

FIGURES

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FIGURE 12-12.2-1 HOST NATION NETWORK PROVIDER FORM

(Please type or print legibly)

Host Nation Provider Name: _____

Address: _____
(actual place of business) _____

Phone Number: (____) _____

Fax Number: (____) _____

Provider Major Specialty: _____

Mailing Address: _____
(Please indicate address _____
to which checks _____
should be mailed.) _____

Comments: _____

Approved by: _____ **Effective Date:** _____

Date: _____

Managed Care Contractor Assigned Provider Number: _____

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FIGURE 12-12.2-2 COVER LETTER FOR TRANSMITTING TRICARE OVERSEAS PROGRAM NON-AUTHORIZED CLAIMS REPORT TO REGIONAL DIRECTOR (SAMPLE)

(Regional Director Name)

(Address)

(Address)

Dear _____:

Enclosed is the weekly report of non-authorized claims received without authorization from TRICARE OVERSEAS enrollees.

Please review and indicate approval as appropriate. Please return the completed report and sign the authorization below. Upon receipt of the report, we will reprocess these claims according to your directions.

Please return the authorization to:

(Name - Managed Care Contractor Representative)

(Name - Managed Care Contractor)

(Address)

(Address)

Sincerely,

(Contractor Representative)

Authorized Signature:

The attached claims listing is approved as noted for reprocessing.

Signature _____

Title _____

Date _____

FIGURE 12-12.2-3 REGIONAL DIRECTOR HOST NATION NON-AUTHORIZED OR HOST NATION NON-NETWORK PROVIDER CLAIMS REPORT

ICN	SPONSOR SSN	PATIENT NAME	SPONSOR NAME	HOST NATION PROVIDER NAME AND ADDRESS	DATES	HCDP	ICD9	CPT ¹ CODE	PURPOSE VISIT	REASON FOR REFERRAL*		APV.	
						DMIS ID CODE				A	P	Y	N
97360 DE 00001	123 45 6789	Smith, Ann S.	Smith, John M.	Bauman, Peter HERDSTR 13 Donauschingn De	11-01-97- 11-15-97								
97360 GB 00002	987 65 4321	Jones, Sally	Jones, Tom M.	Shepherd, Cameran *4TROON Dr Bridge of Weir GB	11-02-97- 11-05-97								
* A = Authorization P = Host Nation Non-Network Provider													

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FIGURE 12-12.2-4 REMOTE SITES NOT REQUIRING AN AUTHORIZATION FOR CARE BY COUNTRIES IN TRICARE EUROPE, TRICARE PACIFIC, AND TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN

TRICARE EUROPE	TRICARE EUROPE	TRICARE EUROPE
Albania	Latvia	Uzbekistan
Algeria	Lebanon	Yemen
Angola	Liberia	Zambia
Armenia	Lithuania	Zimbabwe
Austria	Macedonia	
Azerbaijan	Mali	
Belarus	Malta	
Belgium	Moldova	
Bosnia-Herzegovina	Morocco	
Botswana	Mozambique	
Bulgaria	Namibia	
Burundi	Netherlands	
Cameroon	Niger	
Chad	Nigeria	
Congo, Democratic Republic	Norway	
Croatia	Oman	
Cyprus	Pakistan	
Czech Republic	Poland	
Denmark	Portugal	
Djibouti	Qatar	
Egypt	Romania	
Eritrea	Russia Federation	
Estonia	Rwanda	
Ethiopia	Saudi Arabia	
Finland	Senegal	
France	Serbia - Montenegro	
Gabon	Seychelles	
Georgia	Slovakia	
Germany	Slovenia	
Ghana	South Africa	
Greece	Spain	
Greenland	Sweden	
Guinea, Republic of	Switzerland	
Hungary	Syria	
Ireland	Takjistan	
Israel	Tanzania	
Italy	Togo	
Ivory Coast (Cote D'Ivoire)	Tunisia	
Jordan	Turkey	
Kazakhstan	Turkmenistan	
Kenya	UAE (United Arab Emirates)	
Kuwait	Uganda	
Kyrgyzstan	Ukraine	
	United Kingdom	

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FIGURE 12-12.2-4 REMOTE SITE COUNTRIES NOT REQUIRING AN AUTHORIZATION FOR CARE BY COUNTRIES IN TRICARE EUROPE, TRICARE PACIFIC, AND TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN (CONTINUED)

TRICARE PACIFIC	TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN
American Samoa	Antigua
Australia	Argentina
Bangladesh	Bahamas
Cambodia (<i>Kampuchea</i>)	Barbados
China	Belize
Fiji	Bolivia
Hong Kong	Brazil
India	Chile
Indonesia	Colombia
Laos	Costa Rica
Madagascar	<i>Dominica</i> Republic
Malaysia	Ecuador
Mongolia	El Salvador
Myanmar (<i>Burma</i>)	Grenada
Nepal	Guatemala
New Zealand	Guyana
<i>Northern Mariana Islands</i>	Haiti
Palau, <i>Republic of</i>	Honduras
Philippines	Jamaica
Saipan	Mexico
Singapore	Netherlands Antilles
Sri Lanka	Nicaragua
Taiwan	Panama
Thailand	Paraguay
Vietnam	Peru
	Surinam
	Trinidad & Tobago
	Uruguay
	Venezuela
	Virgin Islands, U.S.

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FIGURE 12-12.2-5 REMOTE SITE CITIES/COUNTRIES NOT REQUIRING AN AUTHORIZATION FOR CARE BY CITIES IN TRICARE EUROPE, TRICARE PACIFIC, AND TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN

TRICARE EUROPE	TRICARE EUROPE	TRICARE EUROPE
Tirana, Albania	Al-Kuwayt, Kuwait	Bujumbura, Burundi
Algier, Algeria	Riga, Latvia	Djibouti, Djibouti
Luanda, Angola	Beirut, Lebanon	Asmara, Eritrea
Yerevan, Armenia	Monrovia, Liberia	Paris, France
Vienna, Austria	Vilnius, Lithuania	Tbilisi, Georgia
Baku, Azerbaijan	Skopje, Macedonia	Berlin, Germany
Minsk, Belarus	Chisinau, Moldova	Bonn, Germany
Sarajevo, Bosnia-Herzegovina	Rabat, Morocco	Bremerhaven, Germany
Gaborone, Botswana	Maputo, Mozambique	Flensburg, Germany
Sofia, Bulgaria	Windhoek, Namibia	Garmish-Partenkirchen, Germany
Bujumbura, Burundi	The Hague, Netherlands	Kalkar, Germany
Yaounde, Cameroon	Rotterdam, Netherlands	Muenster, Germany
N'Djamena, Chad	Niamey, Niger	Munich, Germany
Kinshasa, Congo Democratic Republic of the Kinsha	Lagos, Nigeria	Conakry, Republic of Guinea
Zagreb, Croatia	Oslo, Norway	Jerusalem, Israel
Nicosia, Cyprus	Stavanger, Norway	Ghedi, Italy
Brno, Czech Republic	Madinat Qaboos, Oman	Milan, Italy
Prague, Czech Republic	Islamabad, Pakistan	Poggio Renatico, Italy
Copenhagen, Denmark	Warsaw, Poland	Valetta, Italy
Djibouti, Djibouti	Lisbon, Portugal	Bishkek, Kyrgustan
Cairo, Egypt	Ad-Dawhah, Qatar	Bamako, Mali
Ismail, Egypt	Bucharest, Romania	Valletta, Malta
Maadi, Egypt	Moscow, Russia	Muscat, Oman
New Maadi, Egypt	Dharham, Saudi Arabia	Karachi, Pakistan
Asmara, Eritrea	Jeddah, Saudi Arabia	St. Petersburg, Russia
Tallinn, Estonia	Riyadh, Saudi Arabia	Kigala, Rwanda
Addis-Adoba, Ethiopia	Dakar, Senegal	Belgrade, Serbia-Montenegro
Helsinki, Finland	Bratislava, Slovakia	Seychelles, Seychelles
Istres, France	Ljubljana, Slovenia	Johannesburg, South Africa
Libreville, Gabon	Pretoria, South Africa	Valencia, Spain
Accra, Ghana	Cape Town, South Africa	Chambessy, Switzerland
Athens, Greece	Madrid, Spain	Geneva, Switzerland
Larissa, Greece	Stockholm, Sweden	Dushanbe, Tajikistan
Nuuk, Greenland	Bern, Switzerland	Dar Es Salaam, Tanzania
Budapest, Hungary	Damascus, Syria	Lome, Togo
Dublin, Ireland	Tunis, Tunisia	Istanbul, Turkey
Tel Aviv, Israel	Ankara, Turkey	Ashgabat, Turkmenistan
Rome, Italy	Izmir, Turkey	Kampolo, Uganda
Abidjan, Ivory Coast or Cote D'Ivoire	Kiev, Ukraine	Abu Dhabi, United Arabian Emirates
Amman, Jordan	Tashkent, Uzbekistan	Duba, United Arab Emirates
Almaty, Kazakhstan	Sanaa, Yemen	Croughton, United Kingdom
Nairobi, Kenya	Lusaka, Zambia	Fairford, United Kingdom
	Harare, Zimbabwe	Menwith Hall, United Kingdom
	Brussels, Belgium	

