

TRICARE Fundamentals Course

Claims and Appeals

12

Participant Guide

References

32 CFR § 199.7, 199.10

TRICARE Operations Manual, Chapter 8

TRICARE Reimbursement Manual, Chapter 1, 2 (Addendum A)



Brainteasers

Each of the 8 items below is a separate puzzle.
How many can you figure out?

1. R E A D I N G	2. Go stand	3. LANG4UAGE	4. N I A T P C A
5. dice dice	6. Dribble Dribble	7. GROUND 	8. FRIENDS STANDING FRIENDS miss

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

Module Objectives



- **Explain who can file claims and where claims should be submitted**
- **Describe how to resolve claims issues**
- **Identify three reasons why an Explanation of Benefits may be delayed**
- **Distinguish between what can and cannot be appealed**

Disclaimer: The content in this module applies primarily to claims for health care services, and not to pharmacy or dental claims. See the Pharmacy and Dental modules for claims and appeals information for those services. Fraud information is provided for all contractors.

1.0 Claims

Claims are filed to issue payment for services or supplies provided by civilian sources of medical care which may include, but are not limited to:

- Physicians
- Hospitals
- Skilled nursing facilities
- Pharmacies
- Medical suppliers
- Ambulance companies
- Laboratories
- Physical therapy
- Vendor pharmacies
- Veterans Affairs treatment facilities
- Other TRICARE-authorized providers

2.0 Claims Filing

Authorized providers of services or supplies and beneficiaries may file claims. However, the beneficiary is ultimately responsible for making sure claims are filed.

2.1 Authorized Providers

An authorized provider is one approved under TRICARE for services or supplies provided to a beneficiary. TRICARE denies claims from non-authorized providers except in some emergency situations.

- Professional providers include an independent provider or group practice.
- Institutional providers include hospitals and nursing facilities.

2.2 Network Providers

A network provider is an individual, institution, or organization that serves TRICARE beneficiaries through a contractual agreement with the regional contractor.

2.3 Non-Network Providers

- *Non-Network Participating Provider:* A non-network provider who participates/accepts the TRICARE allowable charge as payment in full for provided services.
- *Non-Network Non-Participating Provider:* A non-network, authorized provider who does not accept the TRICARE allowable charge as payment in full for the covered services and can bill for up to 115% of the TRICARE allowable charge.

2.4 Beneficiary

Any TRICARE-eligible beneficiary may submit a claim. The spouse, parent, or legal guardian of a minor (under age 18) or incompetent beneficiary may submit a claim on behalf of the beneficiary, unless otherwise specified.

2.5 Filing Deadlines

- The filing deadline is within one year of the date of service or date of discharge for inpatient care.
- Beneficiaries should file as soon as possible after services are rendered.

3.0 Submitting Claims

- Claims are submitted to the claims processor responsible for the beneficiary's home region for Standard options and to the claims processor responsible for the enrollment location for Prime options.
- There are two major TRICARE claims processors:
 - *Palmetto Government Benefits Administration (PGBA)*
Processes claims for the North and South regions
 - *Wisconsin Physicians Service (WPS)*
Processes claims for the West and Overseas region, and TRICARE for Life
- If a beneficiary sees a network provider, the provider is responsible for filing the claim. The beneficiary can still be held liable for the charges if the network provider fails to file.
- If a beneficiary sees a non-network provider, the provider is not required to submit the claim, but may do so voluntarily. The beneficiary is responsible for ensuring the claim is filed.
- If a claim is sent to the regional contractor instead of the regional claims processor, the regional contractor forwards the claim to the appropriate claims processor.
- If a claim is sent to the wrong claims processor, the claim is either forwarded to the appropriate claims processor or returned to the sender.
- TRICARE-eligible beneficiaries are responsible for keeping their personal contact information up to date with their providers so that claims go to the correct claims processor and related payment information can be sent to the beneficiary.

4.0 Claims Processing Procedures

TRICARE processes claims using specific procedures to ensure that:

- Government-furnished funds are expended only for those services or supplies authorized by law and regulation.
- All claims are processed in a timely manner.

4.1 Processing Criteria

Claims processors must verify the following criteria in this order:

1. The beneficiary is eligible
2. The beneficiary/provider filed the claim in a timely manner
3. The provider of services or supplies is TRICARE authorized
4. The service or supply provided is a benefit
5. The service or supply provided is medically necessary and appropriate or is an approved TRICARE clinical preventive service
6. The beneficiary is legally obligated to pay for the service or supply (when appropriate)
7. The claim contains sufficient information to determine the TRICARE allowable charge for each service or supply

5.0 Resolving Claims Issues

- The first action beneficiaries should take to resolve claims issues is to call the regional contractor's toll-free number and pick the option for claims assistance, or visit a local TRICARE Service Center (TSC) if near a military treatment facility (MTF).
 - If the claim issue remains unresolved, the beneficiary may contact a MTF or TRICARE Regional Office (TRO) or TRICARE Area Office (TAO) Beneficiary Counseling and Assistance Coordinator (BCAC).
 - If an unresolved debt results in a collection action, the beneficiary should contact the regional contractor or an MTF, or TRO or TAO Debt Collection Assistance Officer (DCAO).
- Registered beneficiaries, BCACs and DCAOs can access the regional claims processor's online system (mytricare.com or tricare4u.com) to review the beneficiary's claim status.

5.1 Assisting the Beneficiary with Claims Issues

When conducting an initial claim inquiry, consider the following questions:

- When was the date of service? What was the beneficiary's eligibility status or category at the time of service?
- What type of service did the beneficiary receive (e.g., medical appointment, hospitalization, medications administered in a provider's office, supplies)?
- Was this an inpatient or outpatient service?
- Did the beneficiary contact the claims processor for their region or plan? If yes, what was the result?
- Did the beneficiary bring their Explanation of Benefits (EOB), summary payment voucher, or bill?
- If the EOB is available, study the notes to determine how and why the claim processed as it did (for example):
 - Point of Service
 - No authorization on file
 - Beneficiary is no longer eligible
 - Not a TRICARE benefit
- If the beneficiary states that he/she never received an EOB, look up claims information online or call the claims processor (PGBA or WPS) to find out if the provider submitted a claim. If not, advise the beneficiary to contact the provider to request that the office file a claim or determine if and when the claim was submitted to the claims processor.

