CHAPTER 12
SECTION 12.2

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:_____________________________

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

	Sponsor	Patient	Sponsor	Host Nation Provider		HCDP DMIS			Purpose	Reason For Referral*		Apv.	
ICN	SSN	Name	Name	Name And Address	Dates	ID Code	ICD9	CPT[1] Code	Visit	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

[1] CPT codes, descriptions and other data only are copyright 2002 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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
Albania
Algeria
Angola
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia-Herzegowina
Botswana
Bulgaria
Burundi
Cameroon
Chad
Congo, Democratic Republic
Croatia
Cyprus
Czech Republic
Denmark
Djibouti
Egypt
Eritrea
Estonia
Ethiopa
Finland
France
Gabon
Georgia
Germany
Ghana
Greece
Greenland
Guinea, Republic of
Hungary
Ireland
Israel
Italy
Ivory Coast (Cote D'Ivoire)
Jordan
Kazakhstan
Kenya
Kuwait
Kyrgyzstan

TRICARE EUROPE
Latvia
Lebanon
Liberia
Lithuania
Macedonia
Mali
Malta
Moldova
Morocco
Mozambique
Namibia
Netherlands
Niger
Nigeria
Norway
Oman
Pakistan
Poland
Portugal
Qatar
Romania
Russia Federation
Rwanda
Saudi Arabia
Senegal
Serbia - Montenegro
Seychelles
Slovakia
Slovenia
South Africa
Spain
Sweden
Switzerland
Syria
Takjistan
Tanzania
Togo
Tunisia
Turkey
Turkmenistan
UAE (United Arab Emirates)
Uganda
Ukraine
United Kingdom

TRICARE EUROPE
Uzbekistan
Yemen
Zambia
Zimbabwe

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
American Samoa
Australia
Bangladesh
Cambodia (Kampuchea)
China
Fiji
Hong Kong
India
Indonesia
Laos
Madagascar
Malaysia
Mongolia
Myanmar (Burma)
Nepal
New Zealand
Northern Mariana Islands
Palau, Republic of
Philippines
Singapore
Sri Lanka
Taiwan
Thailand
Vietnam

TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN
Antigua
Argentina
Bahamas
Barbados
Belize
Bolivia
Brazil
Chile
Colombia
Costa Rica
Dominica Republic
Ecuador
El Salvador
Grenada
Guatemala
Guyana
Haiti
Honduras
Jamaica
Mexico
Netherlands Antilles
Nicaragua
Panama
Paraguay
Peru
Surinam
Trinidad & Tobago
Uruguay
Venezuela
Virgin Islands, U.S.

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
Tirana, Albania
Algier, Algeria
Luanda, Angola
Yerevan, Armenia
Vienna, Austria
Baku, Azerbaijan
Minsk, Belarus
Sarajevo, Bosnia-Herzegowina
Gaborone, Botswana
Sofia, Bulgaria
Bujumbura, Burundi
Yaounde, Cameroon
N'Djamena, Chad
Kinshasa, Congo Democratic Republic of the Kinsha
Zagreb, Croatia
Nicosia, Cyprus
Brno, Czech Republic
Prague, Czech Republic
Copenhagen, Denmark
Djibouti, Djibouti
Cairo, Egypt
Ismail, Egypt
Maadi, Egypt
New Maadi, Egypt
Asmara, Eritrea
Tallinn, Estonia
Addis-Ababa, Ethiopa
Helsinki, Finland
Istres, France
Libreville, Gabon
Accra, Ghana
Athens, Greece
Larissa, Greece
Nuuk, Greenland
Budapest, Hungary
Dublin, Ireland
Tel Aviv, Israel
Rome, Italy
Abidjan, Ivory Coast or Cote D'Ivoire
Amman, Jordan
Almaty, Kazakhstan
Nairobi, Kenya
Al-Kuwayt, Kuwait
Riga, Latvia
Beirut, Lebanon

