Chapter 12 Addendum A

Figures

Revision: C-26, May 30, 2018

FIGURE 12.A-1 APPOINTMENT OF REPRESENTATIVE AND AUTHORIZATION TO DISCLOSE INFORMATION

(Reproduce Locally)

SAMPLE FORMAT

I appoint **(Print/Type Name and Address of Representative)** to act as my representative in connection with my appeal under 32 CFR 199.10, Appeal and Hearing Procedures. To avoid the possibility of a conflict of interest, I understand that an officer or employee of the United States (U.S.), to include an employee or member of a Uniformed Service, an employee of a Uniformed Service legal office, a Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM) Provider or a Beneficiary Counseling and Assistance Coordinator (BCAC), is not eligible to serve as a representative. An exception to this is made when an employee of the U.S. or member of a Uniformed Service is representing an immediate family member.

I authorize the Defense Health Agency (DHA) to release to said representative, information related to my medical treatment, and if necessary, photocopies of any medical records which may be required for adjudication of my claim for TRICARE benefits.

I understand that the representative shall have the same authority as the party to the appeal and notice given to the representative shall constitute notice to the party.

This consent will expire upon the issuance of the final agency decision regarding my appeal; however, I reserve the right to withdraw this authorization at any time.

_____

(Date)

_____

(Signature of Person Giving Consent)

Prohibition on redisclosure:

Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable Federal law.

FIGURE 12.A-2 APPEAL SUMMARY LOG, TMA FORM 607

APPEAL SUMMARY LOG

PART I. TO BE COMPLETED BY MANAGED CARE SUPPORT CONTRACTOR

APPEALING PARTY	CONTRACTOR'S CASE IDENTIFICATION NO.	DATE PREPARED

❑ PROVIDER ❑ BENEFICIARY ❑ REPRESENTATIVE	BENEFICIARY	DATE OF BIRTH

APPEALING PARTY'S ADDRESS	❑ TRICARE ENROLLEE ❑ TRICARE STANDARD ❑ TRICARE EXTRA

SPONSOR	SPONSOR SSN	REPRESENTATIVE'S NAME (IF APPLICABLE)

❑ ACTIVE DUTY ❑ RETIRED ❑ DECEASED	BENEFICIARY'S RELATIONSHIP TO SPONSOR

PROVIDER'S INFORMATION (LIST ADDITIONAL PROVIDERS IN COMMENT SECTION)

NAME(S) (ALL PROVIDERS)			BENEFICIARY HELD HARMLESS	
1.	❑ NON-NETWORK	❑ NETWORK	❑ YES	❑ NO
2,	❑ NON-NETWORK	❑ NETWORK	❑ YES	❑ NO
3.	❑ NON-NETWORK	❑ NETWORK	❑ YES	❑ NO
4.	❑ NON-NETWORK	❑ NETWORK	❑ YES	❑ NO
5.	❑ NON-NETWORK	❑ NETWORK	❑ YES	❑ NO

MEDICAL NECESSITY DETERMINATION ❑ FACTUAL DETERMINATION ❑

YES	NO	
❑	❑	PROPER APPEALING PARTY?
❑	❑	BENEFICIARY ELIGIBILITY ESTABLISHED?
❑	❑	DOUBLE COVERAGE? (IF YES, NAME OF OTHER PLAN) _____
❑	❑	MEDICAID COVERAGE?
❑	❑	PARTICIPATING PROVIDER? (IF NON-NETWORK)
❑	❑	NONAVAILABILITY STATEMENT REQUIRED?
❑	❑	TIMELY FILED? (IF YES, DATE MAILED/RECEIVED) _____
❑	❑	WAIVER OF LIABILITY APPLICABLE?

