

Submitting TRICARE Standard® Claims

As a TRICARE Standard beneficiary, you may have to submit your own claims. When doing so, keep the following in mind to help avoid late or denied payments.

If you get care in the U.S., submit claims to the claims processor in the region where you live, not where you got care. For care you get overseas or in the U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands), submit claims to the TRICARE Overseas Program claims processor, regardless of your home region.

In the United States and U.S. territories, claims must be filed within one year from the date of service or date of inpatient discharge. Overseas, claims must be filed within three years, and you must submit proof of payment. For more information, visit www.tricare.mil/proofofpayment.

Claims Forms

To file a claim, fill out a *TRICARE DoD/CHAMPUS Medical Claim—Patient’s Request for Medical Payment form (DD Form 2642)*. You can download *DD Form 2642* at www.tricare.mil/claims or from your regional contractor’s website. Beneficiaries age 18 or older, spouses, parents or guardians may sign the initial claim form. Forms needed later to process a claim must be signed by the patient, or parent or guardian if the patient has not yet reached age 18.

Items To Include

When filing a claim, attach a readable copy of the provider’s bill to the claim form, making sure it contains the following:

- Patient’s name
- Sponsor’s Social Security number (SSN) or Department of Defense Benefits Number (DBN); eligible former spouses should use their own SSN or DBN and not the sponsor’s
- Provider’s name and address; if more than one provider’s name is on the bill, circle the name of the person who provided the service for which the claim is filed
- Date and place of each service
- Description of each service or supply furnished
- Charge for each service
- Diagnosis; if the diagnosis is not on the bill, complete block 8a on the form

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An Important Note About TRICARE Program Information: At the time of publication, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. **Military hospital and clinic guidelines and policies may be different than those outlined in this publication.** For the most recent information, contact your TRICARE regional contractor or local military hospital or clinic. The TRICARE program meets the minimum essential coverage requirement under the Affordable Care Act.

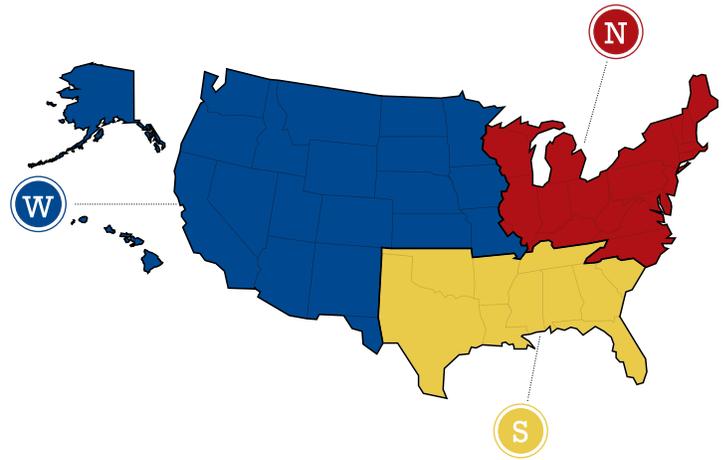
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You may have to pay up front for services if you see a TRICARE-authorized non-network provider who chooses not to accept TRICARE’s payment as payment in full on the claim. In this case, TRICARE reimburses you for the TRICARE-allowable charge, minus any amount toward your annual deductible and cost-shares. A deductible is the amount you pay out of pocket before your health care benefit begins cost-sharing. A cost-share is the percentage of the cost of care that you are responsible for paying when you visit a health care provider. You are responsible for the annual deductible and cost-shares under TRICARE Standard.

Nonparticipating non-network providers may charge up to 15 percent above the TRICARE-allowable charge in addition to your deductible and cost-shares. You are responsible for this cost. Visit www.tricare.mil/costs for more information.

Outside the U.S. and U.S. territories, there may be no limit to the amount that nonparticipating non-network providers may bill, and you are responsible for paying any amount that exceeds the TRICARE-allowable charge. Visit www.tricare.mil/overseas for more information.



