DoD 6010.15-M

Military Treatment Facility Uniform Business Office (UBO) Manual

November 2006

Office of the Assistant Secretary of Defense (Health Affairs)

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FOREWORD

This Manual is issued under the authority of DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities (MTFs)" (Reference (a)). The Manual provides guidelines for the operation of the MTF business office. It prescribes uniform procedures and accounting systems for the management and follow-up of accounts, including recovery, depositing, posting, and reconciliation. It also incorporates procedures for third party collection activities, such as identification of beneficiaries who have other health insurance, coordination of benefits, and recovery of claims. This Manual supersedes DoD 6010.15-M, "Military Treatment Facility Uniform Business Office (UBO) Manual," April 1997 (hereby canceled) (Reference (b)) and is mandatory for use by all DoD Components and MTFs.

This Manual applies to the Office of the Secretary of Defense, all Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, and all DoD Components (to include but not limited to the U.S. Coast Guard (when it is not operating as a Service in the Navy, under agreement with the Secretary of Homeland Security), the National Oceanic and Atmospheric Administration, the U.S. Public Health Service, the Department of Veterans Affairs, and international military personnel). The term "the Services," used in the Manual, refers to the Army, the Navy, and the Air Force. Anyone billing under title 10 of the United States Code must follow prescribed Uniform Business Office Manual procedures.

This Manual does not apply to DoD Component facilities not involved in direct patient care, such as medical research facilities, DoD Component facilities for field service, DoD Component facilities afloat, such as hospital ships and sick bays aboard ships, and DoD Component tactical casualty staging facilities, medical advance base staging facilities, and medical advance base components contained with mobile-type units.

Send recommended changes to this Manual through Service-directed channels to:

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TABLE OF CONTENTS

	Page
FOREWORD	2
TABLE OF CONTENTS	3
APPENDICES	5
LIST OF PRESCRIBED FORMS	7
LIST OF OPTIONAL FORMS	7
TABLES	7
REFERENCES	8
DEFINITIONS	9
ABBREVIATIONS AND ACRONYMS	12
CHAPTER 1 – INTRODUCTION	15
C1.1. PURPOSE	15
C1.2. RESPONSIBILITIES	15
CHAPTER 2 – COMPLIANCE	19
C2.1. GENERAL	19
C2.2. COMPLIANCE PROGRAM REQUIREMENTS	20
C2.3. WRITTEN POLICIES AND PROCEDURES	21
C2.4. THE UBO COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE	24
C2.5. EFFECTIVE COMPLIANCE TRAINING AND EDUCATION	26
C2.6. DEVELOPING EFFECTIVE LINES OF COMMUNICATION	26
C2.7. ENFORCING STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES	27
C2.8. AUDITING AND MONITORING ACTIVITIES	27
C2.9. RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES	29
CHAPTER 3 – MEDICAL SERVICES ACCOUNT	30
C3.1. GENERAL	30
C3.2. APPOINTMENT OF THE MSA OFFICER	30
C3.3. RESPONSIBILITIES OF THE MSA OFFICER	30
C3.4. TRANSFERRING MSA OFFICER RESPONSIBILITIES	32
C3.5. TEMPORARY ABSENCE OF THE MSA OFFICER	32
C3.6. CHANGE FUNDS	33
C3.7. MINIMUM INTERNAL CONTROLS	33

C3.8. RESPONSIBILITY FOR LOSS OF FUNDS AND ACTION TO BE TAKEN 35
C3.9. COMMINGLING OF FUNDS 35
C3.10. APPROPRIATION REIMBURSEMENTS AND RATES 35
C3.11. ACCOUNTS RECEIVABLE 36
C3.12. BILLING PROCEDURES – IN GENERAL 36
C3.13. BILLING PROCEDURES – INVOICE AND RECEIPT (I&R) 37
C3.14. DD FORM 139, PAY ADJUSTMENT AUTHORIZATION 39
C3.15. BILLING PATIENTS WHO DO NOT PRESENT AUTHORIZED PROOF OF ELIGIBILITY OF CARE 39
C3.16. PROCEDURES FOR CHARGING FEES FOR TRAUMA CARE AND OTHER MEDICAL CARE PROVIDED TO CIVILIANS 40
C3.17. BILLING PATIENTS WHO ARE NOT UNIFORMED SERVICES BENEFICIARIES 40
C3.18. COMPLETION OF GROUP HEALTH PLAN OR CLAIM FORM 41
C3.19. BILLING OTHER THAN UNIFORMED SERVICES BENEFICIARY PATIENTS DURING CONTINGENCY OPERATIONS 41
C3.20. BILLING EMERGENCY CHARGES ON BEHALF OF NON-UNIFORMED SERVICES MEDICARE PATIENTS 42
C3.21. BILLING STATE AGENCY SPONSORED PROGRAMS, SUCH AS MEDICAID 42
C3.22. BILLING WORKERS' COMPENSATION (EMPLOYMENT-RELATED INJURIES OR ILLNESSES) CASES 43
C3.23. BILLING TO OTHER FEDERAL GOVERNMENT AGENCIES, DEPARTMENT OF VETERANS AFFAIRS, DEPARTMENT OF STATE, AND OTHER SPECIAL CATEGORIES 44
C3.24. HEALTH CARE BILLING FOR IMET, FOREIGN MILITARY SALES (FMS), NORTH ATLANTIC TREATY ORGANIZATION (NATO) 45
C3.25. ELECTIVE COSMETIC SURGERY 45
C3.26. BILLING PROCESSES 45
C3.27. FORMS OF ACCEPTABLE PAYMENT 46
C3.28. DD FORM 1131, CASH COLLECTION VOUCHER 47
C3.29. UNCOLLECTIBLE OR DISHONORED CHECKS 48
C3.30. METHODS OF SETTLING OUTSTANDING ACCOUNTS RECEIVABLE 48
C3.31. PROCEDURES FOR TRANSFERRING DELINQUENT ACCOUNTS 49
C3.32. CORRECTIONS IN ACCOUNTING RECORDS 51
C3.33. PROCEDURES FOR HANDLING FEES COLLECTED FOR MEDICAL RECORDS COPYING, ETC. 52
C3.34. SAFEGUARDING PATIENT VALUABLES 53
C3.35. MEDICAL SERVICES ACCOUNT REPORTS 54
C3.36. DISPOSITION OF RECORDS 56

CHAPTER 4 – THIRD PARTY COLLECTION PROGRAM 57

C4.1. GENERAL 57

C4.2. HEALTH CARE PLANS NOT SUBJECT TO THE TPC PROGRAM 59
C4.3. MEDICAL SERVICES BILLED 59
C4.4. MEDICAL SERVICES NOT BILLED 60
C4.5. IDENTIFYING BENEFICIARIES WHO HAVE OTHER HEALTH INSURANCE (OHI) 60
C4.6. MANDATORY COMPLIANCE BY THIRD-PARTY PAYERS 62
C4.7. AUTHORIZATION TO RELEASE MEDICAL INFORMATION IN SUPPORT OF TPC 63
C4.8. BILLING ACTIVITIES 64
C4.9. MEDICARE SUPPLEMENTAL INSURANCE 67
C4.10. COLLECTION ACTIVITIES 69
C4.11. MINIMUM INTERNAL CONTROLS 71
C4.12. TPC PROGRAM ANNUAL REPORT 72

CHAPTER 5 – MEDICAL AFFIRMATIVE CLAIMS 73

C5.1. GENERAL 73
C5.2. RECOVERY JUDGE ADVOCATE RESPONSIBILITIES 74
C5.3. MTF RESPONSIBILITIES 75
C5.4. MULTIPLE SOURCES OF RECOVERY 78

CHAPTER 6 – CHARGES FOR MEDICAL SERVICES 80

C6.1. GENERAL OVERVIEW 80
C6.2. INPATIENT RATES 80
C6.3. OUTPATIENT ITEMIZED BILLING 82
C6.4. OVERSEAS OUTPATIENT CHARGES 82
C6.5. APPROPRIATED AND NON-APPROPRIATED EMPLOYEES 84

CHAPTER 7 – SUBSISTENCE CHARGES 86

C7.1. GENERAL OVERVIEW 86
C7.2. SUBSISTENCE CHARGES 86
C7.3. BILLING FOR SUBSISTENCE 86
C7.4. COLLECTION AND DISPOSITION OF SUBSISTENCE CHARGES 87
C7.5. CHARGES IN A LA CARTE SYSTEM (ALACS) FACILITIES 88
C7.6. DISCOUNT RATE 88
C7.7. STANDARD RATE 89

APPENDICES

AP1. Appendix 1, SAMPLE DD FORM 1131, CASH COLLECTION VOUCHER 90
AP2. Appendix 2, SAMPLE DD FORM 2570, THIRD PARTY COLLECTION PROGRAM – REPORT ON PROGRAM RESULTS 91

AP3. Appendix 3, SAMPLE PERMANENT MSA OFFICER TRANSFER CERTIFICATE 92
AP4. Appendix 4, SAMPLE TEMPORARY MSA OFFICER TRANSFER CERTIFICATE 93
AP5. Appendix 5, SAMPLE INVOICE & RECEIPT (I&R) 94
AP6. Appendix 6, SAMPLE PATCAT 95
AP7. Appendix 7, SAMPLE DD FORM 7, REPORT OF TREATMENT FURNISHED PAY PATIENTS – HOSPITALIZATION FURNISHED (PART A) 96
AP8. Appendix 8, SAMPLE DD FORM 7, REPORT OF TREATMENT FURNISHED PAY PATIENTS – OUTPATIENT TREATMENT FURNISHED (PART B) 97
AP9. Appendix 9, SAMPLE SF 1080, VOUCHER FOR TRANSFERS BETWEEN APPROPRIATIONS AND/FUNDS 98
AP10. Appendix 10, SAMPLE DD FORM 139, PAY ADJUSTMENT AUTHORIZATION 99
AP11. Appendix 11, SAMPLE CONSENT STATEMENT FOR DEDUCTION FROM PAY 100
AP12. Appendix 12, SAMPLE DD FORM 2569, THIRD PARTY COLLECTION PROGRAM – RECORD OF OTHER HEALTH INSURANCE 101
AP13. Appendix 13, SAMPLE UB-92 102
AP14. Appendix 14, WORKERS' COMPENSATION PATIENT CATEGORY/BILLING PROCESS 103
AP15. Appendix 15, SAMPLE SF 215, DEPOSIT TICKET 104
AP16. Appendix 16, SAMPLE 2481, REQUEST FOR RECOVERY OF DEBT DUE THE UNITED STATES BY SALARY OFFSET 105
AP17. Appendix 17, SAMPLE SF 1049, PUBLIC VOUCHER FOR REFUNDS 106
AP18. Appendix 18, SAMPLE DD FORM 599, PATIENT'S EFFECT STORAGE TAG 108
AP19. Appendix 19, SAMPLE CMS 1500 109
AP20. Appendix 20, TITLE 10, UNITED STATES CODE, SECTION 1074 110
AP21. Appendix 21, TYPE OF SERVICES BILLED BY BENEFICIARY CATEGORY AND BY INSURANCE POLICY OR GROUP HEALTH PLAN 111
AP22. Appendix 22, SAMPLE 1081, VOUCHER AND SCHEDULE OF WITHDRAWALS AND CREDITS 112
AP23. Appendix 23, PERSONS AUTHORIZED TO EAT IN MTF DINING FACILITIES 113
AP24. Appendix 24, SAMPLE DELINQUENT LETTER 117

LIST OF PRESCRIBED FORMS

The majority of these forms are available electronically in the Composite Health Care System (CHCS) and should be used in that format whenever possible. Forms that are not available electronically are included in the Appendix.

DD Form 7, Report of Treatment Furnished Pay Patients – Hospitalization Furnished (Part A)
DD Form 7A, Report of Treatment Furnished Pay Patients – Outpatient Treatment Furnished (Part B)
DD Form 139, Payroll Adjustment Authorization
DD Form 599, Patient's Effects Storage Tag
DD Form 1131, Cash Collection Voucher
DD Form 2481, Request for Recovery of Debt Due the United States by Salary Offset
DD Form 2569, Third Party Collection Program – Record of Other Health Insurance
DD Form 2570, Third Party Collection Program – Report on Program Results

SF 215, Deposit Ticket
SF 1049, Public Voucher for Refunds
SF 1080, Voucher for Transfers Between Appropriations and/or Funds
SF 1081, Voucher and Schedule of Withdrawals and Credits

CMS 1500, Health Insurance Claim Form
UB-92, Uniform Bill (Instructions – Publication 100-5, Chapter 25, Section 60)

LIST OF OPTIONAL FORMS

Sample Permanent MSA Officer Transfer Certificate 92
Sample Temporary MSA Officer Transfer Certificate 93
Sample Invoice and Receipt (I&R) 94

TABLES

Table AP21.T1. Type of Services Billed by Beneficiary Category 111
Table AP21.T2. Type of Services Billed by Insurance Policy or Group Health Plan 111
Table AP23.T1. Persons Who May Eat in MTF Dining Facilities 115

REFERENCES

(a) DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities (MTFs): Foreign Service Care; Third-Party Collection; Beneficiary Counseling and Assistance Coordinators (BCACs)," October 30, 2002

(b) DoD 6010.15-M, "Military Treatment Facility Uniform Business Office (UBO) Manual," April 1997 (hereby cancelled)

(c) Title 32, Code of Federal Regulations, "National Defense." current edition

(d) Chapter 55, Title 10, United States Code, "Medical and Dental Care," current edition

(e) Health Insurance Portability and Accountability Act of 1996 (HIPAA).[1]

(f) DoD 7000.14-R, "Department of Defense Financial Management Regulations (FMRs)"

(g) DoD Instruction 1400.32, "DoD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures," April 24, 1995

(h) DoD Instruction 3020.41, "Contractor Personnel Authorized to Accompany the U.S. Armed Forces," October 3, 2005

(i) DoD Directive 1404.10, "Emergency Essential (E-E) DoD U.S. Citizen Civilian Employees," April 10, 1992

(j) HA Policy 97-035, "Policy for Billing Occupational Health or Worker's Compensation Cases for Department of Defense Employees in Military Treatment Facilities," April 1997[2]

(k) Chapter 19, Title 37, United States Code, "Administration," current edition

(l) Office of Management and Budget Circular A-129, "Policies for Federal Credit Card Programs and Non-Tax Receivables," November 2000

(m) HA Policy 96-041, "Policy for Newborn Billing," April 1996[3]

(n) Chapter 7, Title 42, United States Codes, "Social Security," current edition

(o) Chapter 32, Title 42, United States Code, "Third Party Liability For Hospital And Medical Care," current edition

(p) Part 43, Title 28, Code of Federal Regulations, "Recovery of Costs of Hospital and Medical Care and Treatment Furnished by the United States," current edition

(q) Chapter 37, Title 31, United States Code, "Claims," current edition

(r) CMAC Rate Table[4]

(s) Non-CMAC Rate Table[5]

(t) Patient Billing Category Standardization Table (PATCAT)[6]

(u) Joint Federal Travel Regulations[7]

[1] http://www.hhs.gov/ocr/hipaa/
[2] http://www.ha.osd.mil/policies/1997/bill9735.html
[3] http://www.ha.osd.mil/policies/1996/newb41.html
[4] http://www.dod.mil/comptroller/rates/index.html
[5] http://www.dod.mil/comptroller/rates/index.html
[6] http://www.dod.mil/comptroller/rates/index.html
[7] https://secureapp2.hqda.pentagon.mil/perdiem/trvlregs.html

DL1. DEFINITIONS

DL1.1. Ambulatory Procedure Visit. An APV provides pre-procedure and post-procedure care observation, and assistance for patients requiring short-term care of less than 24 hours. Same Day Surgeries, also known as Ambulatory Procedure Visits, are performed in a specialized area such as an APU, surgical suite, or extended care area.

DL1.2. Automobile Liability Insurance. Insurance covering legal liability for health and medical expenses resulting from personal injuries arising from the operation of a motor vehicle. Automobile liability insurance includes:

DL1.2.1. Circumstances in which liability benefits are paid to an injured party only when the insured party's tortuous acts are the cause of the injuries.

DL1.2.2. Uninsured and underinsured coverage when there is a third party individual (tortfeasor) who caused the injuries, but the medical expenses are covered by the patient's insurance because the tortfeasor is uninsured or underinsured.

DL1.3. Bill. An itemized list or statement of fees or charges.

DL1.4. Billable Visit. A billable visit must meet the Medical Expense and Performance Reporting System definition of a visit. See the definition for "Visit" in this Appendix.

DL1.5. CHAMPUS Supplemental Plan. An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under CHAMPUS. The term has the same meaning as in Section 199.2 of Reference (c) No insurance, medical service, or health plan provided by an employer or employer group may qualify as a CHAMPUS supplemental plan.

DL1.6. Claim. Any request for payment for services rendered related to care and treatment of a disease or injury that is received from a beneficiary, a beneficiary's representative, or an in-system or out-of-system provider by a CHAMPUS FI/Contractor on any CHAMPUS-approved claim form or approved electronic media. Types of claims and/or data records include Institutional, Inpatient Professional Services, Outpatient Professional Services (Ambulatory), Drug, Dental, and Program for the Handicapped.

DL1.7. Contract Based Health Insurance. Indemnification of medical care expenses based on the contractual rights (i.e., terms of the policy, certificate or booklet) of the insured and/or policyholder, family member, dependent or other third party beneficiary. For example, health insurance policy or plan; automobile no-fault and/or personal injury protection (PIP); medical payments (automobile, boat, commercial and/or public premises and general casualty, airplane (limited); product and/or manufacturers' (limited); and homeowners' and/or renters' insurance); and workers' compensation coverage.

DL1.8. Durable Medical Equipment (DME). Medical equipment that is not disposable (i.e., is used repeatedly) and is only related to care for a medical condition. Examples would include wheelchairs, home hospital beds, and so forth. An area of increasing expense, particularly in conjunction with case management.

DL1.9. Facility of the Uniformed Services. Any MTF or dental treatment facility of the Uniformed Services, as defined in Section 1072 of Reference (d).

DL1.10. Healthcare Services. Inpatient, outpatient, and designated ancillary and prescription drug services.

DL1.1.11. Inpatient Hospital Care. Treatment provided to an individual other than a transient patient, who is admitted (i.e., placed under treatment or observation) to a bed in a facility of the Uniformed Services, which has authorized beds for inpatient medical or dental care.

DL1.12. Insurance, Medical Service, or Health Plan. Any plan or program designed to provide compensation or coverage for expenses incurred by a beneficiary for health or medical services and supplies. It includes:

DL1.12.1. Plans or programs offered by insurers, employers, organizations, or other entities.

DL1.12.2. Plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

DL1.12.3. Medicare supplemental insurance plans.

DL1.13. Medicare Supplemental Insurance Plan. An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" as provided in Section 220.10 of Reference (c).

DL1.14. No-Fault Insurance. An insurance contract providing compensation for health and medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

DL1.15. Observation Services. Those services furnished by a hospital on the hospital's premises, including the use of a bed and periodic monitoring by the hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Most observation care services do not exceed one day. Some patients may require a second day of services. Only in rare and exceptional cases do observation services span more than two calendar days.

DL1.16. Outpatient Care. Visits to a separately organized clinic or specialty service made by patients who are not currently admitted to the reporting MTF. Patient receives healthcare services for an actual or potential disease, injury, or lifestyle-related problem.

DL1.17. Third Party Payer. An entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier, and any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for health care services or products. It also includes health maintenance organization, competitive medical plan, health care prepayment plan, or other similar plan.

DL1.18. Services. For purposes of this Manual, Services shall mean the three Military Departments (Army, Navy, and Air Force). While the Marine Corps is part of the Department of Navy, it does not operate MTFs.

DL1.19. Tort Based Insurance. Indemnification for physical injuries and property damage resulting from a person's negligence established through legal processes or adjudication. For example, automobile liability and uninsured and/or underinsured motorist coverage; commercial and/or public premises ("slip and fall") or general casualty and umbrella (covering a variety of real or personal properties such as business, home, farm, boat, car, airplane, etc.) insurance; product (manufacturer's) liability insurance; homeowners' and/or renters' insurance; medical malpractice coverage; and boat or airplane casualty insurance.

DL1.20. Uniformed Services Beneficiary. Any person eligible for benefits and authorized treatment in a Uniformed Services facility pursuant to Section 1074 of Reference (d) (see Appendix 20 for the most recent version of this Federal statute) and Section 1076 (a) and (b) of Reference (d). For purposes of Chapter 5 (but not for other sections), a Uniformed Services beneficiary can also be an active duty member of the Uniformed Services.

DL1.21. Non-Uniformed Services Beneficiary. This patient category includes Federal employees, overseas State Department employees and their dependents (while overseas), and contractors.

DL1.22. Visit. Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen. For a visit to be counted, there must be interaction between an authorized patient and a healthcare provider, independent judgment about the patient's care, and documentation (including, at a minimum, the date, clinic name, reason for visit, patient assessment, description of the interaction between the patient and the healthcare provider, disposition, and signature of the provider of care) in the patient's authorized record of medical treatment.

DL1.23. Workers' Compensation. Expenses incurred to cover injury or illness due to a work-related accident or cumulative trauma. Workers' compensation law varies from State to State.

ABBREVIATIONS AND ACRONYMS

ABBREVIATION OR ACRONYM	MEANING (TERM)
A&D	Admissions and Disposition
ADA	American Dental Association
AIDS	Acquired Immune Deficiency Syndrome
AIS	Automated Information Systems
ALACS	A La Carte System
APU	Ambulatory Procedure Unit
APV	Ambulatory Procedure Visit (formerly Same Day Surgery)
ASA	Adjusted Standard Amount
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASF	Aeromedical Staging Facility
BAS	Basic Allowance For Subsistence
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCS	Composite Health Care System
CMA	Centrally Managed Allotment
CMS	Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration [HCFA])
DAO	Defense Accounting Officer
DFAS	Defense Finance and Accounting Service
DME	Durable Medical Equipment
DMS	Durable Medical Supplies
DO	Disbursing Officer
DoD	Department of Defense
DOL	Department of Labor
DRG	Diagnosis Related Group
EOB	Explanation of Benefits
FI	Fiscal Intermediary
FL	Form Locator
FMS	Foreign Military Sales
FSO	Financial Services Officer

ABBREVIATION OR ACRONYM	MEANING (TERM)
GLOS	Geometric Length of Stay
HIPAA	Health Insurance Portability and Accountability Act
HHS	Department of Health and Human Services
HMO	Health Maintenance Organization
I&R	Invoice and Receipt
IG	Inspector General
IMET	International Military Education and Training
JAG	Judge Advocate General
KPI	Key Performance Indicator
LOS	Length of Stay
MAC	Medical Affirmative Claims (formerly Third Party Liability Claims)
MAJCOM	Major Command
MCO	Managed Care Organization
MHS	Military Health System
MMSAR	Monthly Medical Services Activity Report
MOU	Memorandum of Understanding
MSA	Medical Services Account
MTF	Military Treatment Facility
NATO	North Atlantic Treaty Organization
NCO	Non-Commissioned Officer
NMA	Non-Medical Attendant
NoPP	Notice of Privacy Practices
O&M	Operations and Maintenance
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OCONUS	Outside the Continental United States
OIB	Outpatient Itemized Billing
OHI	Other Health Insurance

ABBREVIATION OR ACRONYM	MEANING (TERM)
PAD	Patient Administration
PATCAT	Patient Category
PATCAT Table	Patient Billing Category Standardization Table
PIP	Personal Injury Protection
RJA	Recovery Judge Advocate
RM	Resource Management
ROTC	Reserve Officer Training Corps
SIK	Subsistence In Kind
SIMS	Service Information Management System
SIT	Standard Insurance Table
SJA	Staff Judge Advocate
TDY	Temporary Duty
TMA	TRICARE Management Activity
TPC	Third Party Collection
TPL	Third Party Liability (now Medical Affirmative Claims [MAC])
TPOCS	Third Party Outpatient Collection System
UBO	Uniform Business Office
UCF	Uniform Claim Form
USD(C)	Under Secretary of Defense (Comptroller)
USO	United Service Organization
VA	Veterans Affairs

C1. CHAPTER 1

INTRODUCTION

C1.1. PURPOSE

C1.1.1. The purpose of the Military Treatment Facility Uniform Business Office Manual ("UBO Manual") is to provide standardized guidance for the business office portions of the revenue cycle function at Military Treatment Facilities (MTFs).

C1.1.2. This Manual outlines policies and procedural business practices for Uniform Services MTF Medical Services Account (MSA), Third Party Collection (TPC), and Medical Affirmative Claims (MAC) activities.