TRICARE EUROPE
Monrovia, Liberia
Vilinus, Lithuania
Skopje, Macedonia
Chisinau, Moldova
Rabat, Morocco
Maputo, Mozambique
Windhoek, Namibia
The Hague, Netherlands
Rotterdam, Netherlands
Niamey, Niger
Lagos, Nigeria
Oslo, Norway
Stavanger, Norway
Madinat Qaboos, Oman
Islamabad, Pakistan
Warsaw, Poland
Lisbon, Portugal
Ad-Dawhah, Qatar
Bucharest, Romania
Moscow, Russia
Dharham, Saudi Arabia
Jeddah, Saudi Arabia
Riyadh, Saudi Arabia
Dakar, Senegal
Bratislava, Slovakia
Ljubljana, Slovenia
Pretoria, South Africa
Cape Town, South Africa
Madrid, Spain
Stockholm, Sweden
Bern, Switzerland
Damascus, Syria
Tunis, Tunisia
Ankara, Turkey
Izmir, Turkey
Kiev, Ukraine
Tashkent, Uzbekistan
Sanaa, Yemen
Lusaka, Zambia
Harare, Zimbabwe
Brussels, Belgium
Bujumbura, Burundi
Djibouti, Djibouti
Asmara, Eritrea
Paris, France
Tbilisi, Georgia
Berlin, Germany

TRICARE EUROPE
Bonn, Germany
Bremerhaven, Germany
Flensbury, Germany
Garmish-Partenkirchen, Germany
Kalkar, Germany
Muenster, Germany
Munich, Germany
Conakry, Republic of Guinea
Jerusulem, Israel
Ghedi, Italy
Milan, Italy
Poggio Renatico, Italy
Valetta, Italy
Bishkek, Kyrgustan
Bamako, Mali
Valletta, Malta
Muscat, Oman
Karachi, Pakistan
St. Petersberg, Russia
Vladivostock, Russia
Kigala, Rwanda
Belgrade, Serbia-Montenegro
Seychelles, Seychelles
Johannesburg, South Africa
Valencia, Spain
Chambessy, Switzerland
Geneva, Switzerland
Dushanbe, Tajikistan
Dar Es Salaam, Tanzania
Lome, Togo
Istanbul, Turkey
Ashgabat, Turkmenistan
Kampala, Uganda
Abu Dhabi, United Arabian Emirates
Dubai, United Arab Emirates
Croughton, United Kingdom
Fairford, United Kingdom
Menwith Hall, United Kingdom

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
Pago Pago, American Samoa
Nuuuli, American Samoa
Alice Springs, Australia
Brisbane, Australia
Canberra, Australia
Darwin, Australia
Edinburgh, Australia
Exmouth, Australia
Katherine, Australia
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

TRICARE PACIFIC
Taipei, Taiwan
Chiangmai, Thailand
Nakhon Ratchasima, Thailand
Nonthaburi, Thailand
Pattaya City, Thailand
Phuket, Thailand
Da Nang, Vietnam
Hanoi, Vietnam
Ho Chi Minh City, Vietnam

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
English Harbour, Antigua
Buenos Aires, Argentina
AUTEC, Bahamas
Nassau, Bahamas
Bridgetown, Barbados
Belize City, Belize
La Paz, Bolivia
Brasilia, Brazil
Rio, Brazil
Sao Pablo, 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

TRICARE LATIN AMERICA, CANADA, & CARIBBEAN BASIN
Caracas, Venezuela

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

TRICARE EUROPE COUNTRIES
Afghanistan
Albania
Algeria
Andorra
Angola
Armenia
Ascention Island
Austria
Azerbaijan
Bahrain
Bassas da India
Belarus
Belgium
Benin
Bosnia
Botswana
Bowet (Bouvel) Island
Bulgaria
Burkina-faso
Burundi
Cameroon
Cape Verde Island
Central Africa Republic
Chad
Camoro Island
Congo (Brazzaville)
Croatia
Cyprus
Czech Republic
Czechoslovakia
Democratic Republic of Kongo
Denmark
Djibouti
Egypt (United Arab Emirates)
Eritrea
Equatorial Guinea
Estonia
Ethiopa
Faroe Island
Finland
France
Gabon
Gambia
Georgia
Germany
Ghana

