

## Chapter 10

## Addendum A

### Figures

Revision:

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#### FIGURE 10.A-1 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)

**Note:** Use of this letter is not mandatory.

(Addressee)  
(Address)  
(City, State, ZIP)

DATE: (Enter date mailed.)  
LAST FOUR  
DIGITS OF  
SSN: (If debtor is the sponsor, enter  
sponsor's SSN; if debtor is not the  
sponsor, enter SSN, if known.  
Leave blank if debtor's SSN is not  
available.)  
PRINCIPAL:  
ICN:

Dear \_\_\_\_\_:

**(Use first paragraph only if the recipient has advised the contractor of an overpayment.)**

Thank you for your recent notification that this office made an erroneous payment on claims in your **(or Beneficiary's Name)** behalf. We appreciate your cooperation in bringing this matter to our attention.

**(If the first paragraph is not applicable, use the following introductory paragraph to the letter;)**

The purpose of this letter is to inform you that an overpayment may have been made to you. We are required to provide you with the following information:

On **(Date of Check)** we sent you a check in the amount of \$\_\_\_\_\_ for services furnished to you **(or Beneficiary's Name if he/she is under 18 years of age and the letter is being sent to the sponsor/parent/guardian)** by **(Name and Address of Provider)** on **(Dates of Care)**. This was for **(Type of Service)**. However, that check represents an overpayment of \$\_\_\_\_\_.

**(Insert a paragraph which provides a clear and complete explanation of how the overpayment arose, how the overpayment was calculated, why it was not correct, and how the error was discovered.) (If the payment arose as a result of contractor error, the contractor shall add the following sentence at the end of the explanation.)** We truly regret any inconvenience this error may have caused you, and we will make every effort to prevent such errors from happening in the future.

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**FIGURE 10.A-1      SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT  
(RECOUPMENT) (FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

Since our records indicate that an overpayment was made, we are required to collect funds which were mistakenly issued from our accounts. We are also required to collect interest on all delinquent debts. Interest shall begin to accrue not earlier than 30 days following notice of the overpayment. The interest rate being assessed is \_\_\_\_% (Enter the rate which would be collected under the Federal Claims Collections Act or the rate allowed by state law, whichever is lower.) Accrued interest will be waived if this debt is paid in full within 30 days from the date of this letter. If payment is not made within 30 days, interest will accrue from the date of this letter.

**(If administrative costs will be assessed for expenses in collection of the debt the debtor shall be advised of these charges. Assessment of these charges must be approved by the Defense Health Agency).**

We are required to annotate your records to enable us to collect an erroneous payment by offset against current or future TRICARE claims. However, no such offset action will be taken for thirty days from the date of this letter. Since the possibility of offset against your TRICARE claim exists, we are also required to provide the following information to you.

You have the right to inspect and copy all records pertaining to this debt. If you believe this determination regarding your TRICARE coverage is incorrect or dispute the amount of the debt as calculated above, you have a right to request an administrative review of the indebtedness.

**If the recoupment action is being initiated as part of a decision rendered by the TRICARE appeals and hearings process, do not include the next two sentences.** For the purposes of this recoupment action, your right to an administrative review includes your right to a "Reconsideration" under the regulation which governs TRICARE appeals ([32 CFR 199.10](#)). If you request an administrative review, you will be advised if you have further appeal rights to the Defense Health Agency.

If you request an administrative review, it must be in writing and be received by this office within 90 days from the date of this letter. Your request should state specific reasons why you believe you do not owe this debt. You should also attach any supporting documentation, such as bookkeeping and medical records, and a copy of this letter.

If you need to request a waiver of this debt based upon an inability to pay, you will be required to complete a financial affidavit. If it then appears that you are financially unable to make a full refund at this time, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Please note, however, that any payment plan will include an interest charge at the rate specified above.

Please make your payment, for the total amount shown above, within 30 days in order to preclude interest and late charges from accruing. Send your check or money order, payable to TRICARE, to **(Name Of Contractor)** in the enclosed self-addressed envelope. However, if you do not believe you owe this debt, please contact us immediately with a request for an administrative review and include all supporting documentation.

**FIGURE 10.A-1      SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT  
(RECOUPMENT) (FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

Your cooperation and prompt attention to this matter are very much appreciated.

Sincerely,

(Signature)

(Title)

Enclosure:  
Self-addressed envelope

**FIGURE 10.A-2 SAMPLE LIABILITY QUESTIONNAIRE TRANSMITTAL LETTER**

**Note:** To be dated same day as mailed.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

LAST FOUR DIGITS OF SPONSOR'S SSN \_\_\_\_\_  
 CLAIM # \_\_\_\_\_  
 PROVIDER \_\_\_\_\_

Dear \_\_\_\_\_:

We recently received a claim from you or your medical care provider for medical services required by (you/your dependent) which reflected a diagnosis indicating injury or certain other consequences of external causes. The diagnosis codes are utilized by medical providers, insurance companies, and medical benefit programs, such as TRICARE and Medicare, to reflect the nature of a patient's illness or injury. These diagnoses often, but not always, indicate that the patient suffered an accidental injury or illness. Because of the diagnosis code or codes on your claim form, we must ask you to complete the enclosed DD Form 2527 (Statement of Personal Injury--Possible Third Party Liability).

If someone else caused the illness or injury of you or your dependent, the Government has the right to recover the money spent for medical care from that person or that person's insurer. The information you provide on the DD Form 2527 will not affect your legal rights in any personal claim or action you may have against the person who caused your injury. However, you should not furnish that person or his or her insurance company any information that might adversely affect your claim. Also, you should not sign any releases or agree to any settlement with that person or his or her insurance company without first discussing the case with a Uniformed Services Legal Officer or your own attorney.

The enclosed form must be completed by the TRICARE beneficiary, or your representative, even if your medical provider accepts TRICARE assignment and files the TRICARE claim for you. We encourage civilian medical providers to obtain a completed DD Form 2527 from the patient so that it can be submitted with the TRICARE claim form. However, if a claim has been submitted without the required DD Form 2527, the completed DD Form 2527 will be required before the claim is processed.

Remember, if you have other medical coverage such as insurance obtained through your employment, or student insurance, TRICARE cannot pay your claims until the other insurer has issued its payment toward your medical bills. The other insurer must also be listed on your TRICARE claim. A copy of the Explanation of Benefits from your other insurance company must be sent in with your TRICARE claim. If your claim is denied by the primary insurer, you must provide proof of the denial with your TRICARE claim. Any attempt to conceal the existence of other insurance that is primary to TRICARE constitutes fraud and may subject you to civil or criminal penalties. All insurance is primary to TRICARE except Medicaid and insurance which is specifically designed to supplement TRICARE benefits.

Your claims for medical care will be held in a suspense status pending receipt of the enclosed DD Form 2527. To expedite the processing of your claim, please return the completed form with this letter within 10 days in the enclosed, self-addressed envelope. Be sure to sign the form. Forms which have not been fully completed or which have not been signed will be returned to you, and your suspended claims will be denied.

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**FIGURE 10.A-2      SAMPLE LIABILITY QUESTIONNAIRE TRANSMITTAL LETTER (CONTINUED)**

If the form is not returned within 35 calendar days from the date of this letter, your claim and any related claims that have been suspended or are subsequently received will be denied. If you have already submitted a DD Form 2527 for the same accident, notify this office immediately. Even if your illness or injury was not caused by someone else, your TRICARE claims will not be processed until you return the completed and signed DD Form 2527. The information you provide on the DD Form 2527 will not affect payment of benefits on your TRICARE claim.

If you have any questions regarding the form, please contact the Health Benefits Advisor or Judge Advocate General (JAG) at the nearest military hospital. Thank you for your cooperation.

Sincerely,

(Signature)

(Title)

Enclosures:

DD Form 2527

Self-addressed envelope

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**FIGURE 10.A-3      SAMPLE TRANSMITTAL LETTER TO GOVERNMENT CLAIMS OFFICER**

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

REFERENCE: Beneficiary:

Sponsor:

Sponsor's SSN:

Dear Sir or Madam:

Enclosed is a DD Form 2527, completed by the referenced beneficiary, representing a possible third party liability recovery under the Federal Medical Care Recovery Act. Also, enclosed are Explanations of Benefits representing current amounts paid by TRICARE for medical care provided the beneficiary.

Pursuant to [32 CFR 199.12](#), your office is responsible for the development of this case with respect to third party liability. Should you determine that this case warrants further action, any additional information you may need will be provided upon your request. Please contact **(Name Of Contractor Contact)** at **(Telephone Number Of Contractor Contact)** for assistance.

Sincerely,

(Signature)

(Title)

Enclosures:

EOB

DD Form 2527

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**FIGURE 10.A-4      SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT  
(RECOUPMENT) (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Note:** Use of this letter is mandatory unless an alternative has been approved by the Defense Health Agency, Office of General Counsel.

