Chapter 13 Addendum A

Figures

Revision: C-98, September 16, 2021

FIGURE 13.A-1 VIOLATION OF THE PARTICIPATION AGREEMENT (SAMPLE)

(**Provider Address**)

Dear_____:

We have been notified that you are in breach of the participation agreement. **(Name of Patient)** advised us that **(He/She)** has been billed for amounts in excess of **(His/Her)** cost-share for services provided on **(Dates)**, which is a violation of your participation agreement.

Please be advised that by signing the TRICARE claim form and indicating your willingness to accept assignment for these services, you agreed to accept the TRICARE, determined allowable charge for medical services/supplies listed on the claim form as payment in full. This is true even if you requested the beneficiary to complete a form agreeing to pay the full amount not paid by other health coverage or insurance plans.

Under TRICARE, authorized professional providers and institutional providers, other than certain hospitals, have the option of participating on a claim-by-claim basis. Participation is required for inpatient claims only for hospitals which are Medicare-participating providers. Hospitals which are not Medicare-participating but which are subject to the TRICARE DRG-based payment system must sign agreements to participate on all TRICARE inpatient claims in order to be authorized providers under TRICARE. All other hospitals may elect to participate on a claim-by-claim basis. Participating providers must indicate participation by signing the appropriate space on the applicable TRICARE claims form and submitting it to the appropriate TRICARE contractor. In the case of an institution or medical supplier, the claim must be signed by an official having such authority. This signature certifies that the provider has agreed to accept the amount paid by TRICARE or the TRICARE payment combined with the cost-sharing amount paid by or on behalf of the beneficiary as full payment for the covered medical services or supplies. Therefore, when costs or charges are submitted on a participating basis, the patient is not obligated to pay any amounts disallowed as being over the TRICARE-determined allowable cost or charge for authorized medical services or supplies.

A breach of the participation agreement which results in the patient being billed in excess of the allowable amount is specifically listed in the 32 CFR 199.9 as a fraudulent act. Your failure to honor the participation agreement is considered to be a serious infraction of TRICARE rules and regulations which could have repercussions with your TRICARE-authorized provider status as well as that of other Government agencies, such as Medicare and Medicaid.

To preclude any adverse action against your authorized provider status, please notify **(Name of Patient)** in writing that all attempts to collect amounts in excess of (His/Her) deductible and cost-share have ceased.

FIGURE 13.A-1 VIOLATION OF THE PARTICIPATION AGREEMENT (SAMPLE) (CONTINUED)

The total billed amount is **(Amount)** and the correct TRICARE allowable is **(Allowable Amount)**. (Name of Patient) cost-share amount is **(Appropriate Percentage)**, of **(Put In Dollar Amount)**. The total payment amount to you is **(Government's Cost-Share Plus Patient's Deductible and Cost-Share Amount)**. **(Name of Patient)** is only responsible for **(His/Her)** cost-share amount **(Amount)**. Any amounts billed to the patient in excess the patient's cost-share and deducible amount **(Deductible Amount, if any)**, is a violation of your participation agreement.

Please provide to us a copy of your letter to **(Name of Patient)** within 15 days of the date of this letter. Please contact me in writing if you have any questions regarding this matter.

Sincerely,

Name, Title, and Office

cc:
Beneficiary

NOTE TO CONTRACTOR

Letter must be addressed to an individual. Do not use "Dear Provider."

FIGURE 13.A-2 VIOLATION OF THE PARTICIPATION AGREEMENT - FOLLOW-UP (SAMPLE)

(**Provider Address**)

Dear_____:

In a letter dated **(Date)**, we informed you that you violated your participation agreement for a TRICARE beneficiary. You were requested to write to **(Name of Patient)** and advise (HIM/HER) that attempts to collect amounts in excess of the deductible and cost-share amount are canceled and to provide a copy of the letter to us within 15 days of the date of our letter. To date, we have not heard from you.

The 32 CFR 199.9 cites a breach of provider participation agreement which results in the beneficiary being billed for amounts which exceed the TRICARE-determined allowable charge or cost as an example of fraud. Further, administrative remedies for fraud/abuse may result in a provider being excluded or suspended as an authorized TRICARE provider.

Cease collection action for amounts over the TRICARE-determined allowable amount, tell **(Name of Patient)** you are stopping all collection action; and provide a copy of your letter to us within 15 days of the date of this letter. If we do not hear from you, we will refer this matter to the Defense Health Agency (DHA), Program Integrity Office (PI).

