CHAPTER 11
ADDENDUM A

FIGURES

FIGURE 11-A-1 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is not mandatory.

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

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

Dear _____:

(Use first paragraph only if the recipient has advised the contractor of an overpayment.) Thank you for your recent notification that this office made an erroneous payment on claims in your **(Or Beneficiary's Name)** behalf. We appreciate your cooperation in bringing this matter to our attention. **(If the first paragraph is not applicable, use the following introductory paragraph to the letter;)** The purpose of this letter is to inform you that an overpayment may have been made to you. We are required to provide you with the following information:

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

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

FIGURE 11-A-1 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (AT-RISK FUNDS INVOLVED) (CONTINUED)

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

(If administrative costs will be assessed for expenses in collection of the debt the debtor must be advised of these charges. Assessment of these charges must be approved by the TRICARE Management Activity (TMA)).

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

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

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

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

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

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

FIGURE 11-A-1 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (AT-RISK FUNDS INVOLVED) (CONTINUED)

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

Sincerely,

(Signature)
(Title)

Enclosure:
Self-addressed envelope

FIGURE 11-A-2 ILLUSTRATION OF DD FORM 2527 - "STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY"

STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY
CHAMPUS / CHAMPVA

Form Approved
OMB No. 0720-0003
Expires Jan 31, 1994

IF A PREADDRESSED ENVELOPE IS NOT ENCLOSED WITH THIS FORM, PLEASE RETURN YOUR COMPLETED FORM TO EITHER OF THESE LOCATIONS:

(1) THE CHAMPUS CLAIMS PROCESSOR WHO SENT YOU THE FORM; OR

(2) THE CHAMPUS CLAIMS PROCESSOR FOR THE STATE / COUNTRY IN WHICH YOU RECEIVED THE MEDICAL CARE (the Health Benefits Advisor at your nearest military installation can provide you with this address).

Public reporting burden for this collection of information is estimated to average 57 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0090), Washington, DC 20503.

PRIVACY ACT STATEMENT

AUTHORITY: 42 U.S.C. 2651 - 2653; 10 U.S.C. 1079, 1085, 1086 and 1092; E.O. 9397; 38 U.S.C. 613.

PRINCIPAL PURPOSE(S): To assist in determining possible third party liability for medical supplies and services claims under CHAMPUS/CHAMPVA. Information requested is used in reviewing claims to obtain additional information to determine proper liability of third parties for claims and to facilitate possible recovery by the United States for improperly paid claims.

ROUTINE USE(S): Information 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 collections agencies in connection with recoupment claims; and to members of Congress with the consent of the individual involved. Appropriate disclosures may be made to other Federal, state, local and/or foreign law enforcement 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 a claims processing delay and may result in denial of the claim.

INSTRUCTIONS

According to information submitted with your recent CHAMPUS or CHAMPVA claim, you were treated for an injury of some kind. Because the CHAMPUS claim form does not include information about how you were injured, we are asking that you also complete this form. The Federal Medical Recovery Act, 42 U.S.C. 2651-2653, allows the Government to be reimbursed for its costs of treating you, if you were injured in an accident caused by someone else. The Government can often recover its costs from (1) the person who caused the accident or that person's insurance company; or (2) the owner of the property where the accident occurred or the owner's insurance company. The Government also may be able to recover its costs from (1) any insurance company which insures your family for hospital and medical expenses; or (2) your employer's Worker's Compensation or other insurance, if you were injured at work.

If you were not treated for an injury, please describe the circumstances of your treatment in the Remarks section on Page 1. If you do not believe that someone else caused your injury, please describe in detail the circumstances surrounding your injury in the Remarks section on Page 1. If you use the Remarks section for either of these purposes you do not need to complete the rest of the form. However, be sure to sign and return it according to the other instructions you have received.

This form is to be completed by persons who have received medical care at Government expense or by a responsible family member. In cases of young children, this form should be completed by a parent or guardian.

Answer all questions in as much detail as possible. The information you provide may be of great help to the Government and to you in recovering from the person who caused your injuries. We suggest you retain a copy of this form for your own use.

The words "None," "N/A," and "Unknown" should be inserted where appropriate.

Attach additional sheets where necessary to provide complete information.

Complete all items to the best of your knowledge. **BE SURE TO SIGN AND DATE THE FORM ON PAGE 5. RETURN IT WITHIN 10 DAYS.**

IMPORTANT

This information is requested solely for the purpose of processing your CHAMPUS reimbursement claim. It has no bearing on any legal action you may pursue as a result of your injury. All questions you may have regarding possible legal actions should be referred to an attorney. Do not execute a release or settle any personal injury claim you may have without notice to a military claims officer.

DD Form 2527, NOV 91 *Previous editions are obsolete* Detachable Front Cover

FIGURE 11-A-2 ILLUSTRATION OF DD FORM 2527 - "STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY" (CONTINUED)

STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY
CHAMPUS

SECTION I - GENERAL INFORMATION

1. SPONSOR

a. SPONSOR'S NAME *(Last, First, Middle Initial)*	b. SSN

2. INJURED BENEFICIARY

a. INJURED BENEFICIARY'S NAME *(Last, First, Middle Initial)*	b. AGE	c. RELATIONSHIP TO SPONSOR *(X one)*
		☐ SELF ☐ NATURAL/ADOPTED CHILD ☐ STEPCHILD ☐ SPOUSE ☐ FORMER SPOUSE ☐ OTHER

d. HOME ADDRESS *(Street, Apartment Number, City, State, ZIP Code)*	e. SPONSOR'S ADDRESS *(If different from injured beneficiary's) (Street, Apartment Number, City, State, ZIP Code)*
TELEPHONE NO. *(Include Area Code)*	TELEPHONE NO. *(Include Area Code)*

SECTION II - REMARKS

3. USE THIS SECTION TO DESCRIBE IN YOUR OWN WORDS HOW YOU WERE INJURED.

SECTION III - NON-VEHICULAR ACCIDENTS
Complete if injuries did not result from a motor vehicle accident. If injuries resulted from a vehicular accident, go to Section IV.