(Addressee)  
(Address)  
(City, State, ZIP)

DATE:      **(Enter date mailed.)**  
  
LAST FOUR  
DIGITS OF  
SSN:      **(If debtor is the sponsor, enter  
sponsor's SSN; if debtor is not the  
sponsor, enter SSN, if known.  
Leave blank if debtor's SSN is not  
available.)**  
  
PRINCIPAL:  
ICN:

Dear \_\_\_\_\_:

**(Use first paragraph only if the recipient has advised the contractor of an overpayment.)**

Thank you for your recent notification that this office made an erroneous payment on claims in your **(or Beneficiary's Name)** behalf. We appreciate your cooperation in bringing this matter to our attention. **(If the first paragraph is not applicable, use the following as the introductory paragraph to the letter.)** The purpose of this letter is to inform you that an overpayment may have been made to you. The law requires that we provide you with the following information:

On **(Date of Check)** we sent you a check in the amount of \$\_\_\_\_\_ to cover services furnished you **(or Beneficiary's Name if he/she is under 18 years of age and the letter is being sent to the sponsor/parent/guardian)** by **(Name and Address of Provider)** on **(Dates of Care)**. This was for **(Type of Service)**. However, that check represents an overpayment of \$\_\_\_\_\_.

**(Insert a paragraph which provides a clear and complete explanation of how the overpayment arose, how the overpayment was calculated, why it was not correct, and how the error was discovered. If the payment arose as a result of a contractor error, the contractor shall add the following sentence at the end of the explanation.)** We truly regret any inconvenience that this error may have caused you, and we will make every effort to prevent such errors from happening in the future.

Since our records indicate that overpayment was made, we must formally advise you of the applicable laws governing the recoupment funds. Specifically, the Federal Claims Collection Act, beginning at 31 USC 3701, requires that federal agencies, including Defense Health Agency (DHA), collect Government funds which were mistakenly issued from their accounts. Further, Government agencies are required to collect interest on all delinquent debts at the rate of **(Enter the Rate of the Current Value of Funds to the United States (U.S.) Treasury)** percent per year. Interest charges will be waived if this debt is paid in full within 30 days from the date of this letter. If payment is not made within 30 days, interest will accrue from the date of this letter.

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**FIGURE 10.A-4      SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT  
(RECOUPMENT) (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

Additionally, federal agencies are required to assess a penalty charge, not to exceed 6% per year, upon any portion of the amount you owe that is outstanding for more than 90 days, as well as administrative costs, based upon the costs incurred in processing and handling the case.

Finally, we are required to annotate your records to enable us to collect an erroneous payment by administrative offset against current or future TRICARE claims. However, no such offset action will be taken for 30 days from the date of this letter. Since the possibility of offset against your TRICARE claim exists, we are also required to provide the following information to you.

You have the right to inspect and copy all records pertaining to this debt. If you believe this determination regarding your TRICARE coverage is incorrect or dispute the amount of the debt as calculated above, you have a right to request an administrative review of the indebtedness.

**(If this recoupment action is being initiated as a result of a decision rendered from the TRICARE appeals and hearings process, do not include the next two sentences.)** For the purposes of this recoupment action, your right to an administrative review includes your right to a "Reconsideration" under the regulation which governs TRICARE appeals ([32 CFR 199.10](#)). If you request an administrative review, you will be advised if you have further appeal rights to DHA.

If you request an administrative review, it must be in writing and be received by this office within 90 days from the date of this letter. Your request should state specific reasons why you believe you do not owe this debt. You should also attach any supporting documentation, such as bookkeeping and medical records, and a copy of this letter.

If you need to request a waiver of this debt based upon an inability to pay, you will be required to complete a financial affidavit. If it then appears that you are financially unable to make a full refund at this time, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Please note, however, that any payment plan will include an interest charge at the rate specified above.

Please make your payment, for the total amount shown above, within 30 days in order to preclude interest and late charges from accruing. Send your check or money order, payable to TRICARE, to **(Name of the Contractor)** in the enclosed self-addressed envelope. However, if you do not believe you owe this debt, please contact us immediately with a request for an administrative review and include all supporting documentation.

Your cooperation and prompt attention to this matter are very much appreciated.

Sincerely,

(Signature)  
(Title)

Enclosure:  
Self-addressed envelope

**FIGURE 10.A-5 SAMPLE LETTER TO PROVIDER REGARDING OVERPAYMENT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Note:** Use of this letter is mandatory unless an alternative has been approved by the Defense Health Agency, Office of General Counsel.

(Addressee)

(Address)

(City, State, ZIP)

DATE: (Enter date mailed.)  
SSN: (Enter provider's taxpayer identification number, if known. If unknown leave blank.)

PRINCIPAL:  
ICN:

Dear \_\_\_\_\_:

**(Use first paragraph only if the recipient has advised the contractor of an overpayment.)**

Thank you for your recent notification that this office made an erroneous payment on claims in your (or beneficiary's name) behalf. We appreciate your cooperation in bringing this matter to our attention. The law requires that we provide you with the following information:

On **(Date of Check)** we sent you a check in the amount of \$\_\_\_\_\_ to cover services you furnished **(Beneficiary's Name)** on **(Dates of Care)**. This was for **(Type of Service)**. However, that check represents an overpayment of \$\_\_\_\_\_.

**(This paragraph must provide a clear and complete explanation of how the overpayment arose, how the overpayment was calculated, why it was not correct, and how the error was discovered.)** At the end of the explanation, the Contractor shall add the following sentence: We regret any inconvenience that this error may have caused.

The Federal Claims Collection Act, beginning at 31 USC 3701, requires that federal agencies, including DHA, collect Government funds which were mistakenly issued from their accounts. Further, Government agencies are required to collect interest on all delinquent debts at the rate of **(Enter the Rate of the Current Value of Funds to the United States (U.S.) Treasury)** percent per year. Interest charges will be waived if this debt is paid in full within 30 days from the date of this letter. If payment is not made within 30 days, interest will accrue from the date of this letter. If the claim(s) on which this recoupment action is based was assigned to a participating provider, both the provider and the TRICARE beneficiary have the right to appeal this determination. If the claim(s) was not assigned, only the beneficiary may appeal this determination.

Additionally, federal agencies are required to assess a penalty charge, not to exceed 6% per year, upon any portion of the amount you owe that is delinquent for more than 90 days, and administrative costs, based upon the costs incurred in processing and handling the case because it became delinquent.

Finally, we are required to annotate your records to enable us to collect the erroneous payment by administrative offset against future TRICARE claims. No such offset action will be taken for 60 days from the date of this letter, however. Since the possibility of offset against your TRICARE claim exists, we are required to provide the following information to you.

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**FIGURE 10.A-5      SAMPLE LETTER TO PROVIDER REGARDING OVERPAYMENT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

You have the right to inspect and copy all records pertaining to this debt. If you believe this determination regarding your TRICARE coverage is incorrect or dispute the amount of the debt as calculated herein, you have a right to request an administrative review of the indebtedness.

**Note:** If this recoupment action is being initiated as a result of a decision rendered during the appeals process, do not include the last two sentences of this paragraph.

For the purposes of this recoupment action, your right to an administrative review includes your right to a Reconsideration under the regulation which govern TRICARE appeals ([32 CFR 199.10](#)). If you request an administrative review, you will be advised if you have further appeal rights to DHA.

Your request must be in writing and must be received by this office within 90 days from the date of this letter. Your request should state specific reasons for believing that you are not indebted for any amount listed herein, and should be accompanied by supporting documentation, such as bookkeeping and medical records, and a copy of this letter. If you wish to request a waiver based upon an inability to pay, you will be required to complete a financial affidavit. If it then appears that you are financially unable to make a full refund at this time, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Please note, however, that any payment plan will include an interest charge at the rate specified above.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to TRICARE, (name of the contractor) in the enclosed self-addressed envelope. If payment is not received within 30 days, interest and other late charges will accrue.

Your cooperation and prompt attention to this matter is very much appreciated.

Sincerely,

(Signature)  
(Title)

Enclosure:  
Self-addressed envelope

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**FIGURE 10.A-6      SAMPLE LETTER TO BENEFICIARY OR PROVIDER ADVISING OF OFFSET  
(NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Note:** Use of this letter is mandatory unless an alternative has been approved by the DHA OGC.

**Note:** To be dated same day as mailed. Limit use of SSN to the last four digits.

Dear **(Name of provider or beneficiary) (sponsor, parent or guardian):**

On **(Date)** we sent you a letter concerning an overpayment of \$\_\_\_\_\_ that was made on your claim for services provided to **(Name of Patient)** in which you were informed that if you did not refund that amount within 30 days (60 days if debtor is a provider) of the date of the letter, the overpayment would be withheld from any future claim payments.

This is to advise that since we have not received the requested refund nor a response to our letter, we have withheld \$\_\_\_\_\_ from the amount due on your current claim and have applied it against the cited overpayment which leaves a balance due of \$\_\_\_\_\_. (If the balance due is zero, the Contractor should skip to the last two paragraphs; include either one, or both, if appropriate. If neither paragraph is appropriate, and the balance due is zero, the preceding sentence will conclude the letter.) Please remit payment of this amount within 30 days from the date of this letter. Your check or money order should be made payable to **(TRICARE Contractor Name)** and may be mailed in the enclosed self-addressed envelope.

