CHAPTER 8
ADDENDUM A

FIGURES

FIGURE 8-A-1 DD FORM 2642

CHAMPUS CLAIM
PATIENT'S REQUEST FOR MEDICAL PAYMENT

Form Approved
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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project 0720-0006, Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO EITHER OF THESE ADDRESSES. RETURN COMPLETED FORM TO THE APPROPRIATE CHAMPUS CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A HEALTH BENEFITS ADVISOR OR OCHAMPUS (303) 361-1000.

PRIVACY ACT STATEMENT

AUTHORITY: 44 U.S.C. 3101; 10 U.S.C. 1079 and 1086; 38 U.S.C. 613; E.O. 9397.

PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

IMPORTANT - READ CAREFULLY

Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT

NONAVAILABILITY STATEMENT REQUIREMENTS: If the patient resides within the catchment area of a Military Treatment Facility (MTF) or Uniformed Services Treatment Facility (USTF) (generally within a 40-mile radius of the MTF or USTF), the patient must obtain a Nonavailability Statement for most inpatient care that is not a bona fide emergency. A Nonavailability Statement is also required for some outpatient procedures. *Contact your Health Benefits Advisor for more information. The claims processor will deny your claim if you need a nonavailability statement authorization and do not have one.*

* * * * * *

ITEMIZED BILL: Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

1. Doctor's or provider's name/address (the one that actually provided your care). If there is more than one provider on the bill, circle his/her name;
2. Date of each service;
3. Place of each service;
4. Description of each surgical or medical service or supply furnished;
5. Charge for each service;
6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.

DRUGS: All prescriptions require the name of the patient; the name, strength, and quantity of each drug; the prescription number of each drug; the name and address of the pharmacy; and, the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements.

* * * * * *

TIMELY FILING REQUIREMENTS: All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. Contact a CHAMPUS Health Benefits Advisor or OCHAMPUS if you need the name and address of your claims processor. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice – whichever date is later.

* * * * * *

WHERE TO OBTAIN ADDITIONAL FORMS: You may obtain additional claim forms from your claims processor, the Health Benefits Advisor at the nearest military treatment facility or OCHAMPUS, Aurora, CO 80045-6900.

*** * *REMINDER* * ***

Before submitting your claim to the claims processor be sure that you have:

1. **Completed all 12 blocks on the form.** *If not signed, the claim will be returned.*
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance or Medicare supplemental insurance.
5. Obtained a Nonavailability Statement if required (see information above).
6. Attached DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability" if accident or work related. See instruction number 7 on reverse side.
7. Ensured that the patient's name, sponsor's name and sponsor's SSN are on all attachments.
8. Made a copy of this claim and attachments for your records.

DD Form 2642, OCT 93 COPY 2 - PROCESSOR'S COPY

FIGURE 8-A-1 DD FORM 2642 (CONTINUED)

1. PATIENT'S NAME *(Last, First, Middle Initial)*		**2. PATIENT'S TELEPHONE NUMBER** *(Include Area Code)* DAYTIME ( ) EVENING ( )	
3. PATIENT'S ADDRESS *(Street, Apt. No., City, State, and ZIP Code)*		**4. PATIENT'S RELATIONSHIP TO SPONSOR** *(X one)* ☐ SELF ☐ STEPCHILD ☐ SPOUSE ☐ OTHER *(Specify)* ☐ NATURAL OR ADOPTED CHILD	
5. PATIENT'S DATE OF BIRTH *(MMDDYY)*	**6. PATIENT'S SEX** *(X one)* ☐ MALE ☐ FEMALE	**7. IS PATIENT'S CONDITION** *(X both if applicable)* ACCIDENT RELATED? ☐ YES ☐ NO WORK RELATED? ☐ YES ☐ NO	
8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTION BELOW.		**8b. WAS PATIENT'S CARE** *(X one)* ☐ INPATIENT? ☐ OUTPATIENT? ☐ DAY SURGERY?	
9. SPONSOR'S NAME *(Last, First, Middle Initial)*		**10. SPONSOR'S SOCIAL SECURITY NUMBER**	

11. OTHER HEALTH INSURANCE COVERAGE

a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide CHAMPUS supplemental insurance information, but do report Medicare supplements. YES ☐ NO ☐

b. TYPE OF COVERAGE *(Check all that apply)*

☐ (1) EMPLOYMENT *(Group)* ☐ (3) MEDICARE ☐ (5) MEDICARE SUPPLEMENTAL INSURANCE
☐ (2) PRIVATE *(Non-Group)* ☐ (4) STUDENT PLAN ☐ (6) OTHER *(Specify)*