Sincerely,

Name, Title, and Office

cc:
Beneficiary

FIGURE 13.A-3 (SAMPLE) **VIOLATION OF REIMBURSEMENT LIMITATION (BALANCE BILLING)**

(**Provider Address**)

RE: Patient:
Sponsor:
Date(s) of Service:
ICN:
Total Charges:

Dear_____:

We have been advised that you have billed **(Name of Patient)** for an amount greater than 115% of the CHAMPUS Maximum Allowable Charge (CMAC). Federal Law, 10 USC 1079(h)(4) limits the amount that a nonparticipating provider may bill a beneficiary to the same percentage used by Medicare.

Within 30 days of the date of this letter, you are to:

- Refund the beneficiary the amount over the 115% of the CMAC, or
- If no overpayment was made by the beneficiary, then credit the account and stop billing the beneficiary over 115% of the CMAC. The enclosed Explanation of Benefits (EOB) contains the procedure code(s) for each service, the date(s) of service, and the CMAC for each procedure. The 115% of the CMAC can be easily calculated from the information provided on the EOB (1.15 x CMAC = Balance Billed Amount).
- As background, the DoD put provisions in place as noted in a final rule published in the **Federal Register** on October 1, 1993, effective November 1, 1993. These provisions apply to all services provided on or after that date. Failure by a nonparticipating provider to comply with this requirement is a basis for exclusion from TRICARE as an authorized provider.

If you have any further questions, contact **(List Appropriate Point Of Contact/List Telephone Number)**.

Sincerely,

Name, Title, and Office

cc:
Beneficiary

NOTE TO CONTRACTOR

Letter must be addressed to an individual. Do not use "Dear Provider."

FIGURE 13.A-4 VIOLATION OF REIMBURSEMENT LIMITATION (BALANCE BILLING) FOLLOW-UP (SAMPLE)

(**Provider Address**)

RE: Patient:
Sponsor:
Sponsor SSN: XXX-XX-1234 (Provide only last four)

Dear_____:

In a letter dated **(Date of Initial Letter)**, copy enclosed, you were advised of an incorrect billing practice, and advised to refund to the beneficiary (or credit the account) any amount billed in excess of 115% of the CHAMPUS Maximum Allowable Charge (CMAC). To date, we have not heard from you. Within 15 days of the date of this letter, notify us of your intent to correct this error and follow public law. TRICARE's limit is based on a similar Medicare law. Because TRICARE is a much smaller federal program not all providers are as familiar with the TRICARE requirements as they are with Medicare requirements.

If you require additional information or you disagree with our interpretation of your billing, please contact our Service Department at **(List Appropriate Point Of Contact/List Telephone Number)**.

Sincerely,

Name, Title, and Office

cc:
Beneficiary

FIGURE 13.A-5 STATISTICAL SAMPLING FOR OVERPAYMENT DETERMINATIONS AND IDENTIFICATION OF PROBABLE FALSE CLAIMS

Prior to the selection of the Statistically Valid Random Sample (SVRS), the claims universe shall also be properly focused and analyzed to determine the sampling plan and methodology. Focusing the universe is performed by targeting specific claims which match the approach and/or allegations of the case, and removing unnecessary low dollar claims. The overall sampling plan and methodology may include a stratified sampling approach consisting of one or more SVRS(s) and/or 100% claims audit(s).

In order to determine the probable scope and extent of overpayments, regardless of how the overpayment was incurred, a SVRS shall be drawn from each identified stratum (or the entire universe of claims in some cases). Denied claims or claims where TRICARE paid zero dollars shall always be removed from the Universe prior to stratification and sampling. Only netted records shall be used.

This primary sample shall be selected using a random number generator with a known seed number. Using a known non-zero seed number is critical, as it will provide for the reproduction of the same set of random numbers with the same sample and universe.

The sample size shall be calculated using the following parameters:

- 90% confidence level
- 10% precision level
- 50% occurrence rate (if there is no established rate of occurrence) or an estimate of the occurrence rate from a previously documented statistically valid analysis (by a Federal health care entitlement program) of the units of audit (e.g., same provider, same procedures, same time period) of the possible fraud.

An oversample of 20% shall always be randomly selected from the specific stratum or universe, and audited with the primary sample at the beginning of an audit.