AMOUNT IN DISPUTE DATA (IF ADDITIONAL CLAIMS, LIST ON ADDITIONAL SHEETS)
(See reverse for instructions)

Date Of Service	(a) Initial) Determination Date	(b) ICN(s) Of Claims Appealed	(c) Billed Charges	(d) Allowable Charges	(e) Amount Denied	(f) Deductible Amount	AMOUNT PAID BY (g) Other INS	(h) TRICARE	(i) Cost Share

Comments (Identify Service):

Managed Care Support Contractor Point of Contact:

PART II. TO BE COMPLETED BY NATIONAL QUALITY MONITOR CONTRACTOR (IF APPLICABLE)

SECOND RECONSIDERATION Determination

YES	NO	
❑	❑	PROPER APPEALING PARTY?
❑	❑	TIMELY FILED? (IF YES, DATE MAILED/RECEIVED) _____
❑	❑	WAIVER OF LIABILITY APPLICABLE?
❑	❑	AMOUNT IN DISPUTE REMAINS $900 OR MORE?

TQMC Point of Contact	DATE PREPARED

TMA FORM 607
REV. JAN. 88

FIGURE 12.A-2 APPEAL SUMMARY LOG, TMA FORM 607 (CONTINUED)

PREPARATION OF AMOUNT IN DISPUTE DATA

a. Initial determination date	Enter date of the initial determination, which is usually the TRICARE Explanation of Benefits (EOB) date.
b. ICN(s) of claims appealed	Enter the ICN of each claim being appealed.
c. Billed charges	Enter total amount billed for this (these) claim(s).
d. Allowable charges	Enter total allowable amount. For purposes of determining "amount in dispute," include the amount which would have been "allowable" if the service/supply denied would have been payable.
e. Amount denied	Enter the amount of the "allowable charges," which were denied. Do not include any "allowable charge" reductions.
f. Deductible amount	Enter amount of deductible, if any, applied to this (these) claim(s).
g. Amount paid by other insurance	Enter amount of other insurance payment applicable.
h. Amount paid by TRICARE	Enter amount actually paid by TRICARE on this (these) claim(s).
i. Amount paid by cost-share	Enter amount actually to be paid by the beneficiary/sponsor. If other insurance covers the entire cost-share, enter Ø.

TMA FORM 607
REV. JAN. 88

FIGURE 12.A-3 PROFESSIONAL QUALIFICATIONS, TMA FORM 780

Form Approved
OMB No.: 0720-0005
Expires: 31 May 07

PROFESSIONAL QUALIFICATIONS
MEDICAL/PEER REVIEWERS

The Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining 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 (0720-0005), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

Privacy Act Statement

AUTHORITY:	10 USC 1079, 1086 and 1092
PRINCIPAL PURPOSE:	To solicit the professional qualifications of medical specialists and their credentials for Medical/Peer Reviewers positions. Individuals selected will review medical documentation contained in appeal or hearing case files.
ROUTINE USE:	None.
DISCLOSURE:	Voluntary. No effect on respondents for not providing requested information.

Physician's/Reviewer's Name:	Year of Birth:
Address:	

Medical Education

State:	Year of Degree:
School:	Year of License:
American Specialty Boards:	
Specialties:	
Type of Practice:	
National Scientific Medical Societies:	

CHAMPUS Form 780
May 2004

Previous editions are obsolete

FIGURE 12.A-3 PROFESSIONAL QUALIFICATIONS, TMA FORM 780 (CONTINUED)

PROFESSIONAL APPOINTMENTS		
State:	School:	
Title and Current status		
Other Information:		
SOURCES OF INFORMATION (PROFESSIONAL LISTING)		
Name of Directory:		
Year:	Edition:	Page:
Other Sources:		

CHAMPUS Form 780
May 2004

Previous editions are obsolete

FIGURE 12.A-4 LETTER TO PROPER APPEALING PARTY WHEN REVIEW HAS BEEN REQUESTED BY AN IMPROPER APPEALING PARTY

An appeal in your behalf has been received from **(Name of Person who requested Appeal)**. Under 32 CFR 199.10, **(Name of Person)**, is not an appropriate appealing party, and, consequently, the request cannot be accepted as an appeal.