	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE *(Street, City, State, and ZIP Code)*	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE *(MMDDYY)*
INSURANCE 1			
INSURANCE 2			

12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.

a. SIGNATURE	b. DATE SIGNED (MMDDYY)	c. RELATIONSHIP TO PATIENT

HOW TO FILL OUT THE CHAMPUS FORM

You must attach an itemized bill (see front of form) from your doctor / supplier for CHAMPUS to process this claim.

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's daytime telephone number and evening telephone number to include the area code.
3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., former spouse.
5. Enter patient's date of birth (month/day/year).
6. Check the box for either male or female (patient).
7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury-Possible Third Party Liability CHAMPUS/CHAMPVA." The form may be obtained from the claims processor, Health Benefits Advisor or OCHAMPUS.

8a. Describe patient's condition for which treatment was provided; e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened; e.g., fell on stairs at work, car accident.

8b. Check the box to indicate where the care was given.

9. Enter the Sponsor's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."

10. Enter the Sponsor's Social Security Number (SSN).

11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.

NOTE: All other health insurances except Medicaid and CHAMPUS supplemental plans must pay before CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to the CHAMPUS claim. *The CHAMPUS claims processor cannot process claims until you provide the other health insurance information.*

12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a. and sign the claim. Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.

DD Form 2642, OCT 93 (BACK) COPY 2 - PROCESSOR'S COPY

FIGURE 8-A-2 SUGGESTED LETTER INFORMING THE BENEFICIARY OR PARTICIPATING PROVIDER OF THE TRANSFER OF CLAIM(S) TO THE CORRECT CONTRACTOR

Date of Notice and Transfer: _____
Beneficiary Name: _____
Sponsor's Name: _____
Social Security Number: _____
Provider's Name and Address: _____
Dates of Service: _____

_____
_____
_____

Dear _____:

Your claim(s) for TRICARE benefits has / have been forwarded to _____, the contractor having jurisdiction for the area where your services or supplies were provided. Any questions should be directed to:

(Name, Address, and Telephone Number of the Contractor responsible for processing the claim(s))

Your claim(s) for TRICARE benefits has / have been forwarded to _____, the contractor having jurisdiction for the area of your residence. Any questions should be directed to:

(Name, Address, and Telephone Number of the Contractor responsible for processing the claim(s))

Sincerely,

FIGURE 8-A-3 SUGGESTED LETTER INFORMING THE BENEFICIARY OF THE TRANSFER OF PART(S) OF CLAIM(S) TO THE CORRECT CONTRACTOR

Date of Notice and Transfer: _____
Beneficiary Name: _____
Sponsor's Name: _____
Social Security Number: _____
Provider's Name and Address: _____
Dates of Service: _____

_____
_____
_____

Dear _____:

Your claim for multiple providers has been received by our office. The services or supplies provided within our contract jurisdiction are being processed.

The remainder of the services or supplies on the claim have been forwarded to _____, the contractor responsible for the area where the services were provided. Since more than one contractor will be processing your claim simultaneously, there is a possibility an excess deductible will be applied. If this occurs, request an adjustment from the processor applying the excess deductible. Include copies of the relevant Explanations of Benefits with your request. Any questions should be directed to:

(Name(s), Address(es), and Telephone Number(s) of the Contractor(s))

Sincerely,

FIGURE 8-A-4 SUGGESTED LETTER INFORMING THE CLAIMANT THAT CLAIM FOR ACTIVE DUTY MEMBER HAS BEEN FORWARDED TO THE APPROPRIATE UNIFORMED SERVICE

Date of Notice and Transfer: _____

_____
_____
_____

Dear _____:

TRICARE is a medical benefits program provided by the Federal Government to help pay for civilian medical care provided to spouses and children of active duty Uniformed Services personnel, to retirees and their spouses and children, and to spouses and children of deceased active duty and deceased retired personnel. **An active duty member is not eligible for benefits under TRICARE.**

Billings for civilian medical care provided to active duty members are the responsibility of the appropriate Uniformed Services. We have forwarded your claim to the address listed below. Any further questions concerning your claim should be directed to them.