4. LOCATION

a. SITE OF INJURY *(Street/Place, City, County, State)*	b. TIME *(Hour)* ☐ A.M. ☐ P.M.	c. DATE *(YYMMDD)*

d. NAME AND ADDRESS OF OWNER OF PROPERTY WHERE INJURY OCCURRED	e. NAME OF OCCUPANT OF PROPERTY *(If different from Owner)*

5. PERSONS INVOLVED

a. NAME *(Last, First, Middle Initial)*	b. ADDRESS *(Street, City, State, ZIP Code)* AND TELEPHONE NO. *(Include Area Code)*

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FIGURE 11-A-2 ILLUSTRATION OF DD FORM 2527 - "STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY" (CONTINUED)

SECTION III - NON-VEHICULAR ACCIDENTS *(Continued)*

6. WITNESSES

a. NAME *(Last, First, Middle Initial)*	b. ADDRESS *(Street, City, State, ZIP Code)* AND TELEPHONE NO. *(Include Area Code)*

7. POLICE INVESTIGATION

a. WAS AN INVESTIGATION CONDUCTED? *(If Yes, state by whom (e.g.,City/ State Police, Sheriff's Dept.)*	b. WAS ANYONE ARRESTED OR CITED AS CAUSING THE ACCIDENT? *(If Yes, give name and charge)*	c. DISPOSITION OF CASE *(e.g., Dismissal, Fine, Jail Sentence)*
☐ YES ☐ NO	☐ YES ☐ NO	

d. EXPLAIN IN YOUR OWN WORDS WHO WAS AT FAULT AND WHY

e. WERE OTHER FAMILY MEMBERS INJURED IN THE ACCIDENT? *(If Yes, give name(s) and relationship)*

☐ YES
☐ NO

f. WAS THE ACCIDENT WORK RELATED? *(If Yes, state circumstances)*

☐ YES
☐ NO

8. INSURANCE

a. INSURANCE COMPANY OF OWNER OF PROPERTY WHERE INJURY OCCURRED *(e.g., Homeowner's Insurance Company)*	b. INSURANCE COMPANY OF PERSON WHO CAUSED ACCIDENT *(If different from Item a.)*	c. YOUR OWN INSURANCE COMPANY
(1) COMPANY NAME	(1) COMPANY NAME	(1) COMPANY NAME
(2) ADDRESS *(Include ZIP Code)*	(2) ADDRESS *(Include ZIP Code)*	(2) ADDRESS *(Include ZIP Code)*
(3) POLICY NUMBER	(3) POLICY NUMBER	(3) POLICY NUMBER
(4) AMOUNTS AND TYPES OF COVERAGE	(4) AMOUNTS AND TYPES OF COVERAGE	(4) AMOUNTS AND TYPES OF COVERAGE

SECTION IV - VEHICULAR ACCIDENT

Attach a copy of the official police report to this form.

9. ADDITIONAL INFORMATION ON VEHICULAR ACCIDENT

a. INJURED BENEFICIARY'S AUTOMOBILE INSURANCE COMPANY	b. INSURANCE COMPANY'S ADDRESS *(Include ZIP Code)*
c. INSURANCE COMPANY TELEPHONE NO. *(Include Area Code)*	

d. POLICY NUMBER	e. AMOUNTS AND TYPE OF COVERAGE			
	(1) LIABILITY	(2) MEDICAL PAYMENT	(3) UNINSURED MOTORIST	(4) NO FAULT
	$	$	$	$

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FIGURE 11-A-2 ILLUSTRATION OF DD FORM 2527 - "STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY" (CONTINUED)

SECTION IV - VEHICULAR ACCIDENT *(Continued)*

9.f. WAS ACCIDENT REPORTED TO YOUR INSURANCE COMPANY? *(If No, explain)*	g. HAS YOUR INSURANCE COMPANY ASSIGNED A CLAIM OR FILE NUMBER? *(If Yes, provide number)*
☐ YES ☐ NO	☐ YES ☐ NO

h. WAS ACCIDENT WORK RELATED? *(If Yes, state circumstances)*

☐ YES
☐ NO

SECTION V - MISCELLANEOUS

10. GOVERNMENT HOSPITALIZATION
If you were hospitalized or expect to be hospitalized in a government hospital, complete the following:

a. NAME OF HOSPITAL	b. ADDRESS *(Include ZIP Code)*	c. DATES HOSPITALIZED FROM	c. DATES HOSPITALIZED TO	d. IS TREATMENT COMPLETED? *(X one)* YES	d. IS TREATMENT COMPLETED? *(X one)* NO

11. YOUR ATTORNEY

a. ATTORNEY'S NAME	b. ADDRESS *(Street, City, State, ZIP Code)*
c. TELEPHONE NO. *(Include Area Code)*	

12. RELEASE STATEMENTS

a. HAVE YOU FURNISHED ANYONE OTHER THAN THE POLICE A STATEMENT AS TO WHAT HAPPENED? *(If Yes, to whom was it given?)*	b. HAVE YOU SIGNED ANY RELEASE OR WAIVER OF RIGHTS? *(If Yes, to whom was it given?)*
☐ YES ☐ NO	☐ YES ☐ NO
c. HAVE YOU RECEIVED ANY OFFER OF SETTLEMENT FOR YOUR INJURY? *(If Yes, from whom?)*	d. HAVE YOU ACCEPTED ANY SETTLEMENT? *(If Yes, from whom and how much?)*
☐ YES ☐ NO	☐ YES ☐ NO

SECTION VI - CERTIFICATION

13. I have completed this form and state that the information is true to the best of my knowledge and belief. Federal Laws (18 USC 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.

a. YOUR SIGNATURE	b. DATE SIGNED *(YYMMDD)*

DD FORM 2527, OCT 94 Page 4 of 4 Pages

FIGURE 11-A-3 LIABILITY QUESTIONNAIRE TRANSMITTAL LETTER

NOTE: To be dated same day as mailed.