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FIGURE 12-12.2-5 REMOTE SITES NOT REQUIRING AN AUTHORIZATION FOR CARE BY CITIES IN TRICARE EUROPE, TRICARE PACIFIC, AND TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN (CONTINUED)

TRICARE PACIFIC	TRICARE PACIFIC
Pago Pago, American Samoa	Taipei, Taiwan
Nuuuli, American Samoa	Chiangmai, Thailand
Alice Springs, Australia	Nakhon Ratchasima, Thailand
Brisbane, Australia	Nonthaburi, Thailand
Canberra, Australia	Pattaya City, Thailand
Darwin, Australia	Phuket, Thailand
Edinburgh, Australia	Da Nang, Vietnam
Exmouth, Australia	Hanoi, Vietnam
Katherine, Australia	Ho Chi Minh City, Vietnam
Melbourne, Australia	
Newcastle, Australia	
Nowra, Australia	
Puckapunyal, Australia	
Richmond, Australia	
Sydney, Australia	
Toowoomba, Australia	
Townsville, Australia	
Dhaka, Bangladesh	
Phnom Penh, Cambodia	
Beijing, China	
Hong Kong, China	
Shanghai, China	
Nadi, Fiji	
Suva, Fiji	
Coimbatore, India	
Haryana, India	
New Delhi, India	
Jakarta, Indonesia	
Vientiane, Laos	
Antananarivo, Madagascar	
Kuala Lumpur, Malaysia	
Saipan, North Mariana Islands	
Ulaanbaatar, Mongolia	
Yangon, Myanmar	
Auckland, New Zealand	
Christchurch, New Zealand	
Wellington, New Zealand	
Manila, Philippines	
Quezon City, Philippines	
Koror, Republic of Palau	
Singapore	
Colombo, Sri Lanka	
Bangkok, Thailand	

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FIGURE 12-12.2-5 REMOTE SITES NOT REQUIRING AN AUTHORIZATION FOR CARE BY CITIES IN TRICARE EUROPE, TRICARE PACIFIC, AND TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN (CONTINUED)

TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN	TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN
English Harbour, Antigua	Caracas, Venezuela
Buenos Aires, Argentina	
Bahamas, AUTECH	
Nassau, Bahamas	
Bridgetown, Barbados	
Belize City, Belize	
La Paz, Bolivia	
Brasilia, Brazil	
Rio, Brazil	
Sao Paulo, Brazil	
Sarocabo, Brazil	
Santiago, Chile	
Bogota, Colombia	
San Jose, Costa Rica	
Goodwill Roseau, Dominica	
Santo Domingo, Dominican Republic	
Manta, Ecuador	
Quito, Ecuador	
San Salvadore, El Salvadore	
St George's, Grenada	
Guatemala City, Guatemala	
Guyana, Guyana	
Port Au' Price, Haiti	
Soto Cano, Honduras	
Tegucigalpa, Honduras Embassy	
Kingston, Jamaica	
Chiguagua, Mexico	
Mexico City, Mexico	
Monterey, Mexico	
Aruba, Netherlands Antilles	
Williamstad Curacao, Netherlands Antilles	
Managua, Nicaragua	
Chiriqui, Panama	
Panama City, Panama	
Santiago, Panama	
Asuncion, Paraguay	
Lima, Peru	
Para Maribo, Suriname	
Port of Spain, Trinidad & Tobago	
Monte Video, Uruguay	
US Virgin Island	

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FIGURE 12-12.2-6 LIST OF OVERSEAS COUNTRIES BY REGION

TRICARE EUROPE COUNTRIES	TRICARE EUROPE COUNTRIES	TRICARE EUROPE COUNTRIES
Afghanistan	Gibraltar	Oman
Albania	Greece	Pakistan
Algeria	Greenland	Poland
Andorra	Guernsey	Portugal
Angola	Guinea, Republic of	Qatar
Armenia	Guinea-bissau	Romania
Ascention Island	Herzegovina	Russia
Austria	Hungary	Rwanda
Azerbaijan	Iceland	St. Helena
Bahrain	Ile Europa	St. Pierre and Miquelon
Bassas da India	Iran	Saotane an Principe
Belarus	Iraq	San Marino
Belgium	Iraq-Saudi Arabia Neutral Zone	Saudi Arabia
Benin	Ireland	Senegal
Bosnia	Isle of Man	Serbia (Serbia-Montenegro)
Botswana	Israel	Seychelles
Bowet (Bouvel) Island	Italy	Sierra Leone
Bulgaria	Ivory Coast (Cote D' Ivoire)	Slovakia
Burkina-faso	Jersey	Slovenia
Burundi	Jordan	Somalia
Cameroon	Kazakhstan	South Africa
Cape Verde Island	Kenya	Spain
Central Africa Republic	Kuwait	Sudan
Chad	Kyrgyzstan	Svalbard and Jan Mayan
Camoro Island	Latvia	Swaziland
Congo (Brazzaville)	Lebanon	Sweden
Croatia	Lesotho	Switzerland
Cyprus	Liberia	Syria
Czech Republic	Libya	Tajikistan
Czechoslovakia	Liechtenstein	Tanzania
Democratic Republic of Kongo	Lithuania	Togo
Denmark	Luxembourg	Tunisia
Djibouti	Macedonia	Turkey
Egypt (United Arab Emirates)	Malawi	Turkmenistan
Eritrea	Mali	Uganda
Equatorial Guinea	Malta	Ukraine
Estonia	Mauritania	United Arab (Arabian) Emirates
Ethiopa	Moldova	United Kingdom
Faroe Island	Monaco	Uzbekistan
Finland	Morocco	Vatican City (Holy City)
France	Mozambique	Western Sahara (Port of Morocco)
Gabon	Namibia	Yemen
Gambia	Netherlands	Yugoslavia
Georgia	Niger	Zaire
Germany	Nigeria	Zambia
Ghana	Norway	Zimbabwe

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FIGURE 12-12.2-6 LIST OF OVERSEAS COUNTRIES BY REGION (CONTINUED)

TRICARE PACIFIC COUNTRIES
American Samoa
Antartica
Australia
Bangladesh
Bhutan
British Indian Ocean
Brunei
Burma
Cambodia
China (Peoples Republic of)
Christmas Island (Indian Ocean)
Cocos Island (Indian Ocean)
Cook Island
Fiji
French Polynesia
French Southern & Antartic Lands
Guam
Heard and McDonald Islands
Hong Kong
India
Indonesia
Japan (Includes Ryukyus)
Johnston Atoll
Kampuchea
Kiribati
Korea
Korea, North
Korea, Republic
Laos
Macao
Madagascar (Malagasy Republic)
Malaysia
Maldives
Maurititus
Mayotte
Micronesia
Midway Island
Mongolia
Myanmar
Naura
Nepal
New Caledonia
New Zealand
Niue
Norfolk Island