If we do not receive the requested payment or a response to this letter, the following actions are required under our TRICARE contract and the Federal Claims Collection Act.

1. Apply all payments of future claims to the overpayment until the amount is recouped.
2. Refer the overpayment to DHA Office of General Counsel (OGC) for collection which will result in added administrative costs and fees as well as an adverse credit rating.

**(Insert the following paragraph if the debtor has not previously been told of his right to appeal a denial based upon TRICARE eligibility or because a service or supply is not a TRICARE benefit. If the Contractor is uncertain whether appeal rights have previously been offered, the paragraph shall be included.)**

If you believe that this recoupment action is improper or incorrect, you have the right to request a reconsideration. Your written request, stating specific reasons why you feel the action taken is incorrect or improper, is to be attached to this letter and received within 90 days from the date on the enclosed original demand letter.

**(Use the following additional paragraph if the debtor is a participating provider.)** The offset taken against your claim has been applied toward your indebtedness to the U.S. Government and constitutes payment of the claim. You may not seek reimbursement for offset amounts from the TRICARE beneficiary for whom the services were provided.

Sincerely,

(Signature)

(Title)

Enclosures:

Self-addressed envelope

Initial demand letter

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**FIGURE 10.A-7      SAMPLE LETTER TO BENEFICIARY ADVISING PROVIDER RESPONSIBLE FOR OVERPAYMENT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

(Addressee)

(Address)

(City, State, ZIP)

RE: Provider Name:

Dates of Service:

Patient Name:

Last four digits of Sponsor's SSN:

Provider Number:

Claim Number:

RCN:

Dear \_\_\_\_\_:

On **(Date)**, we made a payment to **(Name and Address of Provider)** for services rendered to **(Beneficiary Name)** from **(Dates of Service)**. Upon review by our Claims Processing Center, it has been determined that an overpayment in the amount of \$\_\_\_\_\_ was made to the provider referenced above.

This letter is a courtesy copy only to inform you of the refund request. No response or payment from you is required as the provider is responsible for the repayment. If the provider contacts you for payment, or if you have any questions, please contact **(Name and Phone Number of Contractor)**.

Sincerely,

(Signature)

(Title)

**FIGURE 10.A-8 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE LESS THAN \$600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Note:** Use of this letter is mandatory unless an alternative has been approved by the DHA OGC.

(Addressee)

(Address)

(City, State, ZIP)

DATE: **(Enter date mailed.)**

LAST FOUR

DIGITS OF

SSN: **(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter SSN, if known. Leave blank if debtor's SSN is not available.)**

PRINCIPAL:

INTEREST: **(Enter interest on principal at current rate for 30 days.)**

TOTAL DUE:

Dear \_\_\_\_\_:

On **(Date)** we wrote to you explaining that an overpayment of \$\_\_\_\_\_ was made in our check dated \_\_\_\_\_. A copy of that letter is enclosed. If you have not already read our initial letter, please read it carefully. It contains important information about your rights.

You were requested to refund the overpayment within 30 days. That period has elapsed and we have had no response from you. As we advised you in our first letter, interest charges will accrue from the date of that letter.

The Debt Collection Act of 1982, authorizes the Federal Government to disclose delinquent account information to consumer reporting agencies. Such a report could adversely affect your ability to obtain future credit. The information identifying you as shown in this letter; i.e., name, address, and Social Security Number, the amount, status, and history of the claim, and the name of the federal agency and/or program to which the debt is owed, may be referred to consumer reporting agencies 60 calendar days from the date of this letter if the debt remains outstanding and you have made no arrangements for repayment.

If you are unable to refund the full amount in one payment, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Any payment plan will include an interest charge of **(Enter the rate of the current value of funds to the United States (U.S.) Treasury)** percent per year.

**(If debtor is not the sponsor, and debtor's Social Security Number is not otherwise available, add the following paragraph.)**

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**FIGURE 10.A-8      SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE LESS THAN \$600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

You are requested to furnish your Social Security Number by completing the blanks below and returning this letter to our office. The Federal Claims Collection Act, the Debt Collection Act of 1982, Public Law 97-365, and the Federal Claims Collection Standards, 4 Code of Federal Regulations 101-105, provide authority for requesting this information. Your Social Security Number will be used only in connection with actions involving the investigation, assertion, collection, compromise, waiver, and termination of the Government's claim against you. Disclosure of your Social Security Number is voluntary; however, should this claim be referred to the Department of Justice for collection, disclosure may be obtained by legal methods.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to **(TRICARE Contractor Name)** in the enclosed self-addressed envelope.

Failure to respond to this second request will result in forced collection by administrative offset against any future claims filed by you.

Sincerely,

(Signature)  
(Title)

Enclosures:

Initial demand letter

Self-addressed envelope

**(Add the line below if debtor is not the sponsor, and the debtor's Social Security Number is unavailable. The paragraph above, which explains to the debtor how the Social Security Number will be used, under what authority it is requested, and that disclosure is voluntary, must be included in the letter to the debtor.)**

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Social Security Number

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Signature

**FIGURE 10.A-9 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Note:** Use of this letter is mandatory unless an alternative has been approved by the DHA OGC.

(Addressee)

(Address)

(City, State, ZIP)

DATE: **(Enter date mailed.)**

LAST FOUR

DIGITS OF

SSN: **(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter SSN, if known. Leave blank if debtor's SSN is not available.)**

PRINCIPAL:

INTEREST: **(Enter interest on principal at current rate for 30 days.)**

TOTAL DUE:

Dear \_\_\_\_\_:

On **(Date)** we wrote to you explaining that an overpayment of \$\_\_\_\_\_ was made in our check dated \_\_\_\_\_. A copy of that letter is enclosed. If you have not already read our initial letter, please read it carefully. It contains important information about your rights.

You were requested to refund the overpayment within 30 days. That period has elapsed and we have had no response from you. As we advised you in our first letter, interest charges will accrue from the date of that letter.

The Debt Collection Act of 1982, authorizes the Federal Government to disclose delinquent account information to consumer reporting agencies. Such a report could adversely affect your ability to obtain future credit. The information identifying you as shown in this letter; i.e., name, address, and Social Security Number, the amount, status, and history of the claim, and the name of the federal agency and/or program to which the debt is owed, may be referred to consumer reporting agencies 60 calendar days from the date of this letter if the debt remains outstanding and you have made no arrangements for repayment.

If you are unable to refund the full amount in one payment, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Any payment plan will include an interest charge of **(enter the Rate of the Current Value of Funds to the United States (U.S.) Treasury)** percent per year.

**(If debtor is not the sponsor, and debtor's Social Security Number is not otherwise available, add the following paragraph.)**

**FIGURE 10.A-9 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

You are requested to furnish your Social Security Number by completing the blanks below and returning this letter to our office. The Federal Claims Collection Act, the Debt Collection Act of 1982, Public Law 97-365, and the Federal Claims Collection Standards, 4 Code of Federal Regulations 101-105, provide authority for requesting this information. Your Social Security Number will be used only in connection with actions involving the investigation, assertion, collection, compromise, waiver, and termination of the Government's claim against you. Disclosure of your Social Security Number is voluntary; however, should this claim be referred to the Department of Justice for collection, disclosure may be obtained by legal methods.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to **(TRICARE Contractor Name)** in the enclosed self-addressed envelope.

If we do not hear from you within 30 days, your file will be transferred to Defense Health Agency - Aurora and involuntary collection action will be initiated. This may include administrative offset of future claims or other federal funds owed you or a referral to the Department of Justice for appropriate legal action.

Sincerely,

(Signature)

(Title)

Enclosures:

Initial demand letter

Self-addressed envelope

**(Add the line below if debtor is not the sponsor, and the debtor's Social Security Number is unavailable. The paragraph above, which explains to the debtor how the Social Security Number will be used, under what authority it is requested, and that disclosure is voluntary, must be included in the letter to the debtor.)**

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

**FIGURE 10.A-10 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE LESS THAN \$600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Note:** Use of this letter is mandatory unless an alternative has been approved by the Defense Health Agency, Office of General Counsel.

(Addressee)

(Address)

(City, State, ZIP)

DATE: **(Enter date mailed.)**

LAST FOUR

DIGITS OF

SSN: **(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter SSN, if known. Leave blank if debtor's SSN is not available.)**

PRINCIPAL:

INTEREST: **(Enter interest on principal at current rate for 30 days.)**

TOTAL DUE:

Dear \_\_\_\_\_:

On **(Date)** we wrote to you explaining that an overpayment of \$\_\_\_\_\_ was made in our check dated \_\_\_\_\_ covering services you provided **(Beneficiary)**. A copy of that letter is enclosed. If you have not already read our initial letter, please read it carefully. It contains important information about your rights.

You were requested to refund the overpayment within 30 days. That period has elapsed and we have had no response from you. As we advised you in our first letter, interest charges will accrue from the date of that letter.