C1.1.2.1. MSA activities involve the primary-payer billing of individuals and other Government Agencies for services rendered in MTFs.

C1.1.2.2. TPC activities involve billing third-party payers on behalf of beneficiaries, excluding active duty, for treatment provided by or through MTFs.

C1.1.2.3. MAC activities involve billing all areas of liability insurance, such as automobile, products, premises and general casualty, homeowner's, renter's, medical malpractice (by civilian providers), and workers' compensation (other than Federal employees). MAC includes active duty.

C1.1.3. Additional policy guidance can be found in the Compliance Binder on the TRICARE Management Activity (TMA) web site.

C1.2. RESPONSIBILITIES

C1.2.1. The Executive Director, TRICARE Management Activity (TMA), under the Assistant Secretary of Defense (Health Affairs), shall:

C1.2.1.1. Issue TMA policy guidance and provide oversight to ensure MTF business office operations are cost-effective and result in optimum collections within compliance guidelines.

C1.2.1.2. Facilitate MTF effectiveness and efficiency by providing automated information systems (AIS) that support successful management of the MTF business office.

C1.2.1.3. Establish a systematic process by which recommendations, program changes, and AIS changes can be jointly evaluated and implemented, thereby reducing inconsistency and facilitating standardization.

C1.2.1.4. Maintain a database of all Service policies and procedures issued to implement this guidance document and to ensure that these Service policies and procedures are in compliance with this guidance document.

C1.2.2. The Secretary of each Military Department shall:

C1.2.2.1. Ensure that the provisions contained in this document are implemented at each MTF.

C1.2.2.2. Provide a copy of all Service policies and procedures issued to implement the provisions in this guidance document to the TMA Office.

C1.2.2.3. Develop a marketing program to achieve maximum Other Health Insurance (OHI) capture.

C1.2.2.4. Compromise, settle, or waive claims, as appropriate, consistent with existing Federal statutes and regulations.

C1.2.2.5. Provide Service-consolidated and MTF-level metrics reports to TMA.

C1.2.2.6. Participate in Tri-Service and TMA workgroups to facilitate the systematic evaluation of policy recommendations, program changes, and AIS changes.

C1.2.3. Each Surgeon General shall:

C1.2.3.1. Implement the provisions of this guidance document, taking into account any Service policies and procedures. Distribute copies of all Service policies and procedures implementing the provisions of this guidance document to TMA through the respective Service Secretary.

C1.2.3.2. Develop a training program addressing all aspects of the MTF business office. Training shall include patient interview techniques, identification and verification of healthcare coverage, claims processing, compliance, automated systems usage, and relevant provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Reference (e)).

C1.2.3.3. Aggressively implement MSA, TPC, and MAC activities and provide leadership, training, and support for successful operation of MTF business offices.

C1.2.3.3.1. Consolidate MSA, TPC, and MAC procedures, as appropriate.

C1.2.3.3.2. Maintain separation of medical record coding, billing, and collection activities.

C1.2.3.4. Ensure all TPC Program revenues collected are used only to enhance healthcare services and to resource the Third Party Collection Program, in compliance with Section 1095 of Reference (d).

C1.2.3.5. Submit periodic reports to higher authority as required.

C1.2.3.6. To the extent possible, use the Tri-Service and TMA workgroups to request policy determination on recommendations and program or system changes.

C1.2.4. Each MTF commander shall:

C1.2.4.1. Establish and maintain a business office. Where practical, all functions of the Uniform Business Office (UBO) shall be consolidated within this office. This includes TPC, MSA, and MAC Programs.

C1.2.4.2. Establish and maintain a compliance program pursuant to the provisions this document.

C1.2.4.3. Where practical, and as resources permit, appoint a UBO Manager to consolidate the management of the programs.

C1.2.4.3.1. The UBO Manager position may be a responsible military or a civilian equivalent of a non-commissioned officer (NCO).

C1.2.4.3.2. This position may not be held by a contracted employee. Contracted employees may not manage the MSAs; nor may they supervise government employees or perform inherently governmental functions.

C1.2.4.4. Appoint, in writing, a primary and alternate officer, qualified NCO, or civilian equivalent for the MSA and TPC officer positions.

C1.2.4.5. Develop appropriate systematic back up and chain-of-command procedures for all automated claims systems to ensure protection of claims data.

C1.2.5. The Director, Defense Manpower Data Center (DMDC), shall:

C1.2.5.1. Establish a central Master Standard Insurance Table (SIT) resident on the Defense Enrollment Eligibility Reporting System (DEERS).

C1.2.5.1.1. Authorized access to the Master SIT will be given to the MTFs, the Managed Care Support Contractors, the Designated Providers, the Pharmacy Data Transaction Service, and designated support and contractor staffs of the Military Health System (MHS).

C1.2.5.1.2. The DMDC will provide the tools to the designated staff of the TMA, UBO for maintenance of the Master SIT.

C1.2.5.2. Provide a central repository in DEERS of OHI developed using the carrier data maintained in the Master SIT.

C1.2.5.3. Provide a shared access and update of beneficiary OHI to authorized MHS agencies.

C1.2.5.4. Provide a basic reporting capability to TMA, UBO of policies maintained in the DEERS central repository and carriers stored in the Master SIT.

C2. CHAPTER 2

COMPLIANCE

C2.1. GENERAL

C2.1.1. Compliance program guidance in this chapter is adapted from guidance documents released by the Department of Health and Human Services (HHS) Office of Inspector General for various provider groups.

C2.1.2. Implementing a compliance program advances the prevention of healthcare billing fraud, waste, abuse, and mismanagement. A compliance program supports the overall mission of providing quality health care.

C2.1.3. This guidance document shall be used as a tool to assist MTFs in the development of effective internal controls that promote adherence to applicable Federal laws relating to healthcare billing requirements.

C2.1.3.1. It applies to the MSA, TPC, and MAC Programs of the UBO, as well as any additional healthcare billing activities designated by the Department of Defense, e.g., DoD/Veterans Affairs (VA) Resource Sharing Agreements.

C2.1.3.2. Each MTF shall provide documentation to the respective Service UBO reflecting adherence with this guidance document.

C2.1.4. Each Service and respective MTFs shall develop compliance program implementation plans, policies, and procedures implementing the guidance contained herein.

C2.1.4.1. Each Service and respective MTFs shall establish procedures for reporting fraud, waste, abuse, and mismanagement through the respective Inspectors General (IGs), as well as other internal review and audit activities, external audit agencies, and criminal investigation activities.

C2.1.4.2. Each Service and respective MTFs shall establish fraud, waste, abuse, and mismanagement hotlines through the respective IGs, as well as other internal review and audit activities, external audit agencies, and criminal investigation activities.

C2.1.4.3. A copy of the MTF's policies and procedures shall be forwarded to the UBO Manager for the Service as appropriate.

C2.2. COMPLIANCE PROGRAM REQUIREMENTS

C2.2.1. To ensure an effective compliance program, each MTF shall designate a UBO compliance officer and compliance committee.

C2.2.2. The UBO compliance officer shall have direct access to the MTF command group.

C2.2.2.1. It is recommended that the UBO Compliance Officer be the Chief of the Patient Administration Division, the Chief of Resource Management, or a member of the MTF's Internal Review and Audit Department. These individuals have the experience and training to develop a compliance program.

C2.2.2.2. The UBO Compliance Officer and compliance committee shall report through the chain of command to the MTF/unit commanding officer.

C2.2.3. At a minimum, each compliance program shall have the following elements:

C2.2.3.1. Written policies and procedures, including standards of conduct, to validate the facility's commitment to compliance.

C2.2.3.2. Regular, monitored, education and training programs for all affected employees.

C2.2.3.3. Effective and efficient lines of communication.

C2.2.3.4. Enforcement of standards by referencing disciplinary (e.g., IG, civilian, or military personnel) and other documented and well-publicized regulations, directives, or other instructions and guidelines.

C2.2.3.5. The use of periodic internal audits as directed by the Services and MTF Commanders and other evaluation techniques, such as Key Performance Indicators (KPIs), to monitor compliance and assist in the reduction of identified problem areas. Examples of KPIs include:

C2.2.3.5.1. Registration error rates.

C2.2.3.5.2. Identified under-payments.

C2.2.3.5.3. Collections as a percentage of net revenues.

C2.2.3.6. Appropriate references to IG, internal review and audit activities, external audit and review agencies, and criminal investigation activities procedures to respond to detected offenses and to take corrective action.

C2.3. WRITTEN POLICIES AND PROCEDURES

C2.3.1. Through its compliance officer and committee, each MTF shall develop and distribute written policies and procedures that promote the MTF's commitment to healthcare compliance.

C2.3.2. At a minimum, the policies and procedures for the UBO Compliance Program shall include:

C2.3.2.1. Standards of Conduct

C2.3.2.1.1. The standards shall articulate the entire facility's commitment to compliance to ensure the delivery of quality health care in an ethical environment to all patients.

C2.3.2.1.2. Any standards document shall include the individual facility's mission, goals and its expectation of adherence to compliance policies and procedures by all employees, whether they are active duty or civilian contractors.

C2.3.2.1.3. This document shall be easily understood by all, with language translations as needed.

C2.3.2.2. List of known billing risk areas. These include, but are not limited to:

C2.3.2.2.1. Using improper DoD billing rates (e.g., third party versus interagency).

C2.3.2.2.2. Upcoding.

C2.3.2.2.2.1. Changing source and procedure codes for higher reimbursement.

C2.3.2.2.2.2. Using incorrect evaluation and management codes denoting a higher intensity or level of care than provided.

C2.3.2.2.2.3. Charging outpatient clinic rates for ancillary services that are already included in the cost or otherwise accounted for.

C2.3.2.2.2.4. Assigning inapplicable diagnosis and procedure codes for ancillary procedures.

C2.3.2.2.3. Charging for services without appropriate provider documentation or substantiation.

C2.3.2.2.4. Billing for services without an established rate.

C2.3.2.2.5. Billing clinic visits as same day surgeries (e.g., ambulatory procedure visits).

C2.3.2.2.6. Billing Medicare Health Maintenance Organizations (HMOs) for other than civilian emergencies (and at an incorrect rate).

C2.3.2.2.7. Accepting overpayments from Medicaid and commercial payers unless otherwise advised by TMA.

C2.3.2.2.8. Commingling third party and medical service accounts to conceal over-collected accounts and post overpaid funds to other partially paid or denied claims.

C2.3.2.2.9. Destroying years of partially paid or otherwise improperly denied claim documentation or accounts receivables (6 year statute of limitations).

C2.3.2.2.10. Failing to implement or follow marginal internal fiscal controls, including the separation of duties such as:

C2.3.2.2.10.1. Creation and submission of bills.

C2.3.2.2.10.2. Mail and check receipt.

C2.3.2.2.10.3. Posting, logging, and prompt depositing of checks.

C2.3.2.2.10.4. Entries to financial reports.

C2.3.2.2.10.5. Recording receivables, checks, or payments accurately and promptly, properly reconciling financial records and reports (e.g., Invoices & Receipts, DD Form 1131, Cash Collection Voucher (Appendix 1), DD Form 2570, Third Party Collection Program – Report on Program Results (Appendix 2), Daily Activity Logs, Monthly MSA Reports, and Reports of Treatment Furnished Pay Patients.

C2.3.2.2.10.6. Ensuring an adequate audit trail of all financial receipts—again, to conceal improper billing practices.

C2.3.2.2.11. Blocking investigations.

C2.3.2.2.12. Medical facility administration overlooking or disregarding, defending, and affirmatively concealing the MTF's illegal billing practices.

C2.3.2.3. Claims Development and Submission Process

C2.3.2.3.1. Policies and procedures shall require timely and legible documentation of all professional and technical services provided before the submission of any claims.

C2.3.2.3.2. The diagnosis and procedures reported on the claim form shall be based on the medical record. The coding staff shall have access to the documentation to validate code assignment.

C2.3.2.3.3. Claims shall only be processed when this documentation is evident.

C2.3.2.4. HIPAA Administrative Simplification, Privacy, Standardization, and Security

C2.3.2.4.1. All MTFs shall comply with the administrative simplification requirements as mandated by HIPAA.

C2.3.2.4.2. There are, essentially, three areas of HIPAA compliance:

C2.3.2.4.2.1. Privacy

C2.3.2.4.2.1.1. HIPAA requires certain steps when using or disclosing patient health information (protected health information).

C2.3.2.4.2.1.2. The final rule implementing this mandate and other relevant information can be found on the HHS Office of Civil Rights Web site.

C2.3.2.4.2.1.3. Facilities shall adhere to DoD privacy policies found on the TMA web site.

C2.3.2.4.2.1.4. In particular, facilities shall make a good faith effort to ensure that the Notice of Privacy Practices (NoPP) is posted in a public area, that patients are given a copy of the notice, and that all patients acknowledge, in writing, receipt of the NoPP.

C2.3.2.4.2.1.5. All staff shall complete the requisite Privacy training courses.

C2.3.2.4.2.2. Standardization of electronic transactions

C2.3.2.4.2.2.1. HIPAA mandated the adoption of standards from among those already approved by private standards developing organizations for certain electronic health transactions, including claims, enrollment, eligibility, payment, and coordination of benefits.

C2.3.2.4.2.2.2. Additional information may be found at the HHS Centers for Medicare and Medicaid Services (CMS) and TMA Web sites.

C2.3.2.4.2.3. Electronic security. HIPAA mandated that information transmitted electronically should have appropriate safeguards. Additional information may be found at the CMS and TMA Web sites.

C2.3.2.5. Retention of records

C2.3.2.5.1. Each Service shall have a records information management program including a regulation, policies, and procedures detailing the creation, distribution, retention, storage, retrieval, and destruction of documents.

C.2.3.2.5.2. Each MTF shall maintain all requisite records to confirm the effectiveness of the facility's compliance program, such as training records, reports from the hotline, investigations of any allegations of suspected fraud, and the results of audits.

C2.3.2.6. Compliance. As an element of a work performance plan, objective, or standard.

C2.4. THE UBO COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

C2.4.1. The UBO Compliance Officer, shall:

C2.4.1.1. Oversee and monitor implementation of the Compliance Program.

C2.4.1.2. Periodically review the program to ensure relevance and compliance with current Federal laws, and DoD and Service policy (update as needed).

C2.4.1.3. Ensure the components of the Compliance Program are implemented to reduce fraud, waste, abuse, and mismanagement within the business office and throughout the revenue cycle.

C2.4.1.4. Ensure that contractors, vendors, and agents who furnish medical services to the facility are aware of the facility's compliance program and its respective coding and billing policies and procedures.

C2.4.1.5. Have the authority to review all documents and other information relevant to compliance activities.

C2.4.1.6. Assist the business office and internal review activities in conducting internal compliance reviews, including reviews of departments involved in the revenue cycle within the facility.

C2.4.1.7. Investigate issues related to compliance. Take corrective action and document compliance issues as necessary.

C2.4.1.8. Encourage reporting of suspected fraud, waste, abuse, or mismanagement (without fear of retaliation) through training and other means of communication. Notify employees of applicable regulations, procedures, and guidelines.

C2.4.1.9. Ensure the separation of duties.

C2.4.1.9.1. Minimal internal controls including the separation of duties or functions of the staff and business office are also set forth in the MSA and TPCP chapters of this document.

C2.4.1.9.2. The Resource Manager, Comptroller, Patient Administration (PAD), or Facility Administrative Officer responsible for business office functions may not also perform the duties of an MSA Officer (also known as Treasurer) or TPC Program Manager.

C2.4.1.10. Report to the MTF commander, who will report through the appropriate chain-of-command to the UBO Service Manager, on a regular basis on the progress of the Compliance Program. Similarly, report the results of any audits, fraud, waste, abuse, and mismanagement investigations, and any resulting employee discipline.

C2.4.2. The UBO Compliance Committee shall:

C2.4.2.1. At a minimum, be comprised of representatives from:

C2.4.2.1.1. The UBO.

C2.4.2.1.2. The legal office.

C2.4.2.1.3. Resource management.

C2.4.2.1.4. Internal review.

C2.4.2.1.5. Health information management.

C2.4.2.1.6. Medical and nursing staffs.

C2.4.2.1.7. Also include other offices such as Risk Management and Quality Assurance.

C2.4.2.2. Advise the Compliance Officer and assist in the implementation of the compliance program. This includes, but is not limited to:

C2.4.2.2.1. Continually assessing current policies and procedures to ensure compliance, relevance, and practicability.

C2.4.2.2.2. Working with appropriate personnel to develop standards of conduct and policies and procedures, to promote adherence to the facility's compliance program.

C2.4.2.2.3. Monitoring internal controls to implement the program and recommending changes as needed.

C2.4.2.2.4. Ensuring that periodic audits of claims development and claims processing procedures are performed and that internal fiscal and administrative controls are implemented and adhered to.

C2.5. EFFECTIVE COMPLIANCE TRAINING AND EDUCATION. Each MTF shall develop and implement regular, effective business office compliance education and training programs, and periodic updates for all personnel involved in the business office.

C2.5.1. All education and training shall be documented, including staff attendance. The Compliance Officer shall maintain documentation of training.

C2.5.2. Education topics include, but are not limited to:

C2.5.2.1. Specific risk areas associated with the business office.

C2.5.2.2. Summaries of fraud, waste, and abuse laws.

C2.5.2.3. Privacy and security requirements pursuant to HIPAA and the Privacy Act.

C2.5.2.4. Duty to report misconduct.

C2.5.2.5. Coding requirements.

C2.5.2.6. Claims development and submission processes.

C2.6. DEVELOPING EFFECTIVE LINES OF COMMUNICATION

C2.6.1. Each Service and respective MTFs shall have well-developed, published, and effectively promoted guidelines to respond to allegations of improper or illegal billing activities. The guidelines shall enforce appropriate disciplinary action against personnel who have violated internal compliance policies, applicable statutes, regulations, or Federal healthcare program requirements.

C2.6.2. Those processes include written confidentiality and non-retaliation policies for all staff to encourage communication, and the reporting of incidents of potential fraud, waste, abuse, and mismanagement related to the MTF business office.

C2.6.3. There are multiple independent reporting paths, e.g., Inspector General (IG) DoD, Service IGs, MTF IGs, internal auditing activities at MTF, higher headquarters and Service command levels, external auditing, and criminal investigative activities located at every Uniformed Service base throughout the world, for an employee to report suspected healthcare billing-related fraud, waste, abuse, and mismanagement to prevent diversion by other personnel. Multiple hotlines and other well documented forms of confidential communication procedures are readily available for all staff and affiliates, e.g., contract employees and vendors, of the MTF.

C2.6.4. Provide, to the extent possible, feedback to the individual(s) reporting suspected fraud, waste, abuse, or mismanagement.

C2.7. ENFORCING STANDARDS THROUGH WELL-PUBLICIZED DISCIPLINARY GUIDELINES

The compliance program shall include or reference the location (e.g., Web site) of a written policy outlining the potential disciplinary actions against any MTF staff member or contract employee who does not follow the policies and procedures contained in a facility's compliance program. The policy shall include or reference applicable Regulations, Directives, Instructions, or other publications, including:

C2.7.1. Levels of sanctions that may be imposed on any employee or contractor depending upon the degree of noncompliance.

C2.7.2. Sanctions may range from warnings to termination as appropriate.

C2.7.3. Sanctions may include identification of individuals responsible for imposing the sanction.

C2.7.4. For example, some noncompliant activities may warrant discipline by the department head, while others may warrant discipline by the MTF commander.

C2.8. AUDITING AND MONITORING ACTIVITIES

C2.8.1. MTFs may use the UBO Compliance Audit Checklist Template to perform business office audits.

C2.8.2. An MTF commandershall appoint the internal review auditor, a disinterested officer, an NCO at the grade of E–7 or above, or a civilian of comparable grade, to audit and evaluate the MTF business office at least each fiscal quarter.

C2.8.2.1. The appointed audit officer shall evaluate MTF business office processes on a quarterly basis.

C2.8.2.2. When a change occurs in the business office staff, the audit officer shall:

C2.8.2.2.1. Verify the security of funds.

C2.8.2.2.2. Verify the accuracy and completeness of records.

C2.8.2.2.3. Verify the overall compliance with DoD and Service-specific policies and regulations.

C2.8.2.3. The audit officer shall use audits and other standardized key performance indicators such as error registration rates, identified underpayments, etc., to monitor compliance and assist in the reduction of identified problem areas.

C2.8.3. Each MTF shall implement coding and billing audits to monitor and audit the accuracy of coding and billing on a regular basis.

C2.8.3.1. Audits shall be performed by someone other than the individual performing the task being audited.

C2.8.3.2. The audit shall verify, at a minimum, that:

C2.8.3.2.1. Requirements for storage and deposit of funds are met.

C2.8.3.2.2. Separation of functions is maintained. For example, the individual who posts accounts may not be the same person who collects and deposits funds.

C2.8.3.2.3. Individual change funds and local lock boxes are used.

C2.8.3.2.4. Outstanding accounts are followed up appropriately and are transferred promptly.

C2.8.3.2.5. All deposits are validated by a cash control machine or voucher number and the signature of the Financial Services Officer (FSO), Defense Accounting Officer (DAO), or Disbursing Officer (DO).

C2.8.3.2.6. Deposits agree with the automated system and Cash and Sales Journal. Postings to patient accounts shall equal amounts received and deposited.

C2.8.3.2.7. Cash on hand agrees with the automated system and Cash and Sales Journal.

C2.8.3.2.8. MSA and TPC officers are appointed in writing.

C2.8.3.2.9. All accountable forms are kept in a locked safe.

C2.8.3.2.10. Claims transferred to the designated legal office are followed up according to Service-specific guidance and regulations and are appropriately accounted for.

C2.8.3.2.11. MSA and TPC accounts, records, and reports are reconciled with the automated system on a monthly basis.

C2.9. RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

C2.9.1. The DoD Components and Services have procedures in place for investigating alleged noncompliance, violations of applicable Federal laws, or other types of misconduct according to established Federal guidelines.

C2.9.2. The DoD Components and Services have procedures in place for prompt reporting of any offenses to the appropriate authorities according to established Federal guidelines.

C2.9.3. Copies of all such reports and subsequent actions taken shall be sent to the UBO Service Manager.

C3. CHAPTER 3

MEDICAL SERVICES ACCOUNT

C3.1. GENERAL

C3.1.1. The MSA office shall be located in an area that is easily accessible for, and clearly identifiable by patients.

C3.1.2. The MSA function consists of billing and collecting funds for medical and dental services from Uniformed Services beneficiaries, cosmetic surgery procedures, civilian emergency patients, and other patients authorized treatment in MTFs.

C3.1.3. MSA provides a complete and reliable financial record of transactions including collections control, accounts receivable, and deposits.

C3.1.4. At MTFs where the volume of cash transactions does not support an MSA office, the parent MTF or local or supporting FSO, DAO, or DO shall make collections and deposits.

C3.2. APPOINTMENT OF THE MSA OFFICER. Each fixed-facility commander shall appoint an MSA officer in writing.

C3.2.1. The appointment letter shall include a statement in which the MSA officer acknowledges that he is "strictly liable to the United States for all public funds under my control." It also shall include a statement confirming that the individual has been counseled regarding pecuniary liability. This is according to Volume 5, Chapter 2 (Disbursing Offices, Officers, and Agents), in DoD 7000.14-R (Reference (f)).

C3.2.2. The MSA officer shall be a commissioned officer, non-commissioned officer, warrant officer, or civilian employee not otherwise accountable for appropriated funds or Government property.

C3.2.3. The functions of this position may not be performed by an individual under contract with the U.S. Government.

C3.3. RESPONSIBILITIES OF THE MSA OFFICER

The MSA officer shall provide necessary information to patient admissions personnel so that patients are adequately informed of expected inpatient hospitalization or outpatient visit charges through the initial interview, admissions process, clinic check-in, discharge interview, and marketing materials such as inpatient and outpatient handbooks. Additionally, the MSA officer shall:

C.3.3.1. Bill and collect for medical and dental services rendered and subsistence, as prescribed in Chapters 6 (“Other Medical Services”) and 7 (“Subsistence”), respectively, of this Manual.

C3.3.2. Make every effort to collect accounts receivable before they become delinquent.

C3.3.3. Safeguard funds and controlled forms from loss or theft, according to Volume 5, Chapter 3 (Keeping and Safeguarding Public Funds) in Reference (f).

C3.3.4. Obtain and administer a change fund as necessary. The MSA officer may not use or permit the use of undeposited collections or personal money as a change fund.

C.3.3.5 Maintain an accounting record of all applicable medical and dental service charges and collections.