Remember, when you visit a TRICARE network provider, you are using TRICARE Extra (not available overseas), and your provider files the claim for you. With TRICARE Extra, you also have lower out-of-pocket costs. For additional claims information, visit www.tricare.mil/claims. ■

Regional Claims-Processing Information

TRICARE North Region	TRICARE South Region	TRICARE West Region
Send claims to: Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587	Send claims to: TRICARE South Region Claims Department P.O. Box 7031 Camden, SC 29021	Send claims to: TRICARE West Region Claims Department P.O. Box 7064 Camden, SC 29021
Check the status of your claim at www.myTRICARE.com or www.hnfs.com .	Check the status of your claim at www.myTRICARE.com or HumanaMilitary.com .	Check the status of your claim at www.myTRICARE.com or www.uhcmilitarywest.com .

TRICARE Overseas Region			
Active Duty Service Members (ADSMs) (all overseas areas)	Non-ADSMs Eurasia-Africa	Non-ADSMs Latin America and Canada	Non-ADSMs Pacific
Send claims to: TRICARE Active Duty Claims P.O. Box 7968 Madison, WI 53707 USA	Send claims to: TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708 USA	Send claims to: TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707 USA	Send claims to: TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707 USA

TRICARE Standard and TRICARE Extra Costs

You can use both TRICARE Standard and TRICARE Extra to get care. The option you use determines your out-of-pocket costs. The costs that follow are for care you get from civilian providers. These costs are for fiscal year (FY) 2016 (Oct. 1, 2015–Sept. 30, 2016), and may change each year on Oct. 1. You are required to meet an annual deductible each FY for outpatient services before cost-sharing begins. For more information on costs, visit www.tricare.mil/costs. ■

Active Duty Family Members¹

Type of Care	TRICARE Standard (Non-Network Provider)	TRICARE Extra (Network Provider)
Outpatient	20% of the allowable charge	15% of the negotiated rate
Inpatient	\$18 per day (\$25 minimum charge)	\$18 per day (\$25 minimum charge)

1. Costs for families of National Guard and Reserve members called or ordered to active service for more than 30 consecutive days are the same as for active duty family members.

Retired Service Members, Their Families and All Others

Type of Care	TRICARE Standard (Non-Network Provider)	TRICARE Extra (Network Provider)
Outpatient	25% of the allowable charge	20% of the negotiated rate
Inpatient	\$810 per day or 25% for institutional services, whichever is less, plus 25% for separately billed professional charges	\$250 per day or 25% for institutional services, whichever is less, plus 20% for separately billed professional charges

Your Out-of-Pocket Costs Are Limited under the Comprehensive Autism Care Demonstration

TRICARE covers applied behavior analysis (ABA) services for beneficiaries diagnosed with autism spectrum disorder (ASD) under the Comprehensive Autism Care Demonstration. ASD affects essential human behaviors, such as social interaction, the ability to communicate ideas and feelings, imagination and the establishment of relationships with others.

On Oct. 1, 2015, TRICARE began limiting the out-of-pocket costs you pay for ABA services to your cost-shares and applying these cost-shares to your TRICARE catastrophic cap. Your catastrophic cap is the maximum out-of-pocket amount you or your family pays per fiscal year (FY) (Oct. 1–Sept. 30) for TRICARE-covered services. This means that no matter how many hours of ABA services your child needs under his or her treatment plan, you will pay no more than your catastrophic cap in a given FY.

ABA uses behavior modification principles, such as positive reinforcement, to increase or decrease targeted behaviors. ABA can help develop different skills, such as speech, self-help and play. It can also help decrease behaviors, such as aggression or self-injury. ABA services are covered under the

Autism Care Demonstration for all qualifying dependents of active duty service members (ADSMs), retirees and certain National Guard and Reserve members.

To qualify for covered ABA services, two other requirements must be met:

- Have been diagnosed with ASD by a TRICARE-authorized ASD-diagnosing provider.
- If the sponsor is an ADSM, your child with ASD must be enrolled in the Exceptional Family Member Program and registered in the Extended Care Health Option (unless waived in specific situations).

Other services are covered under your TRICARE program option (for example, TRICARE Standard). These services include occupational therapy, physical therapy, physician services, psychological services, psychological testing, prescription drugs and speech therapy.