5.2 Working with Claims Processors

BCACs and DCAOs should try to work consistently with one key claims processor staff member to build rapport and maintain consistency in the communication process when researching/resolving beneficiary claim issues.

6.0 Other Health Insurance

Special circumstances exist when beneficiaries have other health insurance (OHI).

- If a beneficiary has OHI, the beneficiary or the provider must file a claim with that health insurance plan before filing with TRICARE. (Exceptions: Medicaid, Indian Health Service, and certain other programs identified by the Director, TRICARE Management Activity (TMA), e.g., State Victims Assistance Plans.)
- After a claim is processed by the OHI, it can be filed with TRICARE along with a copy of the other health plan's payment determination and the itemized charges (bill).
- Beneficiaries should notify their regional contractor or the claims processor about other health insurance and any associated changes in carriers or coverage to avoid delays in claims processing or possible denials.

7.0 Claim Forms

- Beneficiaries cannot combine different types of claims; they should send a separate claim and claim form for each visit to a provider's office or for each service provided by different providers.

- Beneficiaries must submit a separate claim for each family member even if several family members visit the same provider on the same day.

7.1 Claim Forms Used by Beneficiaries

- Beneficiaries use DD Form 2642, *TRICARE DoD/CHAMPUS Medical Claim - Patient's Request for Medical Payment* to submit claims for services or supplies provided by civilian sources of medical care. DD Forms 2642 submitted by a provider will be returned to the provider.
- DD Form 2642 is available online for download at:
 - The TRICARE web site: www.tricare.mil/mybenefit/Forms.do
 - PGBA's web site: www.mytricare.com
 - WPS web site: www.tricare4u.com
- Beneficiaries may request DD Forms 2642 by calling the regional contractor's toll-free number, or visiting a local TSC if one is nearby.

7.2 Claim Forms Used by Providers

- Professional providers submit claims using the CMS 1500 (08/2005), *Health Insurance Claim Form*.
- Institutional providers submit a claim using the CMS 1450 (UB-04), *Health Insurance Claim Form*.

7.3 Claims Forms Used for Care Received Overseas

- Beneficiaries submit a DD Form 2642.
- Providers are asked to submit a CMS 1500 (08/2005).

7.4 Items That May Need to be Submitted with a Claim

When a beneficiary files a claim, they must include the following documents:

- An itemized list of charges for each service or supply, with the diagnosis; must be on the provider's letterhead or standard form along with the provider's tax ID number.
- An itemized list of charges from the pharmacy; must be on the pharmacy's letterhead or billing form
- OHI claim forms: The health plan's payment determination or denial statement or EOB
- DD Form 2527, *Statement of Personal Injury-Possible Third-Party Liability*
 - Required with DD Form 2642 when filing in instances in which a beneficiary's condition is potentially accident or work related, or both, and when certain procedure or diagnostic codes indicate there may be third-party liability involved.
 - If the beneficiary does not submit a DD Form 2527 initially, the regional claims processor sends the form to the beneficiary for completion.
 - Failure to submit form DD Form 2527 within the time frame specified on the form may result in the beneficiary's claim being pended or denied.
 - Beneficiaries may submit DD Form 2527 after the initial claim is submitted or as requested by the regional claims processor.

8.0 Explanation of Benefits

- After submitting claims, the beneficiary and provider each receive a TRICARE EOB from the claims processor showing how the claim was settled.
- The EOB is mailed or posted online at either www.tricare4u.com or www.myTRICARE.com, depending on the region.

8.1 When to Expect an EOB

- For the majority of claims processed, the beneficiary and the provider should each receive an EOB within six weeks of submitting a clean claim.
 - Some complex claims may take 60 days or more to complete.
 - To determine if a claim was received, beneficiaries and providers may contact the claims processor or check their web site.
- If the beneficiary does not receive an EOB or cannot find the claim on the claim processor's web site within six weeks of the date of service, he/she should contact the provider or facility to verify that a claim was submitted. This also ensures that the claim does not miss the timely filing deadline of one year from the date of service or date of discharge for inpatient care.
- Remind beneficiaries to follow up with ambulance companies separately, as insurance information isn't typically shared between hospitals, emergency rooms and ambulance companies.

8.2 Reasons for Delays in Processing a Claim or Receiving an EOB

- Wrong address
- Claim is incomplete
- Eligibility is being questioned or DEERS information inaccurate
- Diagnosis is missing or inconsistent with other services provided
- A Third-Party Liability form is required or has not been received
- OHI forms are missing
- Claim is complex and requires an extensive review
- There is a government-directed delay (usually because the provider is being investigated or because of fraud)
- Provider delayed submitting a claim
- There are duplicate claims — more than one claim has been submitted for the same service
- Service is non-authorized
- Medical necessity is not documented
- Provider's Unique Provider Identification Number or National Provider Identification is missing

8.3 Importance of Reviewing EOBs

- Beneficiaries should carefully compare each EOB against their bills, checking that the right provider(s) and right service(s) are being billed.
- Beneficiaries should contact the claims processor about charges for a service they did not receive. Incorrect charges may be due to a simple error in the provider's billing, or an indication of fraud.
- The beneficiary may contact the regional contractor or claims processor by phone, internet, or at the nearest TSC with questions about their EOB.
- The beneficiary may also seek assistance from the nearest MTF or regional BCAC/DCAO if unable to get a claims issue resolved with the regional contractor.
- An EOB may show \$0.00 patient liability if TRICARE pays nothing on the claim, meaning that the beneficiary is liable for all charges; make sure to review the entire claim document to see if TRICARE paid at all.

9.0 Components of an EOB

- **Claims Processor:** The claims processor handles all TRICARE health care claims, depending on the region where the beneficiary lives or if care was received overseas.
- **Regional Claims Contractor:** The name and logo of the regional contractor that is responsible for the claim.
- **Date of Notice:** The date the claims processor prepared the TRICARE EOB.