_____
_____
_____
_____

Sincerely,

cc:
(Active duty service member if claimant is the provider.)

FIGURE 8-A-5 VERIFICATION OF ELIGIBILITY, CHAMPUS FORM 88R

DETERMINATION OF ELIGIBILITY/CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

PURPOSE: To determine eligibility of the patient named hereon to receive medical care under the Civilian Health and Medical Program of the Uniformed Services
REFERENCES: DoD 6010.8-R, OCHAMPUS Manual 6010.24-M, OCHAMPUS Manual 6010.50-M

SECTION I (To be completed only by OCHAMPUS, a Fiscal Intermediary, or a CHAMPUS Contractor)

1. TO

PATIENT		SERVICE MEMBER (Sponsor)	
2. NAME (Last, First, Middle Initial)		9. NAME (Last, First, Middle Initial)	10. GRADE/RATE
2a. SOCIAL SECURITY NUMBER		11. SERVICE ☐ USA ☐ USN ☐ USMC ☐ USAF ☐ USCG ☐ PHS ☐ NOAA	
3. RELATIONSHIP TO SPONSOR (If pertinent)	4. DATE OF BIRTH (If pertinent)	12. STATUS ☐ ACTIVE DUTY ☐ RETIRED ☐ DECEASED ☐ NATIONAL GUARD ☐ RESERVES ☐ VA ☐ UNKNOWN ☐ OTHER (Explain in Block 15)	
5. DATE OF MARRIAGE (If pertinent)	6. DATE OF DIVORCE (If pertinent)	13. SOCIAL SECURITY NUMBER	
7. PERIOD OF MEDICAL CARE FROM: THRU:		14. UNIT, POST, BASE OR STATION (AD); HOME ADDRESS (RET)	
8. LAST KNOWN ADDRESS		15. REMARKS	
16. REQUESTOR'S SIGNATURE	17. TITLE	18. ORGANIZATION	19. DATE
20. RETURN TO			

SECTION II (To be completed by the verifying organization and returned to address in item 20)

21. PATIENT'S ELIGIBILITY DURING PERIOD SHOWN IN ITEM 7 IS AS FOLLOWS:
☐ ELIGIBLE DURING ENTIRE PERIOD ☐ NOT ELIGIBLE (Explain in Block 22)
☐ ELIGIBLE DURING PART OF PERIOD: FROM: _____ THRU: _____
☐ CANNOT BE DETERMINED FOR REASONS SHOWN IN BLOCK 22

22. REMARKS

23. SIGNATURE OF VERIFYING OFFICER (Sponsor's signature not authorized)	24. TITLE	25. ORGANIZATION	26. DATE

CHAMPUS FORM 88R
JUNE 1990
Previous editions of this form are obsolete
(Local Reproduction Authorized)

FIGURE 8-A-6 PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of _____)
) ss
County of _____)

_____ being first duly sworn, deposes and says: I hereby authorize the **(Contractor for TRICARE in the State)** of to accept my facsimile or stamp signature shown below

(Facsimile, stamp or computer generated signature as it will appear on the claim form.)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

Signature

Subscribed and sworn to before me this _____ day of _____ 20___.

_____
Notary Public in and for

_____ County, State of _____

(SEAL)

My Commission expires _____

FIGURE 8-A-7 PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

State of _____)
) ss
County of _____)

Know all persons by these presents:

That I, _____ have made, constituted and appointed and by these presents do make constitute and appoint _____ my true and lawful attorney-in-fact for me and in my name place and stead to sign my name on claims, for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claims forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _____day of _____ 20___.

Signature

Subscribed and sworn to before me this _____ day of _____ 20___.

_____
Notary Public in and for

_____ County, State of _____

(SEAL)

My Commission expires _____

FIGURE 8-A-8 NON-AVAILABILITY STATEMENT, DD FORM 1251

UNIFORMED SERVICES MEDICAL TREATMENT FACILITY NONAVAILABILITY STATEMENT (NAS)

REPORT CONTROL SYMBOL

Privacy Act Statement

AUTHORITY: 44 USC 3101, 41 CFR 101 et seq., 10 USC 1066 and 1079, and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: To evaluate eligibility for civilian health benefits authorized by 10 USC, Chapter 55, and to issue payment upon establishment of eligibility and determination that the medical care received is authorized by law. The information is subject to verification with the appropriate Uniformed Service.

