Beneficiary Claims Correspondence Form

TRICARE West Region

Please use this form to submit requests to TriWest Healthcare Alliance if you need help with denied claims or resolving a bill received from a provider. Please provide as much information as you can to help us resolve your inquiry. Be sure to include your phone number and email in case more information is needed from you and to provide outcome of our research.

Sponsor or Beneficiary Phone Number:

Sponsor or Beneficiary Email Address:

Social Security Number (SSN) (XXX-XX-XXXX) or
Department of Defense Benefits Number (DBN) (XXXXXXXXX - XX):

Beneficiary DOB (MM/DD/YYYY):

Beneficiary First Name: Beneficiary Last Name:

Date of Medical Service(s): Claim Number:

Servicing Provider/Facility Name:

Servicing Provider Address:

Please select the type of request you need assistance with. Please be sure to include any supporting documentation with your request and an explanation for why you don't agree with the bill or claim denial.

☐ **Balance bill or collections notice received:** Share a copy of the bill and explanation of benefits with this form.

☐ **Claim denial/appeal or reconsideration:** Appeals must be in writing and meet the following criteria: Claim was denied due to TRICARE policy limitations, denied as not medically necessary, denied as not covered by TRICARE, or processed as point-of-service (POS) only when the reason for dispute is that the service was for emergency care. Please share a copy of the explanation of benefits with this form.

Signature of Patient: Date (MM/DD/YYYY):

If patient is not able to sign, a legal representative or guardian may sign below:

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian

Signature of Representative or Guardian: Date (MM/DD/YYYY):

Please mail or fax this form with any necessary supporting documentation to:

Mail: TRICARE West Beneficiary Correspondence
P.O. Box 2130
Virginia Beach, VA 23450

Fax: 866-852-1994