In all claim audits using statistical techniques to extrapolate findings of a sample to a specific stratum or a universe of claims, the audit addresses the average overpayment per claim as the single unit of measurement. The claim and the explanation of benefits are the evidentiary documents which demonstrate the billed services submitted by a provider or beneficiary and the payments made to a provider or beneficiary. The claim is compared to the contents of the medical record to validate whether a service was provided, whether it was provided at the level billed, whether it was provided by the authorized provider shown on the claim, or any other information which may be relevant to identify a dollar loss to the Government. This information shall be recorded on a summary spreadsheet generated by Microsoft® Excel, or compatible software, with a .xls file extension for compatibility with other widely used spreadsheet software (typically, the DHA Random Sample Audit Worksheet shall be included for each SVRS). Each claim in the sample shall be listed on the summary spreadsheet and the overpayment totaled. When no overpayment exists, the claim shall appear on the summary spreadsheet with zero listed as the overpayment.

Each claim of the audited oversample shall also be included with the case, either as part of the summary spreadsheet or as part of a separate spreadsheet.

The overpayments shall be expressed in dollars and cents. The total shall then be summed and divided by the number of claims in the sample (remembering that claims with no overpayments are shown in the column to be summed as zero). The product is the average mean overpayment per claim in the sample. The average mean overpayment per claim in the sample shall be multiplied by the number of claims in the specific stratum or universe from which the sample and oversample was taken, and this product expressed in dollars and cents is the extrapolated dollar loss to the Government for that stratum or universe.

FIGURE 13.A-5 STATISTICAL SAMPLING FOR OVERPAYMENT DETERMINATIONS AND IDENTIFICATION OF PROBABLE FALSE CLAIMS (CONTINUED)

DETERMINING EXTRAPOLATION AMOUNT AND VALIDATING THE AUDIT FINDINGS

It is necessary to calculate the standard deviation, standard error of the mean, and sampling error. The contractor shall have the electronic capability to accomplish these calculations and shall execute the computations according to the methodology provided in the following paragraphs.

In the sample technique discussed in the previous section, if the sample has been properly designed and selected, and the specific stratum or universe approximates a normal distribution appropriately, there are 90 chances in 100 that the claim overpayments will fall within the range of the arithmetical mean plus or minus 1.645 times the calculated standard deviation. Additional values shall be calculated as well, to determine the validity of the overpayment estimates.

Calculating the standard deviation of the sample: The standard deviation, which is expressed in dollars and cents, shall be determined using the following steps:

1. Calculate the difference between each claim observation and the average mean overpayment.

2. Square each of the calculated differences.

3. Sum the Squares of the differences for all of the claim observations.

4. Divide the Sum of the Squares by the number of observations in the sample.

Note: When the sample size is less than 40, Divide the Sum of the Squares by the number of observations minus one.

5. Take the Square Root of the Divided Sum of the Squares.

Calculating the standard error of the mean: The standard error of the mean shall be calculated by dividing the standard deviation by the square root of the sample size.

Calculating the sampling error and overpayment estimate range: The sampling error shall be calculated by multiplying the standard error of the mean by the "Z" score (for a 90% confidence level the "Z" score is 1.645). The "Z" score changes as the confidence level changes.

Calculating the precision value: The precision value, expressed in dollars and cents, shall be calculated by multiplying the sampling error by the number of claims in the stratum or universe.

Calculating the overpayment estimates: The overpayment point estimate was calculated above by multiplying the average mean of overpayment per claim by the number of claims in the specific stratum or universe. The high and low (plus or minus) estimates of overpayments shall be calculated respectively by adding and by subtracting the precision value from the overpayment point estimate. The overpayment estimates shall be expressed in dollars and cents.

Calculating the sample precision percentage: The sample precision percentage shall be calculated by dividing the precision value by the overpayment point estimate. The desired precision percentage is 10% or less for tight precision, with approximately 20% or more representing low precision.

Testing the validity of the sample and the overpayment estimates:

1. If the standard deviation is greater than two times the arithmetic mean, this is an indicator that the sample does not demonstrate the confidence level required for validity.

2. If the high estimate of overpayments is greater than the specific stratum or universe amount or the low estimate of overpayments is less than zero, then the computed overpayment amount shall not be used.