TRICARE EUROPE COUNTRIES
Gibraltar
Greece
Greenland
Guernsey
Guinea, Republic of
Guinea-bissau
Herzegovina
Hungary
Iceland
Ile Europa
Iran
Iraq
Iraq-Saudi Arabia Neutral Zone
Ireland
Isle of Man
Israel
Italy
Ivory Coast (Cote D' Ivoire)
Jersey
Jordan
Kazakhstan
Kenya
Kuwait
Kyrgyzstan
Latvia
Lebanon
Lesotho
Liberia
Libya
Liechtenstein
Lithuania
Luxembourg
Macedonia
Malawi
Mali
Malta
Mauritania
Moldova
Monaco
Morocco
Mozambique
Namibia
Netherlands
Niger
Nigeria
Norway

TRICARE EUROPE COUNTRIES
Oman
Pakistan
Poland
Portugal
Qatar
Romania
Russia
Rwanda
St. Helena
St. Pierre and Miquelon
Saotane an Principe
San Marino
Saudi Arabia
Senegal
Serbia (Serbia-Montenegro)
Seychelles
Sierra Leone
Slovakia
Slovenia
Somalia
South Africa
Spain
Sudan
Svalbard and Jan Mayan
Swaziland
Sweden
Switzerland
Syria
Tajikistan
Tanzania
Togo
Tunisia
Turkey
Turkmenistan
Uganda
Ukraine
United Arab (Arabian) Emirates
United Kingdom
Uzbekistan
Vatican City (Holy City)
Western Sahara (Port of Morocco)
Yemen
Yugoslavia
Zaire
Zambia
Zimbabwe

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

Figure 12-12.2-6 List Of Overseas Countries By Region (Continued)

TRICARE Latin America, Canada, & Caribbean Basin Countries
Arguilla
Antigua
Argentina
Bahamas
Barbados
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

TRICARE Latin America, Canada, & Caribbean Basin Countries
Trinidad and Tobago
Turks and Caicos Islands
Uraguay
Venezuela
Virgin Islands, U.S.

Figure 12-12.2-7 Regional Director Active Duty Program Non-Authorized Stateside Claims Report

	Sponsor	Patient	Sponsor	Provider		HCDP DMIS			Purpose	Reason For Referral*	APV.	
ICN	SSN	Name	Name	Name And Address	Dates	ID Code	ICD9	CPT[1] Code	Visit	A	Y	N
19981733260365 A	123 45 6789	Smith, Ann S.	Smith, John M.	Bauman, Peter 121 Jay Street Aurora, CO 80045	11-01-00-11-15-00							
19981753245002 A	987 65 4321	Jones, Sally	Jones, Tom M.	Shepherd, Cameran * 425 Cello Drive Arvada, CO 80005	11-02-00-11-05-00							

* A = Authorization

[1] CPT codes, descriptions and other data only are copyright 2002 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.

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**)

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

City State Zip

Telephone Number is:

(Home) (   ) -

(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

JULY 2002

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 Centretech 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).
- Notify TRICARE Management Activity, Chief Claims Operations Office, 16401 E. Centretech Parkway, Aurora, CO 80011 immediately when POC, POC address, commercial phone and fax number change.

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 Centretech Parkway, Aurora, CO 80011.
    - ➢ TDP issues to the TRICARE Management Activity, Chief, Special Contract Operations Office, 16401 East Centretech 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 190 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 Centretech Parkway, Aurora, CO 80011.
  - ➢ TDP issues to the TRICARE Management Activity, Chief, Special Contract Operations Office, 16401 East Centretech 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.
- Remember to state on the claim form who payment should be made to: Beneficiary or Provider.