TRICARE PACIFIC COUNTRIES
Pacific Island
Papua and New Guinea
Paracel Islands
Philippines
Pitcairn
Republic of Palau
Reunion
Saipan
Singapore
Solomon Islands
Spratly Island
Sri Lanka (Ceylon)
Taiwan
Thailand
Tokelau Island
Tonga
Trust Territory of Pacific Islands
Tuvalu
Vanuatu
Vietnam
Wake Island
Wallis and Futuna
West Samoa

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FIGURE 12-12.2-6 LIST OF OVERSEAS COUNTRIES BY REGION (CONTINUED)

TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN COUNTRIES	TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN COUNTRIES
Arguilla	Trinidad and Tobago
Antigua	Turks and Caicos Islands
Argentina	Uruguay
Bahamas	Venezuela
Barbados	Virgin Islands, U.S.
Belize	
Bermuda	
Boliva	
Brazil	
British Virgin Islands	
British West Indies	
Canada	
Cayman Island	
Chile	
Colombia	
Costa Rica	
Cuba	
Dominica	
Dominica Republic	
Ecuador	
El Salvador	
Falkland Island	
French Guiana	
Grenada	
Guadeloupe	
Guatemala	
Guyana	
Haiti	
Honduras	
Jamaica	
Martinique	
Mexico	
Montserrat	
Nawassa Island	
Netherlands Antiles	
Nicaragua	
Panama	
Paraguay	
Peru	
Puerto Rico	
St Christopher-nevis	
St Lucia	
St Vincent	
Surinam	

FIGURE 12-12.2-8 OVERSEAS PHARMACY PROVIDER NOTICE LETTER (SAMPLE)

(Insert Provider Name)
(Insert Provider Street Address)
(Insert Provider City, State and Zip Code)

Dear **(Insert Provider Name)**:

The Department of Defense, through TRICARE Management Activity, is responsible for appropriate cost containment for services provided to TRICARE beneficiaries. One particular area of concern has been the costs billed for prescription drugs. In an effort to establish a Uniformed Military Services drug benefit and claim processing requirement for all TRICARE eligibles, the Executive Director, TMA, has determined that pharmacy claims submitted for services outside the United States must be reimbursed in accordance with the reimbursement formulas for TRICARE United States (U.S.) claims as established under the Code of Federal Regulations.

This letter notifies you that sixty (60) days from the date on this letter, overseas pharmacy claims must comply with TRICARE requirements for a National Drug Coding (NDC). Claims must include correct and complete NDC coding, whether submitted electronically or using standard claim forms. Drug claims received for processing for dates of service on or after **(insert date sixty (60) days from the date on this letter)** that do not have applicable NDC coding will be returned.

Additionally, effective sixty (60) days from date on this letter, **(insert date)**, overseas pharmacy claims submitted will be processed in accordance with the reimbursement formulas for TRICARE CONUS claims which is Blue book rates plus \$3.00 administration fee. Should you have any questions regarding this requirement, please write me at **(insert contractor mailing address)**.

Sincerely,

(Insert Managed Care Contractor Name)

(Insert Managed Care Contractor Title)

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FIGURE 12-12.2-9 INQUIRY FORM (EXAMPLE)

TOP CLAIM INQUIRY

In order that we may answer your claim quickly, please complete the information below and mail to:
TRICARE Managed Care Contractor - (insert address of managed care contractor)

Address	Last Name	First	Middle	Telephone Number is:
				(Home) () -
	City	State	Zip	(Duty/Work) () -

Date _____

- Check One:** A claim has been submitted, but payment or other notification has not been received.
 Notification or payment concerning a claim has been received, but I feel you may have processed it incorrectly.
 Deductible status
 Other (Explain in "J" below)

A. Coverage is under PRIME STANDARD B. Sponsor's SSN _____

C. Sponsor's Name _____ D. Patient's Name _____

E. Patient's Mailing Address _____

_____ TELEPHONE NUMBER _____

F. Name and location of hospital, physician, pharmacist, etc., who provided these services _____

_____ TELEPHONE NUMBER _____

G. Date(s) of services on claim _____ H. Total Charges _____

I. Claim number that appears on your TRICARE Explanation of Benefits (leave blank if an Explanation of Benefits has not been received) _____

J. Other (Please explain your question in as much detail as possible):

Beneficiary / Provider Signature _____

RESPONSE:

Managed Care Contractor Customer Service _____

FIGURE 12-12.2-10 POC REQUEST DESIGNATION LETTER (EXAMPLE)

LETTER TO TMA FOR OFFICIAL TRICARE POINT OF CONTACT
(If required by the Regional Director Fax the POC request letter
to the Overseas Regional Director)

(Military/Embassy Letterhead)

Date

TO: TRICARE Management Activity
ATTN: Chief, Claims Operations Office
16401 East Centretech Parkway
Aurora, CO 80011-9066

SUBJECT: TRICARE Overseas POC (**Initial or Update**)

1. Request approval of the following individuals as official TOP POCs:

Primary: Name, SSN, Branch of Service (if applicable)
Commercial phone number
Commercial Fax number
Email address
Address:

Alternate: Name, SSN, Branch of Service (if applicable)
Commercial phone number
Commercial Fax number
Email address
Address:

2. If updating indicate if the new individuals nominated will be replacing previously designated POCs or if they are additions to previously designated POCs.

3. Include justification if requesting approval for more than three alternate POCs.

4. (**POC name**) is the TOP point of contact for TOP for the U.S. (**Embassy, DAO or MilGrp Office, etc.**) in (**country**) until (**timeframe**).

4. Thank you for your assistance in this matter. If there are any problems with this request, please contact (**POC**) at (**phone number**).

(signature block for Office In Charge (OIC) or Commanding Officer)

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM

TOP AND TDP POINT OF CONTACT PROGRAM BOOKLET



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FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

TOP AND TDP POINT OF CONTACT PROGRAM

INTRODUCTION

The Point of Contract (POC) Program for TRICARE Overseas Program (TOP) healthcare claims has been in operation since 1991. The POC Program is designed to provide beneficiaries and host nation providers assistance with filing TRICARE claims for care received in foreign countries. This liaison service is designed to ensure timely overseas claim filing and payment. With the expansion of the POC program to include TRICARE Dental Plan (TDP) claims, beginning May 1999, the Department continues to provide another important tool to ensure beneficiary access to quality host nation healthcare. Oversight and support of a designated POC by the various Uniformed Services Branches is critical to assure the continued success of the POC program.

BACKGROUND

Military family members in foreign countries have had trouble getting medical and dental care from host nation providers for the following reasons:

- Delays in beneficiary/provider filing of TRICARE Overseas Program (TOP) claims;
- Delays in host nation mail service;
- Delays in host nation provider payment by the beneficiary, upon receipt of TOP payment.

To reduce these delays, TRICARE Management Activity (TMA) established dedicated foreign claims processing departments to handle TOP and TDP claims. Each specialized foreign claims processing department has a dedicated staff to process only TOP or TDP claims, dedicated data fax capabilities, and a dedicated post office box for the receipt of TOP or TDP claims and correspondence. TOP/TDP dedicated foreign claims processing departments also have electronic mail capability for receiving TDP correspondence.

Although the volume of TOP and TDP claims is small, the claims receive priority processing. The special handling provided by the dedicated TOP and TDP foreign claims processing departments, combined with the valuable liaison service provided by local designated POCs results in the retention of quality host nation providers to treat the Department's beneficiary population while on overseas assignment.