ROUTINE USE: CHAMPUS and its contractors use the information to control and process medical claims for payment; for control and approval of medical treatments and interface with providers of medical care; to control and accomplish reviews of utilization; for review of claims related to possible third party liability cases and initiation of recovery actions; and for referral to Peer Review Committees or similar professional review organizations to control and review providers' medical care.

DISCLOSURE: Voluntary; however, failure to provide information will result in denial of, or delay in payment of, the claim.

1. NAS NUMBER *(Facility) (Yr - Julian) (Seq. No.)*

2. PRIMARY REASON FOR ISSUANCE *(X one)*

- ☐ a. PROPER FACILITIES ARE TEMPORARILY NOT AVAILABLE IN A SAFE OR TIMELY MANNER
- ☐ b. PROFESSIONAL CAPABILITY IS TEMPORARILY NOT AVAILABLE IN A SAFE OR TIMELY MANNER
- ☐ c. PROPER FACILITIES OR PROFESSIONAL CAPABILITY ARE PERMANENTLY NOT AVAILABLE AT THIS FACILITY
- ☐ d. IT WOULD BE MEDICALLY INAPPROPRIATE TO REQUIRE THE BENEFICIARY TO USE THE MTF *(Explain in Remarks)*

3. MAJOR DIAGNOSTIC CATEGORY FOR WHICH NAS IS ISSUED *(Use code from reverse)*

4. PATIENT DATA

a. NAME *(Last, First, Middle Initial)*

b. DATE OF BIRTH *(YYMMDD)*

c. SEX

d. ADDRESS *(Street, City, State, and ZIP Code)*

e. PATIENT CATEGORY *(X one)*

- ☐ (1) Dependent of Active Duty
- ☐ (2) Dependent of Retiree
- ☐ (3) Retiree
- ☐ (4) Survivor
- ☐ (5) Former Spouse

f. OTHER NON CHAMPUS HEALTH INSURANCE *(X one)*

- ☐ (1) Yes, but only CHAMPUS Supplemental
- ☐ (2) Yes *(List in Remarks)*
- ☐ (3) No

5. SPONSOR DATA *(If you marked 4e(3) Retiree above, print "Same" in 5a.)*

a. NAME *(Last, First, Middle Initial)*

b. SPONSOR'S OR RETIREE'S SOCIAL SECURITY NO.

6. ISSUING OFFICIAL DATA

a. NAME *(Last, First, Middle Initial)*

b. TITLE

c. SIGNATURE

d. PAY GRADE

e. DATE ISSUED *(YYMMDD)*

7. REMARKS *(indicate block number to which the answer applies.)*

DD Form 1251, OCT 90
1512/046

Outside the United States and Puerto Rico, previous editions may be used until exhausted.
Inside the United States and Puerto Rico, previous editions are obsolete.

FIGURE 8-A-8 NON-AVAILABILITY STATEMENT, DD FORM 1251 (CONTINUED)

INSTRUCTIONS TO THE PATIENT

Concerning use by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

1. The medical care requested is not available to you at a Uniformed Services Medical Treatment Facility (USMTF) in this area.

2. This form does NOT guarantee that CHAMPUS will cost share your care.

a. If you receive medical care from civilian sources and such care is determined to be authorized care under CHAMPUS, it will be cost shared by the Government to the extent that the program permits, provided such care is not obtained in a facility which discriminates in its admission and treatment practices on the basis of race, color, or national origin.

b. If you receive medical care from civilian sources and it is determined that all or part of the care is not authorized under CHAMPUS, the GOVERNMENT WILL NOT PAY for the unauthorized care.

c. The determination of whether medical care you receive from civilian sources is covered under CHAMPUS can not be made at this time because this determination depends, among other things, upon the care you actually receive and not upon the statement regarding your condition or diagnosis made on this form.

3. This form must be presented with your Uniformed Services Identification and Privilege Card when you obtain civilian medical care. For your claim to be processed, you must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

4. This form is valid only for medical care requested from and determined not available at a Uniformed Services medical treatment facility in this area.