The Debt Collection Act of 1982, authorizes the Federal Government to disclose delinquent account information to consumer reporting agencies. Such a report could adversely affect your ability to obtain future credit. The information identifying you as shown in this letter; i.e., name, address, and Taxpayer's Identification Number or Social Security Number, the amount, status, and history of the claim, and the name of the federal agency and/or program to which the debt is owed, may be referred to consumer reporting agencies 60 calendar days from the date of this letter if the debt remains outstanding and you have made no arrangements for repayment.

If you are unable to refund the full amount in one payment, you may be afforded an opportunity to enter into a written agreement for repayment of the debt. Any payment plan will include an interest charge of **(enter the rate of the current value of funds to the United States (U.S.) Treasury)** percent per year.

**(If debtor is not the sponsor, and debtor's Taxpayer's Identification Number or Social Security Number is not otherwise available, add the following paragraph.)**

**FIGURE 10.A-10 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE LESS THAN \$600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

You are requested to furnish your Taxpayer's Identification Number (TIN) or Social Security Number (SSN) by completing the blanks below and returning this letter to our office. The Federal Claims Collection Act, the Debt Collection Act of 1982, Public Law 97-365, and the Federal Claims Collection Standards, 4 Code of Federal Regulations 101-105, provide authority for requesting this information. Your SSN will be used only in connection with actions involving the investigation, assertion, collection, compromise, waiver, and termination of the Government's claim against you. Disclosure of your SSN is voluntary; however, should this claim be referred to the Department of Justice for collection, disclosure may be obtained by legal methods.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to **(TRICARE Contractor Name)** in the enclosed self-addressed envelope. If payment is not made within 30 days, interest and other late charges will continue to accrue. Failure to respond to this second request will result in forced collection by administrative offset against any future claims filed by you.

Sincerely,

(Signature)

(Title)

Enclosure

Initial demand letter

Self-addressed envelope

**(Add the line below if debtor is not the sponsor, and the debtor's Social Security Number is unavailable. The paragraph above, which explains to the debtor how the Taxpayer's Identification Number or Social Security Number will be used, under what authority it is requested, and that disclosure is voluntary, must be included in the letter to the debtor.)**

\_\_\_\_\_  
Taxpayer's Identification Number or  
Social Security Number

\_\_\_\_\_  
Signature

**FIGURE 10.A-11 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Note:** Use of this letter is mandatory unless an alternative has been approved by the Defense Health Agency, Office of General Counsel.

(Addressee)

(Address)

(City, State, ZIP)

DATE: **(Enter date mailed.)**

LAST FOUR

DIGITS OF

SSN: **(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter SSN, if known. Leave blank if debtor's SSN is not available.)**

PRINCIPAL:

INTEREST: **(Enter interest on principal at current rate for 30 days.)**

TOTAL DUE:

Dear \_\_\_\_\_:

On **(Date)** we wrote to you explaining that an overpayment of \$\_\_\_\_\_ was made in our check dated \_\_\_\_\_ covering services you provided **(Beneficiary)**. A copy of that letter is enclosed. If you have not already read our initial letter, please read it carefully. It contains important information about your rights.

You were requested to refund the overpayment within 30 days. That period has elapsed and we have had no response from you. As we advised you in our first letter, interest charges will accrue from the date of that letter.

The Debt Collection Act of 1982, authorizes the Federal Government to disclose delinquent account information to consumer reporting agencies. Such a report could adversely affect your ability to obtain future credit. The information identifying you as shown in this letter; i.e., name, address, and Taxpayer's Identification Number or Social Security Number, the amount, status, and history of the claim, and the name of the federal agency and/or program to which the debt is owed, may be referred to consumer reporting agencies 60 calendar days from the date of this letter if the debt remains outstanding and you have made no arrangements for repayment.

**(If debtor is not the sponsor, and debtor's Taxpayer's Identification Number or Social Security Number is not otherwise available, add the following paragraph.)**

**FIGURE 10.A-11 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

You are requested to furnish your Taxpayer's Identification Number (TIN) or Social Security Number (SSN) by completing the blanks below and returning this letter to our office. The Federal Claims Collection Act, the Debt Collection Act of 1990 Public Law 97-365, and the Federal Claims Collection Standards, 4 Code of Federal Regulations 101-105, provide authority for requesting this information. Your SSN will be used only in connection with actions involving the investigation, assertion, collection, compromise, waiver, and termination of the Government's claim against you. Disclosure of your SSN is voluntary; however, should this claim be referred to the Department of Justice for collection, disclosure may be obtained by legal methods.

Payment of the total amount shown above within 30 days is considered payment in full. To satisfy your debt immediately, send a check or money order for the total amount, made payable to **(TRICARE Contractor Name)** in the enclosed self-addressed envelope. If payment is not made within 30 days, interest and other late charges will continue to accrue.

If we do not hear from you, your file will be transferred to the Defense Health Agency and involuntary collection action will be initiated. This may include administrative offset of future claims or other Federal funds owed you or a referral to the Department of Justice for appropriate legal action.

Sincerely,

(Signature)  
(Title)

Enclosures:

Self-addressed envelope

Initial demand letter

**(Add the line below if debtor is not the sponsor, and the debtor's Taxpayer's Identification Number or Social Security Number is unavailable. The paragraph above, which explains to the debtor how the Social Security Number will be used, under what authority it is requested, and that disclosure is voluntary, must be included in the letter to the debtor.)**

\_\_\_\_\_  
Taxpayer's Identification Number or  
Social Security Number

\_\_\_\_\_  
Signature

**FIGURE 10.A-12 PROMISSORY NOTE IN REPAYMENT OF PRE-EXISTING DEBT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

The note must be printed back to back.

1. **Obligation** - For value received, I (we, jointly and severally,) the maker(s), promise to pay to the order of **(Name of Contractor)**, the principal sum of \_\_\_\_\_ dollars, with interest accruing from \_\_\_\_\_, 20\_\_ at the rate of \_\_\_\_ percent per year. I (we) hereby acknowledge and admit the validity and amount of that preexisting debt which the principal sum stated in this note is intended to repay.
2. **Installments** - This note is to be paid in monthly installments payable at **(Name and Address of Contractor)**, on or before the \_\_\_\_\_ day of the month) beginning on \_\_\_\_\_, 20\_\_, and continuing until either the principal sum and all interest and other charges assessed under the provisions of this note have been fully paid, or this note is considered to be in default. The monthly installment amounts shall be not less than \_\_\_\_\_ dollars beginning on \_\_\_\_\_, and not less than \_\_\_\_\_ dollars beginning on \_\_\_\_\_.
3. **Administrative Charges** - Administrative charges to cover the costs incurred by the United States (U.S.) in handling and processing past due amounts will be assessed at the rate of \$5.00 for each payment more than 30 days past due; an additional \$12.00 for each payment more than 60 days past due; and an additional \$15.00 for each payment more than 90 days past due.
4. **Late Payment Penalties** - Late payment penalties will be assessed on any amounts more than 90 days past due, at the rate of 6% per year.
5. **Payment Crediting** - The payments that I (we) make under this note will be credited as of the date received by the **(TRICARE Contractor Name)**, first to outstanding penalties and administrative charges; second to accrued interest; and third to the outstanding principal sum. Any payments that I (we) made to the U.S. on this debt during the period from the date from which interest accrues under this note (as specified in paragraph 1) until the effective date of this note (as specified in paragraph 10.) shall be applied to the principal sum, interest, and other charges accruing under this note in accordance with the provisions of this paragraph.
6. **Default, Acceleration, and Other Remedies** - If any installment shall remain unpaid for a period of 30 days or more, this note shall at the option of the U.S. be considered to be in default. In the event of default, the full amount of the principal sum, together with any accrued interest and other charges assessed under this note, less any payments actually received by the U.S. from me (us), shall be due and payable in full immediately, without the need for further demands or notices to me (us). Furthermore, in that event, the U.S. may exercise any collection options legally available to it, including but not limited to, taking administrative offset, filing adverse credit reports to local and national credit bureaus, and referring my (our) account for legal action.
7. **Default Costs and Fees** - In the event of default, I (we) agree to pay all reasonable collection costs, court costs, and attorney's fees incurred by the U.S. as a result of the default and any appropriate collection actions taken by the U.S.
8. **Controlling Law** - Except where controlled by Federal Law, all disputes concerning this note shall be controlled by the law of the jurisdiction in which I (we) reside at the time this note is signed.
9. **Changes** - The provisions of this note may not be changed except by a written agreement which specifies the agreed upon changes and which is signed by both me (us) and an authorized representative of the U.S.

**FIGURE 10.A-12 PROMISSORY NOTE IN REPAYMENT OF PRE-EXISTING DEBT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

**10. Legal Effect** - This note shall not be legally binding upon me (us) or the U.S. until it has been first signed by me (us).

**11. Signatures and Certification** - I (we), the maker(s) of this note, do hereby certify that I (we) have read and understood the terms of this note, and that all blank spaces above my (our) signature(s) in this note were filled in when I (we) signed it.