C3.3.6. Deposit collections as reimbursements to the proper appropriation according to Service guidance. These deposits shall be made according to guidance from the servicing accounting and finance office.

C3.3.7. Prepare and submit financial reports according to Service guidelines.

C3.3.8. Validate deposits by a cash control machine or voucher number and the signature of the servicing finance officer.

C3.3.9. Ensure deposits agree with the automated system.

C3.3.10. Ensure postings to patient accounts equal amounts received and deposited.

C3.3.11. Establish internal controls to ensure security of funds and separation of duties according to Volume 5, Chapter 3 (Keeping and Safeguarding Public Funds) in Reference (f) and Service resource protection requirements.

C3.3.12. Ensure storage of safeguarded forms and accuracy of records when MSA duties are delegated to other individuals.

C3.3.13. Deposit all collections received for administrative services (such as copy charges) to the Operations and Maintenance (O&M) appropriation according to Service guidance.

C3.3.14. Ensure audit controls are established to accurately bill all applicable patients for services rendered, including pay patients overseas, civilians in remote locations, and civilian emergencies.

C3.4. TRANSFERRING MSA OFFICER RESPONSIBILITIES

C3.4.1. To transfer responsibilities from one MSA Officer to another. The incumbent MSA Officer shall post and update accounting records for all transactions up to the end of the day before the transfer and document in the files.

C3.4.2. Deposit all cash collections on hand according to guidance from the servicing accounting and finance office.

C3.4.3. Return all cash change funds to the supporting finance office, or effect transfer according to disbursing officer requirements.

C3.4.4. Close the books as of the day before the transfer.

C3.4.5. Prepare and verify a statement listing all outstanding accounts receivable and a transfer certificate showing the inclusive numbers of all unused numbers or controlled forms (Appendix 4).

C3.4.6. The incumbent MSA Officer shall retain a copy of the completed statements and certificates and distribute the original and other copies as follows:

C3.4.6.1. Original to the MSA files.

C3.4.6.2. One copy to the incoming MSA Officer.

C3.4.6.3. One copy to the MTF Commander.

C3.4.7. The incumbent MSA Officer shall be responsible for briefing the incoming officer.

C3.5. TEMPORARY ABSENCE OF THE MSA OFFICER

C3.5.1. When the appointed MSA officer is absent from duty for a period of fewer than thirty (30) calendar days, the MTF commander shall decide if transfer of MSA responsibilities is warranted. If a transfer is warranted, the duties of the MSA officer shall be assumed by the alternate MSA officer or delegated by the MTF commander to the responsible Resource Management (RM), Comptroller, or Patient Administration (PAD) officer, or to a designated representative.

C3.5.2. The appointed individual shall be fully responsible and shall assume the same responsibilities as the MSA officer during the period of absence of the MSA officer.

C3.5.3. A certificate of transfer shall be completed. See Appendix 5 for a sample certificate.

C3.6. CHANGE FUNDS

C3.6.1. The MSA officer shall request in writing, initial authority from the responsible disbursing officer to maintain a change fund.

C3.6.2. The MSA Officer shall request in writing a new and certified fund site each fiscal year.

C3.6.3. The MSA officer shall be responsible for the change fund and for issuing required amounts to cashiers by hand receipt or Receipt for Transfer of Cash and Vouchers.

C3.6.4. The minimum amount of funds required to provide a separate internal MSA change fund shall be maintained for each assigned alternate or relief cashier.

C3.6.5. The MSA officer shall ensure change funds and other funds are not used to cash personal checks, postal money orders, or other negotiable instruments for the convenience of individuals.

C3.6.6. Personal checks shall only be accepted for the amount due.

C3.6.7. Change funds may not be recorded in the cash and sales journal, nor included as a part of daily receipts.

C3.7. MINIMUM INTERNAL CONTROLS

C3.7.1. The MSA officer shall establish the minimum internal control procedures as listed below.

C.3.7.2. The RM, Comptroller, or PAD officer responsible for business office functions shall establish additional controls as deemed necessary.

C3.7.3. The cashier shall record all receivables accurately and promptly.

C3.7.4. The MSA officer shall reconcile subsidiary records (e.g., Invoice and Receipts I&Rs, DD Form 1131) to the Monthly Medical Services Activity Report (MMSAR) of the MTF. (See Appendix 6 for a sample I&R.)

C3.7.4.1. The MMSAR shall be forwarded to the servicing accounting and finance office if requested.

C3.7.4.2. System limitations may require creation and maintenance of a manual report since the MMSAR does not reflect current collections.

C3.7.5. At the time of receipt, the MSA officer shall account for all unused forms that require storage safeguarding or are controlled by serial number. The officer shall account for handling, receipt, and safeguarding of these forms as if they were cash.

C3.7.5.1. This process is necessary if the Composite Health Care System (CHCS) is not functional and manual receipts are necessary.

C3.7.5.2. Most MSA forms are generated, numbered, and controlled by CHCS.

C3.7.6. The MSA officer may not be the primary cashier. A separation of duties is necessary to ensure the integrity of the accounts.

C3.7.7. When feasible, one person shall perform cashier duties so responsibility for change funds and cash receipts is clearly identified.

C3.7.7.1. If more than one person has access to the safe where funds are kept, each responsible person shall have an individual lock box for storage inside the safe.

C3.7.7.2. Cashiers and alternates shall be assigned in writing and approved by the responsible RM, Comptroller, or PAD officer.

C3.7.7.3. The MSA officer shall assign separate change funds and lock boxes to alternate or relief cashiers.

C3.7.7.4. All cashiers shall ensure change funds are secured in a location where unauthorized persons may not access them.

C3.7.7.5. Each cashier shall retain and safeguard I&Rs and other voucher forms generated for those collection transactions they process.

C3.7.8. The MSA officer shall advance a change fund to the cashier and ensure that appropriate documentation is signed by the cashier and retained by the MSA officer as evidence of accountability for the cash.

C3.7.9. The MSA officer shall maintain documentation when transferring cash and vouchers to a cashier and account for returned vouchers.

C3.7.9.1. New receipts shall be used whenever a change of cashier takes place during the day.

C3.7.9.2. Numbered vouchers (I&Rs) transferred to the cashier shall be identified by serial or account numbers.

C3.7.10. The cashier shall settle the account with the MSA officer by turning over the cash collections and receipt vouchers at the end of the day or when relieved during the day. The MSA

officer shall verify that the change fund remaining in the cashier's cash box agrees with the receipt for the fund.

C3.7.11. Cashiers shall use separate I&Rs for foreign currency.

C3.7.12. The MSA officer shall receipt permanent change funds to permanent cashiers.

C3.7.13. Collections and settled accounts shall be handled as outlined in this chapter, except daily verification of change funds is not required.

C3.7.14. At least once a month, the MSA officer shall perform an unannounced audit of all funds entrusted to permanent cashiers.

C3.8. RESPONSIBILITY FOR LOSS OF FUNDS AND ACTION TO BE TAKEN

C3.8.1. The MSA officer may not procure surety bonds with appropriated funds.

C3.8.1.1. MSA officers may not be required to provide bond at their personal expense.

C3.8.1.2. The absence of bond coverage does not relieve the custodian of responsibility for funds, patient valuables, or financial liability in case of loss.

C3.8.2. Anyone discovering a loss or deficiency of Government funds, vouchers, or papers shall immediately advise the MTF commander in writing.

C3.8.2.1. The MTF commander shall submit a request for an investigation from the base or post.

C3.8.2.2. If a loss occurs, the appropriate action to be taken shall be consistent with the procedures outlined in subsections 060302 and 060403 of Volume 5, Chapter 6 (Irregularities In Disbursing Officer Accounts), of Reference (f).

C3.9. COMMINGLING OF FUNDS

MSA funds and records may not be mixed with other patient accounts funds and records, including TPC, MAC, charity drive funds, lost and found currency, and imprest funds.

C3.10. APPROPRIATION REIMBURSEMENTS AND RATES

C3.10.1. The O&M account of the MTF or other appropriations accounts must be reimbursed for costs of providing medical services and subsistence to beneficiaries. Refer to the Patient Billing Category Standardization Table (PATCAT table) in CHCS for entitlements, appropriate rates, and mode and site of collection. See Appendix 7 for a sample PATCAT.

C3.10.2. Depending on the patient, a full, interagency, or International Military Education and Training (IMET) rate shall be charged.

C3.10.2.1. Use DD Form 7, Report of Treatment Furnished Pay Patients – Hospitalization Furnished (Appendix 8), DD Form 7A, Report of Treatment Furnished Pay Patients – Outpatient Treatment Furnished, (Appendix 9), or SF 1080, Voucher for Transfer between Appropriated and/or Funds (Appendix 10) for interagency billing.

C3.10.2.2. The forms may be collected locally by the MSA Officer or centrally by Service headquarters. See Chapter 6 of this Manual for a complete discussion of reimbursement rates.

C3.11. ACCOUNTS RECEIVABLE

C3.11.1. The MSA officer shall ensure an accounts receivable, is established for any health-related services or supplies requiring payment from an outside activity.

C3.11.2. The same individual may not be responsible for establishing the account receivable, collecting, and depositing cash funds.

C3.11.3. Payments to the MTF shall be received only via acceptable forms of payment described in Section 3.28.

C3.12. BILLING PROCEDURES – IN GENERAL

C3.12.1. The MSA officer shall ensure a bill is generated for each MSA eligible patient.

C3.12.2. The PATCAT table indicates applicable pay modes, patient billing categories, and appropriate billing forms for all categories of patients.

C3.12.3. Patient OHI data, credit card information, and other applicable means of reimbursement for healthcare services shall be captured immediately upon outpatient visit or inpatient admission.

C3.12.4. Upon discharge, inpatients that owe subsistence shall have the opportunity to pay their bill or elect other payment arrangements.

C3.12.4.1. The MSA officer shall ensure procedures are in place for patients discharged after normal duty hours.

C3.12.4.2. Payment arrangements for pay patients shall be according to Reference (f).

C3.13. BILLING PROCEDURES – INVOICE AND RECEIPT (I&R)

C3.13.1. The I&R serves as a receipt for patients.

C3.13.1.1. It shows the charges billed for subsistence and health services, and payments made on the account.

C3.13.1.2. The I&R serves as a record of cash receipts, an accounts receivable record for local collections, and the basic instrument for posting to the Cash and Sales Journal.

C3.13.1.3. For the hospital dining facility or nutritional medicine service officer, the I&R serves as a receipt for cash collected and turned in to the MTF business office.

C3.13.1.4. It may also serve as a receipt for completed Cash Meal Logs and dining hall signature records returned to the MSA officer.

C3.13.2. The MSA office shall complete the patient identification data no later than the next business day after the patient is admitted. Identification data include patient demographics, employer, OHI information, and credit card information (when applicable).

C3.13.3. The MSA officer shall ensure that an I&R is on file or established in the automated system for each inpatient who has been charged for medical services or subsistence. The MSA office shall compare I&Rs on file or in the automated system with the Admissions and Dispositions (A&D) report.

C3.13.4. MSA office staff shall maintain an I&R, whether charges are paid locally by a Government or non-Government agency.

C3.13.4.1. When the I&R is prepared for patients whose charges are paid locally by other Government agencies, the I&R shall be kept with the SF 1080 until the payment is received. The DO shall enter the DO voucher number on the I&R.

C3.13.4.2. The DO voucher number provides a ready cross-reference to the SF 1080.

C3.13.4.3. A copy shall be stapled to the paid copy of the SF 1080.

C3.13.4.4. An additional copy shall be placed in both the alphabetical file and the inactive accounts receivable file.

C3.13.5. Upon receipt of I&Rs, the responsible RM, Comptroller, or PAD officer (or designated representative other than cashiers or bookkeepers) shall immediately number the new I&Rs consecutively on a fiscal year basis.

C3.13.5.1. The numbered forms shall be issued to the MSA officer and kept in a locked safe.

C3.13.5.1.1 Only the MSA officer and the alternate designated in writing shall use and control the forms.

C3.13.5.1.2. Under no circumstances may the MSA officer be provided unnumbered forms.

C3.13.5.1.3. Any unused numbered forms shall be inventoried quarterly concurrent with the MSA audit.

C3.13.5.2. After patient is discharged, the staff shall file the I&R alphabetically by the following categories:

C3.13.5.2.1. Inpatients discharged from the hospital.

C3.13.5.2.2. Outpatients from whom payment in full has not yet been received.

C3.13.5.2.3. Accounts reported as delinquent.

C3.13.5.3. The preparer of the I&R shall initial, as appropriate, and the individual receiving payment (usually the cashier) shall sign the form.

C3.13.5.4. A copy of the I&R shall be given to the patient or sponsor upon initial billing and when payment is received on an account.

C3.13.5.5. Dates of billings or payments shall be recorded on the master accounts receivable record and additional copies shall be stapled to the back of the master copy.

C3.13.5.6. Patients hospitalized for thirty (30) days or more shall be advised monthly, in writing, of charges due.

C3.13.5.7. The MSA office shall count the day of admission as a day of hospitalization and exclude the day of discharge to determine appropriate subsistence charges.

C3.13.5.7.1. Record a one-day charge if the patient is admitted and discharged on the same day.

C3.13.5.7.2. The MSA office shall coordinate with the PAD office to distinguish between a valid same-day admission and discharge and a canceled admission.

C3.13.5.7.3. Staff shall use the “change to Inpatient Status” action on the A&D list to determine proper charges.

C3.14. DD FORM 139, PAY ADJUSTMENT AUTHORIZATION (APPENDIX 11)

C3.14.1. The MSA office shall always attempt to collect payment from the patient at time of discharge.

C3.14.1.1. If the military member voluntarily consents to payroll deduction, DD Form 139 and a signed consent statement shall be forwarded to the member's servicing accounting and finance office no later than the next duty day. (See Appendix 12 for a sample consent statement for deduction from pay.)

C3.14.1.2. The MSA officer shall also advise the service member that charges owed will be deducted from his pay if payment is not received within thirty (30) days.

C3.14.1.3. No consent statement is required if pay deduction is involuntary due to delinquency according to Volume 5, Chapter 3 (Keeping and Safeguarding Public Funds) in Reference (f).

C3.14.2. If the member requests payroll deduction, MSA staff shall prepare a DD Form 139 with the statement, "The charges are for the hospitalization of (name) for the period (admission and discharge dates and times)." If the member is scheduled to separate from the Service within 30 days, notify the servicing accounting and finance office of the projected separation date.

C3.14.3. If the service member does not request payroll deduction or fails to pay at the time of discharge, refer to Volume 7a, Chapter 50 (Collection without Member's Consent) in Reference (f). The DD Form 139 shall be forwarded to the member's servicing accounting and finance or military pay office no later than the next duty day.

C3.14.4. A check (possibly a composite check for several deductions) shall be received from the payroll office and the amounts credited and deposited as amounts collected in the usual manner. Otherwise, the credited fund site shall be provided on the DD Form 139 and the amount credited through the payroll voucher and only a deduction listing sent to the MTF.

C3.15. BILLING PATIENTS WHO DO NOT PRESENT AUTHORIZED PROOF OF ELIGIBILITY FOR CARE

A statement of eligibility form must be completed for the patient before treatment and this form must be forwarded to the MSA office.

C3.15.1. For any treatment, the patient has thirty (30) calendar days after the visit to present documentation of eligibility. Otherwise, the MSA officer shall bill the patient as a non-Uniformed Services beneficiary at the full reimbursement rate using an I&R.

C3.15.2. If the patient or sponsor provides proof of eligibility to the PAD office or MSA office after the bill is generated, void the I&R within thirty (30) calendar days.

C3.16. PROCEDURES FOR CHARGING FEES FOR TRAUMA CARE AND OTHER MEDICAL CARE PROVIDED TO CIVILIANS

C3.16.1. Except as provided in Paragraphs C3.19 and C3.22, an MTF shall charge civilian patients who are not eligible beneficiaries (or the insurers of these patients) for the reasonable charge, as determined by the Secretary of Defense, for trauma and other medical care. An MTF shall retain and use the amounts collected for the following:

C3.16.1.1. Trauma consortium activities.

C3.16.1.2. Administrative, operating, and equipment costs.

C3.16.1.3. Readiness training.

C3.16.2. Example of "other medical care." If a civilian visiting a military installation suffers a coronary attack while on the installation, that civilian would receive stabilizing medical care.

C3.16.3. A reasonable charge is a fee that usually covers the cost of medical care but does not generate a profit.

C3.16.4. The Third-Party Collections Program does not apply to these patients because they are not eligible beneficiaries.

C3.16.4.1. Civilian emergency patients shall be treated at their own expense and billed using an I&R.

C3.16.4.2. The MSA Officer shall ask the patient to complete a DD Form 2569, Third Party Collection Program – Collection of Other Health Insurance (Appendix 13), which includes an assignment of benefits to the MTF. The signed DD Form 2569 may be retained in hard copy or electronic format as long as it is available for purposes of assignment of benefits.

C3.16.4.3. The MTF is not required to file a claim directly with the patient's third-party payer unless the patient signs an assignment of benefits form and an authorization to release medical information.

C3.16.4.4. The MTF may submit a claim to a third-party payer.

C3.17. BILLING PATIENTS WHO ARE NOT UNIFORMED SERVICES BENEFICIARIES

C3.17.1. A statement of eligibility form must be completed for the patient before treatment and this form must be forwarded to the MSA Officer.

C3.17.2. For a complete listing of patients, refer to the PATCAT table. Examples of patients are:

C3.17.2.1. State Department employees and their dependents.

C3.17.2.2. Contractors and some Federal employees overseas and in remote areas.

C3.17.2.3. Civilian employees and their dependents paid from non-appropriated funds.

C3.17.3. Medical record coding shall be completed before the patient receives the final bill.

C3.18. COMPLETION OF GROUP HEALTH PLAN OR CLAIM FORM

Under DD Form 2569, if a claim is filed, the MSA officer shall advise the patient that he is personally liable for any amounts not paid by the third-party payer within one hundred eighty (180) days from the date the claim is filed.

C3.18.1. The MSA office shall obtain a signed statement from the patient acknowledging his indebtedness to the MTF. The patient shall be asked to notify the MSA office of any change of address.

C3.18.2. The MSA officer shall retain the signed statement acknowledging a debt with the I&R in the active accounts receivable file until the account has been paid in full.

C3.18.2.1. The MSA officer shall transfer the account to the local or servicing accounting and finance office for collection thirty (30) days after the patient has been notified of non-payment by the third-party payer.

C3.18.2.2. If payment is received from the third-party payer after transfer, the officer shall forward the payment to the servicing or accounting and finance office.

C3.19. BILLING OTHER THAN UNIFORMED SERVICES PATIENTS DURING CONTINGENCY OPERATIONS

C3.19.1. In some instances, there are categories of individuals other than uniformed services beneficiaries who are eligible for treatment during contingency operations in forward deployed nonfixed medical facilities..

C3.19.2. U.S. Government employees and contractors may be eligible for care. See DoD Instruction 1400.32 (Reference (g)) and DoD Instruction 3020.41 (Reference (h)).

C3.19.3. Eligibility of treatment does not imply that the treatment is furnished without cost to the individual.

C3.19.4. The UBO establishes rates, but not eligibility nor billing policy for forward deployed nonfixed medical facilities.

C3.19.5. A patient needing healthcare services beyond the deployed nonfixed medical facility shall be billed for those services according to the billing guidelines set forth in this Manual.

C3.19.6. A DoD civilian employee may not be billed for healthcare services related to injuries or illnesses caused or exacerbated by deployment; however, reimbursement may be sought from the employee's third-party payer. This is according to DoD Directive 1404.10 (Reference (h)).

C3.20. BILLING EMERGENCY SERVICES ON BEHALF OF NON-UNIFORMED SERVICES MEDICARE PATIENTS

C3.20.1. The MSA Officer shall bill Medicare on behalf of Non-Uniformed Services Medicare-eligible emergency patients.

C3.20.2. The MSA Officer shall collect the co-insurance and deductible amounts from non-Uniformed Services beneficiaries as noted on the Medicare Explanation of Benefits (EOB) or remittance advice form.

C3.20.2.1. The MSA billing office shall prepare a UB-92 (Appendix 14) and submit it to the appropriate Medicare Fiscal Intermediary (FI) depending on the location of the MTF pursuant to Service guidance and regulation.

C3.20.2.2. The MSA Officer shall complete an election form annually.

C3.20.3. The MSA Officer shall bill Medicare at the interagency rate.

C3.20.3.1. The MTF shall accept assignment of benefits; therefore, the FI shall pay the MTF directly.

C3.20.3.2. Medicare shall pay 100 percent of the DoD charges, less the patient's applicable deductible and co-pay.

C3.20.3.3. Collection of any unpaid amount in excess of the patient's co-pay share shall be pursued with the FI and may not be billed to the patient.

C3.21. BILLING STATE AGENCY SPONSORED PROGRAMS, SUCH AS MEDICAID

MTFs shall follow Service-specific guidelines for filing claims to state agency sponsored programs, such as Victims of Crime or Medicaid Programs.

C3.21.1. The MSA Officer shall bill Medicaid on behalf of Non-Uniformed Services Medicaid-eligible emergency patients at the full rate.

C3.21.2. The MSA Officer may also bill the patient directly for physician's services if Medicaid does not pay at all, due to the patient not being covered at the time of care.

C3.21.3. Partial payments are accepted as payment in full.

C3.21.4. The MSA Officer shall provide the patient an itemized bill for the services rendered.

C3.21.5. The MSA Officer shall follow Service-specific uncollected debt guidelines.

C3.22. BILLING WORKERS' COMPENSATION (EMPLOYMENT-RELATED INJURIES OR ILLNESSES) CASES

C3.22.1. Workers' compensation cases are covered under both MSA and MAC Programs. (See Appendix 15 for workers' compensation diagram.)

C3.22.1.1. Civilians are covered under MSA.

C3.22.1.2. Uniform Services dependents and retired members are covered under MAC.

C3.22.2. Workers' Compensation involving DoD Employees

C3.22.2.1. Do not bill DoD employees (appropriated fund or nonappropriated fund) for emergency medical care (including initial treatment) for work-related injuries or illnesses. Use the interagency rate to bill nonappropriated fund employees for follow up care. See HA Policy 97-035 (Reference (i)).

C3.22.2.2. The MTF may not bill the Department of Labor (DOL) for DoD Federal employees. The underlying reason is that Congress appropriates DoD funds to provide care for DoD Federal employees under occupational injury and illness situations. If the Department of Defense billed DOL, the Department of Defense would have to pay the cost of medical care plus a surcharge for administrative costs to DOL.

C3.22.2.3. These patients are entitled to the initial emergency care, but are not entitled to follow-up care, unless appropriately authorized.

C3.22.2.4. See Chapter 5, Medical Affirmative Claims (MAC) of this Manual, for the administration of workers' compensation claims for Non-DoD employees who are Uniformed Services beneficiaries.

C3.22.3. Civilian Emergency Patients or Contractor Employees

C3.22.3.1. For non-Uniformed Services beneficiaries (including contractors who are not Uniformed Services beneficiaries or DoD employees), the MSA billing office shall bill the patient or patient's employer if the injury or illness is work-related. The Government may

contract with a company to perform a particular function, but the employee's salary and workers' compensation shall be paid by the company itself, not the Government.

C3.22.3.2. It is the employee's responsibility for filing Workers' Compensation claims with his employer.

C3.22.3.2.1. It is the contract employer's responsibility to forward the bill to the appropriate insurance company.

C3.22.3.2.2. The contract employee is responsible for filing a workers' compensation claim through his employer. The employee must be informed of his responsibility to pay the full charges if the patient's workers' compensation claim is denied.

C3.22.4. Workers' Compensation Involving Other (Non-DoD) Federal Employees

C3.22.4.1. There is no charge for the initial emergency visit.

C3.22.4.2. Follow-up care at no charge is not authorized for patients who are non-Uniformed Services beneficiaries.

C3.22.4.3. The MSA office shall bill for follow-up visits to the appropriate Department, usually through the appropriate civilian personnel office of the employee for non-DoD Federal employees.

C3.22.4.4. A report of injury or illness shall be submitted to the appropriate civilian personnel office for all Federal employees.

C3.22.4.5. The SF 1080 shall be used according to paragraph 3.15. for interagency billings.

C3.22.4.6. The individual with oversight of MSA, TPC, and MAC shall ensure the timely completion of forms required by the healthcare provider on a workers' compensation claim, as required by the insurer, payer, and Workers' Compensation Board.

C3.23. BILLING TO OTHER FEDERAL GOVERNMENT AGENCIES, DEPARTMENT OF VETERANS AFFAIRS, DEPARTMENT OF STATE, AND OTHER SPECIAL CATEGORIES

C3.23.1. The PATCAT table lists, by patient category, the appropriate billing rate and billing form to use.

