

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

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The public reporting burden for this collection of information, 0720-0006, is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

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

PRIVACY ACT STATEMENT

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

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

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

APPLICABLE SORN: EDTMA 04, Medical/Dental Claim History Files (October 27, 2015, 80 FR 65720); <https://dpclid.defense.gov/Privacy/SORNS/index/>
[DOD-wide-SORN-Article-View/Article/570707/edtma-04/](https://www.dodig.mil/Reports-and-Testimony/Testimony/2015/04/01/2015-04-01-EDTMA-04/).

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

FRAUD NOTICE - READ CAREFULLY

Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a TRICARE/CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for TRICARE DoD/CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the TRICARE/CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

IMPORTANT - READ CAREFULLY

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

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

1. Doctor's or provider's name/address (the one that actually provided your care). If there is more than one provider on the bill, circle his/her name;
2. Date of each service;
3. Place of each service;
4. Description of each surgical or medical service or supply furnished;
5. Charge for each service;
6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.

PRESCRIPTION DRUGS: Prescription claims require the name of the patient; the name, strength, date filled, days supply, quantity dispensed, and price of each drug; NDC for each drug if available; the prescription number of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements, unless the receipt provides detailed information required above.

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

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

***** REMINDER *****

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

1. **Completed all 12 blocks on the form.** *If not signed, the claim will be returned.*
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance.
5. Attached DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity" if accident or work related. See instruction number 7 on reverse side.
6. Ensured that patient's name, sponsor's name and sponsor's SSN or DBN are on all attachments.
7. Made a copy of this claim and attachments for your records.
8. Included proof of payment for all out of pocket expenses/services received overseas. TRICARE accepts the following as proof of payment: A canceled check, credit card receipt, or electronic funds transfer (EFT) record showing the beneficiary paid the provider.

