sponsors and individual family members may be accessed in this manner.

Since DEERS does not contain every family member's SSN, the user may access these individuals by using the sponsor's secondary identification information. This returns a list of each family member associated with the sponsor.

7.3. Beneficiary Identification

Beneficiaries in the DEERS database are positively identified using a system-generated DEERS ID. DEERS IDs are internal to DEERS and its interface systems, and therefore are not entered by users. As previously stated, each DEERS ID is a primary identifier, and formed by a combination of the following:

- Family ID, a DEERS-assigned nine-digit number unique to each family, plus a

- Beneficiary ID, a DEERS-assigned two-digit number unique to each individual in a family

Although a person may have more than one DEERS ID, stemming from multiple entitlements (defined previously), DEERS IDs positively identify each beneficiary. DEERS IDs, therefore, serve as primary identifiers and are used by information systems when passing data about individual beneficiaries and families.

A person may have multiple DEERS IDs over time and some of these instances are described as follows:

- A person may be entitled to DoD benefits via his or her simultaneous association to more than one sponsor. For example, a person may be a family member in two sponsored families at the same time. This situation occurs when both spouses in a family are sponsors. This condition is known as multiple entitlements.
- Entitlement periods may be sequential, such as when a son or daughter of a sponsor joins a Uniformed Service and he or she becomes a sponsor. In this case, the person would have a DEERS ID as a family member and as a sponsor. However, becoming a sponsor terminates the individual's previous eligibility for benefits as a family member.

7.4. Secondary Identification

In order to obtain a DEERS ID for a beneficiary, a system interfacing with DEERS must provide secondary identification information in one of several forms. This ensures the correct beneficiary is found, received, and stored with a DEERS ID. In the table below, the "Inquiry Information" column describes required information entering DEERS, and the "Response" column describes information returned by DEERS.

FIGURE 3-1.3-1 SECONDARY IDENTIFICATION

INQUIRY INFORMATION	RESPONSE
Family Member's Person Identifier and Person Identifier Type Code (S=SSN, D=DEERS assigned Temporary ID, F=DEERS assigned Foreign ID), Inquiry Person Type Code (sponsor or family member), Last Name and DOB (optional).	Family member option may return more than one DEERS ID if this beneficiary is in more than one family. User must then select correct beneficiary.
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional), and family option.	Returns entire family of beneficiaries (one DEERS Family ID). User must select beneficiary from family.
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional).	Returns one beneficiary.
AND Family Member's Person Identifier and Person Identifier Type Code (S=SSN, D=DEERS assigned Temporary ID, F=DEERS assigned foreign ID).	
Sponsor's Person Identifier and Person Identifier Type Code (S=SSN, F=DEERS assigned foreign ID), Last Name and DOB (optional).	Usually returns only one beneficiary except in some rare cases of same named twins.
AND Family Member's First Name and DOB.	

7.5. Patient Identification

Patients have a primary identifier called the Patient ID, which is a DEERS-assigned ten-digit number. This is used similarly to the DEERS ID, although the primary purpose is to reliably access patient and person level information. DEERS generates a Patient ID to link all MHS systems. The MCSC system must accommodate both the DEERS Patient ID and the HIPAA Patient ID.

7.6. Person Identification For Business Events

The following table identifies the options and type of data necessary to perform a DEERS/Medical business event for system-to-system interactions.

Legend (an “X” in a column indicates that the information may be used):

- Secondary identification: refer to the secondary identification section above.
- Individual/Family: indicates if the business event can be done for an individual, a family, or both.
- Refer to the specific business events throughout the Interface Operational Description (IOD) and the DEERS Business Rules for additional information.

FIGURE 3-1.3-2 PERSON IDENTIFICATION FOR BUSINESS EVENTS

PERSON IDENTIFICATION FOR BUSINESS EVENTS				
SECONDARY IDENTIFICATION	DEERS ID	PATIENT ID	INDIVIDUAL/FAMILY	BUSINESS EVENT
	X	X	I	Policy Notification
	X (Subscriber only)		I, F Depending on policy type	Enrollment Fee Payment
	X (Subscriber only)		I, F Depending on policy type	Disenrollment for failure to pay fees
X			I, F Depending on policy type	Enrollment Fee Payment Transaction History Request
X			I, F	Health Care Coverage Inquiry for Claims
	X		I	Catastrophic Cap & Deductible Updates
X			I, F	Catastrophic Cap & Deductible Transaction History Request
	X		I, F	Catastrophic Cap & Deductible Totals Inquiry
		X	I	OHI Notification
		X	I, F	OHI Inquiry
		X	I, F	OHI Policy Add/Update
		X	I, F	OHI Cancellation

7.7. HCDP Enrollment Management Contractor Identification

HCDP Enrollment Management Contractors are entities that are authorized to enroll MHS-eligible sponsors and family members into DoD coverage plans and are responsible for maintaining an individual's HCDP policy. The organizations include MCSCs and USFHP providers and are referred to as enrolling organizations. DEERS tracks the enrolling organization that is responsible for an individual's policy. A person only has one enrollment management contractor that is responsible for managing their coverage at any given point in time. DEERS creates a system identifier for each enrolling organization, and distributes the identifier to each system. Each MCSC and USFHP provider system has a system identifier for each contract, not region. This system identifier is used to identify the MCSC or USFHP provider system in system-to-system interactions with DEERS.

7.8. PCM Enrolling Division Identification

The PCM Enrolling Division is the organization that is primarily responsible for delivering the beneficiary's health care. This represents a grouping of providers in the Civilian, DC, resource sharing, and USFHP networks. Examples include MTFs, satellite clinics of MTFs, and possibly clinics within the MTF. DEERS maintains a table of organizations into which eligible subscribers and family members are enrolled. These organizations are identified by Defense Medical Information System (DMIS) IDs, which are associated to the regions in which they are located.

The MCSC shall implement each monthly DMIS table on the first day of the month following the download. Downloads are available on the DMIS web site.

7.9. PCM Identification

DEERS uses the MCSC PCM ID as an interim solution until a National Provider Identifier (NPI) becomes available. At that time, DEERS will utilize the NPI. MCSCs must not re-use PCM IDs. The MCSC is responsible for providing a crosswalk for converting PCM assignments from the MCSC provider ID to the national provider ID. The PCM ID cannot exceed 32 bytes.

7.10. Policy Identification

The MCSC must be able to match a policy using this information. DEERS uses the following combination to uniquely identify a policy:

- DEERS Family ID
- HCDP Type
- HCDP Plan Coverage Code
- DEERS Policy Begin Date

A sponsor can be a subscriber to multiple policies.