CHAPTER 8
SECTION 1

GENERAL

1.0. PURPOSE

The purpose of the TRICARE claims processing procedures is to help ensure that all claims for care received by TRICARE beneficiaries are processed in a timely and consistent manner and that government-furnished funds are expended only for those services or supplies authorized by law and Regulation. The contractor shall review all claims submitted and accept HIPAA transaction and code sets. The review must ensure that sufficient information is submitted to determine:

- The patient is eligible.
- The provider of services or supplies is authorized under the TRICARE Program.
- The service or supply provided is a benefit.
- The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.
- The beneficiary is legally obligated to pay for the service or supply (except in the case of free services).
- That the claim contains sufficient information to determine the allowable amount for each service or supply.

NOTE: Throughout this chapter, where the word "beneficiary" is used with respect to a required action, it is to be understood that the spouse, parent or legal guardian of a minor or incompetent beneficiary may act in behalf of that person, unless there is a specific requirement to the contrary in the text.

2.0. WHO MAY FILE A CLAIM

2.1. Beneficiary/Provider

Any TRICARE eligible beneficiary or any individual who meets the requirements for eligibility under TRICARE, as determined by one of the Uniformed Services, may file a claim. Any institutional or individual professional provider approved under TRICARE may file a claim on a participating basis for services or supplies provided to a beneficiary and receive payment directly from TRICARE. The contractor shall deny any charge imposed by the provider relating to completing and submitting the applicable claim form (or any other related information). Such charges shall not be billed separately to the beneficiary by the

provider nor shall the beneficiary pay the provider for such charges. These charges are to be reported as noncovered charges and denied as such.

2.2. State Agency

A state agency who administers the Medicaid Program may submit a claim, if there has been an agreement signed between the agency and TMA. (Refer to the TRICARE Reimbursement Manual, Chapter 1, Section 20.)

2.3. Participating Provider - Agency Agreement With A Third Party

Occasionally, a participating provider may enter into an agency agreement with a third party to act on its behalf in the submission and the monitoring of third party claims, including TRICARE claims. Such arrangements are permissible as long as the third party is not acting simply as a collection agency. There must be an agency relationship established in which the agent is reimbursed for the submission and monitoring of claims, but the claim remains that of the provider and the proceeds of any third party payments, including TRICARE payments, are paid to the provider. The contractor can deal with these agents in much the same manner as it deals with the provider's accounts receivable department. However, such an entity is not the provider of care and cannot act on behalf of the provider in the filing of an appeal unless specifically designated as the appealing party's representative in the individual case under appeal. Questions relating to the qualifications of any such business entity should be referred to the TMA Office of General Counsel for resolution.

3.0. TRICARE CLAIM FORMS

3.1. Confidentiality

TMA and the TRICARE contractor shall hold the information confidential except when:

- Disclosure is specifically authorized by the beneficiary.
- Disclosure is necessary to permit authorized government officials to investigate and prosecute criminal actions.
- Disclosure is specifically authorized or required under the terms of the Privacy Act or Freedom of Information Act. TMA and TRICARE contractors may, without consent or notice to a beneficiary, release to or obtain from any insurance company or other organization, governmental agency, provider or person any information with respect to any beneficiary when such release constitutes a routine use duly published in the **Federal Register** in accordance with the Privacy Act (5 U.S.C. 522a).

3.2. Acceptable Claim Forms

A properly completed acceptable claim form must be submitted to the contractor before payment may be considered. The contractor shall accept the following claim forms for

TRICARE benefits: the DD Form 2642, the CMS 1500 (08/05), and the CMS 1450 UB-04. The American Dental Association (ADA) claim forms may be used in the processing and payment of adjunctive dental claims.

3.2.1. DD Form 2642, "Patient's Request For Medical Payment" (Figure 8-A-1)

This form is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care. Those include physicians, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Extended Care Health Option (ECHO) providers, or other authorized providers. If a DD Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the CMS 1500 (08/05) or the CMS 1450 UB-04, whichever is appropriate. The new form may be used for services provided in a foreign country but only when submitted by the beneficiary. Contact the TMA Administrative Office to order the DD Form 2642.

4.0. CLAIMS RECEIPT AND CONTROL

All claims shall be controlled and retrievable. The face of each hardcopy TRICARE claim shall be stamped with an individual Internal Control Number (ICN), which will be entered into the automated system within five workdays of actual receipt. For both hardcopy and *Electronic Media Claim (*EMC*)*, the ICN shall contain the Julian date indicating the actual date of receipt. The Julian date of receipt shall remain the same even if additional ICNs are required to process the claim. If a claim is returned, the date of the receipt of the resubmission shall be entered as the new date of receipt. All claims not processed to completion and supporting documentation shall be retrievable by beneficiary name, sponsor's *Social Security Number (*SSN*), Defense Enrollment Eligibility Reporting System (DEERS) family ID,* or ICN within 15 calendar days following receipt.

5.0. NEWBORN CLAIMS

5.1. *Claims for newborns can be processed without eligibility on DEERS as long as:*

- *The newborn date of birth is within 365 days of the contractor's eligibility query; and*
- *The sponsor is/was eligible for TRICARE for the dates of care on the newborn claim.*

5.2. *Newborns are deemed enrolled in Prime as of the day of birth if the uniform service member sponsor is showing as eligible in DEERS (enrolled or non-enrolled), or the non-active duty sponsor or another family member is enrolled in Prime. This deemed enrollment period will continue for 60 calendar days from the newborn's date of birth or until the newborn is formally enrolled in Prime, whichever is earlier. If the newborn is not formally enrolled during the 60-day period, the newborn will revert to a non-enrolled status on the 61st day. Claims for care during the deemed enrollment period will be processed with Prime copayments, according to sponsor's status in DEERS. No referrals are required and Point of Service (POS) provisions do not apply during the deemed enrollment period. See the TRICARE Policy Manual (TPM), Chapter 10, Section 3.1. For additional information on newborns under the TRICARE Retired Reserve (TRR) and TRICARE Reserve Select (TRS) programs, see Chapter 24, Sections 2 and 1 respectively.*