WHO MAY QUALIFY TO BE A POINT OF CONTACT?

A designated Point of Contact (POC), must be either:

- An Active Duty military member; or
- A civilian employee working for, and under the oversight of, the military/U.S. Government who will be remaining at the same location for a least twelve (12) months.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)**POC DESIGNATION**

POC designation is usually limited to one Primary POC and one or two alternate POCs. Additional alternate POC's maybe designated when justified by the commanding officer upon requesting designation.

Requests for POC designation must be in writing, signed by the POC's Commanding Officer of a foreign base or location, Defense Attache Office (DAO), and Security Assistant Organizations, and must be submitted to the TRICARE Management Activity, Chief, Claim Operations Office, 16401 East Centretch Parkway, Aurora, CO 80011. The request must include the POC's complete mailing addresses, telephone, and fax numbers, and email address when available, name of the POC, name(s) of the alternate POC(s), justification of the additional alternate POC's, and indication whether the change is new, replacing existing designated POC's or adding POC designation.

TMA POC designation is "purple suited" and not Uniformed Service specific, nor is designation limited to a specific category of TRICARE benefit (i.e., medical, drug, maternity) or for a specific category of TOP beneficiary (ADSM, ADFM, retiree, etc.).

Upon approval, TMA will notify the requestor, the contractors, Regional Director, via e-mail and/or fax.

DUTIES OF THE POINTS OF CONTACT

Designated POCs must:

- Assist all Uniformed Services TRICARE beneficiaries, and active duty members, regardless of Service affiliation, and host nation providers with completion of and filing TOP and TDP claims with the appropriate claims processor.
- Provide ongoing education to beneficiaries/provider on the TRICARE program benefits and correct claims filing.
 - A. NOT submit claims for care not yet received.
 - B. **NOT FAX NEW Claims** on the contractor's inquiry fax.
- Develop procedures for the coordination, control and tracking of either faxed or mailed claims from within their areas of responsibility to the appropriate claims processing contractors. This process must include the receipt of and distribution of foreign drafts/U.S. dollar checks/explanation of benefits (EOB) received from the contractors as payment for services rendered by host nation providers.
- Establish and maintain a file for the original claim and all related correspondence faxed to the contractor.
- Provide their *commercial*, not DSN or AUTOVON, telephone, and fax numbers address, including e-mail address, if available, on the TOP claim inquiries fax cover sheet with each fax claim submission (see [Figure 12-12.2-9](#)).

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

- Ensure that Faxed claims are correctly completed, signed, by the patient, or by the parent in the case of a minor, or that the beneficiary signature is on file. Attach a copy of the front and back of the family member ID card when the family member is not enrolled in DEERS unless the family member is a newborn, in which case the claims will be processed normally without an enrollment or ID card requirement. All Philippines claims must be signed by the beneficiary/provider. POCs may not use signature on file for Philippines claims.

NOTE: For active duty member claims, if the active duty member signature is not present on the claim form, the military command must submit a letter of explanation along with the claim prior to the contractor payment.

NOTE: *For TDP dental claims*, a properly completed "Non-Availability and Referral Form" must accompany the dental claim form, except for non-orthodontic services performed in remote locations. The form must be issued by the enrolled family member's servicing overseas dental treatment facility (ODTF), or the appropriate overseas regional director, or their designee, depending on where the family member lives and the dental services that are performed. The POC *may not* complete this form. The TDP contractor has published a reference guide to assist ODTFs, overseas regional directors and POCs in the management of TDP dental claims. This "Authorization and Referral Manual" documents the proper procedures for the issuance of TDP authorizations, referrals and claims payment processes. This manual takes precedence over any potential conflicting instructions in this publication.

- Attach copies of all related itemized bills (not receipts) with the claim.
- Ensure claims for *adjunctive dental care* are sent to the appropriate TRICARE contractor responsible for processing medical claims and not the TDP contractor.
- Provide the specialized foreign claims processors any additional information that may be required by the contractor(s) to finalize the processing of a claim via fax/email, within 10 calendar days of receipt of the request.
- Shall, when submitting a contractor claims inquiry, refer to the claim number of the claim in question and provide a copy of the TRICARE Explanation of Benefit (TEOB) with the inquiry and/or a copy of the contractor letter that requests additional information. POC's may fax or email inquiries to the claims processing contractor. Each fax inquiry should be accompanied by a completed TOP Inquiry Form (Figure 12-12.2-8) that clearly identifies the number of pages in the fax, who to contact about the inquiry, the fax number and phone number.
- Shall allow the contractor twenty-one (21) days to respond to a fax inquiry before requesting claim/fax inquiry status. If after 30 days, the POC is not able to resolve the issue with the claims processing contractor, the POC shall contact the appropriate TOP Regional Director.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

- Shall allow the contractor for new claims, thirty (30) days to process/pay and mail the claims back to POC. If the POC has not received a claim payment/denial notice from the contractor within thirty (30) days, the POC should follow the inquiry process outlined in this section.
- Use priority pouch mail for receipt of foreign drafts/U.S. dollar checks/EOBs from the TRICARE contractors.
- Distribute foreign drafts/U.S. dollar checks/EOBs to appropriate sponsors/beneficiaries or host nation providers immediately upon receipt.
- Report unresolved claims problems or issues between the TRICARE contractor and the POC concerning policies or program requirements for:
 - TOP issues first to the appropriate Regional Director for resolution. If the contractor and the Regional Director are unable to resolve the issues, the TOP issue should be referred to the TRICARE Management Activity, Chief, Claims Operations Office, 16401 East Centretch Parkway, Aurora, CO 80011.
 - TDP issues to the TRICARE Management Activity, Chief, Special Contract Operations Office, 16401 East Centretch Parkway, Aurora, CO 80011.
- Educate local beneficiaries and host nation providers on the correct procedures for filing their claims.
- Stress the importance of filing claims within 30 days following receipt of TOP or TDP since timely filing ensures prompt payment of care received.

DUTIES OF THE MANAGED CARE CONTRACTORS

The TOP and TDP dedicated claims processing departments must:

- Assist the TOP and TDP POCs, Uniformed Services, TRICARE beneficiaries, active duty members where appropriate, and host nation providers with information on the completion of and filing of claims with the appropriate claims processor.
- Develop internal procedures for the coordination, control and tracking of faxed or mailed claims from receipt to final processing. This includes, but is not limited to, storage/maintenance of the claim and all related correspondence, microfilming/imaging of claims upon receipt, the issuance of foreign drafts/U.S. dollar checks/EOBs, and development procedures for missing information needed to process the claim to completion.
- Provide a dedicated P.O. box for the receipt of TOP and TDP claims.
- Provide a dedicated fax number for the receipt of POC claims.
- Accept only faxed claims/inquires/information faxed by an officially designated POC or an alternate POC. Electronic mail may also be used for TOP/TDP inquiries/information.
- Verify beneficiary eligibility for TOP or TDP benefits.
 - For TOP claims, a copy of the front and back of the dependent ID card must be sent in with the TOP claim and may be used as eligibility verification by the managed care contractor when the family member is not enrolled in DEERS.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

