# Chapter 8 Addendum A

## Figures

Due to the size and nature of the first figure, Figure 8.A-1 can be found on page 2.

## FIGURE 8.A-1 DEPARTMENT OF DEFENSE (DoD) DOCUMENT (DD) FORM 2642

| **TRICARE DoD/CHAMPUS MEDICAL CLAIM**<br>**PATIENT'S REQUEST FOR MEDICAL PAYMENT** | *OMB NO. 0720-0006*<br>*OMB approval expires*<br>*Aug 31, 2009* |
|---|---|

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0720-0005). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A BENEFICIARY COUNSELING AND ASSISTANCE COORDINATOR (BCAC) OR TRICARE MANAGEMENT ACTIVITY (303) 676-3400.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 44 U.S.C. 3101; 10 U.S.C. 1079 and 1086; 38 U.S.C. 1781; E.O. 9397.
**PRINCIPAL PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.
**ROUTINE USE(S):** Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.
**DISCLOSURE:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

**IMPORTANT - READ CAREFULLY**

Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for TRICARE DoD/CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

**INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT**

**NONAVAILABILITY STATEMENT REQUIREMENTS:** If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a bona fide emergency. Without a necessary NAS your claim will be denied.

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**ITEMIZED BILL:** Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

1. Doctor's or provider's name/address (the one that actually provided your care). If there is more than one provider on the bill, circle his/her name;
2. Date of each service;
3. Place of each service;
4. Description of each surgical or medical service or supply furnished;
5. Charge for each service;
6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.

**DRUGS:** Prescription claims require the name of the patient; the name, strength, date filled, days supply, quantity dispensed, and price of each drug; NDC for each drug if available; the prescription number of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements, unless the receipt provides detailed information required above.

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**TIMELY FILING REQUIREMENTS:** All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice -- whichever date is later.

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**WHERE TO OBTAIN ADDITIONAL FORMS:** You may obtain additional claim forms from your claims processor, the TRICARE Service Center at the nearest military treatment facility or TRICARE Management Activity. 16401 E. Centretech Pkwy., Aurora, CO 8001 1-9066.

*** * * REMINDER * * ***

Before submitting your claim to the claims processor be sure that you have:

1. **Completed all 12 blocks on the form.** If not signed, the claim will be returned.
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance.
5. Obtained a Nonavailability Statement if required (see information above).
6. Attached DD Form 2527, "Statement of Personal Injury -Possible Third Party Liability TRICARE Management Activity" if accident or work related. See instruction number 7 on reverse side.
7. Ensured that patient's name, sponsor's name and sponsor's SSN are on all attachments.
8. Made a copy of this claim and attachments for your records.

**DD FORM 2642, APR 2007** PREVIOUS EDITION IS OBSOLETE. **COPY 2 - PROCESSOR'S COPY**

## FIGURE 8.A-1 DEPARTMENT OF DEFENSE (DoD) DOCUMENT (DD) FORM 2642

| | |
|---|---|
| **1. PATIENT'S NAME** *(Last, First, Middle Initial)* | **2. PATIENT'S TELEPHONE NUMBER** *(Include Area Code)*<br>DAYTIME ( )<br>EVENING ( ) |
| **3. PATIENT'S ADDRESS** *(Street, Apt No., City, State, and ZIP Code)* | **4. PATIENT'S RELATIONSHIP TO SPONSOR** *(X one)*<br>☐ SELF ☐ STEPCHILD<br>☐ SPOUSE ☐ FORMER SPOUSE<br>☐ NATURAL OR ADOPTED CHILD ☐ OTHER *(Specify)* |
| **5. PATIENT'S DATE OF BIRTH** *(YYYYMMDD)*<br>**6. PATIENT'S SEX** *(X one)*<br>☐ MALE ☐ FEMALE | **7. IS PATIENT'S CONDITION** *(X both if applicable)*<br>ACCIDENT RELATED? ☐ YES ☐ NO<br>WORK RELATED? ☐ YES ☐ NO |
| **8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.** | **8b. WAS PATIENT'S CARE** *(X one)*<br>☐ INPATIENT? ☐ PHARMACY?<br>☐ OUTPATIENT?<br>☐ DAY SURGERY? |
| **9. SPONSOR'S OR FORMER SPOUSE'S NAME** *(Last, First, Middle Initial)* | **10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER** |