C3.23.2. The MSA officer shall transmit bills as soon as possible and pursuant to Service guidance and regulations, shall collect from other Government agencies. This paragraph does not apply to Federal employees treated for work-related injury or illness. (See Section C3.22 of this chapter.)

C3.23.3. For non-DoD interagency billings, the MSA officer shall use the SF 1080.

C3.23.4. If the patient is a Secretarial Designee non-Uniformed Services beneficiary, according to Service definitions, the MTF may not bill Medicaid or other third-party payer on behalf of the patient.

C3.24. HEALTH CARE BILLING FOR IMET, FOREIGN MILITARY SALES (FMS), NORTH ATLANTIC TREATY ORGANIZATION (NATO)

C3.24.1. The MSA Officer shall obtain a copy of the invitational orders for Healthcare Billing for International Military.

C3.24.2. Information on the charges for health care, and the collection and processing of bills for international military students and their dependents is indicated in the annual Medical and Dental Rates package.

C3.24.3. Reciprocal agreements guidance can be found at the Security Assistance Web site https://fhp.osd.mil/portal/rhas.jsp (available at ".mil" addresses only).

C3.25. ELECTIVE COSMETIC SURGERY

C3.25.1. All patients (active duty and their dependents, retired members and their dependents, and survivors) shall be charged elective cosmetic surgery rates.

C3.25.2. The rates are specified in the regularly published reimbursable medical and dental rates.

C3.25.3. All patients, including active duty members are responsible for the cost of implant(s), injectable(s) and the prescribed cosmetic surgery rate. The implants and procedures used for augmentation mammaplasty shall be in compliance with Federal Drug Administration guidelines.

C3.25.4. The patient shall be asked to sign a letter acknowledging the debt. A copy of the letter shall be filed in the MSA office accounts receivable file.

C3.26. BILLING PROCESSES

C3.26.1. If a patient who is not a DoD civilian overseas does not pay upon discharge, the MSA officer shall advise the patient of his obligation to pay within sixty (60) days.

C3.26.1.1. DoD civilians overseas shall be advised of their obligation to pay within ninety (90) days.

C3.26.1.2. This allows sufficient time for the patient to be reimbursed by his insurer.

C3.26.2. For active duty members and their dependents, the MSA officer shall advise the sponsor that charges owed shall be deducted from the member's pay if payment is not received within (thirty) 30 days.

C3.27. FORMS OF ACCEPTABLE PAYMENT

The MSA officer shall accept payment of amounts due to the MTF in the following authorized forms:

C3.27.1. Cash. U.S. Currency and Coin.

C3.27.2. Negotiable Instruments. Authorized negotiable instruments may not be accepted in amounts larger than the amount due. Negotiable instruments made payable or endorsed to the servicing accounting and finance office, as prescribed locally, are acceptable in the following forms:

C3.27.2.1. U.S. Treasury checks.

C3.27.2.2. Certified checks, cashier's checks, and bank drafts.

C3.27.2.3. Personal checks. (Personal checks for more than the amount due may not be accepted.) Personal checks for partial payments may not be accepted if they carry any conditional endorsements such as "payment in full."

C3.27.2.4. Traveler's checks.

C3.27.2.5. U.S. Postal money orders or money orders issued by banks or other financial establishments.

C3.27.2.6. Credit cards where applicable.

C3.27.2.7. Military payment certificates. Military payment certificates shall be accepted outside the Continental United States (OCONUS) where such certificates are required for use as currency.

C3.27.2.8. Foreign currency.

C3.27.2.8.1. Transactions affected by military payment certificates and foreign currency are governed by directives of the overseas command concerned.

C3.27.2.8.2. The MSA officer shall use separate I&Rs for foreign currency and military payment certificates.

C3.28. DD FORM 1131, CASH COLLECTION VOUCHER

C3.28.1. The MSA officer shall use DD Form 1131 to transfer monies received to the local or supporting finance office or to document deposits into the accounting records.

C3.28.1.1. The Composite Health Care System (CHCS) generates pre-numbered forms.

C3.28.1.2. If manual forms are used, the MSA officer shall assign a standard document number series of consecutive numbers by fiscal year to the DD Form 1131.

C3.28.1.3. The MSA officer shall transfer all proceeds from sales to the local or supporting finance office, or make deposit to the Federal Reserve Bank or designated depository by SF 215, Deposit Ticket (Appendix 16), according to requirements of the MSA officer's servicing or accounting and finance office.

C3.28.1.4. Confirmed copies of the SF 215 shall be sent to the servicing or accounting and finance office.

C3.28.1.5. If funds are stored overnight, the MSA officer shall ensure storage meets the requirements of Volume 5, Chapter 3 (Keeping and Safeguarding Public Funds), in Reference (f) and Service resource protection requirements. The MSA officer shall obtain approval for fund containers.

C3.28.2. The MSA officer shall prepare a separate DD Form 1131 for each fiscal year.

C3.28.2.1. Credit each collection to the fiscal year in which services were rendered.

C3.28.2.2. The accounting classification block shows the full listing of major accounting classifications.

C3.28.3. Sales codes shall be appropriately reported as part of the fund cite and different sales codes shall be reported as necessary.

C3.28.4. The MSA officer shall use a separate line for each accounting classification, if appropriate.

C3.28.5. The appropriate agent shall sign each DD Form 1131 collection voucher. The MSA officer shall retain a copy of the DD Form 1131 with supporting documentation containing the disbursing office voucher number and shall record the collection into the finance system (if authorized).

C3.28.6. The MSA officer shall use a separate DD Form 1131 to transfer foreign currency to the supporting finance office. The officer shall indicate the units and quantities of foreign currency and the equivalent value in U.S. currency, based on the actual rate on the date of receipt or transfer.

C3.29. UNCOLLECTIBLE OR DISHONORED CHECKS

C3.29.1. The MSA officer shall handle uncollectible and dishonored checks according to Service-specific guidance.

C3.29.2. When a recorded cash collection is rendered null and void by a dishonored check, the MSA officer shall follow the manual or automated procedures:

C3.29.2.1. Manual Procedures

C3.29.2.1.1. Pull the original I&R copies from the files and adjust them by striking the collection entry column J and inserting the amount due in column K.

C3.29.2.1.2. Initial the adjustment and explain the adjustment in a footnote.

C3.29.2.1.3. File the forms in the unpaid section of the accounts receivable file.

C3.29.2.1.4. Immediately follow up on these accounts.

C3.29.2.1.5. An administrative fee for dishonored checks may not be charged.

C3.29.2.2. Automated Procedures

C3.29.2.2.1. Zero out collections in the automated system by printing a Cash Collection Voucher.

C3.29.2.2.2. Post the negative amount corresponding to the original payment and print a negative final Cash Collection Voucher.

C3.29.2.2.3. Immediately follow up on these accounts.

C3.29.2.2.4. An administrative fee for dishonored checks may not be charged.

C3.30. METHODS OF SETTLING OUTSTANDING ACCOUNTS RECEIVABLE

C3.30.1. The MSA office shall make every effort to collect accounts before they become delinquent. Accounts receivable are delinquent if not paid within thirty (30) days of the date of the I&R or notice of payment due.

C3.30.2. If charges are not paid within 30 days of date of invoice, the MSA office shall prepare a DD Form 139 or DD Form 2481, Request for Recovery of Debt Due the United States By Salary Offset (Appendix 17), with the following statement in the Remarks section:

> "The member named above was notified in writing on [date] concerning these unpaid charges. The charges are for health care services for [name of patient] for the period of

[admission and discharge date and time of appointment]. The member has not paid as of this date."

C3.30.2.1. Additionally, include a statement on the DD Form 139/DD Form 2481 certifying the patient was provided due process according to subsection 500104.A.2., Volume 7A, Chapter 50 (Stoppages And Collections Other Than Courts Martial Forfeitures), in Reference (f). Include the statutory authority 37 U.S.C. 1007 (Reference (j)) for the debt.

C3.30.2.2. The MSA office will forward the DD Form 139/DD Form 2481 to the member's servicing accounting and finance office.

C3.30.2.3. The MSA office shall not close out the accounts receivable at this time.

C3.30.2.4. The MSA officer shall follow up in writing according to Service-specific guidelines at sixty (60) and ninety (90) days.

C3.30.2.5. DoD civilians overseas and Non-Uniformed Services beneficiaries have ninety (90) days from date of invoice before account becomes delinquent.

C3.30.3. For civilian emergencies whose health insurance plan has been billed, the MSA office will send a follow-up letter after sixty (60) and ninety (90) days from date of initial invoice.

C3.30.3.1. If payment has not been received from the third-party payer within 180 days from the date the claim was submitted, the MSA officer shall collect payment from the patient.

C3.30.3.2. The patient shall be simultaneously notified of debt due each time a follow-up letter or contact is made to the insurer.

C3.30.4. The MSA office will transfer delinquent accounts with other Federal agencies not settled within 180 days of the first billing, to the servicing accounting and finance office for collection according to Service guidelines.

C3.30.5. The MSA office shall process unpaid accounts of Service members who have been found mentally incompetent according to applicable guidance from the servicing accounting and finance office.

C3.30.6. The MSA office may not contact next of kin for deceased Federal employees, but shall forward the account to the appropriate Defense Finance and Accounting Service (DFAS) office.

C3.31. PROCEDURES FOR TRANSFERRING DELINQUENT ACCOUNTS

C3.31.1. When an account receivable becomes delinquent, the MSA office shall transfer it to the appropriate servicing accounting and finance office for further collection action or write-off. Refer to Section 3104 of Volume 5, Chapter 31 (Debt Compromise: Suspending And

Terminating Collection Activity; Debt Write-Off And Retention), in Reference (f) for additional guidance on debts that are determined to be uncollectible to be consistent with the Office of Management and Budget guidance in Circular A-129, "Policies for Federal Credit Programs and Non-Tax Receivables" (Reference (l)).

C3.31.2. The MSA office shall use the following procedures to transfer delinquent accounts receivable to the servicing accounting and finance office:

C3.31.2.1. Review the account to ensure patient identification data is complete, charges are accurate, and past collection efforts are fully documented.

C3.31.2.2. Include copies of follow-up letters, records of phone calls or personal contacts made to generate collection, and any other information that shall assist the servicing accounting and finance office in further collection efforts.

C3.31.2.3. Send two copies of all related documents and pertinent correspondence to the servicing accounting and finance office.

C3.31.2.4. Include in a transmittal letter the following elements to substantiate the status of the account:

C3.31.2.4.1. The patient's name and Social Security Number.

C3.31.2.4.2. Sponsor's name and Social Security Number.

C3.31.2.4.3. Sponsor's grade.

C3.31.2.4.4. Sponsor's organization.

C3.31.2.4.5. Address.

C3.31.2.4.6. Any other identifying data.

C3.31.2.4.7. Dates of service and subsistence provided.

C3.31.2.4.8. The amount of collections, if any, applied against the charge.

C3.31.2.4.9. The outstanding balance.

C3.31.2.4.10. A complete fund citation of the specific program and appropriation to which collections will be deposited as reimbursements.

C3.31.2.4.11. A record of follow-up actions.

C3.31.2.4.12. Any other pertinent information.

C3.31.2.5. Send the delinquent account to the servicing accounting and finance office or follow Service guidance regarding monetary ceilings of transferred accounts.

C3.31.2.6. Attach the original and reproduced copies, as needed, of the I&R top copy to the transmittal letter.

C3.31.2.7. Staple one copy of the transmittal letter to the back of the second copy of the I&R and write "Reported Delinquent on (date)" across the face of the form.

C3.31.2.8. Place the form in the delinquent account section of the accounts receivable file.

C3.31.2.9. Note the "Reported Delinquent on (date)" on the I&R retained in the numerical file.

C3.31.3. After performing these actions and transferring the account to the servicing accounting and finance office, the MSA officer shall be relieved of further responsibility for collecting on the account.

C3.31.4. Follow Service guidance regarding debt management procedures.

C3.32. CORRECTIONS IN ACCOUNTING RECORDS

C3.32.1. The procedures described below contain both automated and manual procedures.

C3.32.2. Manual procedures are provided for instruction when the automated systems is not able to perform these procedures.

C3.32.3. Processing Refunds

C3.32.3.1. Submit a claim for reimbursement of overcharges to the servicing accounting and finance office on an SF 1049, Public Voucher for Refunds (Appendix 18).

C3.32.3.2. The SF 1049 must show the appropriation number and the DD Form 1131 under which the funds were deposited with the servicing accounting and finance office.

C3.32.3.3. Staple a copy of the SF 1049 to the back of the patient's I&R after entries are made on the front of the card adjusting the account.

C3.32.3.4. Cash refunds or refunds with purchased money orders are not authorized.

C3.32.4. Collecting Interest Payments. The amount of money stated to be interest by the third-party payers is payment for the reasonable cost of healthcare provided to a non-Uniformed Services beneficiary, as long as the amount remitted, both payment and interest, does not exceed

what the MTF billed the carrier for inpatient admission or other healthcare service, excluding any co-payment or deductibles.

C3.32.4.1. The MTF does not charge interest on delayed payment of bills.

C3.32.4.2. If the third-party payer chooses to call its payment "interest," it is accepted as payment on the approved DoD Medical and Dental rate charge stated on the bill.

C3.32.4.3. For overpayments caused by interest payments, the amount overpaid shall be deposited into the General Treasury.

C3.32.5. Processing Undercharges

C3.32.5.1. When a patient has been undercharged, the MSA officer shall contact the patient or sponsor to collect the balance due the U.S. Government.

C3.32.5.2. The MSA officer shall make the necessary adjusting entries on the I&R and other appropriate MSA records.

C3.33. PROCEDURES FOR HANDLING FEES COLLECTED FOR MEDICAL RECORDS COPYING, ETC

C3.33.1. The PAD or medical records office shall process requests for clinical information received from non-Government agencies.

C3.33.2. The office personnel shall use a locally developed transmittal letter or a copy of the transmittal letter from the insurance company to release this information according to Volume 11A, Chapter 4 (User Charges), in Reference (f).

C3.33.3. When payment is received, the PAD or medical records office shall send the payment to the MSA office with a copy of the locally developed transmittal letter or transmittal letter from the insurance company. The MSA officer shall indicate on the receipt of funds transmittal "Received ($ dollar amount received) on (date)."

C3.33.4. The medical records office shall retain a copy of the locally developed transmittal letter or transmittal letter from the insurance company as a source document attached to the DD Form 1131.

C3.33.5. The MSA officer shall deposit the funds with the servicing accounting and finance office and attach all related papers to the receipt copy of the DD Form 1131 for filing.

C3.34. SAFEGUARDING PATIENT VALUABLES

C3.34.1. The MSA Office shall provide adequate facilities (such as a safe or locked cabinet) to store and safeguard patient valuables (cash, jewelry, etc.).

C3.34.2. MTFs shall advise patients of the availability of these storage facilities.

C3.34.2.1. Valuables shall be tagged and a receipt shall be given to the patient.

C3.34.2.2. The MSA office may not permit the use of patient valuables as security for check cashing, loans, or other similar purposes.

C3.34.3. Patients shall acknowledge the availability of storage facilities for valuables when they sign the admission authorization.

C3.34.3.1. In those cases when the patient is unable to sign the authorization form, the immediate next of kin, if present, is authorized to sign for the patient.

C3.34.3.2. If the immediate next of kin is not present, the command duty officer or PAD officer shall make an entry in the form stating that the patient was unable to sign and that the officer shall secure the patient's signature as soon as reasonably possible.

C3.34.4. The MSA office may not accept personal firearms, knives with blades above the length permitted by law and regulation, or any other item or object that may be considered a menace to safety or health.

C3.34.5. The MTF commander shall designate in writing an individual to serve as the custodian for patient valuables.

C3.34.5.1. The custodian shall maintain the necessary records and protect the security of the valuables accepted for safeguarding.

C3.34.5.2. Individuals authorized to perform the duties in the absence of the custodian shall be designated in writing.

C3.34.5.3. The current custodian shall properly transfer patient valuables and related records when a new custodian is designated.

C3.34.6. The designated custodian shall use a valuables container as designated by the specific Service for storing and safeguarding personal valuables.

C3.34.7. When storing large items, DD Form 599, Patient's Effects Storage Tag, shall be used and cross-referenced to the valuables envelope, as noted in Appendix 19.

C3.34.8. The MSA officer shall consecutively number the storage forms immediately upon receipt and record them in a log.

C3.34.8.1. As each storage form is used, the patient's name shall be entered in the log along with the name of the individual receiving the valuables.

C3.34.8.2. The MSA officer shall furnish to the designated custodian only the quantity of forms needed to meet expected requirements for a reasonable period.

C3.34.8.3. The MSA officer shall maintain all excess forms in a locked safe or cabinet inaccessible to the custodian and other individuals.

C3.34.8.4. The custodian shall enter a description of all items for storage on the Service-specific form.

C3.34.8.4.1. Be specific in listing cash and money orders by amounts, check numbers, and articles of jewelry.

C3.34.8.4.2. Jewelry shall be referred to as "gold in color" instead of "gold ring," and include any identifying marks or inscriptions.

C3.34.8.5. The custodian shall provide the patient with the detachable receipt from DD Form 599, or other valuables envelopes, for items received into custody.

C3.34.8.5.1. The patient or the patient's designated representative shall surrender the receipt to the custodian at the time valuables are returned.

C3.34.8.5.2. The patient or the patient's designated representative shall also acknowledge receipt of the returned valuables by signing opposite the depositor's original signature and envelope number.

C3.34.9. Any individual who discovers a loss of patient valuables shall report that loss immediately to the MTF commander for administrative action. The report shall state how the loss was discovered and any other facts concerning the loss.

C3.34.10. To verify adequacy of controls, the MTF commander or designee shall appoint in writing a disinterested officer, Non-Commissioned Officer, or civilian equivalent, to conduct a monthly inspection of secured patient valuables, related records, and forms (Service-specific). Patients whose valuables are lost, mistakenly released, or stolen while in the custodian's possession may file claims for compensation with the appropriate Service legal office.

C3.35. MEDICAL SERVICES ACCOUNT REPORTS

The MSA office shall prepare the following reports:

C3.35.1. The MSA officer shall type the word "Initial" or "Final" in the top margin of all reports covering the first or last month's operation or portion thereof resulting from activation,

redesignation, opening operations at a new station, or completion of operations at a station before moving to a new station.

C3.35.2. A corrected report automatically and entirely cancels any previous report for the same period of time, subject, and data.

C3.35.2.1. For automated systems, corrections made to a previous month's report shall be reflected in the current report.

C3.35.2.2. For manual systems, the MSA officer shall produce all corrected reports (e.g., corrected reports from 3 months previous as well as subsequent reports) for submission, unlike the automated system, which updates subsequent reports.

C3.35.2.3. Place an asterisk ("*") by each corrected entry on the corrected report.

C3.35.2.4. Type "Corrected – (date of corrected copy)" in the top margin of all corrected reports.

C3.35.2.5. Enter the actual month and year of the initial report in the block provided for the date on the report.

C3.35.2.6. Corrected DD Form 7 and 7A reports shall indicate only the differences from what was originally submitted.

C3.35.3. DD Form 7, Report of Treatment Furnished Pay Patients— Hospitalization Furnished (Part A).

C3.35.3.1. At the end of each calendar month, the MSA officer shall prepare a report of inpatient care on DD Form 7 for each of the categories of pay patients in the PATCAT table.

C3.35.3.2. A person who received inpatient care and for whom a bed is maintained in the facility shall be reported as a pay patient on DD Form 7.

C3.35.3.3. The MSA officer shall prepare a separate report for each major category of patient (e.g., active duty, active duty dependant, retired member, or retired member dependant).

C3.35.3.4. The MTF shall issue a report no later than calendar day seven (7) of the following month.

C3.35.3.5. An original plus one copy shall be sent to Service headquarters, if required.

C3.35.4. DD Form 7A, Report of Treatment Furnished Pay Patient – Outpatient Treatment Furnished (Part B).

C3.35.4.1. At the end of each calendar month, the MSA officer shall prepare a DD Form 7A.

C3.35.4.2. The MTF shall issue a report no later than calendar day seven (7) of the following month.

C3.35.4.3. The MSA officer shall send an original plus one copy to Service headquarters, if required.

C3.35.5. MMSAR.

C3.35.5.1. At the end of each month, the MSA officer shall produce a summary of MSA activity showing billing and collections for reimbursable services and subsistence.

C3.35.5.2. The MSA officer shall submit a separate report for the current and prior fiscal years until all prior years' outstanding accounts receivable have been resolved.

C3.35.5.3. The MSA officer shall report the following separate sections by sales code:

C3.35.5.3.1. Subsistence.

C3.35.5.3.2. Medical Services.

C3.35.5.3.3. Food Service Rate collections.

C3.36. DISPOSITION OF RECORDS

C3.36.1. The MSA officer shall retain all accounting forms and records used to operate the MSA office for six (6) years and three (3) months.

C3.36.2. The MSA officer shall dispose of records according to Service guidelines and requirements for handling sensitive material.

C4. CHAPTER 4

THIRD PARTY COLLECTION PROGRAM

C4.1. GENERAL

C4.1.1. The Third Party Collection (TPC) office shall be located in an area that is easily accessible for, and identifiable by, patients.

C4.1.2. Section 1095 of Reference (d), as implemented by 32 CFR Part 220 (Reference (c)) and supplemented by Service guidelines, requires MTFs to collect from third-party payers the reasonable charges for medical services provided to Uniform Services beneficiaries, excluding active duty.

C4.1.2.1. Each MTF shall designate an office responsible for TPC Program Management to include:

C4.1.2.1.1. Program marketing and education.

C4.1.2.1.2. Oversee identification and collection of third-party plan or policy information.

C4.1.2.1.3. Filing claims with third-party payers.

C4.1.2.1.4. Collecting and depositing funds.

C4.1.2.1.5. Reporting TPC Program status.

C4.1.2.1.6. Referring outstanding claims for legal action.

C4.1.3. Implementing an effective TPC program requires a review of all aspects of the revenue cycle as it pertains to the business office.

C4.1.4. Participation in these reviews shall include, at a minimum, the following:

C4.1.4.1. Accounts receivable management.

C4.1.4.2. MTF finance offices.

C4.1.4.3. Physician and nursing staffs.

C4.1.4.4. Admissions.

C4.1.4.5. Medical records (e.g., encounter documentation and accurate coding).

C4.1.4.6. The legal office.

C4.1.4.7. Utilization and quality assurance review.

C4.1.4.8. Ancillary departments (e.g., laboratory, radiology, and pharmacy).

C4.1.4.9. Information management.

C4.1.4.10. Patient access (including appointments).

C4.1.5. MTFs shall follow rules and procedures outlined for third-party payers pursuant to Reference (c) and Service guidance. The MTF shall establish a TPC Program that performs the following functions:

C4.1.5.1. Identify those Uniformed Services beneficiaries with third-party payer plan, Medicare Supplemental Insurance, or other contractual coverage.

C4.1.5.2. Document coverage in the patient's medical record and the applicable computer system (CHCS).

C4.1.5.3. Comply with third-party payer requirements.

C4.1.5.4. Submit insurance claims to third-party payers for reimbursements.

C4.1.5.5. Follow up to ensure collection activities are processed according to applicable Federal law, regulation, and policy.

C4.1.5.6. Document and report collection activities.

C4.1.5.7. Implement and apply TPC compliance guidelines.

C4.1.5.8. Follow Reference (e) and Service accounting guidelines.

C4.1.5.9. Maintain insurance claims on file for six (6) years and (3) months.

C4.1.6. For inpatient hospital care, authority to collect applies to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after April 7, 1986.

C4.1.6.1. For Medicare supplemental insurance policies, automobile liability and no-fault insurance plans, and outpatient care, authority to collect applies to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after November 5, 1990.

C4.1.6.2. An amendment to a policy or plan may include, but is not limited to, premium rate changes, benefit changes, carrier changes, or conversions from insured plans to self-insured plans or the reverse.

C4.2. HEALTH CARE PLANS NOT SUBJECT TO THE TPC PROGRAM

Plans not subject to the TPC Program include TRICARE, TRICARE supplemental plans, income (or wage) supplemental plans, and plans administered under Titles XVIII and XIX of the Social Security Act (Medicare and Medicaid, respectively) (Reference (n)).

C4.2.1. Medicare includes replacement plans and Medicare Pharmacy Plans (e.g., Medicare Part D).

C4.2.2. Medicaid includes all forms of Medicaid plans, such as State Medicaid provider and Medicaid managed care plans.