**SIGNED:**

\_\_\_\_\_  
Maker's signature

\_\_\_\_\_  
Maker's name (printed)

\_\_\_\_\_  
Maker's address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Maker's signature

\_\_\_\_\_  
Maker's name (printed)

\_\_\_\_\_  
Maker's address

\_\_\_\_\_  
Date

\_\_\_\_\_  
Maker's signature

\_\_\_\_\_  
Maker's name (printed)

\_\_\_\_\_  
Maker's address

\_\_\_\_\_  
Date

**TRICARE Operations Manual 6010.59-M, April 1, 2015**

Chapter 10, Addendum A

Figures

**FIGURE 10.A-13 COVER SHEET - CASE RECOUPMENT**

ASAP Acct #: \_\_\_\_\_ Program Type (e.g., TFL or NAR): \_\_\_\_\_

Financially Underwritten/Non-Financially Underwritten (circle one) RCN or ICN: \_\_\_\_\_

Debtor's SSAN or TIN: \_\_\_\_\_

Debtor Code Is: (B) Beneficiary; (P) Provider; (S) Sponsor; (O) Other

Debtor's Relationship to Sponsor Code Is: (1) Self; (2) Spouse; (3) Natural/Adopted Child; (4) Step-child; (5) Former Spouse; (6) Widow/Widower; (7) Other

Debtor's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Debtor's Address Line 1: \_\_\_\_\_

Debtor's Address Line 2: \_\_\_\_\_

Debtor's Address Line 3: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Debtor's Telephone: \_\_\_\_\_ Ext.: \_\_\_\_\_

Contractor Number (Prime Contractor): \_\_\_\_\_, Region: \_\_\_\_\_

Date Of Initial Demand Letter: \_\_\_\_\_ Date Debt Discovered: \_\_\_\_\_

Reason For Overpayment: \_\_\_\_\_  
(Numeric Entry)

Original Amount Of Debt: \_\_\_\_\_ Offset Status: \_\_\_\_\_

Sponsor's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Sponsor's Address Line 1: \_\_\_\_\_

Sponsor's Address Line 2: \_\_\_\_\_

Sponsor's Address Line 3: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sponsor's Telephone: \_\_\_\_\_ Ext.: \_\_\_\_\_

Sponsor's SSAN: \_\_\_\_\_

Sponsor's Branch of Service Code Is: (1) Army; (2) Air Force; (3) Marine Corps; (4) Navy; (5) Coast Guard; (6) Public Health Service; (7) National Oceanic & Atmospheric Administration (NOAA)

Beneficiary's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Beneficiary's Relationship to Sponsor Code Is: (1) Self; (2) Spouse; (3) Child; (4) Other; (5) Former Spouse

No. of Months Left Unpaid on Installment Agreement: \_\_\_\_\_

Date Last Installment Payment Received: \_\_\_\_\_

Scheduled Amount of Installment Payment: \_\_\_\_\_

Interest Rate: \_\_\_\_\_

Principal Balance Due: \_\_\_\_\_ Principal Paid to Date: \_\_\_\_\_

Interest Balance Due: \_\_\_\_\_ Interest Paid to Date: \_\_\_\_\_

Interest Paid YTD: \_\_\_\_\_

Due Date of Last Unpaid Installment Payment: \_\_\_\_\_

**FIGURE 10.A-14 CODES TO BE USED WHEN COMPLETING THE COVER SHEETS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

CODE	INCORRECT PAYMENT
01	AUTHORIZATION/PREAUTH NEEDED
02	BENEFIT DETERMINATION WRONG/UNSUPPORTED
03	BILLED AMOUNT INCORRECT
04	COST-SHARE/DEDUCTIBLE ERROR
05	DEVELOPMENT CLAIMS DENIED PREMATURELY
06	DEVELOPMENT REQUIRED - NOT PERFORMED
07	DUPLICATE CLAIM PAID
08	ELIGIBILITY DETERMINATION - PATIENT
09	ELIGIBILITY DETERMINATION
10	MEDICAL EMERGENCY NOT SUBSTANTIATED
11	MEDICAL NECESSITY/REVIEW NOT EVIDENT
13	OHI - GOV'T PAY MISCALCULATED
14	OHI PAYMENT NOT CALCULATED
15	PAYEE WRONG - SPONSOR/PATIENT
16	PAYEE WRONG - PROVIDER
17	PARTICIPATING/NON-PAR ERROR
18	PRICING INCORRECT
19	PROCEDURE CODE INCORRECT
20	SIGNATURE ERROR
21	TIMELY FILING ERROR
99	OTHER - SEE REMARKS

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**FIGURE 10.A-15      DELINQUENCY NOTICE (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

(Addressee)

(Address)

(City, State, ZIP)

**(Contractors may add any identifying information they deem necessary.)**

Dear \_\_\_\_\_:

To date we have not received your payment for \$(**Enter Amount Past Due**). Our records indicate that your account is (**Enter Number**) days delinquent.

In order to bring your account current and to avoid additional interest charges, administrative and penalty fees, please forward your check or money order in the amount of \$(**Enter amount past due plus the amount of the next regular monthly installment**) immediately.

As you have been previously advised, information regarding your delinquent account will be referred to a consumer reporting agency if your payment is not received within 30 calendar days of the date of this notice.

Additionally, if no response is received within 30 days from the date of this notice, your debt will be referred to the Defense Health Agency, Office of General Counsel. Involuntary collection action will be initiated against you. Your debt may be collected by administrative offset from other federal monies you may be owed. Offset may be taken against your salary or retired pay under the authority of 37 USC 1007(c), or your federal income tax refund pursuant to the Debt Collection Act of 1982 and the Deficit Reduction Act of 1984. Your debt may be referred to a collection agency for collection or to the Department of Justice for litigation. If a judgment is obtained against you, execution upon that judgment may result in garnishment of wages and/or seizure and subsequent sale of your assets.

Your prompt attention to this matter will be appreciated.

Sincerely,

(Signature)

(Title)

**Note:** These notices shall be sent in duplicate, so that one copy may be returned with the debtor's next installment payment. Contractors who wish to vary the substance of the delinquency notice must contact the Defense Health Agency, Office of General Counsel, before doing so.

**FIGURE 10.A-16 SAMPLE FINAL DEMAND LETTER (ACCOUNT BALANCE \$600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 90 DAYS (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Note:** Use of this letter is mandatory unless an alternative has been approved by the Defense Health Agency, Office of General Counsel.

(Addressee)  
(Address)  
(City, State, ZIP)

DATE: **(Enter date mailed.)**

LAST FOUR  
DIGITS OF

SSN: **(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter debtor's SSN, if known; unknown leave blank.)**

PRINCIPAL:

INTEREST: **(Enter interest on principal at current rate for 90 days.)**

TOTAL DUE:

Dear \_\_\_\_\_:

On **(Date)** and **(Date)**, we wrote to you asking you to refund an erroneous payment. Enclosed are two copies of a Promissory Note providing for repayment of the debt in monthly installments of **\$(Enter a figure which will allow for repayment of the debt, with interest, within 2 years)**. Please sign and return one copy of the note; you will then be obligated to make monthly payments under the terms of the note.

Your first payment should be sent to arrive not later than **(Enter a date 30 days after the date of this final demand letter)**. Send your checks or money orders, made payable to **(TRICARE Contractor Name)**, directly to this address:

**(Address of the Contractor)**

As you have been previously advised, information regarding your delinquent account may be referred to a consumer reporting agency if the signed Promissory Note and your initial payment are not returned within 30 calendar days of the date of this letter. Additionally, your debt will be referred to the Defense Health Agency, Office of General Counsel. That office will initiate involuntary collection action against you. Your debt may be collected by administrative offset from other federal monies you may be owed. That may include offset against your salary or retired pay under the authority of 37 USC 1007(c), or your federal income tax refund pursuant to the Debt Collection Act of 1982 and the Deficit Reduction Act of 1984.

---

**FIGURE 10.A-16      SAMPLE FINAL DEMAND LETTER (ACCOUNT BALANCE \$600 OR MORE) IF  
NO RESPONSE TO REFUND REQUEST WITHIN 90 DAYS (NON-FINANCIALLY UNDERWRITTEN  
FUNDS INVOLVED) (CONTINUED)**

Your debt may be referred to a collection agency for collection or to the Department of Justice for litigation. If a judgment is obtained against you, execution upon that judgment may result in garnishment of wages and/or seizure and subsequent sale of your assets.