The TRICARE case file does not indicate that you have appointed anyone as representative to act in your behalf. Therefore, if you wish to appeal you have the following options:

a. Appeal in your behalf.

b. Appoint a representative who may request an appeal in your behalf.

If you intend to appeal in your own behalf or through a duly-appointed representative, the appeal must be received within 20 days of the date of this letter or by the appeal deadline set forth in the initial determination notice (whichever is later).

An Appointment of Representative form is enclosed for your convenience should you wish to appoint a representative. Your correspondence should be addressed to:

(Contractor's Name And Address)

Signature

cc:
Improper Appealing Party

FIGURE 12.A-5 TRICARE APPEALS PROCESS - MEDICAL NECESSITY DENIALS

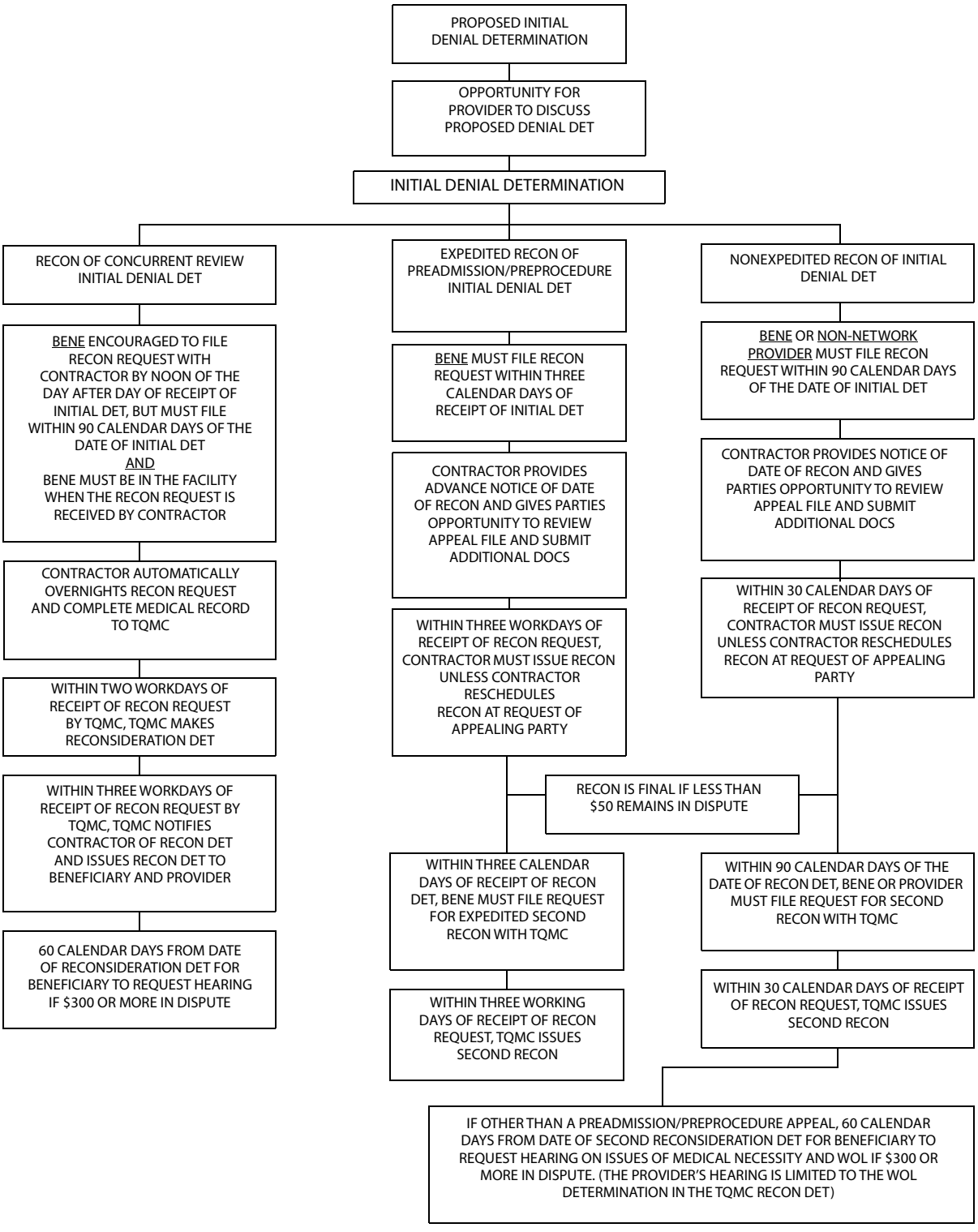

FIGURE 12.A-6 TRICARE APPEALS PROCESS - FACTUAL DETERMINATIONS

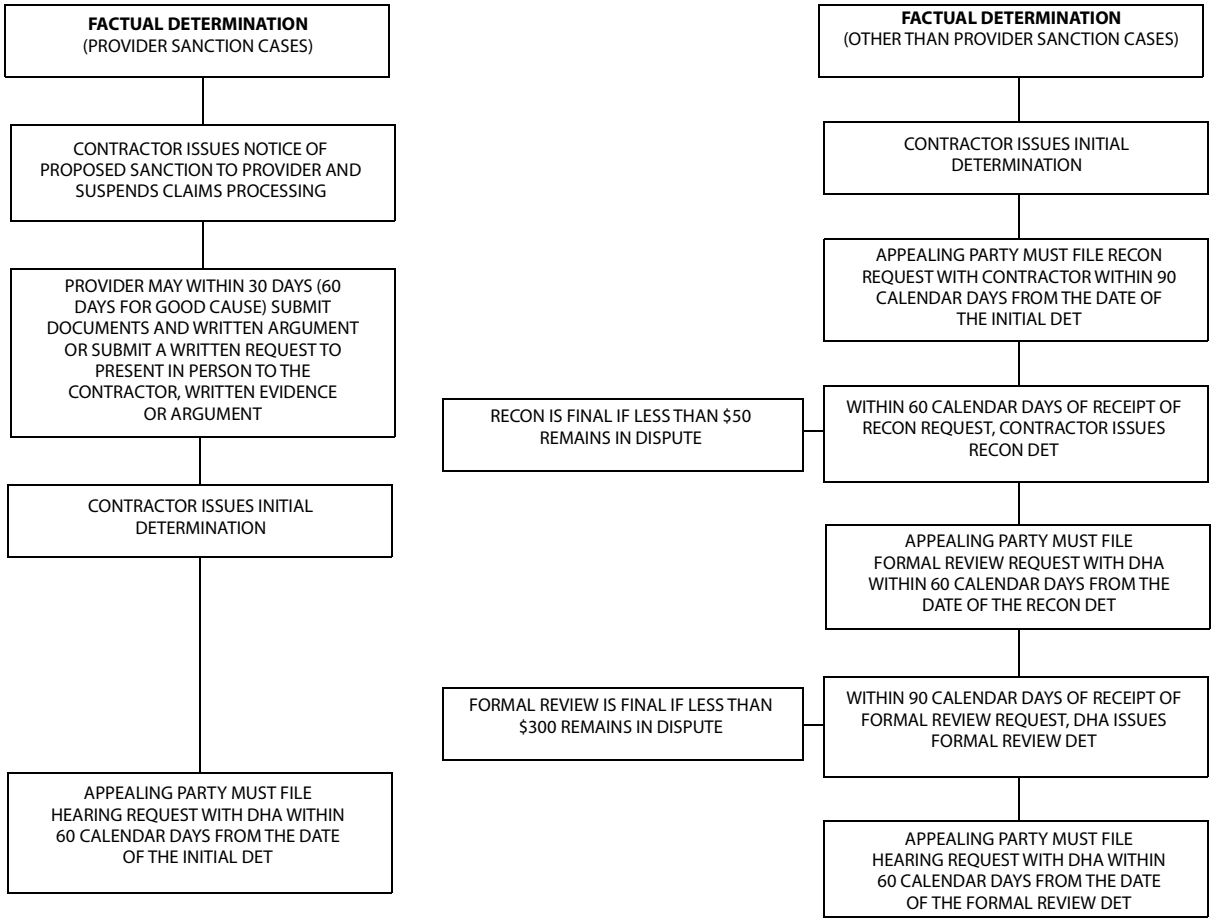

FIGURE 12.A-7 TRICARE/MEDICARE DUAL ELIGIBLE APPEAL PROCESS - MEDICARE PROCESSES CLAIM

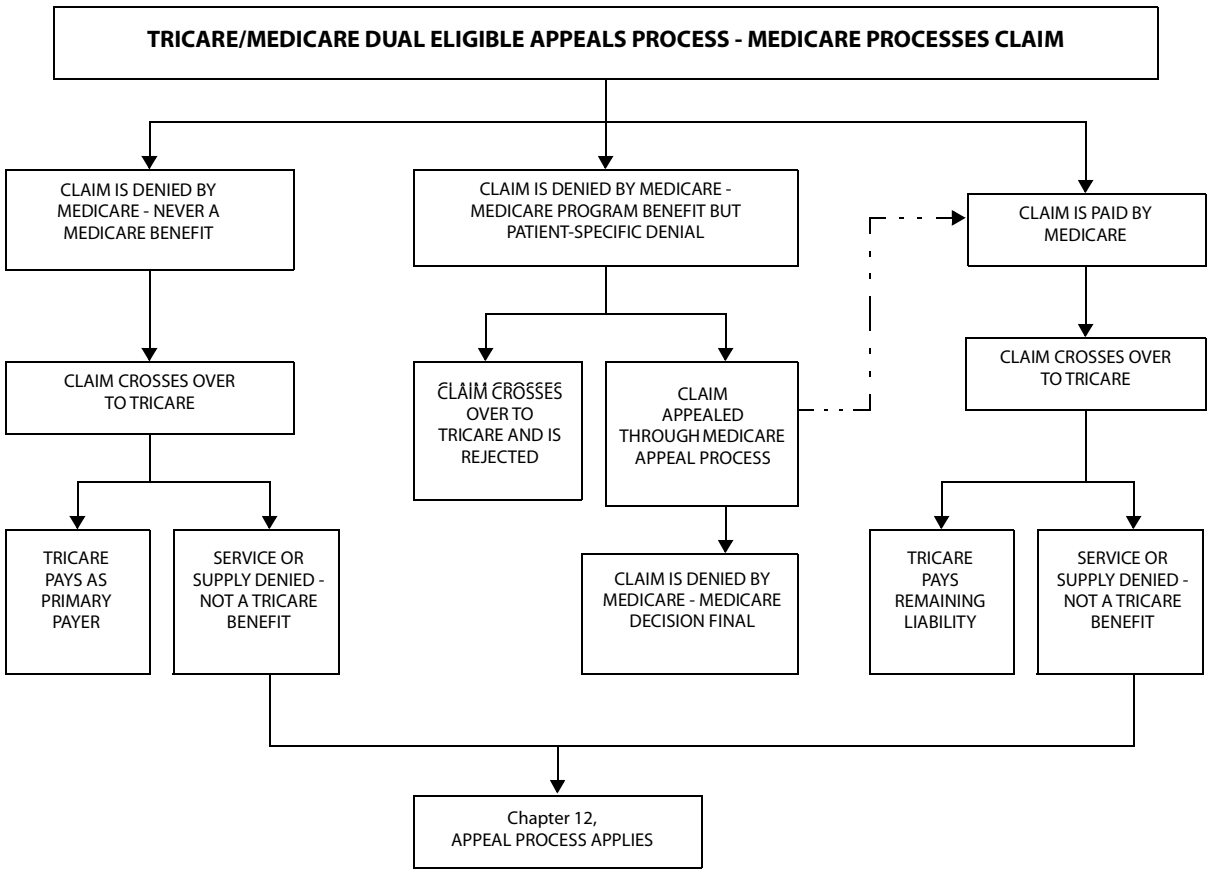

FIGURE 12.A-8 SUGGESTED WORDING FOR NON-EXPEDITED WRITTEN APPEAL NOTICE (INCLUDING FACTUAL DETERMINATIONS)