C4.3. MEDICAL SERVICES BILLED

C4.3.1. The MTF shall file claims to third-party payers for all services rendered, including multiple visits on the same day to different clinics.

C4.3.2. List of billable services:

C4.3.2.1. Inpatient hospital care (e.g., institutional and inpatient professional).

C4.3.2.2. Ambulatory procedure visits.

C4.3.2.3. Outpatient Services.

C4.3.2.4. Ancillary Services including but not limited to, laboratory, pathology, and radiology procedures and prescription drugs.

C4.3.2.5. Observation Services.

C4.3.2.6. Immunizations and Injections.

C4.3.2.7. Dental Care.

C4.3.2.8. Ambulance Services.

C4.3.2.9. Durable Medical Equipment/Durable Medical Supplies (DME/DMS).

C4.3.2.10. Anesthesia Services.

C4.4. MEDICAL SERVICES NOT BILLED

C4.4.1. The medical services not billable are those for which DoD TMA has not yet established rates or rates are set at zero. MTFs may not establish rates in the absence of DoD-provided rates.

C4.4.2. The TPC office shall notify the MTF Commander of any services provided for which there is not an established rate. This information shall be communicated to TMA under Chapter 1 of this guidance.

C4.5. IDENTIFYING BENEFICIARIES WHO HAVE OTHER HEALTH INSURANCE (OHI)

C4.5.1. Timely and accurate identification of beneficiaries with OHI is crucial to a successful TPC Program.

C4.5.2. The pre-admission, admission, outpatient, ancillary (including Pharmacy) or TPC staff shall obtain signed certification from beneficiaries at the time of each inpatient admission, outpatient visit, or encounter if:

C4.5.2.1. Signed certification is not in either the patient medical record or stored electronically in the Composite Health Care System (CHCS), or its replacement system.

C4.5.2.2. Certification has not been updated within the past 12 months.

C4.5.2.3. The patient's OHI information is not available.

C4.5.3. If there are changes to the payer information, the form shall, at a minimum, be updated, signed, and dated.

C4.5.4. To achieve 100% contact rate, each MTF shall establish a process to verify whether or not a patient has OHI.

C4.5.4.1. Use DD Form 2569, Third Party Collection Program – Record of Other Health Insurance. The signed DD Form 2569 may be retained in hard copy or electronic format as long as it is available for purposes of assignment of benefits.

C4.5.4.2. TPC staff shall discuss with patients the requirements and benefits of the TPC Program, the types of policies and plans subject to collection, and the patient's responsibility.

C4.5.4.3. TPC staff shall ascertain Medicare Parts A and B enrollment status, OHI, Medicare supplemental (Medigap) insurance coverage for those patients aged 65 and older, and others eligible for Medicare, such as end-stage renal disease patients.

C4.5.5. If the patient enters the MTF through the Emergency Room, OHI authorization may be obtained after the patient is stable.

C4.5.6. All patients, including those on active duty, who have sustained an injury, shall be asked if the injury is accident or work-related. Refer to Chapter 5 of this Manual if the injury is accident or work-related.

C4.5.7. The patient's and spouse's employer information shall always be obtained, even if the patient states there is no other health insurance. If the patient is an unemancipated minor, the patient's parents' employer(s) information shall be obtained.

C4.5.8. For beneficiaries indicating health plan or policy coverage, obtain and verify:

C4.5.8.1. The payer name.

C4.5.8.2. Group or plan identification information, or both if applicable.

C4.5.8.3. Related employer information, including:

C4.5.8.3.1. The employer or former employer's name.

C4.5.8.3.2. Address.

C4.5.8.3.3. Phone number.

C4.5.8.3.4. Group number.

C4.5.8.3.5. Member identification number.

C4.5.9. When available, copy both sides of the patient's payer card and send the copy to the TPC office.

C4.5.10. During the interview process, MTF personnel shall maintain a friendly and professional demeanor.

C4.5.10.1. In the absence of an existing DD Form 2569 in the patient's medical record or stored electronically in CHCS (or its replacement system), the interviewer shall ask the patient to complete, sign, and date a new DD Form 2569.

C4.5.10.2. The interviewer may begin by asking the patient if he/she, the spouse, or, in the case of an unemancipated minor, a parent, is employed or retired.

C4.5.10.3. If the patient states that he/she has health coverage other than TRICARE, request a copy of the payer card.

C4.5.10.4. Make a copy of the front and back of the payer card.

C4.5.11. If the patient states that his or her admission or visit is due to an injury sustained in an accident, the interviewer shall obtain relevant accident insurance information. Refer to Chapter 5 of this Manual for further guidance.

C4.5.12. Additional information on obtaining OHI information may be found at the UBO Web Site.

C4.5.13. Specific third-party payer questions may include, but are not limited to:

C4.5.13.1. The name and plan or policy number of the policyholder or subscriber.

C4.5.13.2. The effective date(s) of coverage and, if the policy or plan is listed as expired, the end date of coverage.

C4.5.13.3. For group policies, the name of the group or plan and group (e.g., employer) number.

C4.5.13.4. Names of dependents if the plan or policy covers them.

C4.5.13.5. The covered benefits under the plan (including pharmaceuticals), amount of deductible (whole dollar amount), co-insurance (percentage of costs), or co-payment (small charge at time of encounter) under the policy or plan.

C4.5.13.6. If pre-certification is required for an inpatient stay and the phone number needed to call for pre-certification.

C4.5.13.7. The third-party payer's mailing address. This includes the addresses and phone numbers for each coverage type (e.g., pharmacy, hospital, and mental health).

C4.5.14. If the third-party payer information is already in the CHCS, verify the information and enter the date of verification in the Pre-certification or Utilization Review free text fields.

C4.5.14.1. Where necessary, MTF personnel shall make any required changes.

C4.5.14.2. MTF personnel shall verify information for billable plans or policies and input into CHCS, according to Standard Insurance Table (SIT) guidelines.

C4.5.14.3. MTF personnel may not enter TRICARE supplements, income (or wage) supplemental policies, or any other non-billable policies into CHCS.

C4.5.15. For all newly identified billable policies, MTF staff shall check CHCS and TPOCS for prior billable events and verify that claims were filed and payment was received for all services provided during the plan or policy-effective dates.

C4.5.15.1. MTF personnel shall annotate any register numbers for admissions or other encounters within the effective dates of the third-party plan or policy.

C4.5.15.2. MTF shall check records of all dependents listed on the plan or policy for prior billable events, and verify that payment has been received where prior billable events exist.

C4.6. MANDATORY COMPLIANCE BY THIRD-PARTY PAYERS

C4.6.1. Third-party payers are required to abide by the provisions of Section 1095 of Reference (d) and Section 220.2 of Reference (c). Third-party payers may not deny or reduce claims based on the fact that care was rendered in a Government facility.

C4.6.2. MTFs may reach understandings with third-party payers on claims procedures and other administrative matters if these understandings are not pre-conditions to complying with State and local statutory and regulatory requirements.

C4.6.2.1. MTFs may not enter into participation or preferred provider agreements with third-party payers. Participation and preferred provider agreements are predicated on State and local laws, whereas MTFs are governed by Federal statutes and regulations.

C4.6.2.2. Third-party payers may not require MTFs to enter into participating or preferred provider agreements.

C4.6.2.3. Payment may not be contingent upon the MTF entering into a participating or preferred provider agreement with the third-party payer.

C4.6.3. Third-party payers may not require beneficiaries to sign an “assignment of benefits” form with the MTF as a condition of payment to the MTF. The MTF shall provide the DD Form 2569 upon request by the third-party payer.

C4.6.4. Third-party payers may not deny or reject full reimbursement of claims based on the premise that they reimburse only the amount the patient would have been liable for had the plan or policy not existed. Denial of claims for this reason, or for any other invalid reason, shall be referred to the appropriate supporting or designated legal office according to Service guidance and regulations.

C4.7. AUTHORIZATION TO RELEASE MEDICAL INFORMATION IN SUPPORT OF TPC

C4.7.1. Upon request by representatives of third-party payers, MTFs shall make available applicable healthcare records of patients for whom coverage is sought.

C4.7.1.1. Under HIPAA privacy rules, the MTF may release the minimum necessary medical information to third-party payers to ensure payment.

C4.7.1.2. The MTF may not bill the third-party payer for copying records.

C4.7.2. Follow additional Service guidelines, if any, for releasing medical records. Any additional Service guidelines should be forwarded to the TMA UBO pursuant to Chapter 1 of this Manual.

C4.8. BILLING ACTIVITIES

C4.8.1. For family members and retired members of the Uniformed Services with OHI, the MSA office may not charge the patient for medical services or subsistence charges. These amounts are considered covered and payable by the third-party payer. If no payment is received or expected from the third-party payer, the MSA office shall bill the patient for the appropriate inpatient charge.

C4.8.2. The MTF may not require Uniform Services beneficiaries to pay the MTF any deductible, co-payment, or co-insurance amounts imposed by the third-party payer.

C4.8.2.1. A beneficiary is any person eligible for benefits and authorized treatment in a Uniformed Services facility under Section 1074[8] and paragraphs (a) and (b) of Section 1076 of Reference (d).

C4.8.2.2. Beneficiaries may be retired members of the Uniformed Services, family members of retired members of the Uniformed Services, or family members of active-duty personnel.

C4.8.2.3. Civilian emergency patients and Uniform Services civilian employees OCONUS are not beneficiaries.

C4.8.3. The MTF shall bill reasonable charges, as established by TMA, for Uniform Services beneficiary patients to third-party payers or to Government agencies or programs, according to applicable sections of this Manual. MTFs may not establish rates without TMA approval under any circumstances.

C4.8.4. Under Section 220.8 of Reference (c), a third-party payer may submit evidence to an MTF demonstrating that the reasonable charge is too high for the geographic area for the same or similar total groups of services.

C4.8.4.1. An authorized representative of the MTF may agree to a lower amount based on data presented by the third-party payer (Reference (c)).

C4.8.4.2. The facility shall inform TMA UBO of any rate changes made pursuant to this section within five (5) duty days.

C4.8.5. Facilities that perform billing for other facilities are considered parent facilities. Subordinate facilities are those facilities whose billing is performed by a parent facility.

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[8] Appendix 21 (pg. 108) includes a single statutory excerpt providing an amendment to 10 U.S.C. 1074.

C4.8.6. All MTFs, whether a parent or subordinate facility, shall establish and maintain memorandum accounting records according to Service guidance and regulations. The memorandum accounting records shall, at a minimum, include the following data:

C4.8.6.1. Action taken on each claim.

C4.8.6.2. Amount billed.

C4.8.6.3. Amount collected.

C4.8.6.4. Amount in dispute.

C4.8.6.5. Claim adjustment reason(s) with amounts (e.g., out-of-network).

C4.8.6.6. Delinquent amount.

C4.8.6.7. Final account disposition.

C4.8.7. MTFs shall accurately prepare and submit claims to third-party payers using:

C4.8.7.1. CMS–1450/UB–92.

C4.8.7.2. CMS–1500 (Appendix 19).

C4.8.7.3. Universal Claim Form, or UCF.

C4.8.7.4. The American Dental Association (ADA) Claim Form.

C4.8.8. MTFs shall comply with the data elements and code specifications of:

C4.8.8.1. The National Uniform Billing Committee.

C4.8.8.2. The National Uniform Claim Committee.

C4.8.8.3. The National Council for Prescription Drug Programs.

C4.8.8.4. The ADA Claim Form for submitting claims to third-party payers.

C4.8.9. The MTF shall prepare and send inpatient claims to the third-party payer within ten (10) business days following completion of the medical record and coding.

C4.8.10. Outpatient claims shall be prepared and sent within seventeen (17) business days after the outpatient encounter information and coding for billing is obtained.

C4.8.11. The TPC officer shall check the report of discharged OHI patients for the coding status of their medical record. The TPC officer shall also coordinate with the PAD/Medical

Records Officer to ensure that records are complete and coded within forty-five (45) days of the patient's discharge from the MTF.

C4.8.12. The Under Secretary of Defense (Comptroller) (USD(C)), in coordination with TMA, establishes the rates and the methodology used for billing third-party payers.

C4.8.12.1. The USD(C) reviews, revises, and publishes these rates annually in a DoD memorandum and in the Federal Register.

C4.8.12.2. MTFs may not establish rates under any circumstances.

C4.8.13. Refer to the tables in Appendix 21 for the following references:

C4.8.13.1. The "Type of Services Billed by Beneficiary Category" indicates what services to bill by beneficiary category (Table AP21.T1).

C4.8.13.2. The "Type of Services Billed by Plan or Policy" shows which services to bill for each type of plan or policy (Table AP21.T2).

C4.8.14. For inpatient hospital care, institutional rates are based on Diagnosis Related Groups (DRGs). Professional rates are percentage of the DRG and updated annually.

C4.8.15. For outpatient medical care, the MTF shall use the appropriate rate as established by TMA UBO.

C4.8.16. Under TRICARE Resource Sharing agreements, the contractor hires an individual or individuals to work in the MTF. Under such an arrangement, the MTF shall file third-party claims using appropriate established rates.

C4.8.17. The TPC office shall bill HMO plans to the extent the MTF may reasonably expect to be reimbursed. Typically, HMOs only pay for emergency care, urgent care, OPT-OUT (or point-of-service), and out-of-service area care.

C4.8.18. MTFs shall:

C4.8.18.1. Identify patients with HMO (or other Managed Care Organization products) coverage.

C4.8.18.2. Certify admissions, file, and pursue all claims with HMOs (inpatient and outpatient) with OPT-OUT or point-of-service provisions.

C4.8.18.3. Certify all admissions for emergency, urgent, and out-of-service area care.

C4.8.18.4. Identify all outpatient treatment for emergency, urgent, and out-of-service area care.

C4.8.18.5. File and pursue resultant claims with HMOs.

C4.8.19. The TPC office shall prepare separate claims for the mother and a newborn in an inpatient delivery case. See HA Policy 96-041, Policy for newborn billing, April 1996 (Reference (m)).

C4.8.20. An executed written assignment of benefits is not necessary as outlined in Section 220.2 (c) in Reference (c).

C4.8.20.1. MTFs have statutory assignment of benefits, and third-party payers shall pay MTFs directly.

C4.8.20.2. The MTF has no responsibility for, and may not attempt to collect from the patient, any amounts erroneously paid to the patient by a third-party payer.

C4.8.21. To ensure proper payment is made, it is necessary to annotate "Y" for YES in Form Locator (FL) 53 of the UB-92. By indicating a "Y" or defaulting to "Y" in FL 53, the third-party payer shall reimburse the MTF, as opposed to the patient, through the assignment of benefits.

C4.9. MEDICARE SUPPLEMENTAL INSURANCE

Refer to the UBO web site for specific billing guidance.

C4.9.1. Medicare supplemental insurers are required by law to accept TPC claims for Medicare-covered services.

C4.9.1.1. The insurer may not deny a TPC claim on the grounds that a claim had not been submitted previously by the provider or beneficiary to Medicare.

C4.9.1.2. The obligation of a Medicare supplemental plan to pay shall be determined as if the MTF were a Medicare-eligible provider and the provided services as if they were Medicare-covered services.

C4.9.2. In general, Medicare supplemental insurance companies are responsible for paying amounts comparable to beneficiary out-of-pocket costs under normal operation of the Medicare program.

C4.9.3. Currently, MTFs may collect from Medicare supplemental policies for covered services for both inpatient and outpatient coverage and for institutional and professional services.

C4.9.4. The obligation to pay the Medicare inpatient deductible amount only applies to Medicare supplemental policies covering the inpatient deductible.

C4.9.4.1. The Medicare supplemental insurer may not be obligated to pay the MTF if the benefit is required to satisfy a patient's inpatient deductible in a civilian hospital arising from an admission within the same Medicare benefit period.

C4.9.4.1.1. If the benefit has already been paid to a facility of the Uniformed Services, it shall be refunded to permit the benefit to be paid to the civilian hospital.

C4.9.4.1.2. This shall ensure duplicate payment from the insurer does not occur and beneficiaries are not left without insurance coverage for an out-of-pocket expense in connection with the inpatient deductible.

C4.9.4.2. In all cases when the Medicare supplemental payment is refunded, the patient is to be billed the appropriate subsistence amount.

C4.9.5. Collection of the Medicare Part B (professional fee) deductible is limited to outpatient visits.

C4.9.5.1. Outpatient deductibles are based on a calendar year. The annual outpatient deductible amount shall be refunded if the patient was seen by a civilian Medicare participating provider.

C4.9.5.2. When beneficiaries receive similar services from both an MTF and a civilian Medicare participating provider, MTFs shall provide for offsets or refunds to ensure Medicare Supplemental insurers are not required to pay a limited benefit more than once.

C4.9.5.3. MTFs shall keep track of refunds and reconcile accounts for audit and compliance purposes.

C4.9.6. As part of the basic benefits, all Medicare Supplemental insurance plans reimburse for the Part B Coinsurance (generally 20% of the Medicare approved amount) after the calendar year deductible amount is met.

C4.9.6.1. Because MTFs do not bill Medicare for Uniform Services beneficiaries, MTFs may bill the Medicare Supplemental insurance plan based on the actual charge(s) of the outpatient visit.

C4.9.6.2. A Medicare Supplemental insurance plan is required to pay to the extent the plan would reimburse as if a Medicare-Eligible (participating) provider offered the services.

C4.9.6.3. MTFs may bill for the Medicare Part B (professional) coinsurance amount based upon the professional component of the inpatient claim.

C4.9.6.4. MTFs may bill prescription drugs to a Medicare Supplemental insurance company for those policies covering prescription drugs.

C4.10. COLLECTION ACTIVITIES

C4.10.1. Authority to Collect Payments. DoD collection authority under Section 1095 of Reference (d) was supplemented to include contractual payments such as automobile liability and no-fault insurance policies.

C4.10.1.1. For these types of cases, this authority extends to active duty members as well.

C4.10.1.2. See Chapter 5, Medical Affirmative Claims, for more information

C4.10.2. Follow-up Claims Inquiries. The TPC staff shall conduct either a written or telephone follow-up if reimbursement is not received within sixty (60) days of the initial claims submission and again at ninety (90) days, or within Service-specific guidelines.

C4.10.3. Referral of Outstanding Claims. When all efforts to collect on a valid claim have been exhausted, the responsible office shall refer TPC accounts receivable to the appropriate legal office for action. This referral shall be within 180 days of initial billing, but not more than 270 days unless there is clear evidence the claim shall be paid, or within Service guidelines.

C4.10.4. O&M Account Deposits. All collections made by the Staff Judge Advocate (SJA) or Judge Advocate General (JAG) office shall be deposited into the MTF O&M account.

C4.10.5. Closing Claims. The MTF shall close outstanding TPC claims falling into one of the following categories for valid denial:

C4.10.5.1. Amount of coverage.

C4.10.5.2. Care not covered.

C4.10.5.3. TRICARE or income supplemental plans.

C4.10.5.4. Medicare supplemental plans if paid within policy limitations.

C4.10.5.5. HMO.

C4.10.5.6. No utilization review.

C4.10.5.7. Patient co-pays and deductibles.

C4.10.5.8. Other.

C4.10.6. Documenting Closure. The records of these accounts shall be clearly documented and state the reason for closure without collection or collection for less than 100% of the claimed amount, minus deductibles, co-insurance, and appropriate (e.g., within network) co-payments.

C4.10.7. Uncollectible Debts. Refer to Section 3104 of Volume 5, Chapter 31 of Reference (f) for additional guidance on debts that are determined to be uncollectible to be consistent with the Office of Management and Budget guidance in OMB Circular A-129 (Reference (k)).

C4.10.8. Deposits. Deposit third-party collections for the current year in the local O&M appropriation of the MTF providing the medical services. Deposit collections in the year received, not in the year in which medical care was rendered or billed.

C4.10.9. Validating Accuracy of Payments. The TPC office is responsible for ensuring the accuracy of third-party payer payments and shall validate (i.e., check) the payer's EOB.

C4.10.9.1. Ensure the third-party payer has processed the claim properly.

C4.10.9.2. At a minimum, the TPC office shall verify:

C4.10.9.2.1. All charges on the claim are listed on the EOB.

C4.10.9.2.2. All deductibles, co-payments, co-insurance, and any other pertinent factors affecting payments have been considered and comply with applicable Federal law.

C4.10.9.2.3. A valid explanation is given for unpaid or unprocessed charges.

C4.10.9.2.4. Codes listed on the EOB match the codes on the claim.

C4.10.9.3. MTFs shall follow Service-specific guidelines regarding claims closure.

C4.10.10. Collecting Interest Payments. The amount of money stated to be interest by the third-party payer is payment for the reasonable charge of health care provided to a TRICARE beneficiary. This is the case as long as the amount remitted, both payment and interest, does not exceed what the MTF billed the third-party payer, excluding any appropriate (e.g., within network) co-payment, co-insurance, or deductibles.

C4.10.10.1. The MTF may not charge interest on the claims submitted.

C4.10.10.1.1. If a third-party payer chooses to classify any part of its payment as "interest," the amount shall be accepted as payment on the approved DoD Medical and Dental rate charge stated on the claim.

C4.10.10.1.2. The fact that the payer chooses to classify part of a payment as "interest" shall not control its use in the Third Party Collection Program, as long as the total amount of payment received does not exceed the total charge on the claim submitted.

C4.10.10.1.3. A refund is required to the payer for receipt of any payment in excess of the total amount charged.

C4.10.10.2. TPC claims files shall be maintained for at least six (6) years, three (3) months for legal purposes.

C4.11. MINIMUM INTERNAL CONTROLS

C4.11.1. The MTF Commander shall ensure that appropriate separation of duties is maintained to minimize the risk of misappropriation of funds.

C4.11.1.1. The individual responsible for billing may not receive, post, or deposit funds.

C4.11.1.2. Separate accounting records shall be maintained for TPC billing and receipts to provide adequate audit trails.

C4.11.2. The individual responsible for TPC, MSA, and MAC oversight shall ensure the appropriate separation of duties. Separate individuals shall:

C4.11.2.1. Prepare and mail claims.

C4.11.2.2. Receive, post receipt, and deposit checks and validate payments.

C4.11.2.3. Reconcile TPC Program accounting and reporting records.

C4.11.3. The MSA officer shall:

C4.11.3.1. Receive and open mail including mail containing checks or payments from all sources, including MSA, TPC, and MAC.

C4.11.3.2. Ensure checks are logged, posted (recorded), and deposited according to Volume 5, Chapter 5 in Reference (f) and Service resource protection guidance and regulations.

C4.11.4. The TPC officer shall:

C4.11.4.1. Ensure that billers are not assigned the duty of coding the same records for which they are submitting claims.

C4.11.4.2. Immediately upon receipt, forward TPC Program checks or payments received in the mail to the MSA officer or collection agent.

C4.11.4.3. Ensure collections are recorded accurately and in a timely manner.

C4.11.4.4. Reconcile policy or plan documents indicating amounts paid with total charges to validate payment of the full amount, less appropriate (e.g., within network) deductibles and co-payments.

C4.11.4.5. Ensure payments are validated and posted to the correct patient account according to Service guidance and regulations regarding claim closure and disputed claims.

C4.11.4.6. Ensure documents indicating amounts paid or collected equals amounts deposited.

C4.11.4.7. Ensure TPC records are reconciled with TPC deposits, and TPC reports, including DD Form 2570 report. The TPC records shall be reconciled monthly with accounting and finance office records.

C4.12. TPC PROGRAM ANNUAL REPORT

C4.12.1. TMA UBO shall set annual Service collection goals.

C4.12.2. Each Service shall set annual individual MTF collection goals. Annually, by a date established by the Services, each MTF conducting TPC billing/accounts receivable, shall submit a report, in a format prescribed by the Service, reflecting billing collection goals and collections for the fiscal year to its Service headquarters.

C4.12.3. Each Service shall report to TMA UBO no later than December 15 of each year:

C4.12.3.1. The amount billed to third-party payers by each facility during the preceding fiscal year.

C4.12.3.2. The amount collected by each facility from third-party payers during the preceding fiscal year.

C4.12.3.3. Any issues outside of the control of the MTF or the Service that impeded collection.

C4.12.3.4. The fiscal year for which the report is being submitted.

C5. CHAPTER 5

MEDICAL AFFIRMATIVE CLAIMS

C5.1. GENERAL

C5.1.1. The Medical Affirmative Claims (MAC) is the military program that primarily addresses claims for the recovery of the reasonable value of medical care furnished by (or through) the United States, including TRICARE subcontracted providers, to Uniformed Services beneficiaries – including active duty. It addresses claims due to injury or disease incurred under circumstances creating tort liability upon a third party.

C5.1.1.1. It also addresses the collection of accrued pay for lost time of Service members under circumstances creating tort liability upon some third entity.