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

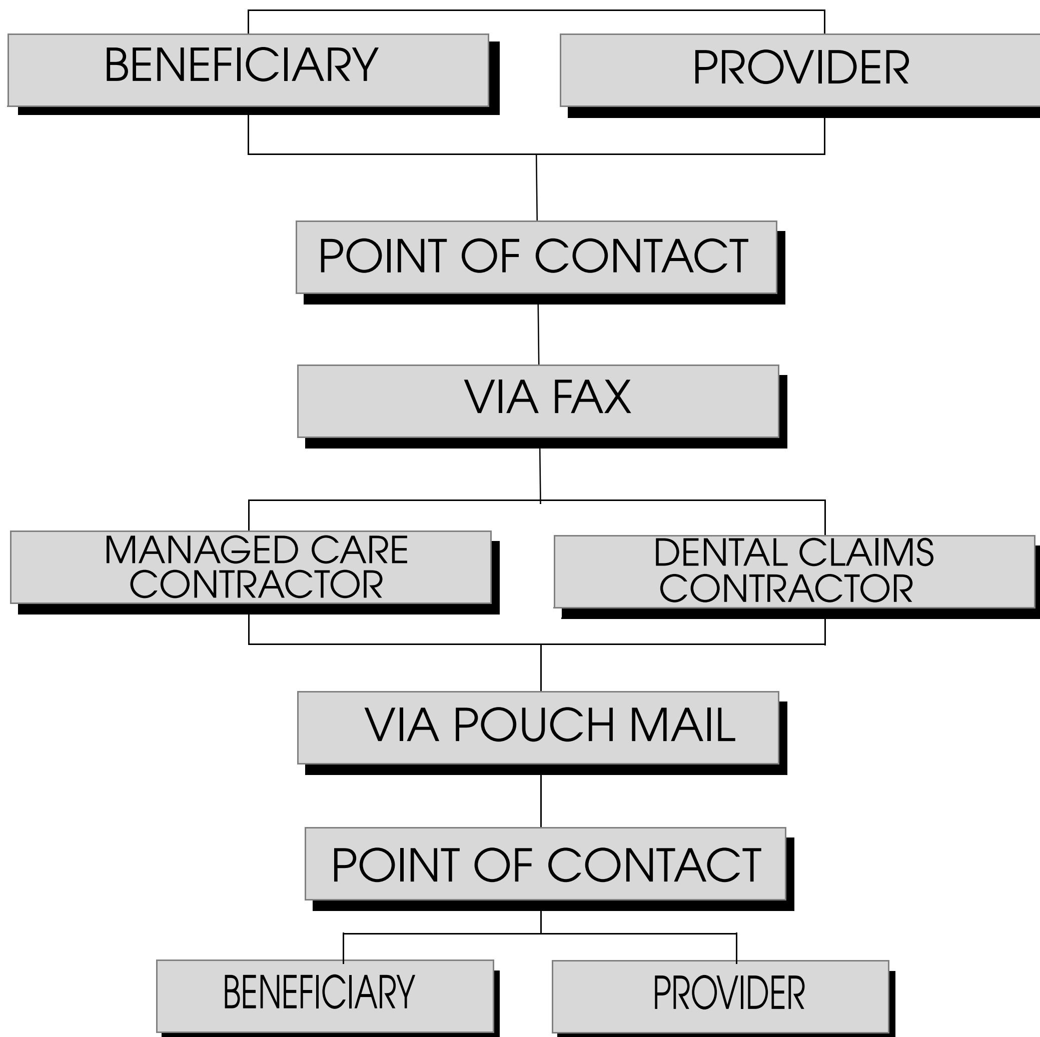

FIGURE 12-12.2-11 TOP AND TDP POINT OF CONTACT PROGRAM (CONTINUED)