- For TDP claims, the family member must first be enrolled in DEERS and the TDP, and the sponsor must pay the appropriate premium, before services can be rendered and his/her claims processed. The sponsor should verify on his/her Leave and Earnings Statement (LES) that the correct payroll deduction has been taken. The sponsor is also advised to contact the TDP contractor before receiving services to ensure that the proper enrollment information has been received and to confirm the actual coverage date.
 - Review claims to ensure the beneficiary/provider has provided complete and accurate information prior to submitting claims for processing/payment.
 - Process TOP claims using guidelines in this chapter.
 - Process TDP claims per contract requirements and the guidelines outlined in the "Authorization and Referral Manual".
 - Be able to translate claims submitted in a foreign language.
 - Pay claims using the exchange rate in effect on the last date of service listed on the claim.
 - Make payment as follows:
 - For TOP Claims:
 - Issue foreign currency drafts for TOP claims. Drafts may not be changed to a U.S. dollar check after the managed care contractor has issued a foreign draft.
 - For TDP Claims:
 - Issue foreign currency drafts for TDP claims submitted by providers via POCs.
 - Issue U.S. dollar checks for TDP claims submitted by a sponsor/family member via POCs. Payment may not be changed to local currency after the U.S. dollar check has been issued.
 - For TOP and TDP Claims:
 - Issue foreign currency drafts for both TOP and TDP claims when the sponsor/family member requests payment in local foreign currency only at the time the claim is submitted.
- NOTE: Foreign drafts are good for 180 days and may be cashed at any time. U.S. dollar checks are good for a limited period of time and must be reissued by the TRICARE contractors upon expiration of the check before the check can be cashed.
- Use priority pouch mail for the mailing of foreign drafts/U.S. dollar checks/EOBs to appropriate sponsors/beneficiaries and/or host nation providers for claims submitted via POCs. The priority pouch mail must be sent using the fastest means available to the POC's location.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

- Report unresolved claims problems or issues between the Regional Director and the managed care contractor concerning policies or program requirements for:
 - TOP issues to the TRICARE Management Activity, Chief, Claims Operations Office, 16401 East Centretrech Parkway, Aurora, CO 80011.
 - TDP issues to the TRICARE Management Activity, Chief, Special Contract Operations Office, 16401 East Centretrech Parkway, Aurora, CO 80011.

HELPFUL HINTS

- Make sure the TOP and TDP claim form is completed and signed by the patient or by the parent (or responsible party) in the case of a minor.
- Do not send TOP or TDP claims provided to two different beneficiaries by the same provider on the same claim form. Each beneficiary should file claims on a separate form.
- Remember the TOP claims department processes only healthcare and adjunctive dental claims for services provided in foreign countries and TOP Prime/Standard healthcare provided in the U.S.
- Remember the TDP claims department processes all TDP claims for enrolled family members, regardless of where the service was performed.
- Remember to remind beneficiaries and providers that the TOP and TDP programs do not share the cost of all types of healthcare or dental care. Therefore, TRICARE payment for every service received can't be guaranteed.
- Remember to use the beneficiary's claim number listed on the EOB when making specific claims inquiries to the TOP and TDP contractors.

NOTE: Do not send a new claim when the first claim has been denied or was processed incorrectly. Contact the appropriate TRICARE contractor for assistance.

SUMMARY

The TRICARE contractors' foreign healthcare and dental claims processing department has produced excellent results for the installations using the system. However, it can only be effective if the Services designate POCs and the designated POCs understand the TOP and TDP programs and the claims processing requirements. The POC must also communicate with the TRICARE contractors' foreign healthcare and dental claims departments on a regular basis.

Although the POC program is not for all locations and situations, the use of the POC concept does improve the situation for accessing and ensuring prompt payment to host nation providers in countries that take full advantage of the system.

The attached flowchart summarizes the recommended foreign claims submission process.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

RECOMMENDED FOREIGN CLAIMS METHOD

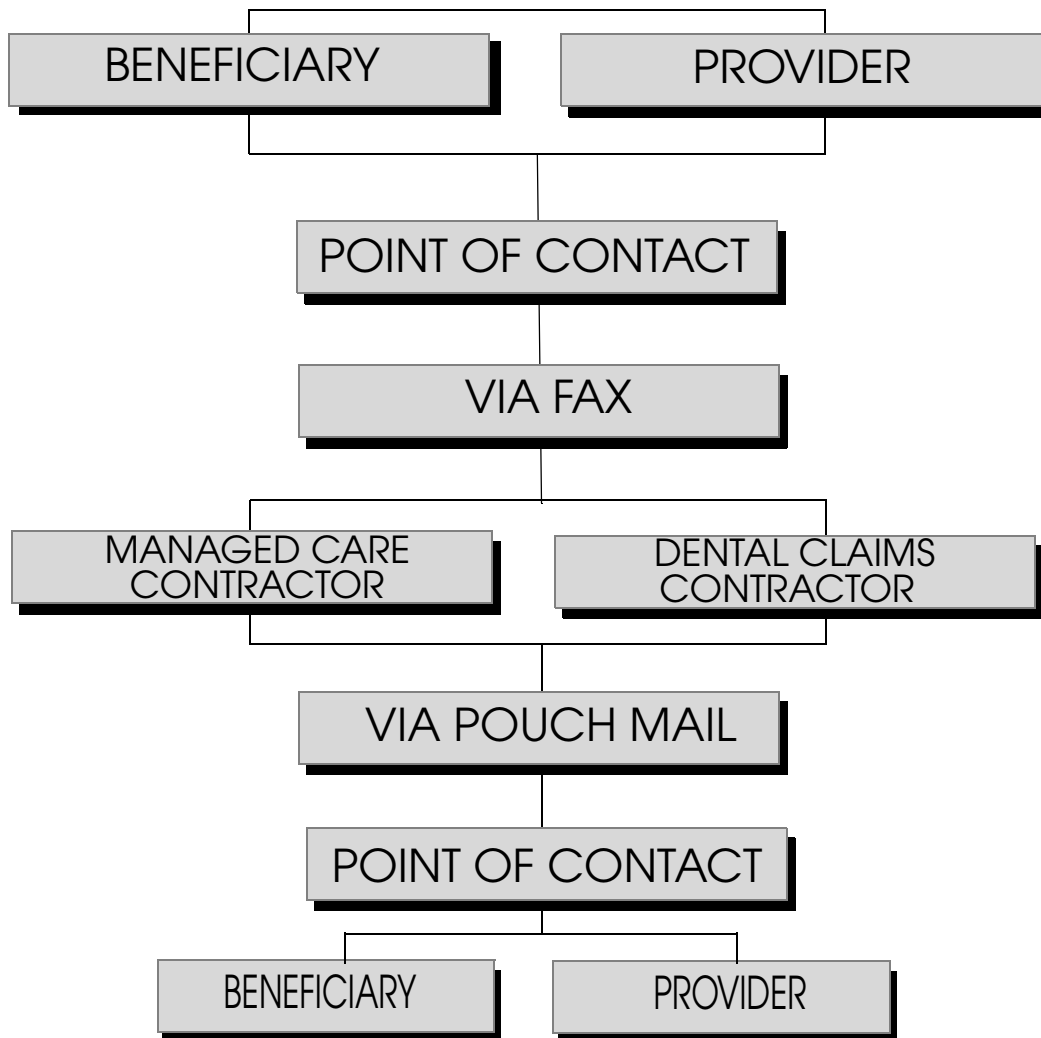


FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

TOP CLAIM FORMS

There are two different claim forms that may be used when filing TOP healthcare claims: the DD Form 2520 (the yellow one) and the new DD 2642 (the white one). Front and back copies of each of the claim forms are attached. Copies of these claim forms may be found and downloaded on the TMA website at <http://www.TRICARE.OSD.mil>.

Directions for completing each claim form are included on the back of each form. If you need help in filling out the claim forms or have questions, please contact either the Overseas Regional Director for your area.

NOTE: If the above forms are not available, the TOP managed care contractor may accept any authorized TRICARE claim **form** current/obsolete.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

CHAMPUS/CHAMPVA CLAIM FORM

For services or supplies provided by civilian sources of medical care.
Read cover instructions and the back of this form before completing and signing!