For more information on the Autism Care Demonstration, visit www.tricare.mil/autism. ■



Update DEERS When You Have a Life Change

The Defense Enrollment Eligibility Reporting System (DEERS) database is for all active duty, National Guard and Reserve and retired service members worldwide, their family members and others who are eligible for military benefits, including TRICARE. The Department of Defense uses the information shown in your DEERS record to confirm your eligibility for TRICARE benefits and programs, as well as to determine your assigned TRICARE region.

Remember to update your DEERS information regularly, especially when you have life events, such as moving, getting married or divorced or having a child. Only sponsors, or a sponsor-appointed individual with valid power of attorney, can add family members in DEERS. When there is a change in information, each family member's DEERS record must be updated separately. Family members age 18 and older may update their own contact information. For more information, visit www.tricare.mil/deers.

Register New Spouses and Children in DEERS

It is important for sponsors to register new spouses and children in DEERS to ensure their TRICARE eligibility is correct. To register a new spouse or child in DEERS, the sponsor needs to provide a copy of the marriage or birth certificate and/or adoption papers to the nearest uniformed

services identification (ID) card-issuing facility, or to a DEERS representative in remote locations. To find an ID card-issuing facility, visit www.dmdc.osd.mil/rsl. New spouses and children are also required to show two forms of ID (for example, any combination of Social Security card, driver's license, birth certificate and/or adoption papers, current uniformed services ID card or Common Access Card).

Update DEERS after a Divorce

Sponsors must update DEERS if they divorce. For information about documentation requirements, call your nearest uniformed services ID card-issuing facility. Visit www.dmdc.osd.mil/rsl to find a facility in your area. Former spouses who have not remarried and may be eligible for continued benefits can check with their sponsor's service personnel office to verify eligibility and what documentation is necessary to continue TRICARE.

Former spouses who are not eligible for TRICARE may not continue getting health care services under the TRICARE benefit. If an ineligible former spouse continues using TRICARE for health care services, the former spouse and/or the sponsor may have to reimburse TRICARE for those services. ■

A Change to Your TRICARE Pharmacy Benefit

A change to the TRICARE Pharmacy benefit, which went into effect Oct. 1, 2015, requires all non-active duty service members and their eligible family members to fill select brand-name maintenance drugs through TRICARE Pharmacy Home Delivery or a military pharmacy. Maintenance drugs are those you take on a regular basis, such as birth control or drugs that control high blood pressure or high cholesterol. The affected drug list is available at www.health.mil/selectdruglist.

If your drug is included in this list, you may get up to two 30-day refills of your prescription from a TRICARE retail network pharmacy before you are required to switch to home delivery or a military pharmacy. Call your military pharmacy to see if your drug is available. If you choose to keep using a TRICARE retail network pharmacy, you will pay the full cost for your drug.

The TRICARE Pharmacy Program contractor, Express Scripts, Inc. (Express Scripts), sent a letter to all affected beneficiaries in September 2015 explaining refill options. If you got a letter and have questions, call Express Scripts at 1-877-363-1303.

If you get a new prescription for a maintenance drug that is on the affected drug list and you fill the drug at a TRICARE retail network pharmacy, you will get a letter from Express Scripts explaining your options for filling the prescription.



For more information about the TRICARE pharmacy benefit change, visit www.tricare.mil/RxNewRules. If you live overseas or have other prescription drug coverage, you are not affected. ■

Filling Your Compound Drug Prescriptions

TRICARE screens all prescriptions for compound drugs to ensure each ingredient is safe, effective and covered by TRICARE before filling the prescription. Compound drugs are made by a pharmacist mixing multiple ingredients to create a prescription drug that is specific to your needs. Your provider may prescribe a compound drug for you if you have an allergy to a commercially available drug, need a unique dosage or concentration of a drug or otherwise need an alternative to commercially available options.

Once your pharmacist receives a prescription for a compound drug from your provider, he or she will submit the claim to Express Scripts, Inc. (Express Scripts) to conduct an electronic screening of each ingredient. If each ingredient passes the

screening, the prescription will process and you will receive your medication. If your prescription contains a non-approved ingredient, your pharmacist has the option of substituting that ingredient with an approved ingredient, or contacting your prescribing provider to request a different medication.