5. An NAS shall normally be valid only for a hospital admission within 30 days of issuance for the specialty code noted on the NAS. It will remain valid from the date of admission until 15 days after discharge for any other required treatment that is directly related to the original admission, with the following exceptions:

a. In maternity cases, the date of admission is the date when the patient entered into the prenatal care program with a civilian provider, and the maternity NAS shall remain valid for 42 days following termination of the pregnancy.

b. If a newborn infant remains in the hospital continuously after the discharge of a CHAMPUS eligible mother, the mother's NAS shall be valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this 15 day limit, the beneficiary must request the issuing facility to make a determination on the availability of care for the infant and to issue an NAS for the infant if the requirements of these instructions are met.

c. If an active duty service member gives birth in a civilian hospital and there are charges for the care of the infant, an NAS is required for the infant if the infant's stay is for four or more days. (At that point, the infant is considered to be a new CHAMPUS eligible patient in his or her own right.)

d. If you do not use this form within 30 days, or if you have questions about the expiration of the form, you should check with your local Health Benefits Advisor (HBA) prior to your admission to the hospital. If you do not use this form, return it to the issuing Uniformed Services medical treatment facility.

6. If you have further questions regarding this form or your CHAMPUS benefits, you should talk with your local Health Benefits Advisor, the CHAMPUS Fiscal Intermediary for your area, or the Beneficiary and Provider Relations Division, Office of CHAMPUS, Aurora, Colorado 80045-6500.

I HAVE REVIEWED AND UNDERSTAND THE ABOVE INSTRUCTIONS

PATIENT'S SIGNATURE

INSTRUCTIONS FOR COMPLETING DD FORM 1251

This form can be issued only in accordance with the provisions of DoDI 6015.19, "Issuance of Nonavailability Statements," as implemented by the issuing facility's host Service (AR 40-121, NAVMEDCOMINST 6320.3, AFR 168.9, PHS General Circular No. 6, CGCOMDTINST 6320.11b, NOAA CO. 4).

The issuing officer or designee should brief the recipient on the Instructions to the Patient on the front of this form. However, if the patient is not enrolled in DEERS, and the HBA has reason to believe the individual is entitled to care, issue a "conditional" NAS and advise the patient that the claim will not be considered until the DEERS enrollment is complete.

If this NAS is being issued retroactively (after the date the patient was admitted to the hospital), the last three digits of the NAS Number, Block 1, must be between 900 and 999 and an explanation provided in Block 7, "Remarks." If this condition is not met, the CHAMPUS Fiscal Intermediary will reject the claim.

1. Enter an NAS Number.
   - The first four digits are the Defense Medical Information System (DMIS) facility identifier.
   - The next four digits represent the date the form is issued. It consists of the last digit of the year plus the Julian Date. (For example, if the date is 1 January 1988, these digits would be 8001.)
   - The final three digits are the facility sequence number:
     - Numbers 000 through 899 may be assigned in accordance with the implementing instructions of the issuing facility's host Service.
     - Numbers 900 through 999 are assigned to NAS's issued retroactively. Enter the civilian hospital name and admission date for which the NAS applies in Block 7, "Remarks."

2. Mark the appropriate box.

3. Enter the code for the major diagnostic category for which the NAS is being issued from the following list. For further information on what goes into each category, consult the Diagnostic Related Group (DRG) Definitions Manual.

01 Diseases and Disorders of the Nervous System
02 Diseases and Disorders of the Eye
03 Diseases and Disorders of the Ear, Nose and Throat
04 Diseases and Disorders of the Respiratory System
05 Diseases and Disorders of the Circulatory System

3. Codes (Cont'd)

06 Diseases and Disorders of the Digestive System
07 Diseases and Disorders of the Hepatobiliary System and Pancreas
08 Diseases of the Musculoskeletal System and Connective Tissue
09 Diseases of the Skin, Subcutaneous Tissue and Breast
10 Endocrine, Nutritional and Metabolic Diseases
11 Diseases and Disorders of the Kidney and Urinary Tract
12 Diseases and Disorders of the Male Reproductive System
13 Diseases and Disorders of the Female Reproductive System
14 Pregnancy, Childbirth and the Puerperium
15 Normal Newborns and Other Neonates with Certain Conditions Originating in the Perinatal Period
16 Diseases and Disorders of the Blood and Blood-Forming Organs and Immunological Disorders
17 Myeloproliferative Disorders and Poorly Differentiated Neoplasms
18 Infectious and Parasitic Diseases (Systemic or Unspecified Sites)
19 Mental Diseases and Disorders
20 Alcohol/Drug Use and Alcohol/Drug Induced Organic Disorders
21 Injuries, Poisonings, and Toxic Effect of Drugs
22 Burns
23 Factors Influencing Health Status and Other Contacts with Health Services
60 Pediatrics

4a-e. Self-explanatory.

