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

OMB No. 0720-0006
OMB approval expires 20280229

RETURN COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, PLEASE VISIT: www.tricare.mil/ContactUsICallUs.

TRICARE Prime Demo by CareSource Military & Veterans beneficiaries should mail completed forms to: CareSource Military & Veterans, PO Box 608, Dayton, OH 45401-0608

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 C.F.R. 199 Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To determine eligibility for medical care under the TRICARE program, determine other health insurance's liability, certify that the medical care was received, and reimbursement for medical services received are authorized by law.

ROUTINE USE(S): Use and disclosure of your records outside of DoD may occur in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Collected information may be shared with entities including the Departments of Health and Human Services, Veterans Affairs, and other Federal, State, local, or foreign government agencies, or authorized private business entities. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, healthcare operations, and the containment of certain communicable diseases. For a full listing of the applicable Routine Uses for this system, refer to the applicable SORN.

APPLICABLE SORN: EDTMA 04, Medical/Dental Claim History Files (October 27, 2015, 80 FR 65720); **https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570707/edtma-04/**.

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in delay of payment or may result in denial of claim.

FRAUD NOTICE - 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 TRICARE/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 TRICARE/CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

IMPORTANT - READ CAREFULLY

Use this form if your provider doesn't file a claim for you. If you receive care overseas you can register on the secure claims portal to file your overseas claim online at www.tricare-overseas.com/beneficiaries/claims/claims-portal-login.

ITEMIZED BILL: Complete this form and attach an itemized bill which must be on the provider's billings letterhead. The bill must include 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.

PRESCRIPTION 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: In the United States and U.S. territories, claims must be filed within one year from the date of service, or one year from the date of discharge for inpatient care. The timely filing deadline for overseas claims is three years from the date of service. If a claim is returned for additional information, you must resubmit the claim within the timely filing deadline, or within 90 days of the notice - whichever date is later.

WHERE TO OBTAIN ADDITIONAL FORMS: You may obtain additional claim forms by calling your regional contractor (telephone numbers are available at www.tricare.mil/contactus) or by going to www.tricare.mil, mytricare.com or tricare4u.com.

* * * REMINDER * * *

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

1. **Completed all 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. 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.
6. Ensured that patient's name, sponsor's name and sponsor's SSN or DBN are on all attachments.
7. Made a copy of this claim and attachments for your records.
8. Included proof of payment for all out of pocket expenses/services received overseas. TRICARE accepts the following as proof of payment: A canceled check, credit card receipt, or electronic funds transfer (EFT) record showing the beneficiary paid the provider.

1. PATIENT'S NAME *(Last, First, Middle Initial)*	2. PATIENT'S TELEPHONE NUMBER *(Include Area/Country Code)* Primary ( ) Secondary ( )
3a. PATIENT'S ADDRESS *(Street, Apt. No., City, State/Country, and ZIP Code)*	OVERSEAS CLAIMS ONLY: 3.b STATE/COUNTRY OF PHYSICAL LOCATION WHERE SERVICES WERE RENDERED *(if different than address in 3a)*

4. PATIENT'S RELATIONSHIP TO SPONSOR *(X one)*

☐ SELF ☐ STEPCHILD ☐ SPOUSE ☐ FORMER SPOUSE
☐ NATURAL OR ADOPTED CHILD ☐ OTHER *(Specify)*

5. PATIENT'S DATE OF BIRTH *(YYYYMMDD)*	6. PATIENT'S SEX *(X one)*	7. IS PATIENT'S CONDITION *(X both if applicable)* *If yes, see #7 in section below*
	☐ MALE ☐ FEMALE	ACCIDENT RELATED? ☐ Yes ☐ No WORK RELATED? ☐ Yes ☐ No

8a. DESCRIBE ILLNESS, INJURY OR SYMPTOMS THAT REQUIRED TREATMENT, SUPPLIES OR REASON FOR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED *(Do not list services performed)***. REFER TO INSTRUCTIONS BELOW.**

8b. WAS PATIENT'S CARE *(X one)*

☐ INPATIENT? ☐ OUTPATIENT?
☐ DAY SURGERY? ☐ PHARMACY?

8c. OVERSEAS CLAIMS ONLY

☐ TELEMEDICINE? ☐ URGENT CARE?
☐ TELEMEDICINE/ AUDIO: reason for audio only:

9. SPONSOR'S OR FORMER SPOUSE'S NAME *(Last, First, Middle Initial)*	10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER OR DOD BENEFITS NUMBER (DBN)

11. OTHER HEALTH INSURANCE COVERAGE

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

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

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

c. OVERSEAS CLAIMS ONLY *(Check all that apply)*

☐ (1) TRAVEL INSURANCE ☐ (2) MEDICARE ADVANTAGE ☐ (3) VA FOREIGN MEDICAL PROGRAM

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

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

12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.

a. SIGNATURE *(Common Access Card or Physical signature required)*	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN US OR FOREIGN CURRENCY? ☐ US Dollar ☐ Local Foreign

PROOF OF PAYMENT: Did you make payment to provider? ☐ YES ☐ NO
REMINDER: Attach proof of payment

HOW TO FILL OUT THE TRICARE/CHAMPUS FORM

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

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's primary telephone number and secondary telephone number to include the area code and/or country code.
3a. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state/country, ZIP Code).
Do not use a Post Office Box Number except for Rural Routes and numbers.
3b. Identify the State/Country of where the services were rendered.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.
5. Enter patient's date of birth (YYYYMMDD).
6. Check the box for either male or female (patient).
7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity." Download the form at https://tricare.mil/forms.
8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident. Include health reason for prescription needs (e.g. diabetic, hypothyroid).
8b. Check the box to indicate where the care was given.
8c. If this claim is for care received overseas, indicate if services were received by telemedicine.
9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."
10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN) or Patient's DoD Benefits Number (DBN). Note: the sponsor number may be your own SSN.
11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICARE/CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim. Pharmacy specific plans must be reported. **NOTE:** All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. If care is provided overseas you must include EOBs for any portion a travel insurance or Medicare Advantage Plan reimbursed. If VA Foreign Medical Program (FMP) reimbursed a portion of services you must include a copy of the FMP EOB. *The claims processor cannot process claims until you provide the other health insurance information.*
12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a. and sign the claim. Physical wet signature or Common Access Card (CAC) is required.
Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.
13. If this is a claim for care received overseas, indicate if you want payment in US or local foreign currency. Check the box if you made payment to the provider and ensure proof of payment is attached to claim.