Sincerely,

(Signature)

(Title)

Enclosures:

Promissory Note

**TRICARE Operations Manual 6010.59-M, April 1, 2015**

Chapter 10, Addendum A

Figures

**FIGURE 10.A-17 SAMPLE AMORTIZATION SCHEDULE**

NUMBER	INTEREST	AMORTIZED	BALANCE	ACCUM. INT
<b>PRINCIPAL \$1000 AT 8% FOR 0 YEARS 24 MONTHS</b>				
<b>REGULAR PAYMENT = \$45.2243</b>				
<b>1</b>	\$6.67	\$38.5543	\$961.446	\$6.67
<b>2</b>	6.41	38.8143	922.631	13.08
<b>3</b>	6.15	39.0743	883.557	19.23
<b>4</b>	5.89	39.3343	844.223	25.12
<b>5</b>	5.63	39.5943	804.628	30.75
<b>6</b>	5.36	39.8643	764.764	36.11
<b>7</b>	5.10	40.1243	724.640	41.21
<b>8</b>	4.83	40.3943	684.245	46.04
<b>9</b>	4.56	40.6643	643.581	50.60
<b>10</b>	4.29	40.9343	602.647	54.89
<b>11</b>	4.02	41.2043	561.442	58.91
<b>12</b>	3.74	41.4843	519.958	62.65
<b>YR. 1</b>	\$62.65	\$480.042		
<b>1</b>	\$3.47	\$41.7543	\$478.204	\$66.12
<b>2</b>	3.19	42.0343	436.169	69.31
<b>3</b>	2.91	42.3143	393.855	72.22
<b>4</b>	2.63	42.5943	351.261	74.85
<b>5</b>	2.34	42.8843	308.376	77.19
<b>6</b>	2.06	43.1643	265.212	79.25
<b>7</b>	1.77	43.4543	221.758	81.02
<b>8</b>	1.48	43.7443	178.013	82.50
<b>9</b>	1.19	44.0343	133.979	83.69
<b>10</b>	0.89	44.3343	89.6448	84.58
<b>11</b>	0.60	44.6243	45.0205	85.18
<b>12</b>	0.30	45.0205	0.00	85.48
<b>LAST PAYMENT = \$45.32</b>				
<b>YR. 2</b>	\$22.83	\$519.95		
<b>DIFFERENCE IN TOTAL INTEREST PAID IS DUE TO ROUNDING-OFF</b>				

---

**FIGURE 10.A-18 LETTER TO BENEFICIARY WHOSE CLAIM WAS OFFSET AGAINST DEBT  
OWED BY PARTICIPATING PROVIDER (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

(Addressee)

(Address)

(City, State, ZIP)

DATE: **(Enter date mailed.)**

ICN:

Dear \_\_\_\_\_:

Enclosed is a copy of the Explanation of Benefits (EOB) for the above referenced claim number. You will note that the TRICARE allowable charge, reduced by your cost-share has been offset to collect a prior erroneous payment issued to the provider who elected to participate on your claim.

The EOB satisfies the TRICARE liability for your claim. Pursuant to 32 CFR 199, the participating provider has agreed to accept the TRICARE payment, together with your cost-share as payment in full. Any attempt by the provider of medical services to collect an amount in excess of the total of your cost-share, deductible, and any noncovered services would violate federal regulation and should be reported to this office.

Sincerely,

(Signature)

(Title)

Enclosure:

EOB

---

**FIGURE 10.A-19 LETTER ESTABLISHING INSTALLMENT PAYMENT AGREEMENT WHEN THE DEBT DOES NOT EXCEED \$600.00 (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

(Addressee)

(Address)

(City, State, ZIP)

RE: Last Four Digits of Sponsor's SSN:

Patient:

Claim Number:

Accounts Receivable Number:

**(Contractors shall include whatever identifying information they deem necessary.)**

Dear \_\_\_\_\_:

Since you indicated a desire to repay your debt of \$(**Enter Principal Amount of Debt**) in monthly installments, this office will accept monthly payments of \$\_\_\_\_\_. Interest will be assessed on the unpaid principal balance at the rate of (**Enter Current Interest Rate**) per year from (**Enter Date of Initial Demand Letter**).

Your first payment should be sent to arrive not later than (**Enter a date approximately one month from the date the debtor requested an installment agreement**). Send your checks or money orders, made payable to (**TRICARE Contractor Name**), directly to:

**(Name and Address of Contractor)**

Payments will be applied first to interest, and then to the outstanding principal balance. You will receive a payment acknowledgment following receipt of each installment. The acknowledgment will reflect the remaining balance and the amount of each installment that was applied to principal and to interest.

Since interest is calculated daily, prompt payment will reduce your total interest assessment. Delinquent accounts will be forwarded to the Defense Health Agency, Office of General Counsel, for involuntary collection action.

**(Contractor's shall request that the debtor include whatever information is necessary to assure proper credit is given. Alternatively, the debtor may be furnished payment coupons or each acknowledgment notice may be duplicated, so that one copy may be returned with the next installment payment. The debtor may be asked to return a copy of this letter with his/her first installment.)**

Your cooperation in this matter is appreciated.

Sincerely,

(Signature)

(Title)

---

**FIGURE 10.A-20 SAMPLE CALCULATION AND APPLICATION OF INTEREST (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**Principal: \$1000.00**

**Interest Rate: 8%**

**Monthly Installment Amount: \$45.22**

**Initial Demand Letter Mailed: 01/05/2014**

**Debtor Requests Installment Repayment Agreement: 03/03/2014**

Promissory Note Prepared by contractor on 03/05/2014; First Installment Due 04/05/2014 (or it may be 04/01/2014, if the contractor chooses to have all installment payments due on the first of each month). For purposes of this example, it is assumed that the due date is 04/05/2014.

1. Debtor's first payment of \$45.22 received 04/03/2014.

Interest on \$1000 from 01/05/2014 until 04/03/2014: Interest = Number of days since last computation of interest (or date interest began to accrue) x daily rate x principal balance.

$88 \text{ days} \times 0.0002191 (1/365 \times 0.08) \times \$1000 = \$19.29$

Monthly Installment Payment (\$45.22) less Interest (\$19.29) = \$25.93 (apply to principal balance). New principal balance is \$974.07. Payment acknowledgment notice issued. Next installment of \$45.22 is due 05/05/2014.

2. (Debtor's second payment of \$50.00 received 05/07/2014.)

Interest on \$974.07 from 04/03/2014 until 05/07/2014:

$34 \text{ days} \times 0.0002191 (\text{daily interest rate calculated above}) \times \$974.07 = \$7.26$

Monthly Payment (\$50.00) less Interest (\$7.26) = \$42.74 (apply to principal balance). New principal balance is \$931.33. Payment acknowledgment notice issued. Debtor paid the 05/05/2014 installment, plus \$4.78 toward the 06/05/2014 installment.

3. Delinquency notice issued 07/10/2014 (35 days after due date).

Debtor's third payment of \$40.00 received 07/12/2014.

Interest on \$931.33 from 05/07/2014 until 07/12/2014:

$66 \text{ days} \times 0.0002191 (\text{daily interest rate}) \times \$931.33 = \$13.47$

Monthly Payment (\$40.00) less Interest (\$13.47) = \$26.53 (apply to principal balance). New principal balance is \$904.80. Payment acknowledgment notice is issued. Debtor paid \$40.00 toward the 06/05/2014 installment. He owes 44 cents on the 06/05/2014 installment and \$45.22 on the 07/05/2014 installment. Debtor must be advised that in order to bring his account current, he must remit \$45.66 to cover the balance due on the June installment and the entire July installment. Since the account is not delinquent by two installments (\$45.22 x 2) the case is not referred to DHA.

**Commercial computer programs are available which will calculate interest daily on the unpaid principal balance in the manner reflected above. A variation of a few cents may be noted due to rounding.**

---

**FIGURE 10.A-21      SAMPLE PAYMENT ACKNOWLEDGMENT (NON-FINANCIALLY  
UNDERWRITTEN FUNDS INVOLVED)**

Thank you for your installment payment in the amount of \$45.22, which was received April 3, 2014. This payment has been applied as follows toward repayment of your indebtedness to TRICARE:

INTEREST CHARGES:	\$19.29
-------------------	---------

PRINCIPAL:	\$25.93
------------	---------

YOUR REMAINING PRINCIPAL BALANCE IS:	\$974.07
--------------------------------------	----------

YOUR NEXT INSTALLMENT PAYMENT IS DUE 05/05/2014.

This information may be useful in the preparation of your income tax return.

**These acknowledgments shall be typed, or computer-generated. They shall include the debtor's name and address and the contractor's account receivable number. They may be sent in duplicate, so that one copy may be returned with the debtor's next installment payment to assist the contractor in identification of the payment. The total interest paid for the calendar year may be added. Contractors who wish to vary the substance of the acknowledgment notice must contact Defense Health Agency, Office of General Counsel, before doing so.)**

---

**FIGURE 10.A-22 LETTER ESTABLISHING INSTALLMENT REPAYMENT AGREEMENT WHEN DEBT EXCEEDS \$600.00 (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

(RE: Last four digits of Sponsor's SSN:

Patient:

Claim Number:

Accounts Receivable Number:

**(Contractors shall include whatever identifying information they deem necessary.)**

Dear \_\_\_\_\_:

Since you indicated a desire to repay your debt in monthly installments, enclosed are two copies of a Promissory Note in the amount of \$(**Principal Amount of Debt**) outlining your repayment schedule. The note requires payment of interest at (**Enter Current Interest Rate**) per year from (**Date of Initial Demand Letter**) with monthly installments of \$\_\_\_\_.