- **Mail to Name and Address:** The TRICARE EOB is mailed to the patient's (or patient's parent or guardian's) address as submitted on the claim.
- **Claim Number:** Each claim is assigned a unique tracking number as it is processed; should be used for reference if there are questions or concerns.
- **Sponsor SSN/Sponsor Name:** Claims are processed using the sponsor's SSN (active duty, retired, or deceased) or the individual's DoD health benefits number.
- **Beneficiary Name:** The individual who received the service/procedure and for whom the claim is filed.
- **Benefits Were Payable To:** This field appears only if the provider accepts TRICARE assignment. This means the provider accepts the TRICARE allowable charge as payment in full for the services the beneficiary received.
- **Service Provided By/Date of Services:** This section lists who provided the care, the number of services and the procedure codes, and the date the beneficiary received the care.
- **Services Provided:** This section describes the medical services received and how many services are itemized (listed) on the claim by listing the specific procedure or medical service.
- **Amount Billed:** The amount the provider charged for a particular service(s).
- **TRICARE Approved:** This is the amount TRICARE approved as payment for the services.
- **See Remarks:** There is a code or a number here specific to a claims processing action; look at the "Remarks" section for more information about how the claim processed.
- **Claim Summary:** A detailed explanation of the action taken by the claims processor. Includes the following: Amount billed, amount approved by TRICARE, non-covered amount (if any) that was already paid to the provider by the beneficiary, amount the OHI paid, amount paid to the provider, and amount paid to the beneficiary. A check number appears here only if a check accompanies an EOB.
- **Beneficiary Liability Summary:** The amount the beneficiary is responsible for paying—may be a deductible, copayment, cost share, point of service, or non-covered service charge.
- **Benefit Period Summary:** This section shows how much of the individual and family annual outpatient deductible and maximum out-of-pocket expense has been paid to date. Claims processors calculate TRICARE Standard or Extra beneficiaries' annual deductibles and maximum out-of-pocket expenses by fiscal year. If a TRICARE Prime beneficiary, they calculate the maximum out-of-pocket expense by enrollment and fiscal year. (Note: The enrollment year date will appear on the EOB only if the beneficiary is enrolled in a TRICARE Prime option.)
- **Remarks:** Explanations of the codes or numbers listed in "See Remarks" appear here.
- **Toll-Free Telephone Number:** The toll-free number to the claims processor for questions about the EOB.

10.0 Application Exercises

The exercises on the following pages test your ability to properly review an EOB and advise a beneficiary who needs assistance. Take a few moments to familiarize yourself with the components of an EOB (previous page) prior to beginning the exercises.

10.1 Group Activity: Reading an EOB

Answer the questions below based on the fictitious sample EOB provided.

EOB: Jane Smith

- What is the date of notice on this EOB?
- Who is the sponsor?
- Who is the beneficiary that received services?
- Who provided the care and what type of care was received?
- How much was billed?
- How much did TRICARE cover, and what is the term for this approved amount?
- What do the remark codes indicate?
- What amount was paid by TRICARE?
- How much (if any) was applied to the deductible?
- How much was the cost share/copay?
- How much was the beneficiary's responsibility?
- Was payment made to the provider or the beneficiary?
- What type of provider was this?
- Which TRICARE option was the beneficiary using? How do you know?

10.2 Practice Scenario

Mrs. Jane Smith just walked into your office, irate and irrational. She recently had a visit at Pierce, Hunnicutt, & Winchester, P.C. She paid the doctor's office \$200 at the time of service and was told that she could file with TRICARE for reimbursement of her payment.

Mrs. Smith filed her reimbursement claim with the appropriate claims processor. She received her EOB, along with a check for \$60.

She is upset because she was not reimbursed the full \$200 that she paid to the doctor's office. Mrs. Smith wants to get this matter resolved and decided she needed to speak with someone face-to-face.

Based on her EOB and your knowledge of TRICARE claims, please assist Mrs. Smith with understanding why she was not reimbursed the full \$200 by TRICARE.



Jane Smith
123 S. Christmas Lane
Nice, SC 20315

If you have questions about this notice, please call
1-800-123-4569 or visit us online at www.tricareu.com

TRICARE EXPLANATION OF BENEFITS

Administered by: TRICARE University

This is a statement of the action taken on your TRICARE claim. Keep this notice for your record.

Date of Notice	January 15, 2010
Sponsor SSN	XXX-XX-XXXX
Sponsor Name	John Smith
Beneficiary Name	Jane Smith
Claim Number	345678901
Provider Number	XX-XX648
Check Number	512340

Explanation of Benefits		THIS IS NOT A BILL		Explanation of Benefits	
SERVICES PROVIDED BY	DATE OF SERVICE	SERVICES PROVIDED	AMOUNT BILLED	TRICARE ALLOWED	REMARKS
Pierce, Hunnicutt, & Winchester, P.C.	11/29/2009	Outpatient Visit (99214)	\$200.00	\$80.00	01, 02, 03
Totals:			\$200.00	\$80.00	
CLAIMS SUMMARY			BENEFICIARY SHARE		
TRICARE Amount Billed	\$200.00		Copay	\$0.00	
TRICARE Allowed	\$80.00		Cost Share	\$20.00	
TRICARE Paid	\$60.00		Deductible	\$0.00	
Other Ins. Allowed	\$0.00		Patient Responsibility	\$20.00	
Other Ins. Paid					
Other Ins. Patient Resp.					
OUT OF POCKET EXPENSE:					
Beginning October 1, 2009			Beginning October 1, 2009		
	Met To Date	Limit		Met To Date	Limit
Deductible	\$150.00	\$300.00	Catastrophic Cap	\$170.00	\$3,000.00
REMARKS					
01 – Billed amount exceeds allowance.					
02 – You receive maximum benefits when you use a network provider. By law, a non-network provider may balance bill an additional 15% above the TRICARE allowable charge.					
03 – \$20.00 has been applied toward the catastrophic cap of \$3,000.00.					
PAID TO		AMOUNT PAID		CHECK NUMBER	
Jane Smith		\$60.00		512340	

11.0 Claims Processors

North Region Claims Processor

North Region Locations			
Connecticut	Delaware	District of Columbia	Florida
Georgia	Illinois	Indiana	Kentucky
Maine	Maryland	Massachusetts	Michigan
Missouri (St. Louis area)	New Hampshire	New Jersey	New York
North Carolina	Ohio	Pennsylvania	Rhode Island
South Carolina	Tennessee (only counties surrounding Ft. Campbell)	Vermont	Virginia
West Virginia	Wisconsin		
PGBA P. O. BOX 870140 Surfside Beach, SC 29587-9740 Telephone: 1-877-874-2273			

South Region Claims Processor

South Region Locations		
Alabama	Arkansas	Florida
Georgia	Louisiana	Mississippi
Oklahoma	South Carolina	Tennessee (excluding the Ft. Campbell area)
Texas (except William Beaumont catchment area in El Paso and Cannon AFB service are ZIP codes that fall in Texas)		
PGBA P.O. BOX 7031 Caden, SC 29020-7031 Telephone: 1-800-403-3950		