C5.1.1.2. MAC often involves collection from health insurance, or other insurance carriers, in cases resulting from accidents, contractual medical coverage, such as no-fault or personal injury protection (PIP), and workers' compensation.

C5.1.1.3. Under the Federal Medical Care Recovery Act (Reference (o)), the United States may recover in any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care, and treatment (including prostheses and medical appliances) to a person who is injured or suffers an illness under circumstances creating tort liability in a third party.

C5.1.2. This program is based primarily upon the authority granted by:

C5.1.2.1. Sections 2651, 2652, and 2653 of Reference (o), as implemented by Title 28, Code of Federal Regulations (CFR), Part 43 (Reference (p)), and

C5.1.2.2. Sections 3711, 3712, 3713, 3714, 3715, 3716, 3717, 3718, 3719, 3720, and 3720A of 31 U.S.C. Chapter 37 (Reference (q)).

C5.1.3. The program also frequently relies upon Section 1095 of Reference (d), as implemented by Part 220 of Reference (c).

C5.1.4. Each Service shall follow Service-specific regulations and other guidelines for more detailed guidance.

C5.1.5. MAC includes collections from all forms of tort liability or contractually based insurance such as:

C5.1.5.1. Automobile (including uninsured and underinsured).

C5.1.5.2. Motorcycle.

C5.1.5.3. Boat and airplane.

C5.1.5.4. Product and manufacturers' (e.g., defective products).

C5.1.5.5. Premises or general casualty (e.g., "slip and fall") or umbrella (covering a variety of real, commercial, or personal properties—business, home, apartment, farm, etc.).

C5.1.5.6. Homeowners' and renters.'

C5.1.5.7. Medical malpractice (other than Federal providers).

C5.1.6. MAC also includes all types of contract-based medical or health indemnity insurance or coverage reimbursable without regard to fault, such as:

C5.1.6.1. Workers' compensation (other than Federal employees) medical care reimbursement for employment related injury, illness or disease, and death.

C5.1.6.2. No-fault and PIP (e.g., automobile accidents).

C5.1.6.3. Medical payments (e.g., automobile, motorcycle, boat, and plane accidents; premises and general casualty, homeowners', renters' "slip & falls").

C5.1.6.4. Defective products.

C5.1.7. Deposits for all claim reimbursements based upon treatment by or through the MTF are deposited in the MTF's appropriation or supporting maintenance and operation account as authorized by Section 1095 of Reference (d) and Section 2651 of Reference (n). If questions arise as to the appropriate account for deposit of claims recoveries, consult your UBO Service Representative.

C5.2. RECOVERY JUDGE ADVOCATE RESPONSIBILITIES

C5.2.1. The Service-designated Recovery Judge Advocate (RJA) is responsible for the assertion and compromise, waiver, or settlement of disputed claims (limited by amount of Service-specific delegation) arising from a recoverable injury or illness. The RJA is responsible for determining if a patient's treatment represents a potentially recoverable claim.

C5.2.2. MTFs shall cooperate and collaborate with their supporting RJA and execute a Memorandum of Understanding (MOU) as appropriate.

C5.2.2.1. MTFs shall ensure that MOUs are consistent with applicable Service regulations and directives.

C5.2.2.2. Each MTF shall establish and implement procedures according to applicable Service regulations and guidance, to facilitate the exchange of information necessary to support recovery activities.

C5.2.2.3. MTFs and RJAs shall coordinate to ensure inpatient and outpatient records (including emergency room, physical therapy, and outpatient or ambulatory procedure, and ancillary services), are screened to identify potential cases. MTFs and RJAs shall also screen requests for information from third parties to identify potentially recoverable treatment.

C5.2.3. The RJA shall provide the treating MTF with copies of final cash collection vouchers for collections deposited to the MTFs O&M or appropriation account or a monthly report containing pertinent information regarding the patient(s) and the amount(s) deposited to the MTF's account. RJAs shall provide the referring MTF a monthly list of claims that were closed without recovery and claims that were transferred to another claims jurisdiction.

C5.2.4. Before settlement of a MAC, the RJA shall contact the MTF (and TRICARE claims processor, see below) to ensure all amounts paid by the Government are included in the claim assertion.

C5.2.5. To the extent possible, the RJA shall review civilian police accident reports, military police blotters, news reports, court proceedings, line of duty investigations, and similar sources to identify other potential medical care recovery claims.

C5.2.5.1. The RJA shall ensure the MTF comptroller, UBO, clinic, and PAD records are screened to identify potential medical care recovery cases.

C5.2.5.2. The RJA shall also coordinate with the other Uniformed Services' claims offices and MTFs to identify potential related claims involving care provided to the injured party at other DoD MTFs.

C5.3. MTF RESPONSIBILITIES

C5.3.1. MTFs shall make all records, including electronic records, available to the RJA for use in identifying, asserting, and collecting claims.

C5.3.1.2. MTFs shall use existing TPC Program procedures and documents to the greatest extent possible to ensure accident and injury information (e.g., who, how, when, where, and how much) is obtained first at point of entry, second during inpatient stay, third at discharge, and fourth by follow-up conversations with patient and family. The procedures and documents used to obtain and record accident information include, but are not limited to:

C5.3.1.2.1. Pre-admission, admission, concurrent stay, and discharge follow-up interviews.

C5.3.1.2.2. Inpatient insurance declaration forms.

C5.3.1.2.3. Outpatient encounter forms.

C5.3.1.2.4. Emergency room logs.

C5.3.1.2.5. Admitting and discharge summaries.

C5.3.1.2.6. Other pertinent medical treatment documents.

C5.3.2. MTFs shall screen:

C5.3.2.1. Admitting, emergency room, physical therapy, and outpatient clinic records.

C5.3.2.2. Outpatient clinic encounter and insurance disclosure forms.

C5.3.2.3. Supplemental care payments.

C5.3.2.4. Patient, attorney, third-party coverage, medical record, or other requisite information or notices.

C5.3.2.5. Other hospital or provider notes.

C5.3.2.6. Work release requests.

C5.3.2.7. Other requests concerning potential MAC cases. The MTF Commander shall also ensure the MTF does not release bills or medical records or respond to requests for assistance with workers' compensation forms without coordinating with the RJA.

C5.3.3. The MTF shall interview patients:

C5.3.3.1. At point of entry (outpatient care, ambulatory surgery, ancillary services such are pharmacy, radiology and laboratory, and inpatient care).

C5.3.3.2. During an inpatient stay.

C5.3.3.3. At discharge.

C5.3.3.4. By follow-up conversations, thereby gathering accident information (e.g., who, how, when, and where).

C5.3.4. The MTF shall forward copies of all accident-related daily treatment logs and completed third-party liability questionnaires using Service-specific forms to the responsible RJA no later than 48 hours after treatment.

C5.3.5. Promptly notify the RJA regarding treatment.

C5.3.5.1. Provide timely claim forms with accurate and complete cost computation.

C5.3.5.2. Provide copies of supporting medical records (e.g., admitting and discharge physician narratives or summaries, outpatient and ancillary service records), as requested by the RJA.

C5.3.5.3. Make available to the RJA all records, including electronic records, for the identification, assertion, and collection of claims.

C5.3.5.4. Provide copies of paid vouchers for patients treated in civilian facilities (e.g., MTF-referred treatment) or other DoD MTFs, as requested by the RJA.

C5.3.6. MTFs shall establish internal controls for cases sent to the RJA for recovery. These controls shall cover:

C5.3.6.1. Dispositions of claims.

C5.3.6.2. Deposits of funds to the MTFs account.

C5.3.6.3. Timely reporting of information about potential or ongoing affirmative claims.

C5.3.6.4. Provision of accurate and complete cost computations for care provided through the MTF.

C5.3.6.5. Copies of supporting medical records.

C5.3.7. MTFs shall provide an updated fund cite for depositing funds at the start of each fiscal year.

C5.3.8. MTFs and RJAs shall also obtain TRICARE claims processor – or electronically-queried per trauma diagnosis and other accident-related diagnosis codes – identified third-party claims and develop all other related claims, supporting documentation, and medical records when required by the RJA.

C5.3.8.1. This process requires coordination through the applicable TRICARE regional claims processor to establish TRICARE accident claims identification and MTF/RJA referral procedures.

C5.3.8.2. Once all TRICARE provider and MTF claims related to an accident are identified, developed, and supporting documentation accumulated, the documentation required by the RJA shall be referred to the RJA for investigation, determination of liability, claim assertion, compromise, or waiver.

C5.3.8.3. The TRICARE claims processor shall promptly identify and transfer, to the applicable MTF and RJA or Uniformed Services claims office, those claims involving trauma diagnosis and other accident related diagnostic codes.

C5.3.8.4. The claim file referred by the TRICARE claims processor shall include "who, how, when, where, and how much" whenever possible.

C5.3.8.4.1. It shall contain a personal injury questionnaire completed by the injured party and a TRICARE explanation of benefits (showing the amount paid by the TRICARE claims processor).

C5.3.8.4.2. However, the TRICARE claims processor may not unduly delay (more than 15 days) referral of the claim to the RJA where, for example, the injured party does not cooperate by completing the personal injury questionnaire in a timely manner.

C5.3.8.5. The MTF, RJA, or Uniformed Service claims office shall work with the TRICARE claims processor to ensure claims are properly identified and forwarded in a timely manner. The MTF, RJA, or Uniformed Service claims office shall document persistent problems and notify a higher command to coordinate with TMA.

C5.4. MULTIPLE SOURCES OF RECOVERY

C5.4.1. Often the patient is covered by one or more group health plans or insurance policies (for TPC claims) and one or more automobile liability and no-fault/PIP or medical payments policies (for MAC claims) or coverage provisions.

C5.4.1.1. State insurance regulations require coordination of employer or group health plan and casualty/liability insurance benefits.

C5.4.1.2. Therefore, TPC and MAC claims shall be pursued simultaneously.

C5.4.2. The Government may not collect more than the total charge of medical care from any one source or combination of sources.

C5.4.3. MTFs shall establish procedures to ensure coordination with and timely notification of the supporting legal office on any TPC employer group health plan claim and subsequent collection or denial in cases where the legal office has a concurrent MAC claim.

C5.4.3.1. The MTF may not wait until payment is received from the employer group health plan to notify the supporting legal office about a potential MAC claim, because the legal office shall assert the MAC claim in a timely manner to preserve the Government's right of recovery.

C5.4.3.2. For Uniformed Services beneficiaries who are non-Federal employees and contractor employees, the MTF may not file a TPC claim to the patient's third-party payer when covered by workers' compensation benefits.

C5.4.3.3. The legal office shall file the workers' compensation claim for DoD beneficiaries (including those who are contractor employees) and non-Federal employees as a MAC claim.

C6. CHAPTER 6

CHARGES FOR MEDICAL SERVICES

C6.1. GENERAL OVERVIEW

C6.1.1. Section 1095 of Reference (d) prescribes the collection of reasonable charges from third party payers. The MTF may not bill eligible dependents or retired members of the Uniformed Services for any deductible, co-payment, or other amount third-party payers deny.

C6.1.2. Section 1078 of Reference (d) prescribes the establishment of fair charges for medical and dental care given to dependents pursuant to Section 1076 of Reference (d).

C6.1.2.1. Inpatient charges shall be DRG-based rates.

C6.1.2.2. Outpatient itemized charges shall be based on charges according to the type of services or procedures provided.

C6.1.2.3. Subsistence charges shall be billed under Chapter 7 of this Manual.

C6.1.3. The USD(C) establishes rates annually or as needed.

C6.1.3.1. The Department of Defense shall publish the rate changes.

C6.1.3.2. When a physician provides services for dependents or retired members under the TRICARE Resource Sharing Agreement (Section 220.8(h) of Reference (c)), the MTF shall bill the third-party payer the same way as it would bill for any similar service.

C6.2. INPATIENT RATES

C6.2.1. When reimbursement is required for hospitalization, the MTF shall bill the appropriate inpatient DRG-based rate.

C6.2.2. No charge is made if the patient is admitted to the MTF and transferred to another MTF on the same day, since the gaining military facility charges for this day.

C6.2.2.1. For transfers to civilian facilities, a charge is made for the admission day if the patient is admitted to the MTF and transferred the same day.

C6.2.2.2. For lengths of stay exceeding one day, the originating MTF bills the patient or third-party payer for any days spent in the MTF, except for the transfer day, which is considered the discharge day.

C6.2.2.3. For patients transferred to other facilities (civilian or military) after the day of admission, the original treating facility is paid the appropriate weighted value of treatment.

C6.2.2.3.1. This calculation is based on the full payment amount (Adjusted Standard Amount [ASA] rate multiplied by DRG case weight) divided by the CHAMPUS DRG geometric length of stay, listed at GLOS in the table, and then multiplied by the actual length of stay, listed as LOS in the table, of the patient.

C6.2.2.3.2. The receiving facility (civilian or military) receives the full reimbursable amount, regardless of what the original treating facility is reimbursed.

C6.2.2.3.3. The billing calculation procedure is as follows:

EXAMPLE:	RG 1	Case Weight:	3.7759
	ASA Rate:		$5000
	GLOS:		7.3 Days
Scenario:	Patient is admitted to MTF A and is transferred to MTF B after 2 inpatient days.		

Full Payment Amount:	$18,880	(3.7759 × $5000)
Per Diem Rate:	$2,586	($18,880 ÷ 7.3)
MTF A Reimbursement:	$5,172	($2,586 × 2)
MTF B Reimbursement:	$18,880	(3.7759 × $5000)

C6.2.2.4. For MSA and TPC accounts, the newborn is charged the applicable rate according to his or her beneficiary category.

C6.2.2.4.1. Newborns of Uniformed Services beneficiaries with OHI shall be charged if they remain hospitalized in their own right (usually after the mother is discharged).

C6.2.2.4.2. For civilian emergencies, charges shall be generated for both mother and infant from the time of birth.

C6.2.2.4.3. Newborns of dependent daughters of Uniformed Services beneficiaries, and former service members shall be billed separately from the time of birth.

C6.2.2.4.4. A separate charge is made for each newborn when there is a multiple birth.

C6.2.2.5. The MTF or aero medical staging facility providing medical care to a transient patient does not charge for medical services.

C6.2.2.5.1. A transient patient is one who is in transit through aero medical evacuation channels.

C6.2.2.5.2. This includes any delay or layover during evacuation, such as remaining overnight, unless the patient is removed from the aero medical evacuation system by the medical authority and admitted to an MTF, either en route or at the final destination.

C6.2.2.5.3. A patient ceases to be a transient patient when admitted to an MTF.

C6.3. OUTPATIENT ITEMIZED BILLING

C6.3.1. When reimbursement is required, these rates are based upon the CMAC rate table (Reference (r)), the non-CMAC rate table (Reference (s)), or other appropriate rate tables as may be determined by TMA.

C6.3.1.1. These rates apply to billing for services provided under the TPC, MSA, and MAC programs.

C6.3.1.2. These rates also apply to follow-up visits meeting the criteria of an encounter.

C6.3.1.2.1. An encounter is a face-to-face contact between a patient and a provider who has primary responsibility for assessing and treating the patient at a given contact, exercising independent judgment.

C6.3.1.2.2. Referrals and consultations are encounters.

C6.3.1.3. The MTF shall submit claims for every service provided under specific guidelines as set forth in the UBO User Guide.

C6.3.1.4. The MSA office establishes controls to ensure all pay patients are identified and billed in a timely manner.

C6.3.1.5. The MTF shall establish procedures to provide the appropriate billing office (TPC, MSA, MAC) with the relevant billing information, including third-party payer information.

C6.3.2. Each MTF shall establish procedures to ensure collections are made and accounts receivable are established for all billable services.

C6.4. OVERSEAS OUTPATIENT CHARGES

C6.4.1. At overseas locations, certain categories of non-DoD beneficiaries are entitled to care at MTFs. See Patient Billing Category Standardization Table (Reference (t)) for a list of those individuals, generally sections K and R, who are entitled to care at MTFs.

C6.4.2. These patients are required to pay for the services they receive; however, if the non-beneficiary pay patient has OHI, the MTF may bill the payer directly, but shall establish an accounts receivable.

C6.4.3. If a reimbursement rate has not been established for a particular service, the MSA office may not bill the patient for the rendered service(s).

C6.4.4. MTFs shall alert the Commander of any services provided for which there is not an established rate.

C6.4.5. This information shall be communicated to the TMA under Chapter 1 of this guidance.

C6.4.6. The MTF shall charge patients for services received such as office visits, ambulatory procedure visits, and follow-up visits for evaluation and management services and referral visits to other clinics within the MTF or paid for by the MTF.

C6.4.7. The following services are provided without charge:

C6.4.7.1. Check-in at “sick call” to make an appointment for a visit on a subsequent day.

C6.4.7.2. Weight checks.

C6.4.7.3. Blood pressure checks when requested by the physician as follow-up treatment.

C6.4.7.4. Follow-up visits for the sole purpose of checking bandages, dressings, sutures, and casts.

C6.4.7.5. Removal of casts if the cast was applied at a MTF.

C6.4.7.6. Vision tests for military driver’s licenses.

C6.4.7.7. Dependent school children’s visits to public health nurses who are employees of the medical facility and located at the school.

C6.4.7.8. Follow-up visits for contact lens adjustment. A new refraction or prescription would result in a chargeable visit.

C6.4.7.9. Physical examinations provided to prospective dependents (pre-adoptive) of Uniformed Services beneficiaries.

C6.4.7.10. Pre-employment physicals provided to civilian employees if required for Federal positions. If the individual is hospitalized for further examination, prior notice shall be submitted and approved.

C6.4.7.11. Physical examinations required for enlistment or induction into the Service or application to one of the Service academies.

C6.4.7.12. Confidential medical care and advice provided at authorized teen clinics and youth health centers to adolescent dependents of Federal civilian employees.

C6.4.7.13. Patient education, such as plaque control, family planning, or expectant parent classes.

C6.4.7.14. Organized group examinations or evaluations, such as school or sports physicals, conducted in schools, community centers, or medical facilities.

C6.4.7.15. Public health measures requested by the base or post military commander upon the recommendation of the principal medical staff officer in the interest of the health of the community, such as:

C6.4.7.15.1. Immunizations.

C6.4.7.15.2. Interviews.

C6.4.7.15.3. Examinations.

C6.4.7.15.4. Outpatient treatment.

C6.4.7.15.5. Follow-up of cases dealing with communicable diseases.

C6.4.7.15.6. Biological tests associated with epidemiological surveys.

C6.4.7.16. Collection of specimens for blood or alcohol tests legally performed at the request of security police.

C6.4.7.17. Follow-up visits for suture removal, bandage check, blood pressure check, etc., by civilian employees from the Continental United States on official temporary duty (TDY) orders at an area overseas.

C6.5. APPROPRIATED AND NON-APPROPRIATED FUND EMPLOYEES

There is no charge for the following services:

C6.5.1. Pre-employment physicals, including referrals, provided to prospective employees if required for Federal positions. If an employee is hospitalized for further examination, prior notice shall be submitted and approved by the MTF commander.

C6.5.2. Physicals, including referrals, required as a condition of their continued employment. If an employee is hospitalized for further examination, prior notice shall be submitted and approved by the MTF commander.

C6.5.3. Ancillary services, including immunizations, as a condition of employment.

C6.5.4. Follow-up visits necessary to review test results accomplished as part of the physical.

C7. CHAPTER 7

SUBSISTENCE CHARGES

C7.1. GENERAL OVERVIEW

C7.1.1. Subsistence charges do not apply to active duty or retired members of the Uniformed Services.

C7.1.2. Subsistence charges do not apply when a patient's OHI covers any portion of the hospitalization, such as the copay, deductible, or any other amount paid by the third-party payer to the MTF.

C7.2. SUBSISTENCE CHARGES

C7.2.1. Subsistence charges cover the basic cost of the food. The food service rate covers overhead, supplies, labor, and associated meal preparation costs. The USD(C) publishes the food service rates annually.

C7.2.2. See Appendix 23 for a list of those persons who may eat in MTF dining facilities and the appropriate rate to charge.

C7.2.3. Appropriated fund food service activities furnish meals to patients, staff, and others.

C7.2.4. The activity meal rate includes a food charge and a related food service rate (discount or standard) according to Chapter 19, Volume 12 of Reference (f), as applicable.

C7.2.5. All Air Force Academy and West Point cadets and Naval Academy midshipmen in a TDY status, who are not inpatients, pay the food service rate unless they are specifically exempted by orders. Cadets and midshipmen may not be charged for subsistence if they are inpatients.

C7.2.6. Individuals receiving physical examinations held over during a meal shall pay the food service rate.

C7.3. BILLING FOR SUBSISTENCE

C7.3.1. Use SF 1080 for billings to other Government agencies for dining hall collections, subsistence in kind (SIK).

C7.3.1.1. The SF 1080 shall be used to process billings for collection from Reserve Forces (Army, Navy and Air Force) and the National Guard.

C7.3.1.2. MTF staff shall use SF 1080 to charge for meal days served to an enlisted member of the Reserve Forces who is authorized subsistence at Government expense and is attached or assigned for duty to base medical services, while on active duty for training, or on inactive duty for training in a pay status. MTF staff shall obtain the appropriation to bill for such assigned personnel.

C7.3.1.3. Staff shall enter the bill number, name and address of the billed office, name and address of the billing office, and billed appropriation citation when billing another DoD Component. Staff shall also enter a description of services and charges.

C7.3.1.4. Staff shall attach any supporting documents—such as DD Form 7 or DD Form 7A—to the SF 1080 or SF 1081, Voucher And Schedule Of Withdrawals And Credits (Appendix 22) or follow Service guidance.

C7.3.2. The RM, Comptroller, PAD officer, and the MSA officer shall indicate the appropriate fund cite on the SF 1080 or SF 1081 and the billed appropriation citation when billing another DoD Component using the SF 1080. SF 1080s are submitted to the appropriate billing office or agency as soon as the billed amount is determined or at the end of the month.

C7.4. COLLECTION AND DISPOSITION OF SUBSISTENCE CHARGES

C7.4.1. Funds shall be collected and deposited locally.

C7.4.1.1. The MSA office shall attempt to collect all subsistence accounts receivable at the time of discharge. The date of original billing is the date of discharge for subsistence charges.

C7.4.1.2. If the per diem charges are not paid within thirty (30) days, the MSA office shall follow up on the account either by a delinquent letter or by documented contact with the patient or sponsor (including certified mail) as indicated by Volume 5, Chapter 29 (Collection of Out-of-Service Debts) in Reference (f). (There is a sample letter in Appendix 24.)

C7.4.1.3. Delinquent letters may be generated through CHCS.

C7.4.2. The MSA office may not charge for subsistence provided to transient patients while they are traveling in the aero medical evacuation system, assigned to an aeromedical staging facility, or otherwise in a transient status awaiting aero medical evacuation.

C7.4.3. For Military Academies (Air Force Academy, West Point, and Naval Academy), the MSA office shall submit a DD Form 139 to the appropriate servicing accounting and finance office at the end of each month.

C7.4.4. The MSA office shall collect monies from trustees or sponsors for mentally incompetent patients.

C7.4.5. If medical activities are supported by the base food service function, the MSA office shall deposit collections of the food service rate to the appropriate fund indicated by the base or post food service officer and the servicing accounting and finance office.

C7.5. CHARGES IN A LA CARTE SYSTEM (ALACS) FACILITIES

C7.5.1. The food charge in ALACS facilities is the sum of prices of the individual food items selected by the patron.

C7.5.2. Item prices are established monthly at the local level using the Nutrition Management Information System to reimburse for the actual cost of subsistence.

C7.5.3. The item prices for locations using the Service Information Management System (SIMS) are contained in the SIMS monthly food service update.

C7.5.4. Each facility shall determine whether to round to the nearest nickel or charge exact prices.

C7.5.5. Menu prices shall be prominently displayed on menu boards and item price signs.

C7.6. DISCOUNT RATE

Under Chapter 19, Volume 12 of Reference (f), the MSA office shall charge a discount rate for meals served to the following:

C7.6.1. Spouses and other dependents of enlisted personnel in grades E-1 through E-4 who are not patients.

C7.6.2. Members of organized nonprofit youth groups sponsored at either the National or local level and permitted to eat in the general dining facility by the Commanding Officer of the installation. These groups include Civil Air Patrol, Junior Reserve Officer Training Corps (ROTC) and Scouting units.

C7.6.3. Officers, enlisted members, and Federal civilian employees who are NOT receiving the meal portion of per diem and who are either:

C7.6.3.1. Performing duty on a U.S. Government vessel.

C7.6.3.2. On field duty.