Please sign and date the Promissory Note and return one copy to (**Address of Contractor**). Your first payment should be sent to arrive not later than (**Date approximately one month from the date the debtor requested an installment agreement**). Send your checks or money orders, made payable to (**TRICARE Contractor Name**) directly to:

**(Address Of Contractor)**

Payments will be applied first to interest, and then to the outstanding principal balance. You will receive a payment acknowledgment following receipt of each installment. The acknowledgment will reflect the remaining balance and the amount of each installment that was applied to principal and to interest.

Since interest is calculated daily, prompt payment will reduce your total interest assessment and allow you to avoid additional late charges. Delinquent accounts will be forwarded to the Defense Health Agency, Office of General Counsel, for involuntary collection action.

**(Contractors shall request that the debtor include whatever information is necessary to assure proper credit is given. Alternatively, the debtor may be furnished payment coupons or each acknowledgment notice may be duplicated, so that one copy may be returned with the next installment payment. The debtor may be asked to return a copy of this letter with his/her first installment.)**

Your cooperation in this matter is appreciated.

Sincerely,

(Signature)

(Title)

Enclosure

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**FIGURE 10.A-23 FINANCIAL AFFIDAVIT TRANSMITTAL LETTER (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

(Addressee)

(Address)

(City, State, ZIP)

RE: Last four digits of Sponsor's SSN:

Patient:

Claim Number:

Accounts Receivable Number:

**(Contractors may include whatever identifying information they deem necessary.)**

Dear \_\_\_\_\_:

Since you indicated that repayment of your debt to TRICARE in the amount of \$\_\_\_\_\_ would result in a financial hardship for you, enclosed for your use is a Financial Statement of Debtor. Please complete the form and return it to this office in the enclosed, self-addressed envelope. The completed financial statement will then be referred to the Defense Health Agency, Office of General Counsel, for consideration of your request for relief from indebtedness. That office will respond directly to you

If you do not complete and return the financial statement within 30 days from the date of this letter, involuntary collection action will be taken against you.

Sincerely,

(Signature)

(Title)

Enclosures:

Financial Statement of Debtor

Self-addressed envelope

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**FIGURE 10.A-24 LETTER ADVISING DEBTOR THAT HIS ACCOUNT HAS BEEN REFERRED TO DEFENSE HEALTH AGENCY (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

(Addressee)

(Address)

(City, State, ZIP)

Accounts Receivable Number:

**(Contractors shall include whatever identifying information they deem necessary.)**

Dear \_\_\_\_\_:

Because (indicate the reason for account referral to Defense Health Agency (DHA), i.e., two full installment payments are past due on your account, your account is delinquent, etc.), your debt has been referred to the DHA for involuntary collection action. All future payments should be sent to the following address:

Contract Resource Management  
Defense Health Agency  
16401 East Centretech Parkway  
Aurora, Colorado 80011-9066

Correspondence regarding your debt should be sent to the following address:

Office of General Counsel  
Defense Health Agency  
16401 East Centretech Parkway  
Aurora, Colorado 80011-9066

Sincerely,

(Signature)

(Title)

---

**FIGURE 10.A-25 PROVIDER'S POWER OF ATTORNEY AND AGREEMENT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

WHEREAS the undersigned has filed claims as a participating provider under TRICARE on behalf of a TRICARE beneficiary, **(Name Of Beneficiary), (Sponsor's Name, Sponsor's SSN)** who is entitled to benefits of TRICARE under applicable provisions of law and regulation and,

WHEREAS the TRICARE program is by law a secondary payor to all other insurance, medical insurance or health plans, to the extent that a particular service or supply is a benefit under such other plans and,

WHEREAS the TRICARE beneficiary is a beneficiary of another medical benefits plan provided through **(Name Of Primary Insurer)** which has ceased honoring claims pursuant to **(Reason, i.e., Filing Petition In Bankruptcy, Having Been Placed In Receivership)**.

NOW THEREFORE, in consideration of TRICARE assuming a first-payor status on claims submitted on behalf of the above-named TRICARE beneficiary, the undersigned provider hereby assigns to the United States of America (USA) to the extent hereinafter indicated, all claims, demands, entitlements, judgments, administrative awards, and the proceeds thereof, and all causes of action which have been assigned by the beneficiary to the undersigned, and which the beneficiary may assign hereafter to the undersigned, by reason of any liability of third parties entitling the beneficiary to hospital care, or medical or surgical treatment, or to reimbursement for all or part of the cost of any such; or recovery of damages for all or part thereof:

(a) based on contract, partially enumerated here as (1) membership in a union, fraternal or other organization; (2) rights under a group hospitalization plan or under any insurance, contract or plan which provides for payment or reimbursement for the cost of medical or hospital care, including "no fault" automobile insurance,

(b) based on statute, State or Federal (other than Public Law 87-693, Stat. 593), and regulations promulgated pursuant thereto, partially enumerated here as (1) "worker's compensation" statutes; (2) "employer's liability" statutes; (3) right to "maintenance and cure" in admiralty.

The extent of this assignment is an amount equal to the total reasonable charges for hospital care, medical, surgical and clinical treatment, or any of them, including ambulance transportation and other auxiliary services provided the beneficiary by the undersigned. This assignment does not include any sums to which the undersigned is entitled on a fixed basis which do not depend upon the amount incurred or disbursed by the beneficiary for such care; (sometimes referred to in the insurance business as a right to indemnity).

The various provisions of this assignment are separable. The execution hereof is without prejudice to any lien in favor of the undersigned, on any such money, and any judgment, which the undersigned recovers, or is or becomes entitled to recover, which lien arises by virtue of statute, or of contract, including this contract, (which shall be construed as granting such a lien, and not as an election of waiver thereof); and the undersigned further agrees that any such rights are and shall be for the benefit of said USA to the extent of the reasonable charges for the care furnished the above-named beneficiary.

The undersigned participating provider hereby irrevocably appoints the USA to do all acts, matters and things deemed necessary or desirable by it with full power and authority in the name of the undersigned provider, but at the cost, risk and charge, and for the sole benefit of said USA to sue for, or compromise, and to recover and receive all or part of the amount hereby assigned; and irrespective of assignment, to collect and disburse such funds in behalf of the undersigned; and to give releases for the same.

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**FIGURE 10.A-25 PROVIDER'S POWER OF ATTORNEY AND AGREEMENT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

The POWER OF ATTORNEY AND AGREEMENT shall remain in effect until such time as the beneficiary is again fully covered by other insurance and any claims outstanding with **(Enter Name Of Primary Insurer)** have been fully resolved and settled or until voluntarily terminated by the USA.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
(Name of Participating Provider)

\_\_\_\_\_  
(Signature of Provider or Authorized Agent)

Witness: \_\_\_\_\_

\_\_\_\_\_  
(Provider's Identification Number)

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**FIGURE 10.A-26      SAMPLE LETTER TO PROVIDER (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

Patient: \_\_\_\_\_

Sponsor: \_\_\_\_\_

Sponsor's SSN: \_\_\_\_\_

Dear \_\_\_\_\_:

Enclosed is a Power of Attorney and Agreement. Federal statute makes TRICARE secondary payor to all other forms of health insurance. However, because **(Name Of TRICARE Beneficiary's Primary Health Insurer), (Name of Primary Insurer)**, has filed a petition in bankruptcy (or has been placed in receivership), this office can process your claim for care provided to **(Name of TRICARE Beneficiary, Sponsor's Name, Sponsor's SSN and Beneficiary/Sponsor address)** as primary payor only if you sign and return the enclosed form.

Please return the signed Power of Attorney and Agreement in the enclosed, self-addressed envelope. If the signed Power of Attorney and Agreement is not returned to this office within 10 days, your claim will be denied.

**(If the contractor does not have documentation to prove that a claim was filed with the primary insurer or that a proof of claim was filed with the bankruptcy court, use the following paragraph.)**

Please provide proof that you have filed a claim with the primary insurer or the bankruptcy court to obtain benefits from the primary insurance for the services in question.

Sincerely,

(Signature)

Enclosure:  
Power of Attorney Agreement

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**FIGURE 10.A-27 BENEFICIARY'S POWER OF ATTORNEY AND AGREEMENT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

WHEREAS the undersigned is a TRICARE beneficiary (**Sponsor's Name, Sponsor's SSN**) entitled to benefits of TRICARE under applicable provisions of law and regulation and,

WHEREAS the TRICARE program is by law a secondary payor to all other insurance, medical insurance or health plans, to the extent that a particular service or supply is a benefit under such other plans and,

WHEREAS, the undersigned is a beneficiary of another medical benefits plan provided through (**Name Of Primary Insurer**), which has ceased honoring claims pursuant to (**Reason, i.e., filing a petition in bankruptcy, having been placed in receivership**).

NOW THEREFORE, in consideration of TRICARE assuming a first-payor status on claims submitted by me, I hereby assign to the United States of America (USA) to the extent hereinafter indicated, all claims, demands, entitlements, judgments, administrative awards, and the proceeds thereof, and all causes of action which I now have, and which I may have hereafter, by reason of any liability of third parties entitling me to hospital care, or medical or surgical treatment, or to reimbursement for all or part of the cost of any such; or recovery of damages for all or part thereof:

(a) based on contract, partially enumerated here as (1) membership in a union, fraternal or other organization; (2) rights under a group hospitalization plan or under any insurance, contract or plan which provides for payment or reimbursement for the cost of medical or hospital care, including "no fault" automobile insurance.