4f. Mark the appropriate box. If "f(2), Yes," is marked, specify the name of the insurance company and the policy number, if available, in Block 7, "Remarks."

5a. Enter the Sponsor's name. If the sponsor is the patient, enter "Same." 5b is self-explanatory.

6a-d. Self-explanatory.

6e. This date should be the same as the date in Block 1, but written in YYMMDD format.

7. Enter remarks as required by these instructions and implementing instructions.

DD Form 1251 Reverse, OCT 90

FIGURE 8-A-9 ABORTION DENIAL NOTICE TO THE BENEFICIARY AND PARTICIPATING PROVIDER

Date: _____
Sponsor's Name: _____
Beneficiary's Name: _____
Type of Service(s): _____
Date of Service(s): _____
Sponsor's SSN: _____

PERSONAL

_____
To: _____
_____

Dear _____:

The Congress has prohibited TRICARE coverage of abortion service, except where the life of the mother would be endangered if the fetus were carried to term.

The legislation which limits abortion coverage applies two different effective dates to groups of TRICARE beneficiaries. For active-duty military dependents, and military retirees and their dependents, as well as survivors of deceased military members--except for the Coast Guard, the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration--the limitation is retroactive to December 29, 1981.

For dependents and retired personnel of the Coast Guard, the Commissioned Corps of the Public Health Service, and the National Oceanic and Atmospheric Administration, the limitation on coverage is retroactive to June 5, 1981.

This means that abortions--except in life-threatening situations--that were performed after these effective dates, will **not** be cost-shared by TRICARE.

Initial review of the claim(s) gave no indication that the circumstances of the abortion would qualify under this exception. Therefore, your claim(s) related to the abortion performed on _____ must be denied.

If you believe the circumstances of the abortion do qualify under the exception, you may request a Reconsideration of the denial decision by submitting a written request for a Reconsideration to this office within 90 days of the date of this notice. Such request must include a copy of this notice and your statement of the matter in dispute along with certification from the attending physician that the abortion was performed because the woman was suffering from a condition that would have endangered her life if the fetus were carried to term. Additional information / documentation which will support your claim should be submitted with your request.

If you have any questions concerning the TRICARE abortion policy, you are urged to contact your Health Benefits Advisor (located at the nearest Uniformed Services medical facility) for more detailed information. You may also contact **(Contractor Name and Address)**.

Sincerely,

FIGURE 8-A-10 SUGGESTED FORMAT FOR INFORMATION OBTAINED FROM EXISTING FILE DATA OR BY TELEPHONE

Date Information Obtained: _____

Beneficiary Name: _____

Sponsor Name: _____

Internal Control Number (ICN): _____

Source of Development:

Check one block **only** and complete blank below that block).

☐ Existing File Data

☐ Name of file or ICN of previously processed claim if data is claim specific _____

Telephone

Name of Person Providing Information

_____

Type of Claim:

☐ Claim Form 2520 ☐ Claim Form 1500 ☐ UB-92 ☐ Other

Item Completed _____ ***(Information Obtained)*** _____

_____

Initials or Signature of Person Obtaining Information

THIS DOCUMENT IS TO BE MICROFILMED OR IMAGED AS PART OF THE CLAIM RECORD (THIS DOCUMENT MAY ALSO BE MAINTAINED ON AN ELECTRONIC RECORD).

Privacy Act Statement:

In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55, Title 10, United States Code, Section 3101, Title 44, United States Code, and 41 Code of Federal Regulations 101-1100 ***et seq****. The information is requested to establish or update information to control or process claims for payment. Routinely, the information will be used to determine eligibility for TRICARE benefits, review and approve medical care as TRICARE benefits, and to determine reasonable charges/costs of care to be cost-shared under TRICARE. Disclosure of the information is voluntary; however, failure to provide the information will result in denial of benefits.*

FIGURE 8-A-11 SAMPLE FORMAT FOR QUARTERLY REBUNDLING REPORT

STATE/REGION	NUMBER OF PROVIDERS	NUMBER OF PATIENTS	AMOUNT BILLED	UNEDITED AMOUNT ALLOWED	EDITED AMOUNT ALLOWED	SAVINGS
Bergstrom AFB						
Fort Polk / England AFB						
TOTAL						