Form Approved
OMB No. 0704-0084
Expires Nov. 30, 1993

SECTION I - PATIENT INFORMATION				SECTION II - SPONSOR INFORMATION				
1. PATIENT'S NAME (Last, First, Middle Initial)		2. PATIENT'S DATE OF BIRTH (MMDDYY)		7. SPONSOR'S NAME (Last, First, Middle Initial)				
3. PATIENT'S ADDRESS (Street, City, State, and ZIP Code)		4. PATIENT'S SEX (X one) MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		8. SPONSOR'S SOCIAL SECURITY NO. OR VA ID NO.		9. VA STATION NO.		
TELEPHONE (Include Area Code)		5. PATIENT'S RELATIONSHIP TO SPONSOR (X one) SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> NATURAL OR ADOPTED CHLD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> OTHER (Specify):		10. SPONSOR'S DUTY STATION OR ADDRESS FOR RETIREES				
5. MILITARY/VA IDENTIFICATION CARD INFORMATION a. CARD NO.		6. EFFECTIVE DATE (MMDDYY)		d. EXPIRATION DATE (MMDDYY)		11. SPONSOR'S BRANCH OF SERVICE (X one) USA <input type="checkbox"/> USAF <input type="checkbox"/> USMC <input type="checkbox"/> USN <input type="checkbox"/> USCG <input type="checkbox"/> USPHS <input type="checkbox"/> NOAA <input type="checkbox"/> VA <input type="checkbox"/>		
b. ISSUE DATE (MMDDYY)		c. EFFECTIVE DATE (MMDDYY)		d. EXPIRATION DATE (MMDDYY)		12. SPONSOR'S GRADE/RANK		
14a. ARE YOU COVERED BY ANY OTHER HEALTH INSURANCE PLAN OR PROGRAM TO INCLUDE HEALTH COVERAGE AVAILABLE THROUGH OTHER FAMILY MEMBERS? IF YES, ENTER NAME OF OTHER PLAN OR PROGRAM.		YES <input type="checkbox"/> NO <input type="checkbox"/>		13. SPONSOR'S STATUS (X one) ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> DECEASED <input type="checkbox"/>		13. SPONSOR'S STATUS (X one) ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> DECEASED <input type="checkbox"/>		
ADDRESS (Include ZIP Code)		15. REASON FOR CONDITION (X all that apply) a. WORK RELATED <input type="checkbox"/> b. MILITARY SERVICE RELATED <input type="checkbox"/> c. AUTOMOBILE ACCIDENT RELATED <input type="checkbox"/>		16. INPATIENT/OUTPATIENT CARE OUTPATIENT <input type="checkbox"/> INPATIENT-SKILLED NURSING FACILITY <input type="checkbox"/> INPATIENT HOSPITAL WITHIN CATCHMENT AREA (Attach DD Form 1227) <input type="checkbox"/> INPATIENT-EMERGENCY <input type="checkbox"/> INPATIENT HOSPITAL-OUTSIDE CATCHMENT AREA PROGRAM FOR THE HANDICAPPED <input type="checkbox"/> INPATIENT-OTHER <input type="checkbox"/>		17. DESCRIBE CONDITION FOR WHICH YOU RECEIVED TREATMENT. IF AN INJURY, NOTE HOW IT HAPPENED.		
b. TYPE OF COVERAGE (X one) Employment (Group) <input type="checkbox"/> MEDICAID <input type="checkbox"/> Student Plan <input type="checkbox"/> Private (Non-Group) <input type="checkbox"/> MEDICARE <input type="checkbox"/> Other (Specify) <input type="checkbox"/>		c. OTHER IDENTIFICATION NUMBER		d. EFFECTIVE DATE (MMDDYY)		18. SIGNATURE OF PATIENT OR AUTHORIZED PERSON, CERTIFIES CLAIM INFORMATION AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION. READ INSTRUCTIONS AND REVERSE BEFORE SIGNING. a. SIGNATURE _____ b. DATE SIGNED _____ c. RELATIONSHIP TO PATIENT _____		
9. OTHER PROGRAM THROUGH EMPLOYMENT? EMPLOYER NAME		YES <input type="checkbox"/> NO <input type="checkbox"/>						
SECTION III - PHYSICIAN/OTHER PROVIDER (Items 19 through 33 are to be completed by the physician or other provider)								
19. REFERRING PHYSICIAN a. NAME		c. TELEPHONE (Include Area Code)		20. FACILITY WHERE SERVICES RENDERED (Other than home/office) a. NAME				
b. ADDRESS (Include ZIP Code)		d. (X one) PRIVATE PRACTICE <input type="checkbox"/> UNIFORMED SERVICES <input type="checkbox"/>		b. ADDRESS (Include ZIP Code)				
21. PROVIDER OF SERVICES ATTENDING PHYSICIAN <input type="checkbox"/> OTHER (Specify) _____		22. HOSPITALIZATION INFORMATION a. ADMISSION DATE (MMDDYY)		b. DISCHARGE DATE (MMDDYY)		23. LAB WORK OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, CHARGES:		
24. DIAGNOSIS, SYMPTOM OR NATURE OF ILLNESS OR INJURY (Relate diagnosis to procedure in column 27e, by reference to numbers 1, 2, 3, or DX Code) 1. _____ 2. _____ 3. _____								
25. SERVICES PROVIDED								
a. DATES OF SERVICE (MO/DAY/YEAR)		b. PLACE OF SERVICE	c. PROCEDURE CODE IDENTIFY	d. DESCRIBE PROCEDURE/SUPPLIES FOR EACH DATE, SUBMIT REPORT EXPLAINING UNUSUAL SERVICES OR CIRCUMSTANCES		e. DIAGNOSIS CODE	f. CHARGES	LEAVE BLANK
26. PATIENT'S ACCOUNT NO.		29. PHYSICIAN OR OTHER PROVIDER a. NAME		g. TOTAL CHARGES \$		30. AMT. PD. BY BENEFICIARY \$	31. AMT. PD. BY OTHER INSURANCE \$	
27. PROVIDER'S SOCIAL SECURITY NO.		b. ADDRESS (Include ZIP Code)		32. AGREEMENT TO PARTICIPATE (Read reverse) YES <input type="checkbox"/> NO <input type="checkbox"/>				
28. PROVIDER'S EMPLOYER I.D. NO.		c. TELEPHONE (Include Area Code)		d. PROVIDER NO.		33. PHYSICIAN OR OTHER PROVIDER (Read reverse before signing) a. SIGNATURE _____ b. DATE SIGNED _____		

DD Form 2520, DEC 90

Previous edition may be used.

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 12, SECTION 12.2

FIGURES

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

<p>Privacy Act Statement</p> <p>AUTHORITY: 44 U.S.C §§3101; 10 U.S.C §§1079 and 1086; 38 U.S.C 5613; E.O. 9397.</p> <p>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.</p> <p>ROUTINE USE(S): Information from claims and related documents may be given to the Department of Veterans Affairs, the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; 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.</p> <p>DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.</p> <p>PATIENT/SPONSOR INFORMATION - ITEMS 1 - 18</p> <p>Items 1 through 18 must be completed and the certificate signed by the beneficiary/patient if he/she is 18 years of age or older. If the beneficiary/patient is unable to sign on his/her own behalf, refer to Fact Sheet 12, "How to File a CHAMPUS Claim." The sponsor may sign for any beneficiary/patient under 18 years of age, or in the absence of the sponsor, the other parent, the beneficiary/patient or beneficiary/patient's guardian may sign. (NOTE: For privacy reasons, a beneficiary/patient under 18 years of age may sign his/her own claim form.)</p> <p>BENEFICIARY/PATIENT CERTIFICATION - ITEM 18</p> <p>By signing Item 18 of this CHAMPUS/CHAMPVA claim form, I certify that to the best of my knowledge and belief the information provided in Items 1 through 17 is complete and correct. I further authorize the release of any medical information necessary to adjudicate and process this claim to the Federal Government including the CHAMPUS Contractor. I also authorize the release of, or obtaining of, medical and/or other coverage information to and from another organization with which I have the other medical benefits plan or health insurance coverage.</p>	<p>If I am submitting this claim for direct reimbursement to me, my signature further certifies that the specific medical services/supplies for which I am claiming benefits were actually rendered to me on the dates indicated and that the attached itemized statement represents a legal obligation to pay.</p> <p>(NOTE: The above is also certified if Item 18 is signed by the sponsor, other parent or guardian.)</p> <p>PROVIDER PARTICIPATION - ITEM 32</p> <p>By checking 'Yes' in Item 32 (and signing in Item 33) of the CHAMPUS/CHAMPVA claim form, I agree to submit this claim to the appropriate CHAMPUS Contractor as a participating provider. I understand that I agree to accept the CHAMPUS-determined allowable charge as the total charge for medical services/supplies listed on the claim form. I will accept the CHAMPUS-determined allowable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-shared amount and deductible, if any, paid by or on behalf of the beneficiary/patient, as full payment for the medical services/supplies. I will make no attempt to collect from the beneficiary/patient (or sponsor) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS agrees to make any benefits payable directly to me, if I submit a claim as a participating provider.</p> <p>(Any alteration of this statement by the provider may result in the claim being returned or processed as a non-participating claim with payment made to the beneficiary.)</p> <p>PROVIDER CERTIFICATION - ITEM 33</p> <p>I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by CHAMPUS regulations.</p> <p>For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysician's must be included in the physician's bill.</p> <p>I further certify that I am not an intern, resident, or otherwise in a training status for which I am receiving compensation for services listed on this claim.</p> <p>I further certify that I am not (1) an active duty member of the Uniformed Services; (2) a civilian employee of the United States Government; or (3) a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536).</p>
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TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 12, SECTION 12.2