FIGURE 13.A-5 STATISTICAL SAMPLING FOR OVERPAYMENT DETERMINATIONS AND IDENTIFICATION OF PROBABLE FALSE CLAIMS (CONTINUED)

3. When high precision is not achieved, the lower overpayment estimate shall be used as the amount of overpayment demanded, as opposed to the point estimate. This procedure yields a conservative demand amount for recovery that is very likely less than the true amount of overpayment, and it allows a reasonable recovery without requiring the tight precision that might be needed to support a demand for the point estimate.

ALTERNATE SAMPLING METHODS

If the tests for the validity of the sample and overpayment estimates are not met, it may be an indicator that the universe should have been stratified appropriately, or other techniques should be used. If this is the case, consult with DHA PI. For example, if there are services subjected to audit where there are large differences in payments (e.g., surgical and medical), there will likely be a need to stratify the universe into two or more separate categories for separate sample selection. When stratification is necessary and after consulting with DHA PI, please seek consultation for such sample techniques from a qualified statistician.

The standard reference for auditing with samples is the Handbook of Sampling for Auditing and Accounting, Third Edition, by Herbert Arkin, McGraw-Hill Book Company, copyright 1984.

FIGURE 13.A-6 SPECIAL NOTICE TO PROVIDER/PHARMACY/ENTITY WHEN PROVIDER/PHARMACY/ENTITY CLAIMS ARE TEMPORARILY SUSPENDED (SAMPLE)

(**Provider/Pharmacy/Entity Address**)

Dear_____:

We are letting you know that as of **(Date)** we have temporarily suspended payment on your claims for an indefinite period of time. They are being reviewed by the United States (U.S) Government (in accordance with 32 CFR 199.9(h)).

Within 30 days of the date of this notice, you may present to the Director, Program Integrity Office (PI), Defense Health Agency (DHA):

- Written information (including documentary evidence) and argument against this action, as long as the additional specific information raises a genuine dispute over the material facts; or

- A written request to personally present evidence to the Director, DHA, or a designee. All such presentations shall be made at your expense and conducted at: DHA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066.

If you have any questions or comments on this action, we suggest you write to:

(**Contractor's Address**)

Sincerely,

Name, Title, and Office

NOTE TO CONTRACTOR

The DHA Program Integrity Office (PI) will be the sole authority for the direction of issuance of a notice of the temporary suspension of a provider's claims from processing. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason(s) for the claims processing suspension provided by DHA.

FIGURE 13.A-7 SPECIAL NOTICE TO A CLIENT BENEFICIARY WHEN A BENEFICIARY'S CLAIM IS TEMPORARILY SUSPENDED (DUE TO TEMPORARY SUSPENSION OF PROVIDER/PHARMACY/ ENTITY) (SAMPLE)

(**Beneficiary Address**)

Dear_____:

This is to inform you that your claim(s) for services provided by **(Provider's/Pharmacy's/Entity's Name and Address)** has been temporarily suspended pending review by the Defense Health Agency (DHA), for an indefinite period of time. This action is being taken by DHA under the provisions of 32 CFR 199.9(h), because of further review by the Government of services/supplies provided by **(Name of Provider/Pharmacy/Entity)**.

Only payments on claims for services provided by (**Name of Provider/Pharmacy/Entity**) are being held pending review. All other claims for care or services you receive shall be paid as normal.

Do not pay the suspended provider any amount above the standard co-pay or cost-share amount(s) normally due for each office visit or pharmacy refill until you receive an Explanation of Benefits (EOB) from (**Contractor's Address**) stating the actual amounts you or the United States (U.S.) Government (may) owe the provider. Receipt of an EOB shall signify validity of any debt owed to your provider (doctor or pharmacy) and should correspond with any provider billing you may receive. Do not pay any amount above the amount '**you owe**' (NOTE: this term may vary by contractor's EOB) reported on the EOB.

During the temporary suspension period the contractor shall not apply the identified patient responsibility (applicable cost-shares, copayments, deductibles) toward the catastrophic cap for care provided by a temporarily suspended provider as the contractor is unable to fully process the claim while it is being held in temporary suspense.

