- PATIENT'S COPY -

TRICARE DoD/CHAMPUS MEDICAL CLAIM PATIENT'S REQUEST FOR MEDICAL PAYMENT

OMB No. 0720-0006 OMB approval expires August 31, 2018

The public reporting burden for this collection of information, 0720-0005, 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dd-information-collections@mail.mil. 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 defense is the subject to any penalty for failing to comply with a collection of information is to the period of the subject to any penalty for failing to comply with a collection of information is to the penalty of the provision of the penalty of the subject to any penalty for failing to comply with a collection of information is to the penalty of the 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, guality 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.

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;
- 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.

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 deadiline, 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 80011-9066.

* * * **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.

- PATIENT'S COPY -

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	S NAME (Last, First, N	liddle Ir	nitial)			2.	PATIENT'S TELEPHONE NU	MBE	R (Inc	lude Area C	ode)				
							DAYTIME ()								
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local currency. NOTE: Payment available only in some local currencies.

TRICARE DoD/CHAMPUS MEDICAL CLAIM PATIENT'S REQUEST FOR MEDICAL PAYMENT

OMB No. 0720-0006 OMB approval expires August 31, 2018

The public reporting burden for this collection of information, 0720-0005, 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. 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, guality 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. 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.

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 deadiline, or within 90 days of the notice -- whichever date is later.

* * * * * *

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 80011-9066.

* * * **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.