SAMPLE FORMAT

If you are the TRICARE beneficiary, the non-network participating provider of care, or a provider of care, or if you are the appointed representative of one of the above, you may appeal this initial determination. Your request must be in writing, must be signed, and must be postmarked or received by (**insert name of contractor, postal address, e-mail address, and fax number**) within 90 calendar days from the date of this decision. If you use the United States Postal Service (USPS), then the postmark or cancellation mark will be used as the date received. If you use a method other than the USPS or if the postmark is not legible, then the date of receipt will be the date your request was filed in our office.

Your appeal should include the following:

- A copy of this decision.
- Additional documentation supporting your appeal (however, due to the 90 day submission deadline, do not delay your appeal pending receipt of additional documentation).
- If additional documentation is expected but not yet received, include a statement describing the documentation expected and the anticipated date of receipt.

When appointing someone to represent you in the appeals process, be aware that officers and employees of the United States (U.S.) are not eligible to serve as representation. This exclusion is to prevent a possible conflict of interest and includes: employees or members of the U.S. military, employees or staff members of a Uniformed Service legal office, or Beneficiary Counseling and Assistance Coordinator (BCAC). This restriction is subject to exceptions in Title 18, United States Code (USC), Section 205. An exception is usually made for an employee or member of the U.S. military who represents an immediate family member.

Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed.

FIGURE 12.A-9 SUGGESTED WORDING FOR AN APPEAL OF A PREADMISSION/ PREPROCEDURE INITIAL DENIAL DETERMINATION

SAMPLE FORMAT

If you are the TRICARE beneficiary, or the appointed representative of the TRICARE beneficiary, and are dissatisfied with this initial determination, you may request an expedited reconsideration. Your request must be in writing, must be signed, and must be postmarked or received by (**insert name of contractor, postal address, e-mail address, and fax number**) within three calendar days from the date of this denial determination. A request for expedited reconsideration received after three calendar days but earlier than 90 calendar days will be treated as a non-expedited, or normal, reconsideration. If you use the United States Postal Service (USPS) to submit your request, then the postmark or cancellation mark will be used as the date received. If you use a method other than the USPS or if the postmark is not legible, then the date of receipt will be the date your request was filed in our office.

Your appeal should include the following:

- A copy of this decision.
- Additional documentation supporting your appeal (however, due to the three day submission deadline, do not delay your appeal pending receipt of additional documentation).
- If additional documentation is expected but not yet received, include a statement describing the documentation expected and the anticipated date of receipt.

When appointing someone to represent you in the appeals process, be aware that officers and employees of the United States (U.S.) are not eligible to serve as representation. This exclusion is to prevent a possible conflict of interest and includes: employees or members of the U.S. military, employees or staff members of a Uniformed Service legal office, or Beneficiary Counseling and Assistance Coordinator (BCAC). This restriction is subject to exceptions in Title 18, United States Code (USC), Section 205. An exception is usually made for an employee or member of the U.S. military who represents an immediate family member.

Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed.