Your pharmacist should work with your prescribing provider and Express Scripts to determine if there is an appropriate alternative. If your provider is unable to substitute an ingredient or prescribe a different drug, he or she may request prior authorization from Express Scripts. For more information about TRICARE's coverage of compound drugs, visit www.tricare.mil/compounddrugs. ■

Shingles and Pneumococcal Vaccines

Protecting yourself from illnesses through vaccines is a lifelong process. Although many people think vaccines stop when you reach adulthood, there are certain vaccines, such as the shingles and pneumococcal vaccines, that are appropriate well into adulthood.

As you age, your immune system weakens. A weakened immune system causes the number and severity of infections to increase. Shingles, which is caused by the same virus that causes chickenpox, can be extremely painful and is most common in older adults and those with weak immune systems. If you had chickenpox, the shingles virus is already in your body, and may come back as you age. Previous infection with the virus does not mean lifelong immunity.

According to the Centers for Disease Control and Prevention (CDC), about 1 million shingles cases occur each year in the U.S. Its main symptoms are a rash, which can last up to four weeks, and pain. The pain can last for weeks, months or years after the rash is gone.

A shingles vaccine, which is given in a single dose, can provide protection against the virus and its complications. The CDC's Advisory Committee on Immunization Practices recommends the shingles vaccine for adults age 60 and older. Check with your health care provider to determine your risk and if you should be vaccinated.

Weakened immune systems also put older adults at risk of pneumococcal disease, which can cause many types of illnesses, such as pneumonia, meningitis or blood infections. According to the CDC, pneumococcal pneumonia is responsible for approximately 400,000 hospitalizations each year. The germ is spread like the flu and can be carried and spread by people without symptoms.

There are two different pneumococcal vaccines. Both vaccines protect against many types of pneumococcal bacteria and



both are recommended. The CDC recommends adults age 65 and older receive one dose of each vaccine, separated by one year. Vaccinations and recommendations vary depending on your age and health. Talk with your health care provider to determine the best plan for you.

For more information about vaccines, call the Immunization Healthcare Support Center at 1-877-GETVACC (1-877-438-8222) and select option 1 or visit www.tricare.mil/vaccines. ■

TRICARE Covers Clinical Preventive Services and Vaccines

Preventive care can help you maintain good health through early detection and treatment of disease. TRICARE covers many preventive medical services including health screenings. As a TRICARE Standard beneficiary, you can receive covered preventive medical services for no out-of-pocket cost. Visit www.tricare.mil/preventivecare for additional information. TRICARE also covers age-appropriate vaccines, including annual flu shots, as recommended by the Centers for Disease Control and Prevention. TRICARE covers a single dose of the shingles vaccine if you are age 60 or older and are not Medicare-eligible. For more information about covered vaccines, visit www.tricare.mil/vaccines. ■

TRICARE Young Adult Program Premiums for 2016

TRICARE Young Adult (TYA) Prime and TYA Standard premiums are established each calendar year. As of Jan. 1, 2016, the monthly premium rates are as follows:

TRICARE Young Adult (TYA) Plan	2016 TYA Monthly Premium
TYA Prime	\$306
TYA Standard	\$228

TYA premiums are required to cover the full cost of health care received by TYA beneficiaries. For the first time since TYA was created in 2011, there is enough cost data to set premiums based on the cost of care that TYA beneficiaries receive.

TYA offers open enrollment; if you qualify, you may purchase coverage at any time. Ongoing premiums must be paid in advance by automated electronic payment. Premiums do not count toward your deductible or catastrophic cap.

TYA is not the only health care coverage option for young adult dependents who are aging out of TRICARE. Young adults and their families should research and compare TYA with other options, such as coverage through an employer, college health plans, or plans available through the Health Insurance Marketplace at www.healthcare.gov. Premium assistance or state Medicaid coverage may be available through the marketplace based on income, family size and state of residence.

The Affordable Care Act (ACA) requires most Americans to maintain basic health coverage, called minimum essential coverage. Most people who do not meet this provision of the law will have to pay a tax penalty for each month they did not have adequate coverage. The penalty will be collected each year with federal tax returns. Please note that TYA meets the minimum essential coverage requirement under the ACA. To continue meeting the minimum



essential coverage requirement for each month of coverage, your TYA premiums must be up to date. For ACA tax questions, visit www.irs.gov/aca. For more information on TYA, including who qualifies and how to purchase coverage, visit www.tricare.mil/tya. ■

TRICARE Nurse Advice Line: Help When You Need It



All TRICARE beneficiaries in the United States can call the Nurse Advice Line 24 hours a day, 7 days a week by dialing 1-800-TRICARE (1-800-874-2273) and selecting option 1.