West Region Claims Processor

West Region Locations				
Alaska	Arizona	California	Colorado	Hawaii
Idaho	Iowa (excluding Rock Island Arsenal area)	Kansas	Minnesota	Missouri(except St. Louis area)
Montana	Nebraska	Nevada	New Mexico	North Dakota
Oregon	South Dakota	Utah	Washington	Wyoming
WPS P.O. BOX 77028 Madison, WI 53707-7028 Telephone: 1-888-915-4001				

TRICARE Eurasia-Africa Claims Processor

TRICARE Eurasia-Africa Locations
Europe, Africa, Middle East
WPS P.O. BOX 897 Madison, WI 53708-8976
Telephone: 1-877-678-1207 (toll free stateside); +44-20-8762-8384, Option #2

TRICARE Pacific Region Claims Processor

TRICARE Pacific Locations
Western Pacific (e.g. Japan, Guam, Korea, Thailand)
WPS P.O. BOX 7985 Madison, WI 53707-7985 Telephone: 1-877-451-8659, option 2

Latin America, Canada, Puerto Rico, and Virgin Islands Region Claims Processor

TRICARE TLAC Locations
All of Latin America, Canada, Bermuda, Puerto Rico, and Virgin Islands
WPS P.O. BOX 7985 Madison, WI, 53707-7985 Telephone: 1-877-451-8659, option 2 (For Puerto Rico) 1-800-700-7104

TRICARE for Life Claims

Stateside and US Territories	Overseas
WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890 Telephone: 1-866-773-0404	TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 USA

12.0 Appeals

To appeal means to request that the regional contractor or TRICARE Management Activity (TMA) review an authorization or claims denial decision.

- The appeals process varies, depending on whether the denial involves:
 - Medical Necessity
 - Factual Determination
 - Dual-Eligible beneficiary (Medicare-TRICARE eligible beneficiaries)
 - Provider Sanction
- All initial denials and appeal denials explain how, where, and by when to file the next level of review.

13.0 Who Is Able to Appeal?

- The appealing party must be able to prove that he/she is eligible for TRICARE benefits including:
 - Any TRICARE beneficiary, or a parent or guardian of a beneficiary who is under 18
 - The guardian of a beneficiary who is not competent to act on their own behalf
 - A health care provider who has been:
 - Denied approval
 - Suspended, excluded, or terminated as a TRICARE-authorized provider
 - Providers who participate in TRICARE and accept the TRICARE-allowable charge as their full fee
 - A representative appointed in writing by a beneficiary or provider
- Certain individuals may not serve as beneficiary representatives due to a conflict of interest including:
 - A legal officer (member of a uniformed services legal office)
 - BCAC/DCAO/Health Benefits Advisor (HBA)
 - Employee of the federal government, such as a military service member, MTF provider, Health Benefits Advisor (HBA) or an employee of a uniformed service, unless the representative is an immediate family member.
- Providers who do not participate in TRICARE and network providers cannot file appeals.

14.0 What Can Be Appealed?

- The facts of the beneficiary's case can be appealed including:
 - The diagnosis
 - The necessity to be an inpatient
 - The denial of pre-authorization for services, including mental health
 - The termination of treatments or services that were previously authorized
 - The denial of TRICARE payment for services or supplies received
 - The denial of TRICARE payment for continuation of services or supplies that were previously authorized
 - The denial of a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE

15.0 What Cannot Be Appealed?

The following are examples of what cannot be appealed:

- The amount of the TRICARE determined costs or charges for a particular medical service
 - The beneficiary may ask the regional contractor for an allowable charge review, but cannot file an appeal.
- The decision by the regional contractor or TMA to ask the beneficiary for more information before taking action on the beneficiary's claim or appeal request.
- Beneficiaries cannot appeal decisions relating to the status of TRICARE providers.
- Although a beneficiary may want to receive care, or already received care from a particular provider, the beneficiary cannot appeal a decision that denies the provider authorization to be a TRICARE provider, or a decision that suspends, excludes, or terminates the provider.
 - The provider in question may appeal on his/her own behalf.
- The decisions relating to eligibility as a TRICARE beneficiary cannot be appealed.
 - The Services determine eligibility and DEERS reports it.
 - Beneficiaries must appeal decisions regarding their eligibility through their branch of Service.

16.0 Appeals of Medical Necessity Determinations

- "Medical Necessity" is based on whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition, to include decisions on custodial and mental health care services.
- It may be necessary to show medical necessity for inpatient, outpatient, and specialty care.
- The beneficiary must send a package to the regional contractor, including a cover letter with relevant case information, a copy of the denial letter, and any associated EOBs, claims, bills, and/or documents that the beneficiary feels support overturning the denial decision.
 - Failure to include a copy of the denial letter may delay the review process or cause the appeal to be routed incorrectly.
 - If the beneficiary cannot get all of the supporting documents in on time, they should send the appeal anyway and state in the cover letter their intention to submit additional information when it becomes available.
 - The beneficiary should keep originals of all paperwork related to the appeal.
- There are two kinds of medical necessity determination appeals:
 - Expedited
 - Non-Expedited

Most appeals are non-expedited.

16.1 Expedited Appeal

- An expedited appeal should only be submitted to reconsider approval of inpatient stays or prior authorization of services.
- A beneficiary must file a request for an expedited reconsideration of a pre-admission/pre-procedure denial within three calendar days after the date of the receipt of the initial denial determination.
- Beneficiaries are notified of a decision within 3 working days after the regional contractor receives the request.
- Overseas beneficiaries may file an appeal online at tricare4u.com or download a TRICARE Overseas Program - Universal Grievance and Complaint Form at tricare-overseas.com.

16.2 Non-Expedited Appeal

- To file a non-expedited appeal, the beneficiary sends the information package (see 16.0) to the regional

contractor at the address specified in the notice of the beneficiary's right to appeal, included on their Explanation of Benefits (EOB) or other notification.

- The package must be postmarked or received within 90 days of the date on the EOB or initial denial determination notice (usually a letter).
- The regional contractor reviews the case and issues a reconsideration review determination-either supporting or overturning the denial.
- If the amount is less than \$50, the decision is final.
- If the denial is again upheld, the beneficiary can appeal to TMA via the TRICARE Quality Monitoring Contractor.