_____ SPONSOR SSN _____
_____ CLAIM # _____
_____ PROVIDER _____

Dear_____:

We recently received a claim from you or your medical care provider for medical services required by (you/your dependent) which reflected a diagnosis code between 800 and 999. The diagnosis codes are utilized by medical providers, insurance companies, and medical benefit programs, such as TRICARE and Medicare, to reflect the nature of a patient's illness or injury. Diagnosis codes between 800 and 999 often, but not always, indicate that the patient suffered an accidental injury or illness. Because of the diagnosis code or codes on your claim form, we must ask you to complete the enclosed DD Form 2527 (Statement of Personal Injury--Possible Third Party Liability).

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

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

Remember, if you have other health coverage, including medical coverage obtained through a homeowner's insurance policy, your employment, student insurance, workers' compensation, personal injury protection or medical coverage through a no-fault, uninsured, or underinsured motorist clause of an automobile insurance policy, TRICARE cannot pay your claims until the other insurer has issued its payment toward your medical bills. The other insurer must also be listed on your TRICARE claim. A copy of the Explanation of Benefits from your other insurance company must be sent in with your TRICARE claim. If your claim is denied by the primary insurer, you must provide proof of the denial with your TRICARE claim. Any attempt to conceal the existence of other insurance that is primary to TRICARE constitutes fraud and may subject you to civil or criminal penalties. All insurance is primary to TRICARE except Medicaid and insurance which is specifically designed to supplement TRICARE benefits.

FIGURE 11-A-3 LIABILITY QUESTIONNAIRE TRANSMITTAL LETTER (CONTINUED)

Your claims for medical care will be held in a suspense status pending the completion and return of the enclosed DD Form 2527. To expedite the processing of your claim, please return the completed form with this letter within 10 days in the enclosed, self-addressed envelope. Please follow the instructions on the form carefully. If you were injured in an automobile accident, you may attach a copy of the police report in lieu of completing the section of the form entitled Vehicular Accidents. If any question on the form does not apply to you, please indicate that fact by placing an "N/A" in the appropriate block. Please utilize the block which invites you to describe in your own words how you were injured. Do not forget to sign the form. Forms that have not been fully completed and signed will be returned to you, and your suspended claims will be denied.

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

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

Sincerely,

(Signature)
(Title)

Enclosures:
DD Form 2527
Self-addressed envelope

FIGURE 11-A-4 TRANSMITTAL LETTER TO GOVERNMENT CLAIMS OFFICER

_____
_____
_____

REFERENCE: Beneficiary:
Sponsor:
Sponsor's SSN:

Dear Sir or Madam:

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

Pursuant to 32 CFR 199, your office is responsible for the development of this case with respect to third party liability. Should you determine that this case warrants further action, any additional information you may need will be provided upon your request. Please contact **(Name Of Contractor Contact)** at **(Telephone Number Of Contractor Contact)** for assistance.

Sincerely,

(Signature)
(Title)

Enclosures:
(EOBs)
(DD Form 2527)

FIGURE 11-A-5 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TRICARE Management Activity (TMA).

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

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

Dear _____:

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

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

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

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

FIGURE 11-A-5 SAMPLE LETTER TO BENEFICIARY REGARDING OVERPAYMENT (RECOUPMENT) (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

(Continued from overpayment explanation above.) Additionally, federal agencies are required to assess a penalty charge, not to exceed six percent per year, upon any portion of the amount you owe that is outstanding for more than 90 days, as well as administrative costs, based upon the costs incurred in processing and handling the case.

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

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

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

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

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

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

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

Sincerely,

(Signature)
(Title)

Enclosure:
Self-addressed envelope

FIGURE 11-A-6 SAMPLE LETTER TO PROVIDER REGARDING OVERPAYMENT (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

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

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

Dear _____:

(Use first paragraph only if the recipient has advised the contractor of an overpayment.) Thank you for your recent notification that this office made an erroneous payment on claims in your (or beneficiary's name) behalf. We appreciate your cooperation in bringing this matter to our attention. The law requires that we provide you with the following information:

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

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

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

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

FIGURE 11-A-6 SAMPLE LETTER TO PROVIDER REGARDING OVERPAYMENT (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

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

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

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

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

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

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

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

Sincerely,

(Signature)
(Title)

Enclosure:
Self-addressed envelope

FIGURE 11-A-7 SAMPLE LETTER TO BENEFICIARY OR PROVIDER ADVISING OF OFFSET (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

NOTE: To be dated same day as mailed.

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

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

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

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

1. Apply all payments of future claims to the overpayment until the amount is recouped.

2. Refer the overpayment to Office of General Counsel, TMA for collection which will result in added administrative costs and fees as well as an adverse credit rating.

