

## Chapter 8

## Addendum A

### Figures

Revision:

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#### FIGURE 8.A-1 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 \_\_\_\_\_

**TRICARE Operations Manual 6010.59-M, April 1, 2015**

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**FIGURE 8.A-2 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 and 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-3**  
**PROVIDER**

**ABORTION DENIAL NOTICE TO THE BENEFICIARY AND PARTICIPATING**

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; or
- 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 -