16.3 TRICARE Quality Monitoring Contractor (TQMC)

- If the regional contractor upholds the denial determination on a second review, the next level of appeal is to the TQMC.
- The beneficiary sends a letter to the TQMC.
 - The letter must be postmarked or received within 90 days of the date on the regional contractor's reconsideration decision determination notice.
 - A copy of the reconsideration decision and any supporting documents not previously submitted must be included with the letter. If the beneficiary cannot get all of the supporting documents in on time, they should state in the cover letter their intention to submit additional information in the near future.
 - The beneficiary should keep copies of all paperwork.
- The TQMC reviews the case and issues a second reconsideration decision.
 - If the amount is less than \$300, the TQMC decision is final.
 - If the beneficiary disagrees, and the disputed services are \$300 or more, the beneficiary can request that TMA schedule an independent hearing. The address for filing this request is:

TRICARE Management Activity
Appeals, Hearings, and Claims Collection Division
16401 E. Centretech Parkway
Aurora, CO 80011-9066

- An independent hearing officer conducts the hearing at a location convenient to both the requesting party and the government.
- The hearing officer makes a decision recommendation and the Assistant Secretary of Defense for Health Affairs issues the final decision.

17.0 Appeals of Factual Determinations

Factual determinations involve issues other than medical necessity, such as coverage issues, provider authorization (status) requests, hospice care, foreign claims, and denial of a provider's request for approval as a TRICARE-authorized provider. Medical or peer review may be necessary to reach a factual determination.

17.1 Factual Determination Appeal Process

- To file a factual determination appeal, the beneficiary submits the same kind of packet they would submit for a medical necessity appeal.
- This reconsideration letter must be postmarked or received within 90 days of the date on the EOB or initial denial determination notice.
- The regional contractor issues a reconsideration determination within 60 days of the beneficiary's request.
 - If the beneficiary appeals an amount less than \$50, the regional contractor's reconsideration (second)

determination is final.

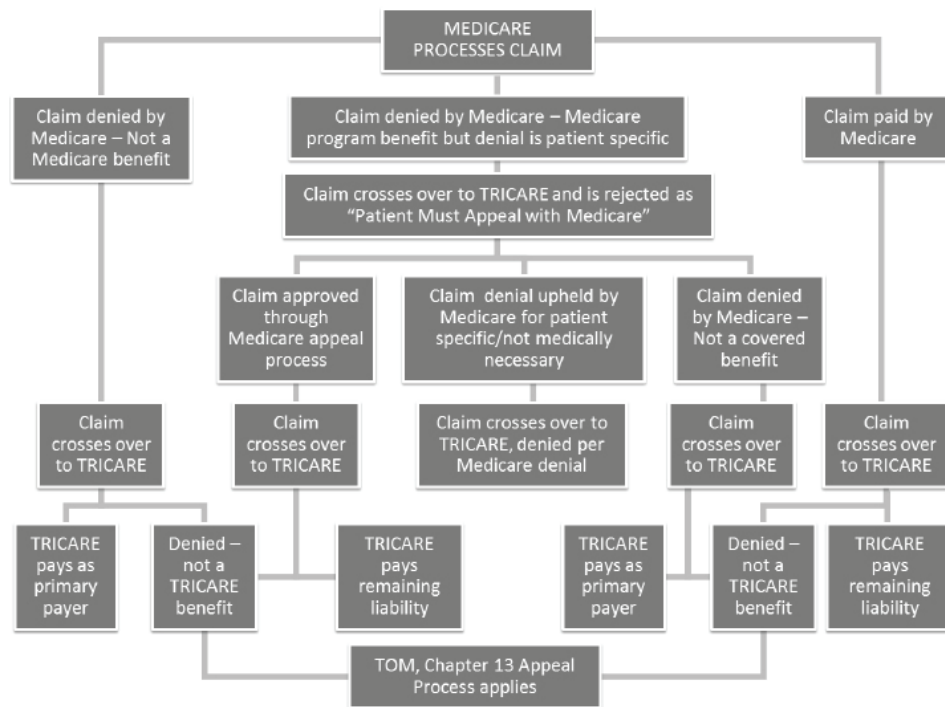
- If appealing an amount greater than \$50, the regional contractor issues a determination and if the denial is upheld, instructs the beneficiary to file a formal review request with TMA.
- To request a formal review, beneficiaries must send a letter to TMA within 60 days (postmarked or received) of the date on the reconsideration decision notice and include copies of the decision along with additional supporting documents.
- TMA typically issues a formal review decision within 90 days.
 - If the disputed amount is less than \$300, TMA's decision is final.
 - If the disputed amount is more than \$300, the beneficiary can request an independent hearing.
- To request an independent hearing, the beneficiary must send a request to TMA-Aurora within 60 days (postmarked or received) from the date of TMA's formal review determination.
- The beneficiary should include a copy of the formal review determination and any supporting documents not previously submitted.
- An independent hearing officer then conducts the hearing at a location convenient to both the requesting party and the government.
- The hearing officer makes a decision recommendation and the Assistant Secretary of Defense for Health Affairs issues the final decision.
- Factual appeals and appeal correspondence for the TMA should be addressed to:

TRICARE Management Activity
Appeals, Hearings and Claims Collection Division
16401 E. Centretech Parkway
Aurora, CO 80011-9066

Overseas beneficiaries may file an appeal online at tricare4u.com or download a *TRICARE Overseas Program - Universal Grievance and Complaint Form* at tricare-overseas.com.

18.0 Appeals for Dual Eligibility Determinations

- Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process.
- However, if a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE.
- Services and supplies denied payment by Medicare will be considered for coverage by TRICARE if the Medicare denial of payment is not appealable under the Medicare appeal process.
- Note: TRICARE regional boundaries do not apply under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC). The TDEFIC contractor, Wisconsin Physician Services, is responsible for processing all medical claims for services, except retail pharmaceuticals, rendered to TRICARE/Medicare dual eligible individuals within the 50 United States and the District of Columbia, as well as Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.



19.0 Provider Sanction

A Sanctioned Provider is a provider who is denied approval as an authorized TRICARE provider or who was terminated, excluded, suspended, or otherwise sanctioned.