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

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

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

Sincerely,

(Signature)
(Title)

Enclosures:
(self-addressed envelop)
(initial demand letter)

FIGURE 11-A-8 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE LESS THAN $600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

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

DATE:	**(Enter date mailed.)**
SSN:	**(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter debtor's SSN, if known. Leave blank if debtor's SSN is not available.)**
PRINCIPAL:	
INTEREST:	**(Enter interest on principal at current rate for 30 days.)**
TOTAL DUE:	

Dear _____:

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

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

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

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

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

FIGURE 11-A-8 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE LESS THAN $600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

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

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

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

Sincerely,

(Signature)
(Title)

Enclosures:
Initial demand letter
Self-addressed envelope

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

_____ _____
Social Security Number Signature

FIGURE 11-A-9 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE $600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

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

DATE:	**(Enter date mailed.)**
SSN:	**(If debtor is the sponsor, enter sponsor's SSN; if debtor is not the sponsor, enter debtor's SSN, if known. Leave blank if debtor's SSN is not available.)**
PRINCIPAL:	
INTEREST:	**(Enter interest on principal at current rate for 30 days.)**
TOTAL DUE:	

Dear _____:

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

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

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

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

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

FIGURE 11-A-9 SAMPLE FOLLOW-UP LETTER TO BENEFICIARY (ACCOUNT BALANCE $600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

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

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

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

Sincerely,

(Signature)
(Title)

Enclosures:
Initial demand letter
Self-addressed envelope

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

_____ _____
Social Security Number Signature

FIGURE 11-A-10 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE LESS THAN $600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

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

DATE: **(Enter date mailed.)**
TIN: **(Enter provider's taxpayer identification number, if known. If unknown, leave blank.)**
PRINCIPAL:
INTEREST: **(Enter interest on principal at current rate for 30 days.)**
TOTAL DUE:

Dear _____:

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

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

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

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

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

FIGURE 11-A-10 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE LESS THAN $600) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

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

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

Sincerely,

(Signature)
(Title)

Enclosure
Initial demand letter
Self-addressed envelope

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

_____ _____

Taxpayer's Identification Number or Social Security Number

Signature

FIGURE 11-A-11 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE $600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

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

DATE: **(Enter date mailed.)**
TIN: **(Enter provider's taxpayer identification number, if known. If unknown, leave blank.)**
PRINCIPAL:
INTEREST: **(Enter interest on principal at current rate for 30 days.)**
TOTAL DUE:

Dear _____:

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

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

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

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

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

FIGURE 11-A-11 SAMPLE FOLLOW-UP LETTER TO PROVIDER (ACCOUNT BALANCE $600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 30 DAYS (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

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

If we do not hear from you, your file will be transferred to the TRICARE Management Activity - Aurora and involuntary collection action will be initiated. This may include administrative offset of other Federal funds owed you or a referral to the Department of Justice for appropriate legal action.

Sincerely,

(Signature)
(Title)

Enclosures:
Self-addressed envelope)
(Initial demand letter)

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

_____ _____

Taxpayer's Identification Number or Social Security Number

Signature

FIGURE 11-A-12 PROMISSORY NOTE IN REPAYMENT OF PRE-EXISTING DEBT (NOT-AT-RISK FUNDS INVOLVED)

The note must be printed back to back.

1. Obligation - For value received, I (we, jointly and severally,) the maker(s), promise to pay to the order of **(Insert Name of Contractor)**, the principal sum of _____ dollars, with interest accruing from _____, 19__ at the rate of ___ percent per year. I (we) hereby acknowledge and admit the validity and amount of that preexisting debt which the principal sum stated in this note is intended to repay.

2. Installments - This note is to be paid in monthly installments payable at (**Insert Name and Address of Contractor)**, on or before the _____ day of the month) beginning on _____, 19__, and continuing until either the principal sum and all interest and other charges assessed under the provisions of this note have been fully paid, or this note is considered to be in default. The monthly installment amounts shall be not less than _____ dollars beginning on _____, and not less than _____ dollars beginning on _____.

3. Administrative Charges - Administrative charges to cover the costs incurred by the United States in handling and processing past due amounts will be assessed at the rate of $5.00 for each payment more than 30 days past due; an additional $12.00 for each payment more than 60 days past due; and an additional $15.00 for each payment more than 90 days past due.

4. Late Payment Penalties - Late payment penalties will be assessed on any amounts more than 90 days past due, at the rate of six percent per year.

5. Payment Crediting - The payments that I (we) make under this note will be credited as of the date received by the **(TRICARE Contractor Name)**, first to outstanding penalties and administrative charges; second to accrued interest; and third to the outstanding principal sum. Any payments that I (we) made to the United States on this debt during the period from the date from which interest accrues under this note (as specified in paragraph 1) until the effective date of this note (as specified in paragraph 10.) shall be applied to the principal sum, interest, and other charges accruing under this note in accordance with the provisions of this paragraph.

6. Default, Acceleration, and Other Remedies - If any installment shall remain unpaid for a period of 30 days or more, this note shall at the option of the United States be considered to be in default. In the event of default, the full amount of the principal sum, together with any accrued interest and other charges assessed under this note, less any payments actually received by the United States from me (us), shall be due and payable in full immediately, without the need for further demands or notices to me (us). Furthermore, in that event, the United States may exercise any collection options legally available to it, including but not limited to, taking administrative offset, filing adverse credit reports to local and national credit bureaus, and referring my (our) account for legal action.

7. Default Costs and Fees - In the event of default, I (we) agree to pay all reasonable collection costs, court costs, and attorney's fees incurred by the United States as a result of the default and any appropriate collection actions taken by the United States.

8. Controlling Law - Except where controlled by Federal Law, all disputes concerning this note shall be controlled by the law of the jurisdiction in which I (we) reside at the time this note is signed.