(b) based on statute, State or Federal (other than Public Law 87-693, 76 Stat. 593), and regulations promulgated pursuant thereto, partially enumerated here as (1) "worker's compensation" statutes; (2) "employer's liability" statutes; (3) right to "maintenance and cure" in admiralty.

The extent of this assignment is an amount equal to the total reasonable charges for hospital care, medical, surgical and clinical treatment, or any of them, including ambulance transportation and other auxiliary services received by me. This assignment does not include any sums to which I am entitled on a fixed basis which do not depend upon the amount incurred or disbursed by me for such care; (sometimes referred to in the insurance business as a right to indemnity).

The various provisions of this assignment are separable. The execution hereof is without prejudice to any lien in favor of the party providing me hospital or other care, on any such money, and any judgment, which I recover, or am or become entitled to recover, which lien arises by virtue of statute, or of contract, including this contract, (which shall be construed as granting such a lien, and not as an election of waiver thereof); and I further agree that any such rights of mine are and shall be for the benefit of said USA to the extent of the reasonable charges for the care furnished me.

I hereby irrevocably appoint the USA to do all acts, matters and things deemed necessary or desirable by it with full power and authority in my name, but at the cost, risk and charge, and for the sole benefit of said USA to sue for, or compromise, and to recover and receive all or part of the amount hereby assigned; and irrespective of assignment, to collect and disburse such funds in my behalf; and to give releases for the same; but no such action shall limit or prejudice my right to recover for my own benefits all sums in excess of those amounts representing said reasonable charges for aid, care and treatment, or other sums to which I may be entitled.

I hereby authorize the USA to disclose to said insurer, or other party against whom liability is asserted, or his or their attorneys, such information concerning me as the responsible representatives of the USA consider appropriate in connection with the subject matter hereof.

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**FIGURE 10.A-27 BENEFICIARY'S POWER OF ATTORNEY AND AGREEMENT (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED) (CONTINUED)**

This POWER OF ATTORNEY AND AGREEMENT shall remain in effect until such time as I am again fully covered by other insurance and any claims outstanding with **(Name Of Primary Insurer)** have been fully resolved and settled or until voluntarily terminated by the USA.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
(Signature of Beneficiary)

Witness: \_\_\_\_\_

\_\_\_\_\_  
(Beneficiary's SSN)

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**FIGURE 10.A-28      SAMPLE LETTER TO BENEFICIARY (NON-FINANCIALLY UNDERWRITTEN FUNDS INVOLVED)**

**(Enter Name And Address Of Beneficiary)**

Patient: \_\_\_\_\_

Sponsor: \_\_\_\_\_

Sponsor's SSN: \_\_\_\_\_

Dear \_\_\_\_\_:

Enclosed is a Power of Attorney and Agreement. Federal statute makes TRICARE secondary payor to all other forms of health insurance. However, because your primary health insurer, **(Name Of Primary Insurer)**, has filed a petition in bankruptcy, this office can process your claim for care provided to **(Name Of TRICARE Beneficiary, Sponsor's Name, Sponsor's SSN)** as primary payor only if you sign and return the enclosed form.

Please return the signed Power of Attorney and Agreement in the enclosed, self-addressed envelope. If the signed Power of Attorney and Agreement is not returned to this office within 10 days, your claim will be denied.

**(If the contractor does not have documentation to prove that a claim was filed with the primary insurer or that a proof of claim was filed with the bankruptcy court, use the following paragraph.)**

Please provide proof that you have filed a claim with the primary insurer or the bankruptcy court to obtain benefits from the primary insurance for the services in question.

Sincerely,

(Signature)

Enclosure:  
Power of Attorney  
Self-addressed envelope

**FIGURE 10.A-29**

**PROVIDER BANKRUPTCY WORKSHEET**

**Claims Pended For Provider Bankruptcy**

Provider

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Provider Number \_\_\_\_\_

Provider TIN \_\_\_\_\_

Number of Claims Suspended \_\_\_\_\_

Value \_\_\_\_\_

Comments

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**FIGURE 10.A-30**

**SAMPLE CONTRACTOR BANKRUPTCY NOTICE COVER SHEET**

**DATE:** \_\_\_\_\_

**TO:** \_\_\_\_\_

**FROM:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

**E-MAIL:** \_\_\_\_\_

**DEBTOR'S FULL SSN OR TIN NUMBER:** \_\_\_\_\_

**DEBTOR'S FULL NAME:** \_\_\_\_\_

**NAME OF BANKRUPTCY COURT IN WHICH BANKRUPTCY  
WAS FILED:** \_\_\_\_\_

**BANKRUPTCY CASE NUMBER:** \_\_\_\_\_

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**FIGURE 10.A-31 REFERRAL TO DEFENSE HEALTH AGENCY OFFICE OF GENERAL COUNSEL**

**(Use of this form is not mandatory.)**

**COLLECTIONS MADE BY OFFSET/REFUND**

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**PRIME CONTRACTOR NUMBER:** \_\_\_\_\_ **DATE OF REPORT:** \_\_\_\_\_

**NAME OF PERSON COMPLETING THIS FORM:** \_\_\_\_\_

**DEBTOR NAME:** \_\_\_\_\_

**DEBTOR SSN OR TIN:** \_\_\_\_\_

**SPONSOR NAME:** \_\_\_\_\_

**DATE REFERRED TO DHA:** \_\_\_\_\_

**ORIGINAL AMOUNT OF DEBT:** \_\_\_\_\_

**BALANCE OF TIME OF REFERRAL:** \_\_\_\_\_

**CURRENT PAYMENT INFORMATION**

---

**DATE PAYMENT RECEIVED:** \_\_\_\_\_ **AMOUNT OF PAYMENT RECEIVED: \$** \_\_\_\_\_

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**PAYMENT HAS BEEN RECEIVED THROUGH: OFFSET** \_\_\_\_\_ **REFUND** \_\_\_\_\_

**COLLECTION INFORMATION**

**UA** [ ] **DATE OF TRANSFER:** \_\_\_\_\_ **UA PAGE NO.:** \_\_\_\_\_

**TEDS** [ ] **ELECTRONIC TRANSFER NO:** \_\_\_\_\_

**CONTRACTOR CHECK #:** \_\_\_\_\_ **DATE OF CONTRACTOR CHECK:** \_\_\_\_\_

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**EXPLANATION:**

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**FIGURE 10.A-32      SUBSTITUTE REPORT FOR PHARMACY EXPLANATION OF BENEFITS -  
REQUIRED DATA ELEMENTS**

If pharmacy EOB do not include the following data elements, a separate report is required. The format of the report is subject to approval of Defense Health Agency, Office of General Counsel.

- Pharmacy Name
  - Address
  - TIN
- Payee Name
  - Address
- Date of Payment
- Check Number
- Patient Name
- Sponsor Name
- Sponsor SSN (last four digits)
- Date(s) Prescription Filled
- Drug Name
- RX Number
- Billed Amount
- Allowed Amount
- Total Paid By Other Health Insurance
- Deductible Applied
- Cost-Share
- Amount Paid
- Amount of Payment Applied to Another Debt
- Reason Codes
- Reason Code Explanation/Remarks
- Interest Paid
- Federal Tax Withheld
- Catastrophic Cap
- Accumulated Towards Catastrophic Cap
- Accumulated Individual Deductible
- Accumulated Family Deductible

If more than one patient is listed, a summary payment record must be provided for each patient including billed amount, allowed amount, deductible, other health insurance paid, cost-share and TRICARE payment.

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**FIGURE 10.A-33      SUBSTITUTE REPORT FOR PHARMACY OFFSET EXPLANATION OF BENEFIT  
- REQUIRED DATA ELEMENTS**

If the pharmacy offset EOB does not include the following data elements, a separate report is required. The format of the report is subject to the approval of Defense Health Agency, Office of General Counsel.

- Date of Payment
- Pharmacy Name
- Pharmacy TIN
- Pharmacy Address
- Patient Name
- Sponsor SSN (last four digits)
- Date(s) Prescription filled
- Drug Name
- RX Number
- Billed Amount
- Allowed Amount
- Total Paid by Other Health Insurance
- Deductible Applied
- Cost-share
- Reason Code
- Total Amount Offset
- Amount Paid
- Information regarding where the offset will be applied
  - Patient Name
  - Claim Number
  - Date Overpayment Requested
  - Amount Requested
  - Offset Amount
  - Collected to Date
  - Amount Outstanding
- Interest Paid
- Federal Tax Withheld
- Catastrophic Cap
- Accumulated Towards Catastrophic Cap
- Accumulated Individual Deductible
- Accumulated Family Deductible

If more than one patient is listed, a summary payment record must be provided for all patients including billed amount, other health insurance paid, allowed amount, cost-share and TRICARE payment.

- END -