FIGURES

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

- PATIENT'S COPY -

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) <input type="checkbox"/> SLLI <input type="checkbox"/> STEPCHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OIHLR (Specify) <input type="checkbox"/> NATURAL OR ADOPTED CHILD	
5. PATIENT'S DATE OF BIRTH (YYYYMMDD)	6. PATIENT'S SEX (X one) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	7. IS PATIENT'S CONDITION (X both if applicable) ACCIDENT RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.		8b. WAS PATIENT'S CARE (X one) <input type="checkbox"/> INPATIENT? <input type="checkbox"/> OUTPATIENT? <input type="checkbox"/> 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)			
<input type="checkbox"/> (1) EMPLOYMENT (Group)	<input type="checkbox"/> (3) MEDICARE	<input type="checkbox"/> (5) MEDICARE SUPPLEMENTAL INSURANCE	
<input type="checkbox"/> (2) PRIVATE (Non Group)	<input type="checkbox"/> (4) STUDENT PLAN	<input type="checkbox"/> (6) OIHLR (Specify)	
c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE (Street, City, State, and ZIP Code)		d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE (YYYYMMDD)
INSURANCE 1			
INSURANCE 2			
12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OIHLR INSURANCE INFORMATION.			
a. SIGNATURE		b. DATE SIGNED (YYYYMMDD)	c. RELATIONSHIP TO PATIENT
HOW TO FILL OUT THE CHAMPUS FORM			
<i>You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.</i>			
1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.		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.	
2. Enter the patient's daytime telephone number and evening telephone number to include the area code.		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. <i>The CHAMPUS claims processor cannot process claims until you provide the other health insurance information.</i>	
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.		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 years 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.	
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." The form may be obtained from the claims processor, Health Benefits Advisor or TRICARE Management Activity.			
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 or: 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).			

DD FORM 2642 (BACK), NOV 1999

COPY 1 - PATIENT'S COPY

TRICARE POLICY MANUAL 6010.54-M, AUGUST 1, 2002

CHAPTER 12, SECTION 12.2

FIGURES

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

- PATIENT'S COPY -

<p>CHAMPUS CLAIM PATIENT'S REQUEST FOR MEDICAL PAYMENT</p>	<p><i>Form Approved</i> <i>OMB No. 0720-0006</i> <i>Expires Sep 30, 2002</i></p>
<p>The 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 the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0108), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.</p> <p>PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS. 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 TRICARE MANAGEMENT ACTIVITY (303) 676-3400.</p>	
<p>PRIVACY ACT STATEMENT</p>	
<p>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 assure 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 recruitment 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 enrollment, 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.</p>	
<p>IMPORTANT - READ CAREFULLY</p>	
<p>Federal Laws (18 U.S.C. 267 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.</p>	
<p>INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT</p>	
<p>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. <i>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.</i></p>	
<p>*****</p>	
<p>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:</p> <ol style="list-style-type: none"> 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. <p>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.</p>	
<p>*****</p>	
<p>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 TRICARE Management Activity 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.</p>	
<p>*****</p>	
<p>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 TRICARE Management Activity, 16401 E. Centretech Pkwy., Aurora, CO 80011-9043.</p>	
<p>*** REMINDER ***</p>	
<p>Before submitting your claim to the claims processor be sure that you have:</p> <ol style="list-style-type: none"> 1. Completed all 12 blocks on the form. <i>If not signed, the claim will be returned.</i> 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 CHAMPUS" if accident or work related. See instruction number 7 on reverse side. 7. Ensured that 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. 	

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

ATTENDING DENTIST'S STATEMENT							
Check <input type="checkbox"/> Dentist's pre-treatment estimate OR <input checked="" type="checkbox"/> Dentist's statement of actual services							
1. Dentist's name Jane J Doe		2. Social Security Number XXXX-XX-XXXX		3. Sex F		4. Patient's birth date 10/29/57	
5. Sponsor's name James T Doe		6. Branch of service Army		7. Sponsor's address TRICARE Family Member Dental Plan		8. Dental base location Education University, Frankfurt	
9. Sponsor's address 999-99-9999		10. Branch of service Army		11. Group name TRICARE Family Member Dental Plan		12. Is patient covered by dental plan? Yes One Dental Insurance Company	
13. Patient's address Box 1267		14. Is patient covered by dental plan? Yes One Dental Insurance Company		15. Insurance ID No. 111-11-1111		16. Group No. 000123450	
17. APO AE 01234 (Germany)		18. Name and address of carrier Dental Insurance Company		19. Name and address of carrier 1415 Main Street Chicago, IL		20. Name and address of carrier 1415 Main Street Chicago, IL	
21. I have reviewed the following treatment plan and authorize release of any information relating to this plan. PATIENT OR PARENT/GUARDIAN SIGN HERE 1/5/99		22. I have authorized payment of my group insurance benefits, whenever payable to me, to the dental plan below. PATIENT OR PARENT/GUARDIAN MUST SIGN HERE: HE/SHE WANTS PAYMENT TO GO TO DENTIST 1/5/99		23. Signature (Print name) Dr. Franz Schmidt		24. Date 1/5/99	
25. Dental rating Dr. Franz Schmidt		26. Is treatment result of occupational injury? No		27. Is treatment result of auto accident? No		28. Date of prior placement None	
29. New zip address Kabingstrasse 30		30. City, state or postal coding code 54290 Furth (Germany)		31. Is this dental plan covered by another plan? No		32. Date of prior placement None	
33. Dental license (011)1489-439-465		34. Is this dental plan covered by another plan? No		35. Date of prior placement None		36. Is treatment for orthodontics? No	
37. Date of birth 1/5/99		38. Place of birth Germany		39. Has program ever been discontinued? No		40. Is treatment for orthodontics? No	
27. Examination and treatment plan in order from Tooth No. 1 through Tooth No. 32. Use shading system shown.							
TOOTH NO. OR SURFACE	SURFACE	DENTIST'S PROCEDURE (INCLUDE PATIENT'S PREVIOUS MATERIALS USED, ETC.)	DENTAL SERVICE APPROVED NO. / DENT. YR.	PROCEDURE CODE	FEE CHARGED	ANALYST'S PAGE	
		① Examination	1 5 99		②		
12		② Filling on one surface	1 5 99		③		
Note: If the claim form is used as the dentist's bill, then include the following information as shown above: ① tooth number, ② description of services provided, ③ date of service, ④ fee charged. (If individual fee service charge is known, please enter. If not known, enter total fee charged.)							
Note: If services are listed on the dentist's bill, attach the bill to this claim. You do not need to complete this section.							
28. Remarks for unusual services:						TOTAL FEE CHARGED 50 DM	
Any person who knowingly furnishes a statement or claim containing any false information or any false, misleading, or deceptive information or conceals or omits material information concerning any fact material to a claim may be guilty of a criminal offense under applicable laws and may also be subject to civil penalties. I hereby certify that the procedures described by code have been performed. Dentist must sign here unless bill is attached. And dentist's name is listed on the bill.						AMOUNT PAID	

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)**TDP CLAIM FORM**

There are numerous claim forms used to process dental claims. To expedite processing, the Government will utilize the existing **stateside** U.S. (CONUS) TDP claim form. The following suggestions for filling out the dental claim form will help to minimize problems and reduce delays in claims processing by the managed care contractor. A copy of the dental claim form and a sample of a completed form are also provided.