**11. OTHER HEALTH INSURANCE COVERAGE**

a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements. ☐ YES ☐ NO

b. TYPE OF COVERAGE *(Check all that apply)*

☐ (1) EMPLOYMENT *(Group)* ☐ (3) MEDICARE ☐ (5) MEDICARE SUPPLEMENTAL INSURANCE ☐ (7) OTHER (Specify)
☐ (2) PRIVATE *(Non-Group)* ☐ (4) STUDENT PLAN ☐ (6) PRESCRIPTION DISCOUNT PLAN

| | c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE *(Street, City, State, and ZIP Code)* | d. INSURANCE IDENTIFICATION NUMBER | e. INSURANCE EFFECTIVE DATE *(YYYYMMDD)* | f. DRUG COVERAGE? |
|---|---|---|---|---|
| **INSURANCE 1** | | | | ☐ YES ☐ NO |
| **INSURANCE 2** | | | | ☐ YES ☐ NO |

*REMINDER: Attach your other health insurance's Explanation of Benefits or pharmacy receipt that indicates the actual drug cost, amount the OHI paid, and the amount that you paid.*

| **12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.** | | | **13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?** |
|---|---|---|---|
| a. SIGNATURE | b. DATE SIGNED *(YYYYMMDD)* | c. RELATIONSHIP TO PATIENT | ☐ YES ☐ NO |

**HOW TO FILL OUT THE TRICARE/CHAMPUS FORM**

*You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.*

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's daytime telephone number and evening telephone number to include the area code.
3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.
5. Enter patient's date of birth (YYYYMMDD).
6. Check the box for either male or female (patient).
7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity," The form may be obtained from the claims processor, BCAC, or TRICARE Management Activity.
8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident.
8b. Check the box to indicate where the care was given.
9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."
10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN).
11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICAREiCHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.
NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. *The claims processor cannot process claims until you provide the other health insurance information.*
12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type hisiher name in Block 12a. and sign the claim. Attach a statement to the claim giving the signer's full name and address. relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.
13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment only in some local currencies.

**DD FORM 2642 (BACK), APR 2007** **COPY 2 - PROCESSOR'S COPY**

**FIGURE 8.A-2 PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION**

State of _____ )
_____ )ss
County of_____ )

_____ being first duly sworn, deposes and says: I hereby authorize the **(Contractor for TRICARE in the State)** of to accept my facsimile or stamp signature shown below.

**(Facsimile, stamp or computer generated signature as it will appear on the claim form.)**

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

Signature

Subscribed and sworn to before me this _____ day of 20____.

_____
Notary Public in and for

_____ County, State of _____

(SEAL)

My Commission expires _____

**FIGURE 8.A-3 PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION**

State of _____ )
_____ )ss
County of_____ )

Know all persons by these presents:

That I, _____ have made, constituted and appointed and by these presents do make constitute and appoint _____ my true and lawful attorney-in-fact for me and in my name place and stead to sign my name on claims, for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claims forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _____day of _____ 20___.

Signature

Subscribed and sworn to before me this _____ day of 20_____.

_____
Notary Public in and for

_____ County, State of _____

(SEAL)

My Commission expires _____

**FIGURE 8.A-4 ABORTION DENIAL NOTICE TO THE BENEFICIARY AND PARTICIPATING PROVIDER**

Date: _____
Sponsor's Name: _____
Beneficiary's Name: _____
Type of Service(s): _____
Date of Service(s): _____
Last four digits of
Sponsor's SSN: _____

PERSONAL

_____
To: _____
_____

Dear _____:

TRICARE coverage of abortion services is specifically limited by federal statute. As implemented by the Department of Defense, TRICARE coverage of abortion services is limited to when:

- The life of the mother is at risk if the fetus is carried to term -- based upon certification from the attending physician that the patient suffers/suffered a condition that endangered her life if the fetus were carried to term; and
- The pregnancy is the result of an act of rape or incest -- as documented in the patient's medical record (effective January 2, 2013).

This means TRICARE won't cost-share on abortions performed for reasons other than those listed above. Since initial review of your claim(s) gave no indication that this abortion met the conditions for coverage, TRICARE denied the claim.

If you believe you do qualify under one of the exceptions, you may request a Reconsideration of the denial decision by submitting a written Reconsideration request to this office within 90 days of the date of this notice. Your request must include a copy of this notice, a statement outlining why you disagree with the decision, and any additional information/documentation from your physician which will support your position.

If you have any questions concerning the TRICARE abortion policy, please contact **(Contractor Name and Address)**.

Sincerely,

- END -