FIGURE 11-A-12 PROMISSORY NOTE IN REPAYMENT OF PRE-EXISTING DEBT (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

9. Changes - The provisions of this note may not be changed except by a written agreement which specifies the agreed upon changes and which is signed by both me (us) and an authorized representative of the United States.

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

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

SIGNED:

_____	_____	_____
Maker's signature	Maker's name (printed)	Maker's address

_____
Date

_____	_____	_____
Maker's signature	Maker's name (printed)	Maker's address

_____
Date

_____	_____	_____
Maker's signature	Maker's name (printed)	Maker's address

_____
Date

FIGURE 11-A-13 COVER SHEET - CASE RECOUPMENT

At-Risk Not-At-Risk (circle one) RCN or ICN:_____

Debtor's SSAN or TIN: _____

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

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

Debtor's Last Name: _____ First: _____ Middle Initial: ___

Debtor's Address Line 1: _____

Debtor's Address Line 2: _____

Debtor's Address Line 3: _____

City: _____ State: _____ Zip Code: _____

Debtor's Telephone: _____ Ext.: _____

Contractor Number (Prime Contractor): _____ , Region:_____

Date Of Initial Demand Letter: _____ Date Debt Discovered: _____ ,

Reason For Overpayment: _____
(Numeric Entry)

Original Amount Of Debt: _____ Offset Status: _____

Sponsor's Last Name: _____ First: _____ Middle Initial: ____

Sponsor's Address Line 1: _____

Sponsor's Address Line 2: _____

Sponsor's Address Line 3: _____

City: _____ State: _____ Zip Code: _____

Sponsor's Telephone: _____ Ext:_____

Sponsor's SSAN:_____

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

Beneficiary's Last Name: _____ First: _____ Middle Initial: ____

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

No. of Months Left Unpaid on Installment Agreement: _____

Date Last Installment Payment Received: _____

Scheduled Amount of Installment Payment:_____

Interest Rate: _____

Principal Balance Due: _____ Principal Paid to Date:_____

Interest Balance Due: _____ Interest Paid to Date: _____

Interest Paid YTD: _____

Due Date of Last Unpaid Installment Payment: _____

FIGURE 11-A-14 CODES TO BE USED WHEN COMPLETING THE COVER SHEETS (NOT-AT-RISK FUNDS INVOLVED)

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

FIGURE 11-A-15 DELINQUENCY NOTICE (NOT-AT-RISK FUNDS INVOLVED)

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

Account Receivable Number:

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

Dear _____:

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

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

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

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

Your prompt attention to this matter will be appreciated.

Sincerely,

(Signature)
(Title)

NOTE: These notices may be sent in duplicate, so that one copy may be returned with the debtor's next installment payment. Contractors who wish to vary the substance of the delinquency notice must contact the Chief, Recoupment Division, TMA, before doing so.

FIGURE 11-A-16 SAMPLE FINAL DEMAND LETTER (ACCOUNT BALANCE $600 OR MORE) IF NO RESPONSE TO REFUND REQUEST WITHIN 90 DAYS (NOT-AT-RISK FUNDS INVOLVED)

NOTE: Use of this letter is mandatory unless an alternative has been approved by the Office of General Counsel, TMA.

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

DATE: **(Enter date mailed.)**
TIN: **(If debtor is the sponsor, enter sponsor's SSN. If debtor is not the sponsor, enter debtor's SSN, if known; unknown leave blank.)**
PRINCIPAL:
INTEREST: **(Enter interest on principal at current rate for 90 days.)**
TOTAL DUE:

Dear _____:

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

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

(Address of the Contractor)

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

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

Sincerely,

(Signature)
(Title)

Enclosures:
Promissory Note

FIGURE 11-A-17 EXAMPLE OF REPAYMENT AMORTIZATION (NOT-AT-RISK FUNDS INVOLVED)

NUMBER	INTEREST	AMORTIZED	BALANCE	ACCUM. INT
PRINCIPAL $1000 AT 8% FOR 0 YEARS 24 MONTHS				
REGULAR PAYMENT = $45.2243				
1	$ 6.67	$ 38.5543	$ 961.446	$ 6.67
2	6.41	38.8143	922.631	13.08
3	6.15	39.0743	883.557	19.23
4	5.89	39.3343	844.223	25.12
5	5.63	39.5943	804.628	30.75
6	5.36	39.8643	764.764	36.11
7	5.10	40.1243	724.64	41.21
8	4.83	40.3943	684.245	46.04
9	4.56	40.6643	643.581	50.60
10	4.29	40.9343	602.647	54.89
11	4.02	41.2043	561.442	58.91
12	3.74	41.4843	519.958	62.65
YR. 1	**$62.65**	**$480.042**		
1	$3.47	$41.7543	$478.204	$66.12
2	3.19	42.0343	436.169	69.31
3	2.91	42.3143	393.855	72.22
4	2.63	42.5943	351.261	74.85
5	2.34	42.8843	308.376	77.19
6	2.06	43.1643	265.212	79.25
7	1.77	43.4543	221.758	81.02
8	1.48	43.7443	178.013	82.50
9	1.19	44.0343	133.979	83.69
10	0.89	44.3343	89.6448	84.58
11	0.60	44.6243	45.0205	85.18
12	0.30	45.0205	0.00	85.48
LAST PAYMENT = $45.32				
YR. 2	**$22.83**	**$519.958**		
DIFFERENCE IN TOTAL INTEREST PAID IS DUE TO ROUNDING-OFF				

FIGURE 11-A-18 LETTER TO BENEFICIARY WHOSE CLAIM WAS OFFSET AGAINST DEBT OWED BY PARTICIPATING PROVIDER (NOT-AT-RISK FUNDS INVOLVED)

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

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

Dear _____:

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

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

Sincerely,

(Signature)
(Title)

Enclosure

FIGURE 11-A-19 LETTER ESTABLISHING INSTALLMENT PAYMENT AGREEMENT WHEN THE DEBT DOES NOT EXCEED $600.00 (NOT-AT-RISK FUNDS INVOLVED)

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

RE: Sponsor SSN:
Patient:
Claim Number:
Accounts Receivable Number:

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

Dear _____:

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

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

(Name and Address of Contractor)

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

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

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

Your cooperation in this matter is appreciated.