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

1. PATIENT'S NAME (Last, First, Middle Initial)
2. PATIENT'S DATE OF BIRTH (MMDDYY)
3. PATIENT'S ADDRESS (Street, City, State, and ZIP Code)
TELEPHONE (Include Area Code)
4. PATIENT'S SEX (X one) — MALE / FEMALE
5. MILITARY/VA IDENTIFICATION CARD INFORMATION
a. CARD NO.
b. ISSUE DATE (MMDDYY) c. EFFECTIVE DATE (MMDDYY) d. EXPIRATION DATE (MMDDYY)
6. PATIENT'S RELATIONSHIP TO SPONSOR (X one) — SELF / SPOUSE / NATURAL or ADOPTED CHILD / STEPCHILD / OTHER (Specify):
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 / NO
ADDRESS (Include ZIP Code)
b. TYPE OF COVERAGE (X one) — Employment (Group) / Private (Non-Group) / MEDICAID / MEDICARE / Student Plan / Other (Specify)
c. OTHER IDENTIFICATION NUMBER
d. EFFECTIVE DATE (MMDDYY)
e. OTHER PROGRAM THROUGH EMPLOYMENT? — YES / NO
EMPLOYER NAME
15. REASON FOR CONDITION (X all that apply) — YES / NO
a. WORK RELATED
b. MILITARY SERVICE RELATED
c. AUTOMOBILE ACCIDENT RELATED
16. INPATIENT/OUTPATIENT CARE
OUTPATIENT
INPATIENT-SKILLED NURSING FACILITY
INPATIENT HOSPITAL WITHIN CATCHMENT AREA (Attach DD Form 1251)
INPATIENT-EMERGENCY
INPATIENT HOSPITAL-OUTSIDE CATCHMENT AREA
PROGRAM FOR THE HANDICAPPED
INPATIENT-OTHER
17. DESCRIBE CONDITION FOR WHICH YOU RECEIVED TREATMENT. IF AN INJURY, NOTE HOW IT HAPPENED.
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

SECTION II - SPONSOR INFORMATION

7. SPONSOR'S NAME (Last, First, Middle Initial)
8. SPONSOR'S SOCIAL SECURITY NO. OR VA ID NO.
9. VA STATION NO.
10. SPONSOR'S DUTY STATION OR ADDRESS FOR RETIREES
TELEPHONE (Include Area Code)
11. SPONSOR'S BRANCH OF SERVICE (X one) — USA / USAF / USMC / USN / USCG / USPHS / NOAA / VA
12. SPONSOR'S GRADE/RANK
13. SPONSOR'S STATUS (X one) — ACTIVE DUTY / RETIRED / DECEASED

SECTION III - PHYSICIAN/OTHER PROVIDER (Items 19 through 33 are to be completed by the physician or other provider)

19. REFERRING PHYSICIAN
a. NAME
b. ADDRESS (Include ZIP Code)
c. TELEPHONE (Include Area Code)
d. (X one) — PRIVATE PRACTICE / UNIFORMED SERVICES
20. FACILITY WHERE SERVICES RENDERED (Other than home/office)
a. NAME
b. ADDRESS (Include ZIP Code)
21. PROVIDER OF SERVICES — ATTENDING PHYSICIAN / OTHER (Specify)
22. HOSPITALIZATION INFORMATION
a. ADMISSION DATE (MMDDYY) b. DISCHARGE DATE (MMDDYY)
23. LAB WORK OUTSIDE YOUR OFFICE? — YES / NO / 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 PROCEDURES/SUPPLIES FOR EACH DATE. SUBMIT REPORT EXPLAINING UNUSUAL SERVICES OR CIRCUMSTANCES	e. DIAGNOSIS CODE	f. CHARGES	LEAVE BLANK

26. PATIENT'S ACCOUNT NO.
27. PROVIDER'S SOCIAL SECURITY NO.
28. PROVIDER'S EMPLOYER I.D. NO.
29. PHYSICIAN OR OTHER PROVIDER
a. NAME
b. ADDRESS (Include ZIP Code)
c. TELEPHONE (Include Area Code) d. PROVIDER NO.
g. TOTAL CHARGES $
30. AMT. PD. BY BENEFICIARY $
31. AMT. PD BY OTHER INSURANCE $
32. AGREEMENT TO PARTICIPATE (Read reverse) — YES / 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.

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

Privacy Act Statement

AUTHORITY: 44 U-S-C §3101; 10 U.S.C §§1079 and 1086; 38 U-S-C S613; 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 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.

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

PATIENT/SPONSOR INFORMATION – ITEMS 1 – 18

Items 1 through I8 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.)

BENEFICIARY/PATIENT CERTIFICATION - ITEM 18

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.