- Providers may be sanctioned by TRICARE because of the following:
 - Failure to maintain credentials
 - Provider fraud
 - Abuse
 - Conflict of interest or other reasons
- Only the provider or their representative can appeal the sanction.
- If the provider appeals the sanction, an independent hearing officer conducts a hearing administered by the TMA Appeals, Hearings, and Claims Collection Division in Aurora, Colorado.

20.0 TRICARE Prime Remote Appeals

- If an active duty service member (ADSM) in a designated remote location stateside or overseas does not receive prior authorization for specialty care his or her claim may be denied:
 - The ADSM may appeal by first contacting the Military Medical Support Office (MMSO) Service Point of Contact (SPOC) or MTF staff if care was based on an MTF referral or the ADSM shows as enrolled in Prime at an MTF on the date of service, or the overseas regional contractor if care was received in an overseas location (other than the Virgin Islands, for which the MMSO authorizes care.)
 - Active Duty Service Members (ADSMs), their primary care manager (network or TRICARE-authorized provider) may send additional written information or documentation to the SPOC to support the ADSM's appeal request.
- If the request is denied on appeal, the ADSM may then appeal to their Surgeon General or the senior medical

officer of their respective Service. The address for this second appeal is provided to the ADSM upon denial of the first appeal.

20.1 Service Points of Contact at the Military Medical Support Office

- ADSMs from the Army, Navy, Air Force, Coast Guard, and Marine Corps may contact their SPOC at 1-888-MHS-MMSO/1-888-647-6676. Send written inquiries to:

[Insert branch of service] Point of Contact
Military Medical Support Office (MMSO)
P.O. Box 886999
Great Lakes, IL 60088-6999
- United States Public Health Service and National Oceanic and Atmospheric Administration members may contact their Beneficiary Medical Program SPOC at 1-800-368-2777, option 2.

21.0 Program Integrity

- The TMA Office of Program Integrity:
 - Is the investigative arm of TMA
 - Provides management of the TMA anti-fraud program
 - Is responsible for national coordination and control of cases through their work with contractors, the Department of Justice, and investigative agencies
 - Provides oversight to all contractor program integrity units to ensure compliance in the area of anti-fraud activities
- Program Integrity is responsible for deterring fraud, waste, and abuse through:
 - Prevention
 - Detection
 - Coordination
 - Enforcement

21.1 What is Fraud?

- Fraud is any intentional deception or misrepresentation that an individual or entity does which could result in an unauthorized TRICARE benefit or payment.
- TRICARE considers the following fraudulent acts under the program:
 - Submitting claims for services not rendered or used
 - Falsified claims or medical records
 - Misrepresentation of dates, frequency, duration, or description of services rendered
 - Billing for services at a higher level than provided or necessary
 - Over-utilization of services
 - Breach of provider participation agreement

21.2 Who Commits Fraud?

- Dishonest health care providers and other health care professionals commit the majority of fraud. Examples: Physicians, dentists, labs, hospitals, psychiatrists, ambulance companies, and clinics.
- Contractors and contract employees
- A lesser percent is attributed to beneficiary fraud

21.3 Fraud Indicators

Excessive charges by provider	Providers routinely billing the same procedures to every patient, regardless of diagnosis	Too many providers for same date of service
Claims with excessive or vague documentation	Claims handwritten in the same ink for both the beneficiary and provider portion of claim	Conflicting dates of service
Correspondence for rapid adjudication	Provider is not in the same geographic area as the beneficiary, particularly when patterns occur	Provider who uses post office boxes for the remit to address
Reluctance of provider to submit records	Excessive billing by provider for low cost items or services	Claims with misused or misspelled medical terms
Diagnosis or treatment inconsistent with patient's age or sex	High volume of treatment for a particular condition or diagnosis	Erasures, cross-outs, or white outs
Illogical places of service	Overlapping services on the same date	

21.4 Potential outcome of cases referred to TRICARE

- Criminal conviction
- Civil settlement
- Administrative action by contractor
- Termination action
- Exclusion action, i.e. removal from the TRICARE program

21.5 Where to Report Potential Fraud Cases

TRICARE Region North

Health Net Federal Services

Fraud Hotline: 1-800-977-6761

E-mail: Program.Integrity@healthnet.com

TRICARE Region West

TriWest Healthcare Alliance

1-888-584-9378

E-mail: PI@triwest.com,

TRICARE Region South

Humana Military Healthcare Services

1-800-333-1620

Online: infocenter.humana-military.com/South/bene/progintegreferral.asp

TRICARE for Life

1-866-773-0404

E-mail: reportit@wpsic.com

TRICARE Management Activity Program Integrity Office

16401 East Centretex Parkway

Aurora, CO 80011

Phone: (303) 676-3824

Fax: (303) 676-3981

E-mail: fraudline@tma.osd.mil.

United Concordia

1-877-968-7455

Online: <https://secure.ucci.com/non-ldap/forms/form.html>

Express Scripts, Inc.

1-800-332-5455

E-mail: FraudTip@express-scripts.com

International SOS

1-800-834-5514 or 1-215-701-2800 (collect)

TRICARE Overseas

1-877-342-2503

Delta Dental

1-888-838-8737

22.0 Summary

22.1 Where to Get Additional Information for Beneficiaries

If Military Health System support staff cannot answer a beneficiary's questions about their claims denials, direct them to the following:

- Regional contractor or claims processor
- National Guard/Reserve members and their families should contact:
 - Nearest MTF or Medical Support Office
 - BCACs at the TRICARE Regional Office or TRICARE Area Office overseas
- TRICARE Service Center

22.2 Beneficiary Appeals Checklist

- Meet all the required deadlines
- Send appeals in writing with signatures
- Include copies of all supporting documents in their appeal. If all paperwork is not available, send the letter within the deadline and note that more information will be sent.
- Keep copies of everything

Module Objectives



Summary

- Explain who can file claims and where claims should be submitted
- Describe how to resolve claims issues
- Identify three reasons why an Explanation of Benefits may be delayed
- Distinguish between what can and cannot be appealed

Appendix: Sample Explanation of Benefits Statements

The following pages list figures and reference details for each regional contractor's explanation of benefits (EOB) statements.