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	MEDICATIC	N. IF AN INJURY	', NO	TE HO	DW IT H	APPENE	D. RE	FER TO	O I	INSTRUCTIONS BELOW.		INF	PATIENT?		PHARN	/ACY?						
												_	TPATIENT?									
												_	Y SURGER									
	SPONSOR					ant Finat	N 4: -1 -11 -	10		PONSOR'S OR FORMER S						IDED						
9.	Initial)	S OR FORMER SI	-003	5E 9 I		ast, First,	Midale	10.	. 3	PONSOR S OR FORMER S	P00	3E 3	SUCIAL SE	CURII		IDER						
11.	OTHER HEA	ALTH INSURANCE	E CO	VERA	GE			-														
a.	Is patient co	vered by any other	heal	lth ins	urance p	lan or pr	oaram t	o inclu	ıde	health coverage available th	nroua	ih oth	er familv me	mbers	?	YES						
										ns below). If no, you must cl												
										urance information, but do re						NO						
									_													
b.	-	OVERAGE (Check	all tha	¬ '' ́	,																	
	(1) EMPLC	YMENT (Group)		(3) N	/IEDICAI	RE		(5) ME	EDI	ICARE SUPPLEMENTAL IN	SUR	ANCE	(7)	OTHE	R (Speci	ify)						
	(2) PRIVAT	ΓΕ (Non-Group)		(4) \$	STUDEN	T PLAN		(6) PR	RES	SCRIPTION DISCOUNT PLA	N											
		c. NAME AND ADD		SOF		FAI TH IN	SURAN	CF.		d. INSURANCE IDENTIFICATIO)N		e. INSURANC	E	f. DRU	G						
		(Street, City, Sta					001011			NUMBER		EFFECTIV (YYYYMM)			ERAGE?							
					,				-				(1111000)	-	1						
IN	SURANCE															YES						
	1															NO						
																YES						
IN	SURANCE																					
2																NO						
	REMI	NDFR: Attach voi	ir oth	er hea	alth insur	ances's	Fxnlana	tion of	f B	enefits or pharmacy receipt t	hat ir	ndicat	es the actua	l drua i	cost	•						
	1(200		ii ouri	01 1100						e amount that you paid.	nat n	laioai		i ulug i	,							
12.	SIGNATUR	E OF PATIENT OF	R AU	THOR	IZED PE		ERTIF	IES CO	OR	RECTNESS OF CLAIM AND	C		13. OVERS	EAS C	LAIMS	ONLY:						
		ES RELEASE OF									-		PAYME		OCAL							
a	SIGNATUR	=				b. DA	TE SIG	NFD	Т	c. RELATIONSHIP TO PATI	FNT		CURRE	NCY?								
ч.		-					YYMMD															
						`		,					Y	S		NO						
																1						
				HO	W TO	FILL O	UT TH	IE TF	RI	CARE/CHAMPUS FOF	RM											
		You must attac	h an	itemiz	ed bill (s	ee front o	of form)	from y	γοι	Ir doctor/supplier for CHAMP	PUS t	o pro	cess this cla	im.								
							,		-			-										
		's last name, first na		nd mid	dle initial	as it appe	ears on tl			By law, you must report if the particular has here by a second se												
military ID Card. Do not use nicknames.										ude health coverage available the plemental TRICARE/CHAMPUS												
Enter the patient's daytime telephone number and evening telephone number to include the area code.										ort Medicare supplemental cov					,	,						
3. Enter the complete address of the patient's place of residence at the time of									insurance coverages. If there are additional insurances, report the information as													
service (street number, street name, apartment number, city, state, ZIP Code).									required by Block 11 on a separate sheet of paper and attach to the claim.													
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									NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the													
overseas when care was provided.								0	exception of Medicaid and CHAMPUS supplemental plans, you must first submit the													
4. Check the box to indicate patient's relationship to sponsor. If "Other" is									claim to the other health insurer and after that insurance has determined their													
checked, indicate how related to the sponsor; e.g., parent.									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													
 Enter patient's date of birth (YYYYMMDD). Check the box for either male or female (patient). 									this claim. The claims processor cannot process claims until you provide the other health insurance information.													
 Check the box to indicate if patient's condition is accident related, work related 								ed 1		The patient or other authorize	ed per	rson r	nust sign the	claim.	If the pa	atient is						
	or both. If accident or work related, the patient is required to complete DD									ler 18 years old, either parent m												
Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity." The form may be obtained from the claims									y then the patient should sign the claim. If the patient is 18 years or older, but ca													
	orm 2527, "St	gement Activity " T													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							
T	orm 2527, "Si RICARE Mana	gement Activity." TI C, or TRICARE Mana	ne for	m may	be obtai			ns s	sigr	n the claim, the person who sig	jns m	nust b	e either the le	gal gua								
Т рі 8а	orm 2527, "Si RICARE Mana rocessor, BCA a. Describe pa	C, or TRICARE Mana tient's condition for w	ne for ageme /hich t	rm may ent Acti treatme	v be obtai vity. ent was p	ned from rovided, e	the clain	ns s a en p	sigr abs pati	n the claim, the person who sig sence of a legal guardian, a spo ient, the signer should print or typ	gns m ouse pe his	or pais/her n	e either the le rent of the pa ame in Block	egal gua tient. l 12a.an	f other t d sign th	han the e claim.						
TI pi 8a ai	orm 2527, "Si RICARE Mana rocessor, BCA a. Describe pa m, appendiciti	C, or TRICARE Mana tient's condition for w s, eye infection. If p	ne for ageme hich t atient	m may ent Acti treatme 's cond	y be obtai ivity. ent was pl lition is th	ned from rovided, e ne result o	the clain	ns s a en p ry,	sigr abs pati At	n the claim, the person who sig sence of a legal guardian, a spo ient, the signer should print or typ ttach a statement to the claim	gns m ouse pe his n giv	or pais/her n ing th	e either the le rent of the pa ame in Block ne signer's fu	egal gua tient. l 12a.an Il name	f other t d sign th e and a	han the e claim. address,						
T pi 8a ai re	orm 2527, "Si RICARE Mana occessor, BCA a. Describe pa m, appendiciti port how it hap	C, or TRICARE Mana tient's condition for w s, eye infection. If p opened, e.g., fell on s	ne for ageme hich t atient tairs a	m may ent Acti treatme 's conc at work	y be obtai ivity. ent was pl lition is th , car acci	ned from rovided, e ne result o	the clain	ns s an p ry, r	sigr abs pati At rela	n the claim, the person who sig sence of a legal guardian, a sp ient, the signer should print or ty tach a statement to the clain ationship to the patient and the	ns m puse pe his n giv reas	or par or par her n ing th on the	e either the le rent of the pa ame in Block ne signer's fu e patient is u	egal gua tient. l 12a.an Il name nable to	f other t d sign th e and a o sign.	han the le claim. address, Include						
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T pi 83 ai re 81 9. j	orm 2527, "Si RICARE Mana rocessor, BCA a. Describe par m, appendiciti port how it hap b. Check the bo Enter the Sp	C, or TRICARE Mana tient's condition for w s, eye infection. If p opened, e.g., fell on s ox to indicate where t consor's or Former S ars on the military ID	ne for ageme hich t atient stairs a he ca spouse	m may ent Acti treatme 's conc at work are was e's last	v be obtai ivity. ant was pl lition is th a, car accio given. name, fii	ned from rovided, e le result o dent. rst name a	the clain .g., broke f an injur and mido	ns s an p ry, r lle s ne b	sigr abs pati At rela doc stat	In the claim, the person who sig- sence of a legal guardian, a spe- ient, the signer should print or ty ttach a statement to the claim titonship to the patient and the sumentation of the signer's ap	gns m pe his n giv reas pointi as be	nust b or pais her n ing th ion the ment een ap	e either the le rent of the pa ame in Block he signer's fu e patient is u as legal gua opointed. If a	egal gua tient. l 12a. and 11 name nable to rdian, o power	f other t d sign th e and a o sign. or provid of attorn	han the le claim. address, Include de your ney has						

local currency. NOTE: Payment available only in some local currencies.