If the temporarily suspended provider attempts to collect any amount(s) held by the Government (other than sending a normal monthly statement of account) using a collection agency or other legal means during the Government suspension period please notify:

Defense Health Agency
Attn: Program Integrity
16401 E. Centretech Parkway
Aurora, CO 80011-9043

Or call Program Integrity Office (PI) at (303) 676-XXXX

If you have any questions or comments concerning this action, we suggest you convey them in writing to this address:

(**Contractor's Address**)

Sincerely,

Name, Title, and Office

FIGURE 13.A-7 SPECIAL NOTICE TO A CLIENT BENEFICIARY WHEN A BENEFICIARY'S CLAIM IS TEMPORARILY SUSPENDED (DUE TO TEMPORARY SUSPENSION OF PROVIDER/PHARMACY/ ENTITY) (SAMPLE) (CONTINUED)

NOTE TO CONTRACTOR

The DHA PI will be the sole authority for the direction of issuance of a notice of the temporary suspension of payment of a provider's, pharmacy's, or entity's claims. Instructions will be provided on an individual case-by-case basis. The contractor shall state the reason(s) for the claim payment suspension provided by DHA.

FIGURE 13.A-8 NOTICE OF PROPOSED ACTION TERMINATING A PROVIDER/PHARMACY/ ENTITY (SAMPLE)

Note: For Pharmacy please change "provider" to "pharmacy".

(**Provider Address**)

Dear_____:

We are proposing to terminate you as an authorized TRICARE provider, effective **(Date and provide one of the following statements: The date on which you did not meet these requirements, or June 10, 1977, the effective date of the Regulation, WHICHEVER DATE IS LATER)**. Your termination ends only after you successfully meet established qualification criteria and are reinstated as a TRICARE authorized provider.

Based upon submitted documents, you do not qualify to be an authorized TRICARE provider (in accordance with 32 CFR 199.9(h)). (NOTE: The contractor shall give the reasons and supporting facts for the proposed termination.)

Authority for this termination is found in 32 CFR 199.9(h), which provides administrative remedies for fraud, abuse and conflict of interest, and for termination when the provider has not met or satisfied the criteria for authorized TRICARE provider status. Since we lack evidence demonstrating you meet all the criteria, you are now considered to have lost or given up ("forfeited or waived") any right to bill TRICARE beneficiaries. If you do bill a beneficiary, payment back to the beneficiary may be required by the Director, Defense Health Agency (DHA), or a designee, as a condition of reinstatement. **(NOTE: If beneficiaries choose to continue to see you as a non-authorized provider, the TRICARE Program will deny their claims.)**

The retroactive effective date of termination is not limited due to the passage of time, erroneous payment of claims, or any other events which are cited as a basis for TRICARE Program recognition of the provider, notwithstanding the fact that the provider does not meet program qualification requirements. Unless specific provision is made to "grandfather" or authorize a provider who does not otherwise meet the qualifications established in 32 CFR 199.9(h) all unqualified providers will be terminated.

We will treat any claims for dates of service on or after your termination date as erroneous payments; they are subject to collection. Further claims actions are temporarily suspended until you get reinstated as an authorized provider.

Within 30 days of the date of this letter, you may:

1. Submit written evidence or argument on why you disagree with the facts of this decision. Submit written documents to: (**Unit or Name Of Person And Address To Whom The Provider Is To Submit Certification Documentation**); or
2. Submit a written request to present, in person, to the staff at the office listed above evidence or argument against this decision. Travel to and from this location is at your expense.

Documents postmarked within 30 days of the date of this letter will be accepted. If you have a good reason as to why you cannot present additional evidence within 30 days, you may submit a written request to extend the deadline to 60 days from the date of this letter. All communications with this office must be in writing.

FIGURE 13.A-8 NOTICE OF PROPOSED ACTION TERMINATING A PROVIDER/PHARMACY/ ENTITY (SAMPLE) (CONTINUED)

Sincerely,

Name, Title, and Office

NOTE TO CONTRACTOR

This letter shall be sent by Return Receipt Requested or any other method which documents receipt.

FIGURE 13.A-9 INITIAL DETERMINATION TERMINATING A PROVIDER/PHARMACY/ENTITY (SAMPLE)

(**Provider Address**)

} Initial Determination
} Contractor Name
} Case File YY-"#"

Dear_____:

On **(Date of Proposed Action Notice)** we sent notice we proposed terminating you as an authorized TRICARE **(Provider/Pharmacy/Entity Type)** under the TRICARE Program. You were told you could submit, within 30 days, either:

- Written evidence you meet the TRICARE Program's authorization requirements as a **(Provider Type)** and written argument against the action; or
- A written request to present, in person, at your expense, evidence or arguments supporting you meet qualification criteria as an authorized provider.