The Nurse Advice Line is staffed by registered nurses who answer urgent health care questions. They give beneficiaries professional health care advice to help determine if self-care is the best option or if you or your family member should see a health care provider. Pediatric nurses are available to answer questions about your child’s health and will call you back at your request if follow-up is needed. For quality and safety purposes, you will be asked to have your child present for the call so the nurse can perform an accurate assessment. The nurses can help you find the closest urgent care center or emergency room or schedule same-day appointments at military hospitals or clinics if available. If you have questions about test results or need a prescription refill, contact your primary care provider.

The Nurse Advice Line is not intended for emergencies and is not a substitute for emergency treatment. If you think you may have a medical emergency, immediately call 911 or go to the nearest emergency room. ■

Understanding Emergency vs. Urgent Care

Sometimes it is difficult to know whether to seek emergency or urgent care services. The following are examples of emergency and urgent care situations to help you identify what type of care you need. ■

Emergency Care	Urgent Care
<p>TRICARE defines an emergency as a serious medical condition that the average person would consider to be a threat to life, limb, sight or safety.</p> <p>Examples of emergencies include:</p> <ul style="list-style-type: none"> • No pulse • Severe bleeding • Spinal cord or back injury • Chest pain • Severe eye injury • Broken bone • Inability to breathe 	<p>TRICARE defines urgent care as medically necessary treatment for an illness or injury that would not result in further disability or death if not treated immediately, but that requires professional attention within 24 hours.</p> <p>Examples of urgent care include:</p> <ul style="list-style-type: none"> • Minor cuts • Migraine headache • Urinary tract infection • Sprain • Earache • Rising fever



Provider Choice under TRICARE Standard and TRICARE Extra

As a TRICARE Standard and TRICARE Extra beneficiary, you can use your TRICARE benefit without having to enroll or pay enrollment fees. TRICARE Standard and TRICARE Extra allow you to manage your own health care and give you the freedom to seek care from any TRICARE-authorized provider you choose. TRICARE-authorized providers meet TRICARE licensing and certification requirements.

The key difference between TRICARE Standard and TRICARE Extra is your choice of providers. With TRICARE Standard, you see TRICARE-authorized providers outside the TRICARE network and pay higher cost-shares. With TRICARE Extra, you see TRICARE network providers and pay lower cost-shares. Using TRICARE Extra saves you 5 percent on cost-shares. Additionally, network providers file claims for you.

Visit www.tricare.mil/findaprovider to find network and non-network providers in your region.

Invite Your Provider To Become TRICARE-Authorized

If your provider is not TRICARE-authorized but is interested in treating TRICARE beneficiaries, let him or her know that it is not necessary to sign a contract with your regional contractor to be a TRICARE-authorized provider. Most providers with a valid professional license (issued by a state or a qualified accreditation organization) can become TRICARE-authorized, and TRICARE will pay them for covered services.

To invite your provider to become TRICARE-authorized, visit www.tricare.mil/findaprovider and download a flyer to give to your provider. The flyer explains the benefits of being TRICARE-authorized and includes information about the authorization process. ■

Prior Authorizations Needed with TRICARE Standard

Under TRICARE Standard, you can visit any TRICARE-authorized provider to get routine, urgent, emergency or specialty care. Referrals are not required, but some services require prior authorization.

Prior authorization is a review of a requested health care service to determine if it is medically necessary at the requested level of care. Some providers may call your regional contractor to get prior authorization for you. The following services require prior authorization:

- Adjunctive dental services (for example, dental care that is medically necessary in the treatment of an otherwise covered medical—not dental—condition)
- Extended Care Health Option services (active duty family members only)
- Home health care services
- Home infusion therapy
- Hospice care
- Nonemergency inpatient admissions for substance use disorders or mental health care
- Outpatient mental health care visits to an authorized provider for a medically diagnosed and covered condition beginning with the ninth visit per fiscal year (Oct. 1–Sept. 30)



- Other mental health care services, such as partial hospitalization, child and adolescent psychiatric residential treatment center care and outpatient psychoanalysis
- Transplants—all solid organ and stem cell

This list is **not** all-inclusive. Each regional contractor has additional prior authorization requirements. Visit your regional contractor's website or call their toll-free number to learn about your region's requirements, which may change periodically. ■

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you the right to be informed of the privacy practices of your health plans and those of most of your health care providers, as well as to be informed of your individual rights with respect to your protected health information.