Sincerely,

(Signature)
(Title)

FIGURE 11-A-20 SAMPLE CALCULATION AND APPLICATION OF INTEREST (NOT-AT-RISK FUNDS INVOLVED)

Principal: $1000.00

Interest Rate: 8%

Monthly Installment Amount: $45.22

Initial Demand Letter Mailed: 01/05/2000

Debtor Requests Installment Repayment Agreement: 03/03/2000

Promissory Note Prepared by contractor on 03/05/2000; First Installment Due 04/05/2000 (or it may be 04/01/2000, if the contractor chooses to have all installment payments due on the first of each month). For purposes of this example, it is assumed that the due date is 04/05/2000.

1. Debtor's first payment of $45.22 received 04/03/2000.

   Interest on $1000 from 01/05/2000 until 04/03/2000: Interest = Number of days since last computation of interest (or date interest began to accrue) x daily rate x principal balance.

   88 days x .0002191 (1/365 x .08) x $1000 = $19.29

   Monthly Installment Payment ($45.22) less Interest ($19.29) = $25.93 (apply to principal balance). New principal balance is $974.07. Payment acknowledgment notice issued. Next installment of $45.22 is due 05/05/2000.

2. (Debtor's second payment of $50.00 received 05/07/2000.)

   Interest on $974.07 from 04/03/2000 until 05/07/2000:

   34 days x .0002191 (daily interest rate calculated above) x $974.07 = $7.26

   Monthly Payment ($50.00) less Interest ($7.26) = $42.74 (apply to principal balance). New principal balance is $931.33. Payment acknowledgment notice issued. Debtor paid the 05/05/2000 installment, plus $4.78 toward the 06/05/2000 installment.

3. Delinquency notice issued 07/10/2001 (35 days after due date).

   Debtor's third payment of $40.00 received 07/12/2001.

   Interest on $931.33 from 05/07/1990 until 07/12/2001:

   66 days x .0002191 (daily interest rate) x $931.33 = $13.47

   Monthly Payment ($40.00) less Interest ($13.47) = $26.53 (apply to principal balance). New principal balance is $904.80. Payment acknowledgment notice is issued. Debtor paid $40.00 toward the 06/05/2000 installment. He owes 44 cents on the 06/05/2000 installment and $45.22 on the 07/05/2000 installment. Debtor must be advised that in order to bring his account current, he must remit $45.66 to cover the balance due on the June installment and the entire July installment. Since the account is not delinquent by two installments ($45.22 x 2) the case is not referred to TMA.

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

FIGURE 11-A-21 SAMPLE PAYMENT ACKNOWLEDGMENT (NOT-AT-RISK FUNDS INVOLVED)

Thank you for your installment payment in the amount of $45.22, which was received April 3, 2000. This payment has been applied as follows toward repayment of your indebtedness to TRICARE:

INTEREST CHARGES:	$19.29
PRINCIPAL:	$25.93
YOUR REMAINING PRINCIPAL BALANCE IS:	$974.07

YOUR NEXT INSTALLMENT PAYMENT IS DUE 05/05/2000.

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

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

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED)

U.S. Department of Justice

Financial Statement of Debtor
(Submitted for Government Action on Claims Due the United States)
(NOTE: Use additional sheets where space on this form is insufficient or continue on reverse side of pages.)

Authority for the solicitation of the requested information is one or more of the following: 5 U.S.C. 301, 901 (see Note, Executive Order 6166, June 10, 1933); 28 U.S.C. 501, *et seq.*; 31 U.S.C. 951, *et seq.*; 44 U.S.C. 3101; 4 CFR 101, *et seq.*; 28 CFR 0.160, 0.171 and Appendix to Subpart Y.

The principal purpose for gathering this information is to evaluate your capacity to pay the Government's claim or judgment against you. Routine uses of the information a established in the following U.S. Department of Justice Case File Systems published in Vol. 42 of the Federal Register: Justice/CIV-001 at page 53321; Justice/TAX-001 at page 1534 Justice/USA-005 at pages 53406-53407; Justice/USA-007 at pages 53408-53410, Justice/CRIM-016 at page 12774. Disclosure of the information is voluntary. If the request information is not furnished, the U.S. Department of Justice has the right to such disclosure of the information by legal methods.

Your Social Security account number is helpful for identification, but you are not required to indicate it if you do not desire to do so.

1. **What is your:**

   a) Full legal name _____

   b) Other names you have ever used _____

   c) Date of birth _____

   d) Social Security Number _____

   e) Driver Licence No. _____

   Issued by state of _____

   f) Residence Address _____

   _____
   (Include City, State, & Zip Code)

   g) Residence telephone (____) _____

   h) Business address _____

   _____
   (Include City, State, & Zip Code)

   Business telephone (____) _____

2. **Employment:**

   a) Full name of current employer _____

   b) Employer address _____

   _____
   (Include City, State, & Zip Code)

   c) Employers telephone No. (____) _____

   d) How long have you worked there? _____

   e) Job title _____

   f) Monthly take-home pay _____
   (Do Not deduct savings-account deposits, etc.)