C7.6.3.3. In a group travel status.

C7.6.3.4. Included in essential unit messing as defined in the Joint Federal Travel Regulation (Reference (u)).

C7.6.4. Officers, enlisted members, and Federal employees who are not receiving the meal portion of per diem, and who are on a U.S. Government aircraft on official duty either as a passenger, or as a crew member engaged in flight operations.

C7.6.5. Officers, enlisted members, and Federal employees on Joint Task Force operations other than training at temporary U.S. installations, or using temporary dining facilities.

C7.7. STANDARD RATE

According to Chapter 19, Volume 12 of Reference (f), the MSA office shall charge a standard rate for meals served to all officers and enlisted members receiving an allowance for subsistence. This includes any officer, enlisted member, or Federal civilian employee receiving the subsistence portion of per diem, and all other personnel (including Reserve Component officers on Inactive Duty Training) authorized to eat in DoD appropriated fund dining facilities.

AP1. APPENDIX 1

SAMPLE DD FORM 1131, CASH COLLECTION VOUCHER

CASH COLLECTION VOUCHER	1. DISBURSING OFFICE COLLECTION VOUCHER NUMBER 2. RECEIVING OFFICE COLLECTION VOUCHER NUMBER

3. RECEIVING OFFICE	
a. ACTIVITY *(Name and Location) (Include ZIP Code)*	
b. RECEIVED AND FORWARDED BY *(Printed Name,Title and Signature)*	d. DATE *(YYYYMMDD)*
c. TELEPHONE NUMBER *(Include Area Code)*: COMMERCIAL: DSN:	
4. DISBURSING OFFICE	
a. ACTIVITY *(Name and Location) (Include ZIP Code)*	
b. DISBURSING OFFICER *(Printed Name, Title and Signature)*	d. DISBURSING STATION SYMBOL NUMBER
c. TELEPHONE NUMBER *(Include Area Code)*: COMMERCIAL: DSN:	e. DATE *(YYYYMMDD)*
5. PERIOD: a. FROM: b. TO:	

6. DATE RECEIVED	7. NAME OF REMITTER DESCRIPTION OF REMITTANCE	8. DETAILED DESCRIPTION OF PURPOSE FOR WHICH COLLECTIONS WERE RECEIVED	9. AMOUNT	10. ACCOUNTING CLASSIFICATION
		11. TOTAL	0.00	

DD FORM 1131, DEC 2003 PREVIOUS EDITION IS OBSOLETE. Reset

AP2. APPENDIX 2

SAMPLE DD 2570, THIRD PARTY COLLECTION PROGRAM – REPORT ON PROGRAM RESULTS

THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS	SEGMENT REPORTED *(X one)* ☐ INPATIENT ☐ OUTPATIENT	REPORT CONTROL SYMBOL DD-HA(Q)1986

1. QUARTER ENDING *(YYYYMM)*	2. REPORTING MEDICAL TREATMENT FACILITY (MTF)	3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NO.

PART I

4. REPORTING PERIOD *(See Note 1)*

FISCAL YEAR (FY) (1)	NO. OF NON-ACTIVE DUTY INPATIENT DISPOSITIONS/VISITS (2)	NO. OF CLAIMS (3)	NO. OF COLLECTIONS (4)	NO. CLAIMS DIVIDED BY DISPOSITIONS/ VISITS (%) (5)	TOTAL $ AMOUNT BILLED/CHARGES (6)
a. CURRENT FY				0%	
PRIOR YEAR (PY) b. PY 1				0%	
c. PY 2				0%	

	$ ADJUSTMENTS AND REFUNDS *(See Note 2)* (7)	$ AMOUNT COLLECTED PY 2 (8)	$ AMOUNT COLLECTED PY 1 (9)	$ AMOUNT COLLECTED CURRENT FY (10)	$ AMOUNT REMAINING UNCOLLECTED *(See Note 3)* *(6)-[(7)+(8)+(9)+(10)]* (11)
a. CURRENT FY					
b. PY 1					
c. PY 2					

PART II

REASON CODES	5. DISTRIBUTION OF REMAINING UNCOLLECTED AMOUNTS	6. UNCOLLECTED AMOUNTS SUBDIVIDED BY FY ($) *(See Notes 1 and 4)*		
		a. FY	b. FY	c. FY
1	OPEN CLAIMS *(Requires additional follow-up action by Medical Treatment Facility for resolution)*			
2	TRANSFERRED TO EXTERNAL AGENT *(e.g., JAG) (Excluding Third Party Liability Cases)*			
REASON CODES 3-7. THIRD PARTY REDUCED / DENIED PAYMENT FOR INVALID REASONS *(Requires additional debt collection/legal action)*				
3	MTF NOT A PARTICIPATING HOSPITAL			
4	PLAN EXCLUDES MILITARY HOSPITALS OR BENEFICIARIES			
5	PATIENT HAD NO OBLIGATION TO PAY			
6	INSURER PAID PATIENT DIRECTLY			
7	OTHER *(Explain)*			
	TOTAL OF ALL OPEN CLAIMS *(Reason Codes 1 through 7)*	0	0	0
REASON CODES 8-16. CLOSED CLAIMS. THIRD PARTY PAID IN FULL OR REDUCED/DENIED PAYMENTS *(No further action required because unpaid amount is not a valid claim)*				
8	AMOUNT OF COVERAGE *(i.e. plan pays less than 100%)*			
9	PATIENT NOT COVERED, CARE PROVIDED NOT COVERED, OR POLICY EXPIRED			
10	CHAMPUS AND/OR INCOME SUPPLEMENTAL PLANS			
11	MEDICARE SUPPLEMENTAL PLANS			
12	HEALTH MAINTENANCE ORGANIZATION (HMO) *(i.e. nonemergency out-of-plan care not covered)*			
13	MTF DID NOT COMPLY WITH UTILIZATION REVIEW PROCEDURES *(i.e. pre-admission screening, concurrent review, second surgical opinions, etc.)*			
14	REFUNDS			
15	PATIENT COPAYS AND DEDUCTIBLES			
16	OTHER *(Explain) (Example - third party provided lower prevailing rate vs. amount billed)*			
	TOTAL OF ALL CLOSED CLAIMS *(Reason Codes 8 through 16)*	0.00	0.00	0.00

NOTES:
1. All activity for amounts claimed and collected shall be reported in the fiscal year that the services were rendered (i.e. care provided in FY 1989 will be reported as an FY 1989 claim and collection, regardless of the year payment is received). This requires cut-off billing for all inpatients at fiscal year end.
2. Amounts reported in Part I, Column (7) for each fiscal year shall equal the subtotal for Reason Codes 8-16 in Part II, for the respective fiscal years.
3. Amounts reported in Part I, Column (11) for each fiscal year shall equal the subtotal for Reason Codes 1-7 in Part II, for the respective fiscal years.
4. Each quarterly report shall be cumulative for the current and two prior fiscal years.

DD FORM 2570, JUN 2001 PREVIOUS EDITION IS OBSOLETE. Reset

AP3. APPENDIX 3

SAMPLE PERMANENT MSA OFFICER TRANSFER CERTIFICATE

"I certify that, to the best of my knowledge and belief, the attached is an accurate and complete summary of all outstanding accounts receivable and an accurate listing of all forms on hand as of (time and date). All transactions within the MSA since the last audit report (date) are accurately reflected in the accounts and records of the MSA, documented by the retained and currently available copies of cash collection vouchers, accounts receivable records, Cash Meal Logs, or other authorized vouchers. All records of the MSA are hereby transferred to my successor."

Signature (full name and grade of outgoing MSA officer)

"I hereby certify that I have examined the records of the MSA and accept accountability as of (time and date)."

Signature (full name and grade of incoming MSA officer)

APPROVED: Signature and grade of MTF commander

AP4. APPENDIX 4

SAMPLE TEMPORARY MSA OFFICER TRANSFER CERTIFICATE

"I hereby certify that, to the best of my knowledge and belief, the records, balances, and supporting documents pertaining to the MSA are both true and correct. The records and accounts are hereby temporarily transferred to the acting MSA officer."

Signature (full name and grade of regular MSA officer)

"I hereby certify that I have examined the records of the MSA and accept accountability as of (time and date)."

Signature (name and grade of temporary MSA officer)

APPROVED: Signature (name and grade of MTF commander)

Note: When the MSA officer will be absent for 5 days or less, his or her direct supervisor assumes the MSA duties. Strict accountability of funds and controlled forms shall be maintained.

AP5. APPENDIX 5

SAMPLE INVOICE & RECEIPT (I&R)

BETHESDA NAVAL CENTER 31 Mar 1995@1450 Page: 1
Personal Data - Privacy Act of 1974 (PL 93-579)

SAIC BETHESDA NAVAL CENTER
123456789 ADMIRAL KIDD DRIVE DEPARTMENT OF THE NAVY
SAN DIEGO, VA 92129 HOSPITAL INVOICE AND RECEIPT

SPONSOR NAME: WALKER, JOE SERVICE: A
DUTY ADDRESS: 13 MORRIS LN GRADE: 06
SAN DIEGO CA 92117

BILLING NAME: WALKER, JOE FMP/SSN: 20/333-45-3345
BILL ADDRESS: 2431 ALEXANDRE EAST
STEUBENVILLE OH 43952

PATIENT NAME: WALKER, PAM ACCOUNT NO: 198
ADM: 29 May 1994@2200 DISCH: 29 May 1994@2400 TOTAL CHARGES: $458.00
----------CHARGES----------

INPATIENT CHARGES:

BEG DATE	END DATE	CHG DAYS	NCHG DAYS	RATE	CHARGE
29 May 1994	29 May 1994	1	0	458.00	458.00

ONE TIME CHARGES:

DATE	DESCRIPTION	CHG CAT	QTY	CHARGE
29 May 1994	UTILITIES	UL	1	123.00

----------INVOICES & RECEIPTS----------

DATE	PAYMENT	TYPE PAY	CONTROL NUMBER	BALANCE
05 Jun 1994	0.00	94-10174	458.00	
31 Jul 1994	0.00	N94-9	0.00	

---

1. Payment of this bill is due upon receipt. You may inspect and copy government records related to this debt to the United States and question its validity or accuracy. If payment is not received for this debt within 30 days of hospital discharge or outpatient date of service, your account is subject to referral to higher authority for collection action, involuntary pay checkage (if you or your spouse is a Federal employee), and referral to your employer.

2. Per the Debt Collection Act of 1982, interest and/or administrative charges will be assessed on accounts not paid within 30 days of the initial billing. If payment in full is not possible at this time, installment payment arrangements may be made by contacting the MSA Business Office at (619) 535-7118.

3. Please make checks payable to: Captain B. Griggs
and mail to: BETHESDA NAVAL CENTER
MSA BUSINESS OFFICE
10260 CAMPUS POINT DR
SAN DIEGO CA 92121
ATTN: JOHN SMITH

Prepared by:_____ Received by:_____

AF FORM 1127/DA FORM 3154/NAVMED FORM 7270/1 (CG-CHCS/SAIC)

AP6. APPENDIX 6

SAMPLE PATCAT

Code	Sub Cat	Patient Category Name	Pay Mode	Status of Patient	IPNT Indiv Sales CD	IPNT Agency Rate	OPNT Indiv Sales CD	OPNT Agency Rate
A11	1	USA ACTIVE DUTY OFFICER		ACTIVE DUTY	NC	NC	NC	NC
A12	2	USA AD RES ENLISTED		ACTIVE DUTY	NC	NC	NC	NC
A15	1	USA NG OFFICER		ACTIVE DUTY	NC	NC	NC	NC
A22	2	USA RES INACT DUTY TRG ENLISTED		ACTIVE DUTY	NC	NC	NC	NC
A23	1	USA NG INACT DUTY TRG OFF		ACTIVE DUTY	NC	NC	NC	NC
A24		USA FRM AD-TRANS ASSISTANCE ACT		OTHER	FMR	NC	NC	NC
A29	A	USA NEWBORN OF SPONSOR'S DAUGHTER	DD139	OTHER	FMR	NC	NC	NC
A31	2	USA RET LOS ENLISTED		RETIRED	NC	NC	NC	NC
A33	2	USA RET TDRL ENLISTED		RETIRED	NC	NC	NC	NC
A37		USA TRICARE RES SELECT FAM MBR		OTHER	FMR	NC	NC	NC
A41		USA FAM MBR AD	DD139	FAM MBR OF ACTIVE DUTY	FMR	NC	NC	NC
A43		USA FAM MBR RET	DD139	FAM MBR OF RETIRED	FMR	NC	NC	NC
A45		USA FAM MBR DECEASED AD		FAM MBR OF RETIRED	FMR	NC	NC	NC
A48		USA UNREMARRIED FRM SPOUSE		OTHER	FMR	NC	NC	NC
B11		NOAA ACTIVE DUTY	DD7/DD7A	ACTIVE DUTY	NC	IAR	NC	IOR
B31		NOAA RET LOS	DD7/DD7A	RETIRED	NC	IAR	NC	IOR
B41		NOAA FAM MBR AD	DD7/DD7A	FAM MBR OF ACTIVE DUTY	NC	IAR	NC	IOR
B43		NOAA FAM MBR RET	DD7/DD7A	FAM MBR OF RETIRED	NC	IAR	NC	IOR
B45		NOAA FAM MBR DECEASED AD	DD7/DD7A	FAM MBR OF RETIRED	NC	IAR	NC	IOR
B49		NOAA FAM MBR UNREMAR FRM SPOUSE	DD7/DD7A	OTHER	NC	IAR	NC	IOR
K53	3	FAA AIR TRF CONTROLLER PHYS EXAM	DD7/DD7A	OTHER	NC	IAR	NC	FAA
K53	S	DOD SCHOOL TEACHER OUTSIDE THE US		OTHER	IAR	NC	IOR	NC
K61	1	VETERANS ADMIN BENEFICIARY		OTHER	NC	IAR	NC	IOR
K61	2	DOD/VA SHARING AGREEMENT		OTHER	NC	FLEX	NC	FLXO
K62	2	WC-CIV, FED EMPL	DD7/DD7A	OTHER	NC	IAR	NC	IOR
K69	F	RED CROSS EMPLOYEE OUTSIDE US		OTHER	SR	NC	NC	NC
K71	A	IMET NATO	DD7/DD7A	OTHER	NC	IMET	NC	NC
K82	5	ARMY SECT DESIGNEE (FRR PAY)		OTHER	FRR	NC	FOR	NC
K91	1	CIVILIAN - HUMANITARIAN		OTHER	NC	NC	NC	NC
K91	1	CIVILIAN - HUMANITARIAN		OTHER	NC	NC	NC	NC
K93		MEDICARE - CIVILIAN EMERGENCY		OTHER	NC	IAR	NC	IOR
K94		MEDICAID - CIVILIAN EMERGENCY		OTHER	NC	FRR	NC	FOR
K95		STATE CHILDREN'S HEALTH INS PROGRAM		OTHER	NC	FRR	NC	FOR
K99	B	PATIENT NOT ELSEWHERE CLASSIFIED		OTHER	FRR	NC	FOR	NC
R74		NON-NATO RECIP AGREE		ACTIVE DUTY	SR	NC	NC	NC

PATCAT Code - Major Categories (Position 1)	
A = Army	M = Marines
B = National Oceanic and Atmospheric Administration	N = Navy
C = Coast Guard	P = Public Health Service
F = Air Force	R = Reciprocal Agreements (US with other nations)
K = "Katch-all" (many "Other" and "Special" categories)	

PATCAT Code - Major Categories (Positions 2 and 3)
1x = Extended Active Duty Sponsors
2x = ROTC; Inactive Duty Guard/Reserves, TAMP/TRS, Former Members, Applicants
3x = Retirees
4x = Family Members, Former Spouses and Family Members
5x – 9x = Used with "K" Codes for U.S. Government Employees and Family Members, Foreign Nationals, Secretarial Designees, Civilian Emergency Patients, and Other Types of Patients

AP7. APPENDIX 7

SAMPLE DD FORM 7, REPORT OF TREATMENT FURNISHED PAY PATIENTS – HOSPITALIZATION FURNISHED (PART A)

REPORT OF TREATMENT FURNISHED PAY PATIENTS HOSPITALIZATION FURNISHED (PART A)				*REPORT CONTROL SYMBOL* DD-HA(M)1990		
1. INSTALLATION PROVIDING HOSPITALIZATION *(Name and address)*				2. MONTH AND YEAR COVERED BY THIS REPORT		
3. CATEGORY OF PATIENTS			4. AUTHORITY FOR ADMISSION			
NAME *(Last, first, middle initial)* AND SSN 5	MILITARY GRADE 6	ORGANIZATION 7	DIAGNOSIS 8	DATES ADMISSION 9	DISCHARGE 10	TOTAL 11
12. DATE	13. AUTHENTICATION *(Signature, military grade, organization of Commanding Officer)*			14. TOTAL DAYS HOSPITALIZED		

DD Form 7, JAN 76 (EG) EDITION OF 1 APR 50 WILL BE USED UNTIL EXHAUSTED Reset Designed using Perform Pro, WHS/DIOR, Nov 94

AP8. APPENDIX 8

SAMPLE DD FORM 7A, REPORT OF TREATMENT FURNISHED PAY PATIENTS – OUTPATIENT TREATMENT FURNISHED (PART B)

REPORT OF TREATMENT FURNISHED PAY PATIENTS OUTPATIENT TREATMENT FURNISHED (PART B)						*REPORT CONTROL SYMBOL* DD-HA(M)1990
1. INSTALLATION PROVIDING TREATMENT *(Name and address)*						2. MONTH AND YEAR COVERED BY THIS REPORT
3. CATEGORY OF PATIENTS				4. AUTHORITY FOR ADMISSION		
NAME *(Last, first, middle initial)* AND SSN 5	MILITARY GRADE 6	ORGANIZATION 7		DIAGNOSIS 8	TREATMENT DATES 9	TREATMENT NUMBER 10
11. DATE	12. AUTHENTICATION *(Signature, military grade, organization of Commanding Officer)*				13. TOTAL	

DD Form 7A, AUG 76 (EG)

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AP9. APPENDIX 9

SAMPLE SF 1080, VOUCHER FOR TRANSFERS BETWEEN APPROPRIATIONS AND/OR FUNDS

Standard Form 1080
Revised April 1982
Department of the Treasury
I TFRM 2-2500
1080-109

VOUCHER FOR TRANSFERS BETWEEN APPROPRIATIONS AND/OR FUNDS

VOUCHER NO.

SCHEDULE NO.

Department, establishment, bureau, or office receiving funds

BILL NO.

PAID BY

Department, establishment, bureau, or office charged

ORDER NO.	DATE OF DELIVERY	ARTICLE OR SERVICES	QUAN-TITY	UNIT PRICE		AMOUNT
				COST	PER	DOLLARS AND CENTS
						0.00
						0.00
						0.00
					TOTAL	0.00

Remittance in payment hereof should be sent to -

ACCOUNTING CLASSIFICATION - *Office Receiving Funds*

CERTIFICATE OF OFFICE CHARGED

I certify that the above articles were received and accepted or the services performed as stated and should be charged to the appropriation(s) and/or fund(s) as indicated below; or that the advance payment requested is approved and should be paid as indicated.

_____ (Date)

_____ (Authorized administrative or certifying officer)

_____ (Title)

ACCOUNTING CLASSIFICATION - *Office Charged*

Paid by Check No.

NSN 7540-00-634-4230

Designed using PerForm Pro software.

Reset

Previous Editions Are Usable

AP10. APPENDIX 10

SAMPLE DD FORM 139, PAY ADJUSTMENT AUTHORIZATION

PAY ADJUSTMENT AUTHORIZATION

NOTE: If member has been transferred, forward this authorization to the officer currently maintaining the member's pay record.

MEMBER *(Last name)* *(First)* *(Middle)*	SSAN	GRADE/RANK/RATE	BRANCH OF SERVICE	DATE

PAY GRADE NO.	LAST PAY RECORD EXAMINED	AMOUNT	APPROPRIATION DATA

FROM	NAME OF ACCOUNTABLE D.O.	
	SYMBOL NO.	G.A.O. EXCEPTION CODE

TO

YOU ARE HEREBY AUTHORIZED TO

☐ CHARGE ☐ CREDIT

THE MILITARY PAY RECORD OF THE MEMBER LISTED ABOVE

EXPLANATION AND/OR REASON FOR ADJUSTMENT

The above adjustment is based on a thorough examination of all available records. If the Disbursing Officer has knowledge that a previous adjustment has been made or why the adjustment should not be made for the same item, this authorization should be returned with a brief statement of the reason for failure to make adjustment.

FROM	CERTIFYING OFFICER *(Name, rank/grade, and signature)*

CERTIFICATE

I CERTIFY that the adjustment indicated above has been entered on the above-named member's Military Pay Record. (If adjustment has not been entered, give explanation on reverse over D.O.'s signature and symbol number.)

TO

TYPED NAME AND GRADE OF D.O.	
D.O. SYMBOL NO.	DATE
SIGNATURE	

DD FORM 139, MAY 53 EDITION OF THIS FORM NOT HAVING SSAN IS OBSOLETE AFTER 30 JUN 69. *Form approved by Comp. Gen., U.S. April 23, 1953*

Reset

AP11. APPENDIX 11

SAMPLE CONSENT STATEMENT FOR DEDUCTION FROM PAY

"I hereby certify that I am not able to make payment directly to the medical facility for charges of _____. I am requesting and consenting to immediate collection of these medical care charges from my pay and understand the collection shall be a one-time deduction."

Patient's Name_____

Date and Time of Admission_____

Date and Time of Discharge_____

AP12. APPENDIX 12

SAMPLE DD FORM 2569, THIRD PARTY COLLECTION PROGRAM – RECORD OF OTHER HEALTH INSURANCE

THIRD PARTY COLLECTION PROGRAM - RECORD OF OTHER HEALTH INSURANCE
(Read Privacy Act Statement before completing this form.)

OMB No. 0704-0323
OMB approval expires Dec 31, 2006

The public reporting burden for this collection of information is estimated to average 3 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, Executive Services Directorate (0704-0323). 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 REQUESTING MILITARY TREATMENT FACILITY.**

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sec. 1095; EO 9397.
PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF) patient. Such monetary benefits accruing to the MTF will be used to enhance health care delivery in the MTF.
ROUTINE USE(S): The information on this form will be released to your insurance company.
DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services.