Health plans and covered health care providers are required to develop and distribute a Notice of Privacy Practices (NoPP) that provides a clear explanation of these rights and practices.

The NoPP is intended to make you aware of privacy issues and concerns, encourage you to exercise your rights and prompt you to have discussions with your health care plan administrators and health care providers.

Visit www.tricare.mil/privacy/hipaa to view the Military Health System NoPP. For other privacy concerns, call your regional contractor. ■

Report Your Other Health Insurance

TRICARE beneficiaries with other health insurance (OHI) must report their OHI coverage. OHI information is shown in the Defense Enrollment Eligibility Reporting System (DEERS). For all non-active duty service members, TRICARE is the last payer to all health care benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service and other programs and plans as identified by the Defense Health Agency. OHI applies to health care services received from civilian providers and at military hospitals and clinics.

You can report your OHI through the following:

- **Online**—Fill out your regional contractor's *TRICARE Other Health Insurance Questionnaire* at www.tricare.mil/forms or enter it into the Beneficiary Web Enrollment website at www.dmdc.osd.mil/appj/bwe.
- **By phone**—Call your regional contractor.
- **In person**—Visit your military hospital or clinic or a uniformed services identification card-issuing facility.

Follow your OHI's rules for filing claims and file your claims with your OHI first. If there is an amount your OHI does not cover, you or your provider can file the claim with



TRICARE for reimbursement. It is important you meet your OHI's requirements. If your OHI denies a claim for failure to follow its rules, TRICARE may also deny your claim. Visit www.tricare.mil/ohi for more information about using your TRICARE benefit when you have OHI. TRICARE is the sole payer for active duty service members. ■

Military/Veterans Crisis Line Connects Service Members and Veterans with Lifesaving Resources

The Military/Veterans Crisis Line connects service members and veterans in crisis, their families and friends with qualified responders from the U.S. Department of Veterans Affairs. The Military/Veterans Crisis Line offers counseling via toll-free telephone, online chat or text messaging.

Call 1-800-273-8255 and select option 1, chat online at www.veteranscrisisline.net/chat or send a text message to 838255 to get confidential support 24 hours a day, 7 days a week. Since 2007, the Military/Veterans Crisis Line has answered more than 1.6 million calls and made more than 45,000 lifesaving rescues.

If a veteran or service member you know is showing signs of crisis, such as loss of hope, anxiety or withdrawal, one conversation can open the door to support. Visit www.veteranscrisisline.net/signsofcrisis for more information. Confidential resources are just one click, one call or one text away.

Visit www.veteranscrisisline.net/spreadtheword to find out how you can help. ■

TRICARE

Standard Health Matters

TRICARE

An Excellent Value

- Generous coverage
- Superior health care
- Decisions are health driven, not insurance driven
- High satisfaction with care
- Low out-of-pocket costs
- Easy access

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TRICARE Benefit Updates

TRICARE is committed to providing you with high-quality, affordable health care choices. TRICARE honors this commitment by offering valuable new benefits and keeping you informed about changes to your coverage. Recent benefit updates follow. For more information, visit www.tricare.mil.

Over-the-Counter Drugs and Supplies

TRICARE covers certain over-the-counter (OTC) drugs and supplies with a prescription from your health care provider in the U.S. and U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands). Most covered OTC drugs and supplies are available from military pharmacies, retail network pharmacies and through home delivery. For more information, visit www.tricare.mil/otcdrugs.

Femoroacetbular Impingement

As of Jan. 1, 2016, TRICARE began offering provisional coverage of surgery for femoroacetbular impingement for all eligible beneficiaries. Prior authorization is required



for this surgery. The end date for the provisional coverage is Dec. 31, 2020. For more information, visit www.tricare.mil/provisionalcoverage. ■

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