Chapter 8 Section 1

General

Revision:

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 Health Insurance Portability and Accountability Act (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.
- That the claim contains sufficient information to determine the allowable amount for each service or supply.

2.0 WHO MAY FILE A CLAIM

2.1 Beneficiary/Provider

Any TRICARE eligible beneficiary may file a claim. Any institutional or individual professional provider certified 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 Defense Health Agency (DHA). (Refer to the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 20.)

2.3 Participating Provider - Agency Agreement With A Third Party

2.3.1 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 may interact with these agents in much the same manner as it interacts 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 DHA Office of General Counsel (OGC), through the Contracting Officer (CO), for resolution.

2.3.2 On a monthly basis, DHA's Office of Program Integrity (PI) provides each contractor with an updated data file of excluded third party billing agents. Based on this file, the contractor shall not accept any claims from excluded third party billing agents. Any claim received from an excluded third party billing agent shall be returned to the provider, instructing the provider that the submission of a valid claim cannot be done through a sanctioned entity, and to resubmit the claim directly, or through an approved third party billing agent. The contractor shall inform the provider that the third party billing agent has been excluded by Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS) and that no claims will be accepted from the third party billing agent until it has been reinstated. The contractor shall also provide notification to the third party billing agent that no claims will be accepted from it until it has been reinstated by HHS/CMS.

3.0 TRICARE CLAIM FORMS

3.1 Acceptable Claim Forms

3.1.1 A properly completed acceptable claim form must be submitted to the contractor before payment may be considered. For paper claims, the contractor shall accept the latest mandated version of the following claim forms for TRICARE benefits: the DoD Document (DD) Form 2642, the CMS 1500 Claim Form, 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. Electronic claims shall be accepted in HIPAA-compliant standardized electronic transactions (see Chapter 19).

3.1.2 The DD Form 2642, "Patient's Request For Medical Payment" (http://www.dtic.mil/whs/directives/forms/eforms/dd2642.pdf) is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care to include physicians, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Extended Care Health Option (ECHO) providers, or other authorized providers. See Appendix A for a definition of "medical." 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 claim must be resubmitted using either the CMS 1500 Claim Form or the CMS 1450 UB-04, whichever is appropriate. The form may be used for services provided in a foreign country but only when submitted by the beneficiary. Contact the DHA Administrative Office to order the DD Form 2642.

3.1.3 Electronic Claim Forms

When submitting an electronic claim form, the physician, supplier, pharmacy, or their representative is attesting to the same information as provided on the back of a CMS 1500 claim form and a CMS 1450 UB-04.

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), and 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 Uniformed 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 to the effective date of enrollment, 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 shall 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 Reserve Select (TRS) program see Chapter 22, Section 1 and for TRICARE Retired Reserve (TRR) see Chapter 22, Section 2.

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