FIGURE 12.A-10 SUGGESTED WORDING FOR A CONCURRENT REVIEW INITIAL DENIAL DETERMINATION

SAMPLE FORMAT

If you are the TRICARE beneficiary who is currently an inpatient in the facility, or if you represent the TRICARE beneficiary who is currently an inpatient in the facility, and if you are dissatisfied with the initial determination, you may request reconsideration. Your request must be in writing, must be signed, and must be postmarked or received by (**insert name of contractor, postal address, e-mail address, and fax number**). Expedited requests must be submitted by noon of the day following the date of receipt of this denial determination. A request received after this deadline but earlier than 90 days from the date of this denial determination will be accepted and processed as a non-expedited, or normal, request. If you use the United States Postal Service (USPS) to submit your request, then the postmark or cancellation mark will be used as the date received. If you use a method other than the USPS or if the postmark is not legible, then the date of receipt will be the date your request was filed in our office.

Your appeal should include the following:

- A copy of this denial determination.
- Additional documentation supporting your appeal (however, due to the noon submission deadline, do not delay your appeal pending receipt of additional documentation).
- If additional documentation is expected but not yet received, include a statement describing the documentation expected and the anticipated date of receipt.

When appointing someone to represent you in the appeals process, be aware that officers and employees of the United States (U.S.) are not eligible to serve as representation. This exclusion is to prevent a possible conflict of interest and includes: employees or members of the U.S. military, employees or staff members of a Uniformed Service legal office, or Beneficiary Counseling and Assistance Coordinator (BCAC). This restriction is subject to exceptions in Title 18, United States Code (USC), Section 205. An exception is usually made for an employee or member of the U.S. military who represents an immediate family member.

Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed.

FIGURE 12.A-11 SUGGESTED WORDING FOR INCLUSION IN A RECONSIDERATION DETERMINATION IN WHICH A PROVIDER IS A NETWORK PROVIDER

SAMPLE FORMAT

"If you decide to proceed with the service or it has already been provided, and the service is provided by a network provider who was aware of your TRICARE eligibility, you may be held harmless from financial liability despite the service having been determined to be non-covered by TRICARE. A network provider cannot bill you for non-covered care unless you are informed in advance that the care will not be covered by TRICARE and you waive your right to be held harmless by agreeing in advance (which agreement is evidenced in writing) to pay for the specific non-covered care. If the service has already been provided when you receive this letter and it was provided by a network provider who was aware of your TRICARE eligibility, and if there was no such agreement and you have paid for the care, you may seek a refund for the amount you paid. This can be done by requesting a refund from (**insert contractor name and address**).

Include documentation of your payment for the care, by writing to the above address. If you have not paid for the care and have not signed such an agreement, and a network provider is seeking payment for the care, please notify (**insert contractor name and address**).

Under hold harmless provisions, the beneficiary has no financial liability and, therefore, has no further appeal rights. If, however, you agree(d) in advance to waive your right to be held harmless, you will be financially liable and the appeal rights outlined below would apply. Similarly, the appeal rights outlined below apply if you have not yet received the care or if you received the care from a non-network provider and there is $50.00 or more in dispute."

FIGURE 12.A-12 SUGGESTED WORDING FOR A NON-EXPEDITED RECONSIDERATION DETERMINATION

SAMPLE FORMAT

If you are the TRICARE beneficiary, the non-network participating provider of care, or a provider of care who has been denied approval under TRICARE, or the appointment representative of one of the above, you have the right to request a (**insert level of appeal**). Your request must be in writing, signed, and postmarked or received by (**insert contractor name, postal address, e-mail address, and fax number** or **Appeals and Hearings Division, DHA, 16401 E. Centretech Parkway, Aurora, Colorado 80011-9066**), within (**insert number of calendar or working**) days from the date of this decision. If you use the United States Postal Service (USPS) to submit your request, then the postmark or cancellation mark will be used as the date received. If you use a method other than the USPS or if the postmark is not legible, then the date of receipt will be the date your request was filed.

Your appeal should include the following:

- A copy of this decision.
- Additional documentation supporting your appeal (however, due to required submission deadlines, do not delay your appeal pending receipt of additional documentation).
- If additional documentation is expected but not yet received, include a statement describing the documentation expected and the anticipated date of receipt.

Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed.

- END -