Monthly Salary (wages):	Monthly Commissions:	Monthly Other:	Monthly Total:

FORM OBD-500

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

g) What is your yearly gross income? _____

h) What was your annual net income last year? _____

i) What was the source of your income last year? _____

_____

_____

j) Last employer's Name and Address? _____

_____

_____
(City, State, & Zip Code)

Length of employment _____

k) If you are self-employed, what is:

Your business licence No. _____

Where are you licenced? _____

Name of business _____

Type of business _____

Address of business _____

Telephone of business _____

Do you own all of the business (yes) or (no)
If no, state:

Date you acquired your interest _____

Present value of your interest _____

Percentage of total your interest represents _____

_____

How and when do you draw or receive money from such business? _____

Your office or position _____

Full name and address of each officer and director or partner, or other part owner.

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

Name _____ Address _____

Name _____ Address _____

Name _____ Address _____

For any bank or other institution at which the business maintains any type of account, state:

Name and address of Institution	Type of Account	Name on Account	Average Daily Balance

3. **If any article of incorporation or partnership or certificate of doing business under an assumed name were filed with any government agency by any business named above, state:**

(a) Nature of document filed _____

(b) Location of office where filed _____

(c) Date of filing _____

4. **If your spouse (husband/wife), children or relatives living with you are employed, then state:**

Full Name	Relation to you	Full name and complete address of employer

5. **Date last Tax Returned Filed** _____ INCLUDE A COPY OF YOUR TAX RETURNS, FEDERAL & STATE

Single _____ Joint _____

Gross Income reported $ _____

6. **If you expect to inherit money, when, from whom, approximate amount**

_____

_____

3

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

7. FINANCIAL DATA

MONTHLY EXPENSES
(List all bills or loans that are paid on a monthly basis)

	MONTHLY	TO WHOM PAID	BALANCE DUE
Rent:			
Mortgage:			
Taxes & Insurance:			
Food:			
Laundry:			
Gasoline:			
Babysitter:			
Gas & Electric:			
Phone:			
Cable TV:			
Water:			
Sewer:			
Trash pickup:			
Insurance: auto:			
health:			
life:			
property (if included in Mortgage so state):			
Drugs:			
Medical/Dental:			
Child Support:			
Alimony:			

4

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

INSTALLMENTS

	MONTHLY PAYMENT	TO WHOM PAID	BALANCE DUE
Car:			
Credit Cards:			
Other loans: (personal, business, etc.)			
Other monthly payments:			
Any other debts you owe?			
Judgments you owe?			

8. **ASSETS**

A) **Checking Accounts:**

a) Bank name: _____

Bank branch: _____

Account Number: _____

In name of: _____

B) **Savings Account:**

a) Bank name: _____

Bank branch: _____

Account Number: _____

In name of: _____

5

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

C) **Stocks and Bonds, Certificate of Deposits, or other securities:**

With whom:

Account Number:

Value:

Pension:

Profit Sharing:

D) **If you, your spouse, or any member of your family living with you have a motor vehicle, trailer, motorcycle, aircraft, boat or other recreational vehicle of any sort, then state:**

	1st Vehicle	2nd Vehicle	3rd Vehicle
Year			
Make			
Model			
License No.			
Motor No.			
Registration No. (aircraft/boats)			
Serial No.			
State			
Est. Value			
Lienholder			
Amt Owed			
Title in Name of			
Present Location			

6

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

Usual Location _____ _____ _____

E) **If you own any firearms, then state:**

Make and Model	Serial Number	Exact Present Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

F) **If you own any Antiques of any kind state:**

Description	Approximate Value	Exact Present Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

G) **If you own any Jewelry/Gold/Silver, state:**

Description	Approximate Value	Exact Present Location
_____	_____	_____
_____	_____	_____
_____	_____	_____

H) **If you own any VCRs, Satellite Antennas, TVs, Stereos, Compact Discs, Computers, Musical Instruments, state:**

Description	Approximate Value	Serial No.	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

7

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

I) **If you own any furniture/Appliances (such as stove, refrigerator, etc.) of any kind, state:**

Description	Approximate Value	Location

J) **If you own any collections of any kind (such as coins, stamps, etc.) state:**

Description	Contents	Estimated Present Market Value	Exact Present Location

K) **If you own any tools or equipment of any sort, state:**

Complete Description of each Piece	Reg. No. Serial No.	Estimated Present Value	Present Location

8

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

L) **If you own any sporting goods or equipment, state:**

Complete Description of each Piece	Reg. No. Serial No.	Estimated Present Value	Present Location

M) **If you own any paintings or other art objects of any kind, state:**

Complete Description of each Piece	Reg. No. Serial No.	Estimated Present Value	Present Location

N) **If you have any other personal property, state:**

Description of each item	Estimated Value	Present Location

O) **Real Estate (include Personal residence):**

Type	Rent/Own	Address of Property	Lienholder

9

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

P) **Other Assets-List, i.e.: Season tickets, Football, Baseball, Basketball, Symphony, etc.**

Description	Approximate Value	Present Location

Q) **If any item of your property has been pledged to secure a debt, state:**

		Item 1	Item 2
(a)	Description of property pledged		
(b)	Amount of debt secured		
(c)	How debt was incurred		
(d)	Date on which debt was incurred		
(e)	Name and address of pledgee:		

Name and Address _____

_____

_____

Name and Address _____

_____

_____

(f) Date on which possession transferred to pledgee _____

9. **Debts owed to you by:**

Name	Address	Type of debt owed	Monthly payment	Balance due

10

FIGURE 11-A-22 FINANCIAL STATEMENT OF DEBTOR, FORM OBD-500 (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

10. **Are you a party in a lawsuit?** (Explain)

_____

_____

_____

_____

11. **Are you a trustee, Executor, or Administrator?** (Explain)

_____

_____

_____

_____

12. **Do you hold a Power of Attorney for someone?** (Explain)

_____

_____

_____

_____

13. **Is anyone holding any money or property on your behalf?**
(Yes or No) (Explain-include name, address, and phone number)

_____

_____

_____

_____

With knowledge of the penalties for false statement provided by 18 United States Code 1001 ($10,000.00 fine and/or five years imprisonment) and with knowledge that this financial statement is submitted by me to affect action by the U.S. Department of Justice. I certify that I believe the above statement is true and that it is a complete statement of all my income and assets, real and personal, whether held in my name or by any other.