North Region

South Region

West Region

North Region - Sample Explanation of Benefits

How to Read Your TRICARE EOB for the North Region

1. **PGHA, LLC (PGHA):** PGHA processes all TRICARE claims for the region where you live.
2. **Regional Contractor:** The name "Health Net Federal Services" and the Health Net Federal Services, LLC logo appear here.
3. **Date of Notice:** PGHA prepared your TRICARE EOB on this date.
4. **Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor.
5. **Beneficiary Name:** This is the name of the patient who received medical care and for whom this claim was filed.
6. **Mail-to Name and Address:** We mail the TRICARE EOB directly to the patient (or patient's parent or guardian for minors) at the address given on the claim. Note: Be sure your doctor has updated your records with your current address.
7. **Benefits Were Payable To:** This field appears only if your doctor accepts assignment. This means the doctor accepts the TRICARE maximum allowable charge as payment in full for the services you received.
8. **Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it is processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
9. **Service Provided By/Date of Services:** This section lists who provided your medical care, the number of services, procedure codes, and the date(s) you received care.
10. **Services Provided:** This section describes the medical services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and labs use to identify the specific medical services you received.
11. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
12. **TRICARE Approved:** This is the amount TRICARE approves for the services you received.
13. **See Remarks:** If you see a code or a number here, look at the "Remarks" section (18) for more information about your claim.
14. **Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) you already paid to the provider, amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we paid to the provider, and benefits we paid to the beneficiary. A check number will appear here only if a check accompanies your EOB.
15. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges we applied to your annual deductible and any cost-share or copayment you must pay.
16. **Patient Responsibility:** This is the total amount you owe for this claim.
17. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the "Fiscal Year Beginning" date in this section for the first date of the fiscal year.
18. **Remarks:** Explanations of the codes or numbers listed in "See Remarks" appear here.
19. **Toll-Free Telephone Number:** If you have questions about your TRICARE EOB, please call PGHA toll-free at 1-877-TRICARE (1-877-874-2273). Our professional customer service representatives will gladly assist you.

1 PGHA, LLC
TRICARE NORTH REGION
P.O. BOX 870340
SUNFISH SPRING, SC 29587-9740

2  **HealthNet**
Federal Services
WWW.HEALTHNETFEDERALSERVICES.COM

TRICARE EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

3 Date of Notice: **October 22, 2009**
4 Sponsor EIN: *****-**-9999**
5 Sponsor Name: **TRICARE SPONSOR**
6 Beneficiary Name: **TRICARE BENE**

7 **TRICARE BENE**
5342 ANY STREET
ANYCITY TX 88888-9999

8 Partial benefits were payable to:
PATHOLOGY LABDOE
STE 999
9999 N JERGENS ST
TOLEDO OH 99999

9 **Claim Number: 999999999-00-00**

Services Provided By/ Date of Service 9	Services Provided 10	Amount Billed 11	TRICARE Approved 12	APC#	See Remarks 13
PATHOLOGY LABDOE 09/22/2009	001 Emergency dept visit (99282)	32.84		11111	1, 2, 3
09/22/2009	001 Repair superficial wound(s) (12002)	161.84	161.84	11111	1, 2
Totals:		194.68	161.84		

Claim Summary 14	Beneficiary Liability Summary 15	Benefit Period Summary 17
Amount Billed: 194.68	Deductible: 0.00	Fiscal Year Beginning:
TRICARE Approved: 161.84	Copayment: 0.00	October 01, 2009
Non-covered: 32.84	Cost Share: 0.00	
Paid by Beneficiary: 0.00	Patient Responsibility: 0.00	Deductible: Individual 0.00 Family 0.00
Other Insurance: 0.00	16	Catastrophic Cap: 0.00
Paid to Provider: 161.84		
Paid to Beneficiary: 0.00		
Check Number: 5990655666		

Remarks: 18

- 1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.
- 2 - YOUR CLAIM HAS BEEN PROCESSED UNDER THE SUPPLEMENTAL HEALTH CARE PROGRAM. IF YOU HAVE QUESTIONS ABOUT THE PROCESSING OF YOUR CLAIM PLEASE CALL PGHA AT 1-877-874-2273. IF YOU WISH TO APPEAL YOUR CLAIM YOU MUST SUBMIT YOUR REQUEST IN WRITING TO YOUR SERVICE POINT OF CONTACT.
- 3 - GREAT NEWS! PGHA IS MAKING TRICARE EASIER. YOU CAN NOW VIEW THE STATUS OF YOUR CLAIMS AT WWW.MYTRICARE.COM. FOR MORE INFORMATION VISIT OUR WEB SITE TODAY.

19 1-877-TRICARE (1-877-874-2273)

THIS IS NOT A BILL.

If you have questions regarding this notice, please call or write us at telephone number/address listed above.



South Region - Sample Explanation of Benefits

How to Read Your TRICARE EOB for the South Region

1. **PGHA, LLC (PGHA):** PGHA processes all TRICARE claims for the region where you live.
2. **Regional Contractor:** The name "Humana Military Healthcare Services" and the Humana Military Healthcare Services, Inc. logo appear here.
3. **Date of Notice:** PGHA prepared your TRICARE BOB on this date.
4. **Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) of the military service member (*active duty, retired, or deceased*) who is your TRICARE sponsor. For security reasons, only the last four digits of your sponsor's SSN appear on the BOB.
5. **Beneficiary Name:** This is the name of the patient who received medical care and for whom this claim was filed.
6. **Mail-to Name and Address:** We mail the TRICARE EOB directly to the patient (*or patient's parent or guardian for minors*) at the address given on the claim. **Note:** Be sure your doctor has updated your records with your current address.
7. **Benefits Were Payable To:** This field appears only if your doctor accepts assignment. This means the doctor accepts the TRICARE maximum allowable charge as payment in full for the services you received.
8. **Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it is processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
9. **Service Provided By/Date of Service:** This section lists who provided your medical care, the number of services, procedure codes, and the date(s) you received care.
10. **Services Provided:** This section describes the medical services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and labs use to identify the specific medical services you received.
11. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
12. **TRICARE Approved:** This is the amount TRICARE approves for the services you received.
13. **See Remarks:** If you see a code or a number here, look at the "Remarks" section (17) for more information about your claim.
14. **Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) you already paid to the provider, amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we paid to the provider, and benefits we paid to the beneficiary. A check number will appear here only if a check accompanies your BOB.
15. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges we applied to your annual deductible and any cost-share or copayment you must pay.
16. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the "Fiscal Year Beginning" date in this section for the first date of the fiscal year.
17. **Remarks:** Explanations of the codes or numbers listed in the "See Remarks" section appear here.
18. **Toll-Free Telephone Number:** If you have questions about your TRICARE BOB, please call PGHA at this toll-free number. Our professional customer service representatives will gladly assist you.