FILLING OUT A TDP DENTAL CLAIM FORM

Most of the blocks on the dental claim form are self-explanatory (see completed example below). But, there are certain blocks to which special attention should be paid as noted below:

Block above Block 1--If the provider or sponsor/family member wishes to obtain a pre-treatment estimate (or predetermination) of the services they would like performed, they should check the box marked "Dentist's pre-treatment estimate". When a pre-treatment estimate is checked, no dates of service should be listed in Block 27, Examination and Treatment Plan. If the provider or sponsor/family member wishes to submit a claim for the actual services rendered, they should check the box above block 1 marked "Dentist's statement of actual services".

Block 1--Only one patient per claim form. But you may attach more than one bill for the same patient. Be sure to use the name as it appears on the patient's ID card--or, for young children, as entered in DEERS.

Block 4--Be sure to enter the patient's birth date here.

Block 5--Indicate if family member is a full time student and, if so, where.

Block 7--Be sure the **Uniformed Services sponsor's** Social Security number is entered.

Block 8--Enter the complete home address of the family member seeking treatment. Indicate APO/FPO or street, city, country and appropriate postal mailing code.

Block 9--Put the sponsor/family member's complete daytime and evening phone numbers in this block so that these parties can be contacted if there is a problem with the claim. Include country and city codes as appropriate.

Signature block immediately under Block 9--This block must be signed and dated by the patient (18 years of age or older) or the parent/guardian if the patient is a minor. Be sure to read the instructions in the TDP Dental Benefit Booklet if someone other than the patient is signing on behalf of the patient.

Block 12--If the sponsor/family member has any other dental insurance at all, such as a spouse's plan through an employer, check "yes". Give the name and address of the other dental insurance carrier, the insured's social security number, and the other insurance carrier's group number in the space provided. If the sponsor/family member has no other dental plan besides the TDP, check the "no" box.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

Signature block immediately under Block 12--This block must be signed and dated by the patient (18 years of age or older) or the parent/guardian if the patient is a minor, if either party wants the provider to receive payment directly ("assignment"). Be sure to read the instructions in the TDP Dental Benefit Booklet if someone other than the patient is signing on behalf of the patient.

Block 13--This should be the provider's complete name.

Block 14--This should be the provider's complete mailing address, to include street, city, country and appropriate postal mailing code.

Block 15--This should be the provider's complete commercial phone number, to include country and city codes.

Blocks 17, 18 & 19--Complete based on information available from the provider, beneficiary and/or other information on itemized provider bill.

Blocks 20, 21 and 22--If the problem for which the family member went to the provider is work related or accident related (i.e., occupational illness/injury, auto accident, other injury), check the corresponding "yes" in Blocks 20, 21 or 22. If "yes", please provide a brief description and the date(s) of the incident. The managed care contractor will follow up with some questions to make sure that worker's compensation or other insurance helps pay the bills.

Blocks 24 and 25--Answer only if the service is for a prosthetic device. Check with the provider for this information.

Block 26--Indicate "yes" if treatment is for orthodontics. If "yes", insert the date the orthodontic appliance was inserted and the expected length of the overall orthodontic treatment plan. Check with the sponsor/family member or provider for this information.

Block 27--From the provider's itemized bill or other available information, provide as much detail to indicate the service(s) that was ordered, performed or prescribed, the specific tooth/teeth treated, and the date(s) of service. Match services with specific tooth numbers to the greatest extent possible. For each service listed, provide the condition for which the patient received treatment and/or the procedure that was performed (attach additional pages as necessary), and the provider's fee that is being charged for each service.

Signature block immediately under Block 27--This block must be signed and dated by the provider.

NOTE: A "Non-Availability and Referral Form" must accompany the claim form and provider's itemized bill for all dental care from non-remote countries and for orthodontic care from remote countries (see the **Overseas** TDP Authorization and Referral Manual for further information). This form is issued by the family member's servicing ODTF or the appropriate Overseas Regional Director or designee, depending on where the family member lives and the services that are performed.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)**COMPLETING THE TDP OVERSEAS CLAIM FORM**

Most of the TDP Overseas Claim Form is self-explanatory; however, there are certain fields to which special attention should be paid:

- **Upper left corner** (“Attending Dentist's Statement”): Check the appropriate box to indicate if your claim is for predetermination (estimate of services to be performed) or for services actually received.
- **Sponsor's ID** (Field 6): The sponsor's nine-digit Social Security Number (SSN) **must** appear on every family member's claim form.
- **Patient's mailing address** (Field 8): Be sure to provide the current and complete mailing address to include APO/FPO and/or street, city, country and postal mailing code.
- **Telephone number** (Field 9): Enter the patient's daytime and evening telephone number including applicable city and country codes.
- **Area below field 9**: Must be signed by the patient, parent or guardian. If the family member is under 18 years old, the parent or guardian must sign the form.
- **Is the patient covered by another dental plan?** (Field 12): Check “No” if the family member has no other dental insurance. If the family member has additional dental insurance, please check “Yes” and include the plan name, SSN, group number, and address of the other carrier.
- **Area below field 12**: Sign **if** the family member, parent, or guardian wants to assign payment of benefits to the dentist. This means that **the TDP contractor** will send payment directly to the dentist.
- **Dentist's address** (Field 14): Enter the dentist's complete mailing address to include street, city, country and postal mailing code.
- **Dentist's phone number** (Field 15): Provide the dentist's telephone number including all applicable city and country codes.
- **Managed Care Contractor Dentist No.** (Field 16): Provide the dentist's Managed care contractor identification number, if known.
- **Examination and Treatment Plan** (Field 27): Provide a detailed description of the services performed including applicable tooth number(s), the date of service, and the fee charged. If services and fees are listed on the dentist's bill, attach the bill to this claim form. In this case, you do not need to duplicate the information in this section.
- **Bottom left corner**: The dentist must sign and date here **if** this claim form is used solely as the dentist's bill. If a bill is submitted with the claim form, and the bill clearly identifies the dentist, the dentist's signature is not required.

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

General Instructions

- Submit a separate claim form for each family member who receives treatment.
- All claim forms should be submitted to the managed care contractor as soon as possible after the service date, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.
- The family member must sign the appropriate sections of the claim form. If the family member is under 18 years old, the parent or guardian must sign the form.
- If you receive care in a non-remote country, submit a completed copy of this claim form along with a valid Non-Availability and Referral Form and the provider's bill to the address on the front of this form.
- For orthodontic care in remote countries, submit a completed copy of this claim form along with a valid Non-Availability and Referral Form and the provider's bill to the address on the front of this form. For nonorthodontic care, only the completed claim form and the provider's bill is required.

Remember

You must submit the following information:

- 1) A completed claim form.
- 2) The dentist's bill (if the claim form is not used solely as the bill).
- 3) A Non-Availability and Referral Form (except for non-orthodontic care in remote locations).

If all necessary information is not included, your claim will be denied.

- END -