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.

(NOTE: The above is also certified if Item 18 is signed by the sponsor, other parent or guardian.)

PROVIDER PARTICIPATION - ITEM 32

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.

(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.)

PROVIDER CERTIFICATION – ITEM 33

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.

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.

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.

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).

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)*
☐ SELF ☐ STEPCHILD
☐ SPOUSE ☐ OTHER *(Specify)*
☐ NATURAL OR ADOPTED CHILD

5. PATIENT'S DATE OF BIRTH *(YYYYMMDD)*

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 INSTRUCTIONS 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 *(YYYYMMDD)*
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 *(YYYYMMDD)*	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." 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 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 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.

DD FORM 2642 (BACK), NOV 1999 COPY 1 - PATIENT'S COPY

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

- PATIENT'S COPY -

CHAMPUS CLAIM PATIENT'S REQUEST FOR MEDICAL PAYMENT	*Form Approved* *OMB No. 0720-0006* *Expires Sep 30, 2002*

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 (0704-0006), 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.

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.

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 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.

* * * * * *

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.

* * * 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 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.

DD FORM 2642, NOV 1999 PREVIOUS EDITION IS OBSOLETE. COPY 1 - PATIENT'S COPY

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

ATTENDING DENTIST'S STATEMENT

Check One: ☐ Dentist's pre-treatment estimate
☒ Dentist's statement of actual services

Patient name: Jane J. Doe — Relationship to sponsor: spouse X — Patient birthdate: 10 27 57 — School: Education University, Frankfurt

Sponsor's name: First James, Middle T., Last Doe — Branch of service: Army

Sponsor's social security no.: 999-99-9999 — Group name: TRICARE Family Member Dental Plan

Patient mailing address: Box 1267, APO AE 01234 (Germany)

Is patient covered by another dental plan? Yes — Dental plan name: Dental Insurance Company
Insured SSN: 111-11-1111 — Group no.: 000123450
Name and address of carrier: Dental Insurance Company, 1415 Main Street, Chicago, IL

Daytime telephone number: (011)0711-638472 — Evening telephone number: (011)0711-527361

I have reviewed the following treatment plan. I authorize release of any information relating to this claim:
PATIENT OR PARENT/GUARDIAN SIGN HERE 1/5/99
Signature (patient or parent if minor) — Date

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dental listed below:
PATIENT OR PARENT/GUARDIAN MUST SIGN HERE: HE/SHE WANTS PAYMENT TO GO TO DENTIST 1/5/99
Signature (Insured person) — Date

Dentist name: Dr. Franz Schmidt
Mailing address: Kabingstrase 30, 54270 Fürth (Germany)
Dentist phone no.: (011)1487-439-465

Is treatment result of occupational illness or injury? No ✓
Is treatment result of auto accident? No ✓
Other accident? No ✓
Are any services covered by another plan? Yes ✓
Is this initial placement? No ✓
Is treatment for orthodontics? No ✓

First visit date current series: 1/5/99 — Place of treatment: Office X

27. Examination and treatment plan—list in order from Tooth No. 1 through Tooth No. 32 – Use charting system shown.

Tooth no. or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo/Day/Yr	Procedure code	Fee charged	Amount paid
		(B) Examination	(C) 1/5/99		(D)	
(A) 12		(B) Filling on one surface	(C) 1/5/99		(D)	

Note: If the claim form is used as the dentist's bill, then include the following information as shown above: (A) tooth number (B) description of services provided (C) date of service (D) fee charged. (If individual fee service charge is known, please enter. If not known, enter total fee charged.)

28. Remarks for unusual services:

Note: If services are listed on the dentist's bill attach the bill to this claim. You do not need to complete this section.

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties. I hereby certify that the procedures as indicated by date have been completed.

Dentist must sign here unless bill is attached and dentist's name is listed on the bill. — Signature (Dentist)
Complete unless date is on the attached bill — Date

TOTAL FEE CHARGED (D) 50 DM — AMOUNT PAID

OCONUS

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 NonAvailability 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 -