(State what the provider did: i.e., by letter dated ___, you submitted additional information, or on {Date} you personally appeared before {State Name and Position of the Informal Review Official}, or you failed to take advantage of the opportunity to submit any documentation or argument contesting the proposed action.)

After reviewing all available information, this initial determination is issued terminating your status as an authorized TRICARE provider effective **(Insert Either June 10, 1977, the Effective Date of the CHAMPUS Regulation or the Date on which the Provider was first approved or lost their license, WHICHEVER IS LATER)**, the date on which you first failed to meet the requirements as a **(Provider/Pharmacy/Entity Type)** under the 32 CFR 199.9(h). This termination action is being taken under authority of 32 CFR 199.9(h). The retroactive date of termination is not limited due to the passage of time, erroneous payments of claims, or any other event which is cited as a basis for TRICARE Program recognition of a provider notwithstanding the fact that the provider does not meet program qualifications. Termination under the TRICARE Program will continue even if you obtain a license to practice in a second jurisdiction during the period of exclusion or revocation of your license by the original licensing jurisdiction. Any claim previously cost-shared or paid under the TRICARE Program for services or supplies furnished on or after the effective date of termination will be deemed an erroneous payment and subject to collection action under appropriate law and regulation.

Under 32 CFR 199.9(h), to be an authorized **(Provider/Pharmacy/Entity Type)**, an individual shall be licensed or certified by the state and meet the following requirements:

(List Specific Requirements From The Regulation)

Our position is you do not meet the requirements because (**Give specific basis for your decision; if the provider submitted any evidence or argument in writing or in person, identify that evidence or argument here and discuss its relevance to this decision.**).

FIGURE 13.A-9 INITIAL DETERMINATION TERMINATING A PROVIDER/PHARMACY/ENTITY (SAMPLE) (CONTINUED)

The period of your termination as an authorized **(Provider/Pharmacy/Entity Type)** under the TRICARE Program is indefinite under the provisions of 32 CFR 199.9(h). The period of termination will end only upon receipt of documentation that you have successfully met the established qualifications and receipt of your request for reinstatement as an authorized provider under the procedures established by 32 CFR 199.9(h). All requests for reinstatement of terminated providers must be submitted to: Contractor Program Integrity Office (PI)

The TRICARE Regulation (32 CFR 199.9(h)) sets forth policies and procedures for providers to appeal a termination decision as long as there is an appealable issue, such as a question on factual matters of the case. If you question the fact(s) serving as the basis for your termination, you may file an appeal. **(NOTE: The appeal process may not be used to challenge any provision of law or regulation.)** You must mail a written request for a hearing within 60 days from the date of this letter to: Chief, Office of Appeals and Hearings, Defense Health Agency (DHA), 16401 East Centretech Parkway, Aurora, Colorado 80011-9066. Include a copy of this letter and any additional documentation/evidence you want considered as part of your hearing package.

Sincerely,

Name, Title and Office

cc:
PI
DHA

NOTE TO CONTRACTOR

This letter shall be sent by Return Receipt Requested or any other method which documents receipt.

FIGURE 13.A-10 NOTIFICATION TO A PROVIDER/PHARMACY/ENTITY PROCEEDS RECEIVED HAVE BEEN PLACED IN GOVERNMENT OWNED "DEPOSIT FUND" (SAMPLE)

(**Provider Address**)

} Initial Determination
} Contractor Name
} Case File YY-"#"

Dear_____:

Funds remitted to (contractor's name) to be applied to the debt of (**Temporarily Suspended Provider's Name**) have been forwarded to Defense Health Agency (DHA), Contract Resource Management (CRM) and shall not be applied as payment to your Debt. The funds shall be placed in a "Deposit Fund" in accordance with the Department of Defense (DoD) Financial Management Regulation (DoD 7000.14-R, Volume 12, Chapter 1, Paragraph 0108 & 010803) "Monies held by the U.S. Government awaiting distribution on the basis of a legal determination or investigation."

If you have any questions or comments concerning this action, we suggest you convey them in writing to this address:

(**Contractor's Address**)

Sincerely,

Name, Title and Office

cc:
Program Integrity Office (PI)
DHA

NOTE TO CONTRACTOR

This letter shall be sent by Return Receipt Requested or any other method which documents receipt.

- END -