1. PATIENT NAME *(Last, First, Middle Initial)*	2. SSN	3. DATE OF BIRTH *(YYYYMMDD)*	4. MARITAL STATUS *(X)* ☐ SINGLE ☐ MARRIED ☐ DIVORCED/WIDOWED
5a. STREET ADDRESS *(Include apartment number)*	b. CITY	c. STATE	d. ZIP CODE / 6. HOME TELEPHONE NO. ( )
7. SPONSOR'S BRANCH OF SERVICE	8. SPONSOR FAMILY MEMBER PREFIX/ SSN	9a. SPOUSE NAME *(Last, First, Middle Initial)*	
10a. PATIENT'S EMPLOYER NAME	b. TELEPHONE NUMBER ( )	b. SPOUSE'S EMPLOYER *(Name, Address and Telephone No.)*	
c. EMPLOYER ADDRESS *(Include ZIP Code)*			

11. IS PATIENT'S CONDITION/APPOINTMENT RELATED TO AN ACCIDENT *(X one)*	☐ YES ☐ NO	a. DATE OF INJURY/ACCIDENT *(YYYYMMDD)*	b. CITY AND STATE WHERE ACCIDENT OCCURRED
c. TYPE OF ACCIDENT *(X)*	☐ AUTO ☐ BOAT ☐ HOME ☐ AIRPLANE ☐ WORKERS' COMPENSATION ☐ SLIP & FALL ☐ OTHER _____		
d. BRIEFLY DESCRIBE HOW INJURY/ACCIDENT OCCURRED			
e. INSURANCE COMPANY NAME	f. POLICY NUMBER	g. COMPANY ADDRESS *(Include ZIP Code)*	
h. TELEPHONE NUMBER ( )	i. NAME OF POLICY HOLDER/INSURED	j. CLAIM NUMBER	

12. DO YOU HAVE MEDICARE/MEDICAID *(X one)*	☐ YES ☐ NO		
a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICAID NUMBER	d. ISSUING STATE
13. ARE YOU COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY? *(Other than Medicare, Medicaid, TRICARE or TRICARE/CHAMPUS Supplement)*	☐ YES ☐ NO		

14.a. PRIMARY MEDICAL INSURANCE COMPANY NAME		15.a. SECONDARY MEDICAL INSURANCE COMPANY NAME	
b. ADDRESS *(Include ZIP code)*		b. ADDRESS *(Include ZIP code)*	
c. TELEPHONE NUMBER ( )	d. IDENTIFICATION NUMBER/GROUP NUMBER	c. TELEPHONE NUMBER ( )	d. IDENTIFICATION NUMBER/GROUP NUMBER
e. POLICY HOLDER'S NAME *(Last, First, Middle Initial)*		e. POLICY HOLDER'S NAME *(Last, First, Middle Initial)*	
f. SSN	g. DATE OF BIRTH *(YYYYMMDD)*	f. SSN	g. DATE OF BIRTH *(YYYYMMDD)*
h. POLICY HOLDER'S EMPLOYER NAME, ADDRESS AND TELEPHONE NO.		h. POLICY HOLDER'S EMPLOYER NAME, ADDRESS AND TELEPHONE NO.	
i. EFFECTIVE DATE OF POLICY *(YYYYMMDD)*		i. EFFECTIVE DATE OF POLICY *(YYYYMMDD)*	

16. FAMILY MEMBERS COVERED BY ABOVE POLICIES *(Use additional pages if necessary)*

a. NAME *(Last, First, Middle Initial)*	b. SSN	c. DATE OF BIRTH *(YYYYMMDD)*	a. NAME *(Last, First, Middle Initial)*	b. SSN	c. DATE OF BIRTH *(YYYYMMDD)*

17. **CERTIFICATION.** I certify that the above information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by 18 USC 1001, which provides for a maximum fine of $10,000 or imprisonment for five years, or both. For non-DoD beneficiaries, the below signature authorizes and requests that the proceeds of any and all benefits be paid directly to the Military Treatment Facility (MTF) for health care services provided me and/or my minor dependents. This signature authorizes Medical Service Account (MSA) patients' release of medical information (medical records) for claims.

a. SIGNATURE	b. DATE *(YYYYMMDD)*

DD FORM 2569, JAN 2004 PREVIOUS EDITION IS OBSOLETE. Reset

AP13. APPENDIX 13

SAMPLE UB-92

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL

5 FED.TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH | 7 COV.D. | 8 N-C.D. | 9 C-I.D. | 10 L-R.D. | 11

12 PATIENT NAME | 13 PATIENT ADDRESS

14 BIRTHDATE | 15 SEX | 16 M.S. | 17 ADMISSION DATE | 18 HR. | 19 TYPE | 20 SRC | 21 D HR. | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31

32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE CODE DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 A B C

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23

50 PAYER | 51 PROVIDER NO. | 52 REL. INFO | 53 A.SG. BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56

57 | DUE FROM PATIENT ▶

58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC. - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 CODE 69 CODE 70 CODE 71 CODE 72 CODE 73 CODE 74 CODE 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78

79 P.C. | 80 PRINCIPAL PROCEDURE CODE DATE | 81 OTHER PROCEDURE CODE DATE A | OTHER PROCEDURE CODE DATE B | 82 ATTENDING PHYS. ID

OTHER PROCEDURE CODE DATE C | OTHER PROCEDURE CODE DATE D | OTHER PROCEDURE CODE DATE E | 83 OTHER PHYS. ID A B

84 REMARKS | OTHER PHYS. ID

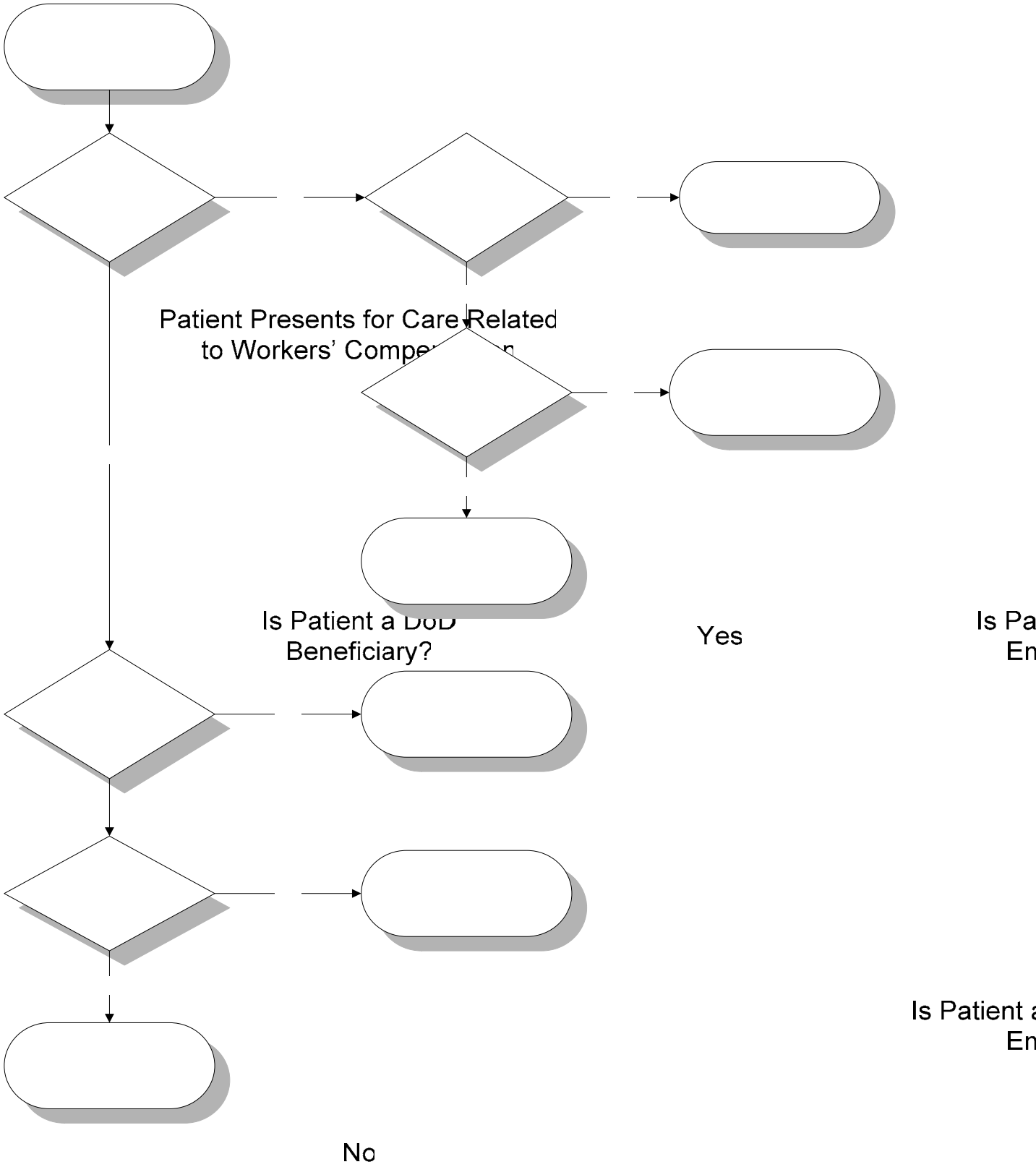
85 PROVIDER REPRESENTATIVE X | 86 DATE

UB-92 HCFA-1450 | OCR/ORIGINAL | I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

(Available from Centers for Medicare and Medicaid Services, US Department of Health and Human Services.)

AP14. APPENDIX 14

WORKERS' COMPENSATION PATIENT CATEGORY/BILLING PROCESS



AP15. APPENDIX 15

SAMPLE SF 215, DEPOSIT TICKET

STANDARD FORM 215 (REV. 5-78)
PRESCRIBED BY DEPT. OF TREASURY
I TFRM 5-3000 215-102

DEPOSIT TICKET

DEPARTMENT OF THE TREASURY
BUREAU OF GOVERNMENT FINANCIAL OPERATIONS

DEPOSIT NUMBER	DATE PRESENTED OR MAILED TO BANK (M M D D Y Y)	8-DIGIT OR 4-DIGIT AGENCY LOCATION CODE (ALC)	AMOUNT
(1)	(2)	(3)	(4)

SINGLE SPACE ALL ENTRIES ON THIS LINE
USE NORMAL PUNCTUATION--OMIT $ SIGN

(6) AGENCY USE

(7) NAME AND ADDRESS OF DEPOSITARY

(8) I CERTIFY THAT THE ABOVE AMOUNT HAS BEEN RECEIVED FOR CREDIT IN THE ACCOUNT OF THE U.S. TREASURY ON THE DATE SHOWN. SUBJECT TO ADJUSTMENT OF UNCOLLECTIBLE ITEMS INCLUDED THEREIN.

AUTHORIZED SIGNATURE

M M D D Y Y
CONFIRMED DATE

(9) DEPOSITORS TITLE, DEPARTMENT OR AGENCY AND ADDRESS

DEPOSITARY FORWARD THIS DOCUMENT WITH STATEMENT OR TRANSCRIPT OF THE U.S. TREASURY ACCOUNT OF THE SAME DATE.

ORIGINAL

AP16. APPENDIX 16

SAMPLE DD 2481, REQUEST FOR RECOVERY OF DEBT DUE THE UNITED STATES BY SALARY OFFSET

REQUEST FOR RECOVERY OF DEBT DUE THE UNITED STATES BY SALARY OFFSET

PRIVACY ACT NOTICE

The data on this form is covered by the Privacy Act of 1974, as amended, 5 U.S.C. Section 552a.

1. PAYING OFFICE IDENTIFICATION		**2. EMPLOYEE IDENTIFICATION**	
a. NAME		a. NAME *(Last, First, Middle Initial)*	
b. ADDRESS *(Street, City, State and Zip Code)*		b. ADDRESS *(Street, City, State and Zip Code)*	
c. CONTACT NAME *(Last, First, Middle Initial)*		c. DATE OF BIRTH *(YYYYMMDD)*	d. SOCIAL SECURITY NUMBER
d. E-MAIL ADDRESS	e. TELEPHONE NO. *(DSN and Commercial)*		

To liquidate a debt to the United States, the named Creditor Component asks that the debt be collected as shown from the current pay of the employee identified above. Notices and inquiries concerning the debt should be sent to the address shown below.

3. DEBT INFORMATION				
a. REASON FOR DEBT		b. DATE RIGHT TO COLLECT ACCRUED *(YYYYMMDD)*		
		c. DEBT IDENTIFICATION NUMBER, IF ANY		
d. ORIGINAL DEBT AMOUNT	$	e. NUMBER OF INSTALLMENTS	(1) @	(2) Amount
f. INTEREST DUE *(If none, show N/A)*	$			$ 0.00
g. PENALTY DUE *(If none, show N/A)*	$			$ 0.00
h. ADMINISTRATIVE COST *(If none, show N/A)*	$			$ 0.00
i. TOTAL COLLECTION TO BE MADE	$ 0.00	j. COMMENCE DEDUCTIONS ON *(YYYYMMDD)*		

4. DUE PROCESS *(X applicable items and either enter date action taken in Column (1) or X Column (2) or (3) and attach acknowledgement or consent.)*

	(1) Date Action Taken	(2) Acknow-ledgement	(3) Consent		(1) Date Action Taken	(2) Acknow-ledgement	(3) Consent
a. CREDITOR COMPONENT 30 DAY SALARY OFFSET NOTICE				d. HEARING HELD			
b. EMPLOYEE DID NOT RESPOND (Consent assumed)				e. DECISION FOR CREDITOR COMPONENT			
c. EMPLOYEE REQUESTED A HEARING				f. OTHER *(Specify)*			

I certify the following:
(1) The debt identified above is properly due the United States from the named employee in the amount shown;
(2) This Agency's regulations implementing 5 U.S.C. 5514 have been approved by the Office of Personnel Management; and
(3) The information concerning this Component's and the employee's actions is correct as stated.

5. CREDITOR COMPONENT INFORMATION		
a. NAME	b. ADDRESS *(Street, City, State and Zip Code)*	
c. CONTACT NAME *(Last, First, Middle Initial)*	d. E-MAIL ADDRESS	e. TELEPHONE NO. *(DSN and Commercial)*
f. ACCOUNTING CLASSIFICATION *(Line of Accounting)*		
g. DOCUMENT NUMBER		
h. CERTIFYING OFFICIAL		
(1) Signature	(2) Date Signed *(YYYYMMDD)*	(3) Title / (4) Telephone No. *(DSN and Commercial)*

6. DFAS ACCOUNTING OFFICE			
a. OFFICE, SYMBOL, AND PROCESSOR'S NAME	b. E-MAIL ADDRESS	c. TELEPHONE NO. *(DSN and Commercial)*	d. DATE *(YYYYMMDD)*

DD FORM 2481, APR 2006 PREVIOUS EDITION IS OBSOLETE. Reset FormFlow/Adobe Professional 7.0

AP17. APPENDIX 17

SAMPLE SF 1049, PUBLIC VOUCHER FOR REFUNDS

Standard Form 1049

September 1973

4 TFM 4-2000

1049 105-01

PUBLIC VOUCHER FOR REFUNDS

VOUCHER NO -

SCHEDULE NO.

(Voucher prepared)

(Give place and date)

U.S. **Defense Accounting Support Activity, DFAS-IN, Indianapolis, IN 46249**

(Department of Establishment, Bureau or Office)

Appropriation or Fund:

THE UNITED STATES, Dr.,

PAID BY

To

DSSN 5053

Address

DASA-IN

Statement of deposit(s) received and applied: Contract No. Date

DATE OF RECEIPT	DEPOSIT NO.	ARTICLES OR SERVICES (ENTER DESCRIPTION, INCLUDING DETAIL OF APPLIED CHARGES, AND OTHER INFORMATION DEEMED NECESSARY)	AMOUNT DEPOSITED DOLLARS CTS	APPLIED CHARGES DOLLARS CTS	BALANCE DUE DEPOSITOR DOLLARS CTS	NOTATIONS

TOTAL 00 00 00

I certify that the above statement of deposit(s) of the payee or depositor named is correct and that the sum of is due said depositor.

** Approved and refund authorized for*

(Sign original only) *

Title

Check No.

Signature

Cash, on

of

payee

Other method,

(Describe)

* If the ability to certify and authority to approve are combined in one person, one signature only is necessary; otherwise the approving officer will sign in the blank space below

"Approved," etc., and over his official title.

☐U.S. GOVERNMENT PRINTING OFFICE: 1989-228-128

AP18. APPENDIX 18

SAMPLE DD FORM 599, PATIENT'S EFFECTS STORAGE TAG

DD FORM 599
OCT 51

PATIENT'S EFFECTS STORAGE TAG	**NO. 000001**
NAME	
SERVICE NUMBER OR CATEGORY OF PERSONNEL	
DATE RECEIVED	**RACK OR BIN**
HOSPITAL	
SIGNATURE OF PATIENT ***(upon withdrawal)***	

PATIENT'S STUB	**NO. 000001**
DATE RECEIVED	**RACK OR BIN**
HOSPITAL	
This identification tag must be presented when access to your personal effects is desired.	

AP19. APPENDIX 19

SAMPLE CMS 1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____.__ 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12/90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

AP20. APPENDIX 20

SECTION 743. CORRECTION TO ELIGIBILITY OF CERTAIN RESERVE OFFICERS FOR MILITARY HEALTH CARE PENDING ACTIVE DUTY FOLLOWING COMMISSIONING (P.L. 109-163)

(a) Correction.—Clause (iii) of section 1074(a)(2)(B) of title 10, United States Code, is amended by inserting before the semicolon the following: "or the orders have been issued but the member has not entered active duty."

(b)<<NOTE: 10 USC 1074 note.>>>Effective Date.—The amendment made by subsection (a) shall take effect as of November 24, 2003, and as if included in the enactment of paragraph (2) of section 1074(a) of title 10, United States Code, by section 708 of the National Defense Authorization Act for Fiscal Year 2004 (Public Law 108-136; 117 Stat. 1530)."

AP21. APPENDIX 21

TABLE AP21.T1. TYPE OF SERVICES BILLED BY BENEFICIARY CATEGORY

Beneficiary Category	Inpatient Hospital Billing	Outpatient Visit Billing	Ancillary Services Billing	No-Fault Accident Billing
Active Duty	NO	NO	NO	YES
Retiree	YES	YES	YES	YES
Dependent	YES	YES	YES	YES

TABLE AP21.T2. TYPE OF SERVICES BILLED BY INSURANCE POLICY OR GROUP HEALTH PLAN

Type of Policy or Plan to be Billed	Inpatient	Outpatient	Ancillary
Private Insurance Policy	YES	YES	YES
Employer Group Health Plan	YES	YES	YES
Association or Organization Health Plan	YES	YES	YES
No-Fault Automobile Insurance	YES	YES	YES
Third Party Automobile Liability (Tort Claim)	YES	YES	YES
Medicare Supplemental Plan	YES	YES	YES
Workers' Compensation Plan (nonfederal employee)	YES	YES	YES
Workers' Compensation Plan (Federal employee)	NO	NO	NO
TRICARE Supplement	NO	NO	NO
Income (wage) Supplement	NO	NO	NO

AP22. APPENDIX 22

SAMPLE SF 1081, VOUCHER AND SCHEDULE OF WITHDRAWALS AND CREDITS

STANDARD FORM 1081
Revised September 1982
Department of the Treasury
I TFRM 2-2500

VOUCHER AND SCHEDULE OF WITHDRAWALS AND CREDITS

Transaction Date

CHARGE AND CREDIT WILL BE REPORTED ON CUSTOMER AGENCY STATEMENT OF TRANSACTIONS FOR ACCOUNTING PERIOD ENDING _____

Document No.

CUSTOMER AGENCY		BILLING AGENCY	
Agency Location Code (ALC)	Customer Agency Voucher No.	Agency Location Code (ALC)	Billing Agency Voucher No.
DEPARTMENT BUREAU ADDRESS		DEPARTMENT BUREAU ADDRESS	

SUMMARY		SUMMARY	
APPROPRIATION, FUND, OR RECEIPT SYMBOL	AMOUNT	APPROPRIATION, FUND, OR RECEIPT SYMBOL	AMOUNT
(MUST AGREE WITH BILLING AGENCY TOTAL) TOTAL		(MUST AGREE WITH BILLING AGENCY TOTAL) TOTAL	

Details of charges or reference to attached supporting documents

SAMPLE ONLY

BILLING AGENCY CONTACT:
PREPARED BY _____
APPROVED BY _____
TELEPHONE NO. _____

CERTIFICATION OF CUSTOMER OFFICE

I certify that the items listed herein are correct and proper for payment from and to the appropriation(s) designated.

_____ *(Date)*

_____ *(Authorized administrative or certifying officer)*

_____ *(Telephone No.)*

NSN 7540-00-634-4234
PREVIOUS EDITION NOT USABLE

AP23. APPENDIX 23

PERSONS AUTHORIZED TO EAT IN MTF DINING FACILITIES

AP23.1. CATEGORY DEFINITION

Charges for persons authorized to eat in a military MTF dining room vary, depending on the status of each person. The five major categories of personnel are: officers, enlisted personnel, military dependents, Federal civilian employees, and others.

AP23.2. GENERAL ENTITLEMENTS

Table AP23.T1., Persons Who May Eat in MTF Dining Facilities, on the next page, covers this information.

AP23.3. SPECIAL CONSIDERATIONS

AP23.3.1. Outpatients and visitors may eat in MTF dining rooms when authorized to do so by the MTF commander, but must pay either the discount or full meal rate, depending on their status.

AP23.3.2. Inpatients traveling in the aeromedical evacuation system are not charged for their meals.

AP23.3.3. Outpatients traveling in the aeromedical evacuation system pay the full rate for their meals in the dining room (exception: dependents of E1-E4).

AP23.3.4. Non-medical attendants traveling in the aeromedical evacuation system pay the full meal rate (exception: dependents of E1-E4).

AP23.3.5. Military members of foreign governments pay the same rates as their U.S. counterparts.

AP23.3.6. National Guard and Air National Guard, ROTC (all Services), and Army, Air Force, Navy, Marine, and Coast Guard Reserves, on active duty or inactive duty for training, pay the same rates as their active duty counterparts. They can pay for meals by cash or cross-Service billing.

AP23.3.7. The discount rate includes the cost of food only.

AP23.3.8. The full rate includes the cost of food and a proportional charge for operating expenses, formerly known as surcharge.

AP23.3.9. Charges for meals are based on annual published DoD rates. The Services provide the rates to medical resource management officers by message in October.

AP23.3.10. Surcharge waiver authority is at DoD level. Requests for waivers should be submitted to the appropriate Service-specific office.

TABLE AP23.T1. PERSONS WHO MAY EAT IN MTF DINING FACILITIES

These Customers	Pay This Amount		
	No Charge	Discount Rate	Full Rate
Enlisted members entitled to SIK.	X		
Ambulatory inpatients eating in the dining room, including aeromedical evacuation patients.	X		
Enlisted members drawing BAS.			X
Federal civilian employees on official duty as a result of an act of providence or civil disturbance when no other comparable food service facilities are available.			X
Commanders as designated in writing by the installation commander.			X
Officers eating a meal to determine the quality and quantity of food served (must have permission in writing from installation commander).			X
Officers on alert status requiring immediate availability that keeps them from leaving the unit area. Such status will be in writing and specify the times on alert.			X
Officers in hostile fire areas as designated by DoD 7000.14-R, Volume 7, Part A			X
IMET and FMS students not receiving the meal portion of per diem and the meal operating charges are recovered through tuition charges.			X
Officer candidate, cadet, midshipman, or ROTC (all Services) students not receiving the meal portion of per diem.			X
Members and chaperones of the Boy Scouts, Girl Scouts, Boys Clubs of America, Big Brothers-Big Sisters of America, Little League Baseball, Inc., and Future Farmers of America, extended the privilege of visiting a base or who are living on base and the installation commander permits them to eat.		X	
Students in DoD Dependents Schools overseas not receiving the meal portion of per diem and alternative student meal facilities are not available.			X
Red Cross volunteers, uniformed and non-uniformed, CONUS and overseas, not receiving the meal portion of per diem.			X
Dependents of E-1 through E-4.		X	
Officers and active duty military dependent at Thanksgiving, Christmas, and the Service birthdays.			X
Outpatients who are active duty enlisted personnel receiving BAS or dependents of active duty E-1 through E-4.			X

These Customers	Pay This Amount		
	No Charge	Discount Rate	Full Rate
Active duty aeromedical evacuation outpatients not receiving per diem.			X
Non-active duty aeromedical evacuation outpatients who are not receiving per diem.			X
Active or non-active duty non-medical attendant (NMA) to an aeromedical evacuation patient, not receiving per diem.			X
Non-Uniformed Services beneficiary civilian employee who is a patient in a military hospital due to a job-related accident or injury while on duty including aeromedical evacuation patients.			X
Active duty aeromedical evacuation patients or NMAs on orders and receiving per diem.			X
Dependents of E-5 through E-9.			X
Outpatients and visitors who are retirees, dependents of retirees, dependents of E-5 through E-9, officers, or dependents of officers.			X
Anyone receiving the subsistence portion of per diem.			X
Officers on duty in the MTF.			X
Federal civilian employees assigned to the MTF, on duty.			X
Dependents of officers, except on Thanksgiving, Christmas, and Service birthdays.			X
Full-time paid professional field and headquarters Red Cross staff workers.			X
Full-time paid secretarial and clerical Red Cross workers on duty in Red Cross offices.			X
IMET and FMS students when the operating charge is not included in tuition.			X
United Service Organization (USO) personnel authorized by the installation commander.			X

AP 24. APPENDIX 24

SAMPLE DELINQUENT LETTER
(NOTE – AUTOMATED SAMPLE CAN BE FOUND IN CHCS)

Department of the Navy
SAIC Bethesda Naval Center
2555 Presidents Street
San Diego, CA 92129

May 9, XXXX

Prudential
1313 Westboro Boulevard
Rockville, MD 20850

Subject: Claim for Hospitalization Charges for John Doe (Req # 123)
Policy Number: 123456789
Hospitalization Date(s): 01 Feb 97 - 03 Feb 97

Dear Sir/Madam:

This is our second request for payment of hospitalization charges for John Doe. A copy of the original Uniform Bill (UB-92) is enclosed. To date, we have not received your payment or reply.

Title 10, United States Code, section 1095, is the basis for this claim. Under this title, Department of Defense (DoD) military treatment facilities are required to collect from third party payers for the reasonable inpatient hospital care costs incurred on behalf of DoD health care beneficiaries.

Please provide your payment or advise us of your processing status as soon as possible. Note that this matter will be forwarded to the office of the Navy Judge Advocate General for additional follow-up if we do not hear from you within 60 days of this letter.

Our collection staff is available at (555) 123-4567, if you have any questions. Your attention and cooperation in this matter is appreciated.

Sincerely,

Jane Smith
Accounts Manager

Enclosure: As stated