1 RBA, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29020-7032

2 HUMANA MILITARY
HEALTHCARE SERVICES
★★★★★
www.humana-military.com

TRICARE EXPLANATION OF BENEFITS

This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

3 Date of Notice: October 1, 2009
4 Sponsor SSN: *xxxx-xx-xxxx*
5 Sponsor Name: NAME OF SPONSOR
Beneficiary Name: NAME OF BENEFICIARY

6 PATIENT, PARENT/GUARDIAN
ADDRESS
CITY STATE ZIP CODE

7 Benefits were payable to:
PROVIDER OF MEDICAL CARE
ADDRESS
CITY STATE ZIP CODE

8
Claim Number: 9279X0000-00-00

Services Provided By/ Date of Service	9	Services Provided	10	Amount Billed	11	TRICARE Approved	12	See Remarks	13
PROVIDER OF MEDICAL CARE									
10/01/2009		001 Initial comprehensive preve (99381)		97.00		81.10		1, 2	
10/01/2009		001 Diphtheria, tetanus toxoids, (90696)		101.00		78.84		1	
10/01/2009		001 Pneumococcal conjugate vacri (90669)		110.00		95.48		1	
Totals:				308.00		255.42			

Claim Summary	14	Beneficiary Liability Summary	15	Benefit Period Summary	16
Amount Billed:	308.00	Deductible:	0.00	Fiscal Year Beginning:	
TRICARE Approved:	255.42	Copayment:	0.00	October 01, 2009	
Non-covered:	255.42	Cost Share:	0.00		
Paid by Beneficiary:	255.42	Patient Responsibility:	0.00	Deductible:	Individual 0.00 Family 0.00
Other Insurance:	255.42			Catastrophic Cap:	9.00
Paid to Provider:	255.42				
Paid to Beneficiary:	0.00				
Check Number:					

Remarks: 17

1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.

2 - VISIT WWW.HUMANA-MILITARY.COM AND WWW.MYTRICARE.COM TO MANAGE YOUR HEALTH CARE ONLINE.
FIND A PROVIDER, READ YOUR BENEFITS INFORMATION, CHECK INDIVIDUAL CLAIM AND REFERRAL
STATUS, ELIGIBILITY, AND MUCH MORE.

18

1-800-463-3850

THIS IS NOT A BILL.

If you have questions regarding this notice, please call or write us at telephone number/address listed above.



West Region - Sample Explanation of Benefits

How to Read Your TRICARE EOB for the West Region

- 1. Mail-to Name and Address:** We mail the TRICARE EOB directly to the patient (or patient's parent or guardian for minors) at the address given on the claim. Note: Be sure your doctor has updated your records with your current address.
- 2. Date of Notice:** This is the date we prepared your TRICARE EOB.
- 3. Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor.
- 4. Patient Name:** This is the name of the patient who received medical care and for whom this claim was filed.
- 5. Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it is processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
- 6. Check Number:** A check number appears here only if a check accompanies your EOB.
- 7. Toll-Free Number/Web Address:** Use this information to contact us, TriWest Healthcare Alliance Corp. (TriWest), if you have questions.
- 8. Services Provided By:** This shows who provided your medical care, the number(s) and type(s) of service(s), and the procedure code(s).
- 9. Date of Service:** This is the date you received care.
- 10. Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
- 11. TRICARE Allowed:** This is the amount TRICARE approves for the services you received.
- 12. Remarks:** If you see a code or a number here, look at the "Remark Codes" section (16) for more information about your claim.
- 13. Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) you already paid to the provider, amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we paid to the provider, and benefits we paid to the beneficiary.
- 14. Beneficiary Share:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges that we applied to your annual deductible and any cost-share or copayment you must pay.
- 15. Out of Pocket Expenses:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the "Fiscal Year Beginning" date in this section for the first date of the fiscal year.
- 16. Remark Codes:** Explanations of the codes or numbers listed in the "Remarks" section (12) appear here.
- 17. Paid To:** This is the name of the provider or facility to whom the claim was paid.
- 18. Regional Contractor:** The name "TriWest Healthcare Alliance" and the TriWest logo appear here.



TRICARE EXPLANATION OF BENEFITS

Administered by: TriWest Healthcare Alliance

This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.

1 John B. Nice
123 Apple Lane
Huntsville, WA 12345-6789

7 If you have any questions about this notice, please call toll-free at **1-888-TRIWEST** (874-9378). You can also visit us online at **www.triwest.com**.

2	Date of Notice	08/14/2009
3	Sponsor SSN	234567890
4	Sponsor Name	John B. Nice
5	Patient Name	John B. Nice
6	Claim Number	2002212 053 0017930
6	Check Number	C0001545337
6	Provider Number	752906887 76550 0001
6	Provider Name	ABC Valley Clinic

THIS IS NOT A BILL

SERVICES PROVIDED BY 8	DATE OF SERVICE 9	AMOUNT BILLED 10	TRICARE ALLOWED 11	REMARKS 12
Michael Smith, MD	03/23/09-03/27/09	\$000,000.00	\$000,000.00	003
Total		\$000,000.00	\$000,000.00	

CLAIM SUMMARY 13		BENEFICIARY SHARE 14	
TRICARE Amount Billed	\$000,000.00	Cost-Share/Copay	\$000,000.00
TRICARE Allowed	\$000,000.00	Deductible	\$000,000.00
TRICARE Paid	\$000,000.00	Beneficiary Responsibility	\$000,000.00
Other Insurance Allowed	\$000,000.00		
Other Insurance Paid	\$000,000.00		
Other Insurance Patient Responsibility	\$000,000.00		
Amount Applied to Offset	\$000,000.00		

15 OUT OF POCKET EXPENSE:

	Beginning October 1, 2009		Beginning October 1, 2008		Beginning October 1, 2007	
	Limit	Met to Date	Limit	Met to Date	Limit	Met to Date
Individual Deductible	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00
Family Deductible	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00
Catastrophic cap	\$0,000.00	\$0,000.00	\$0,000.00	\$0,000.00	\$0,000.00	\$0,000.00

16 Remark Codes:

003: See item 5 on reverse. If you are not satisfied with our determination, you have the right to request a review within 90 days of the notice.

17 PAID TO	AMOUNT PAID	BENEFICIARY RESPONSIBILITY
Skagit Valley Clinic	\$000,000.00	\$000,000.00