_____ _____
Date Signature

11

FIGURE 11-A-23 LETTER ESTABLISHING INSTALLMENT REPAYMENT AGREEMENT WHEN DEBT EXCEEDS $600.00 (NOT-AT-RISK FUNDS INVOLVED)

(RE: Sponsor SSN:
Patient:
Claim Number
Accounts Receivable Number:

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

Dear _____:

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

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

(Address Of Contractor)

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

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

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

Your cooperation in this matter is appreciated.

Sincerely,

(Signature)
(Title)

Enclosure

FIGURE 11-A-24 FINANCIAL AFFIDAVIT TRANSMITTAL LETTER (NOT-AT-RISK FUNDS INVOLVED)

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

RE: Sponsor SSN:
Patient:
Claim Number
Accounts Receivable Number:

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

Dear _____:

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

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

Sincerely,

(Signature)
(Title)

Enclosures:
Financial Statement of Debtor
Self-addressed envelope

FIGURE 11-A-25 LETTER ADVISING DEBTOR THAT HIS ACCOUNT HAS BEEN REFERRED TO TMA (NOT-AT-RISK FUNDS INVOLVED)

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

Accounts Receivable Number:

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

Dear _____:

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

Finance and Accounting Office
TM*A*
16401 East Centretech Parkway
Aurora, CO 80011-90*66*

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

Recoupment Division
Office of General Counsel
TM*A*
16401 East Centretech Parkway
Aurora, CO 80011-90*66*

Sincerely,

(Signature)
(Title)

FIGURE 11-A-26 PROVIDER'S POWER OF ATTORNEY AND AGREEMENT (NOT-AT-RISK FUNDS INVOLVED)

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

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

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

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

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

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

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

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

FIGURE 11-A-26 PROVIDER'S POWER OF ATTORNEY AND AGREEMENT (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

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

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

DATED this _____day of _____, 19__.

_____
(Name of Participating Provider)

_____
(Signature of Provider or Authorized Agent)

Witness:_____

_____
(Provider's Identification Number)

FIGURE 11-A-27 SAMPLE LETTER TO PROVIDER (NOT-AT-RISK FUNDS INVOLVED)

(Enter Name And Address Of Provider)

Patient: _____
Sponsor: _____
Sponsor's SSN:_____

Dear _____:

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

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

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

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

Sincerely,

(Signature)

Enclosure
cc:
(Enter Name and Address Of Beneficiary)

FIGURE 11-A-28 BENEFICIARY'S POWER OF ATTORNEY AND AGREEMENT (NOT-AT-RISK FUNDS INVOLVED)

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

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

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

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

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

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

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

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

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

FIGURE 11-A-28 BENEFICIARY'S POWER OF ATTORNEY AND AGREEMENT (NOT-AT-RISK FUNDS INVOLVED) (CONTINUED)

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

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

DATED this _____day of _____, 19__.

_____
(Signature of Beneficiary)

Witness:_____

_____
(Beneficiary's SSN)

FIGURE 11-A-29 SAMPLE LETTER TO BENEFICIARY (NOT-AT-RISK FUNDS INVOLVED)

(Enter Name And Address Of Beneficiary)

Patient: _____
Sponsor: _____
Sponsor's SSN:_____

Dear _____:

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

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

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

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

Sincerely,

(Signature)

Enclosure

Figure 11-A-30 Biannual Report Of Claims Paid By TRICARE As Primary Insurer Due To OHI Bankruptcy/Insolvency

Beneficiary	Sponsor Name	Sponsor SSN	Provider	Claim #s Paid	Amount Paid By OHI (Assets Distributed)	Amount Of TRICARE Over Payment (If Any)	Date Recoupment Initiated

FIGURE 11-A-31 PROVIDER BANKRUPTCY WORKSHEET

CLAIMS PENDED FOR PROVIDER BANKRUPTCY

Provider_____ ,

_____ ,

_____ ,

Provider Number_____

Provider TIN_____

Number of Claims Suspended_____

Value _____

Comments

_____

_____

_____

_____

_____

_____

FIGURE 11-A-32 REFERRAL TO RECOUPMENT DIVISION, TMA

(Use Of this form is not mandatory)

COLLECTIONS MADE BY OFFSET/REFUND

PRIME CONTRACTOR NUMBER: _____ ***DATE OF REPORT:*** _____

DEBTOR NAME: _____

DEBTOR SSN OR TIN: _____

SPONSOR NAME: _____

DATE REFERRED TO TMA: _____

ORIGINAL AMOUNT OF DEBT: _____

BALANCE OF TIME OF REFERRAL: _____

CURRENT PAYMENT INFORMATION

DATE: _____ ***AMOUNT OF PAYMENT ON CLAIM:*** $ _____

PAYMENT HAS BEEN RECEIVED THROUGH: OFFSET _____ ***REFUND*** _____

EXPLANATION:

OFFSET INFORMATION:

FORM COMPLETED BY: