TRICARE West Region How to Submit a Claim, Check Claim Status, and Read an EOB

Quick Reference Guide

Key Points

- Submitting a claim
- Checking the status of submitted claims
- Selecting a preferred communication method for claims notifications
- Understanding your Explanation of Benefits (EOB)
- Special considerations regarding claims notifications
- Resources for assistance and support in resolving common claims issues

Contents

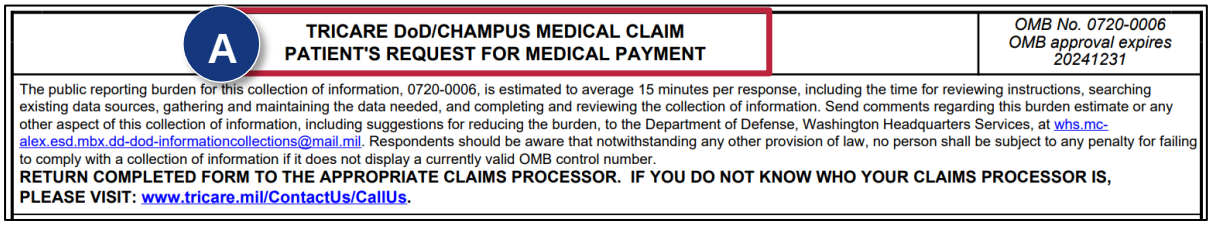
Introduction

TRICARE claims are requests for payment for services received. This quick reference guide will walk beneficiaries and their representatives through the process of submitting a claim. They will also learn how to check the status of a claim using TriWest self-service tools in the secure TRICARE West Region Beneficiary Portal. Beneficiaries will learn about reading an Explanation of Benefits (EOB) for their claims and how to resolve common claims issues.

Submitting a Claim

In most cases, your provider will submit your medical claims for you. However, there are instances where you may need to submit your own claims, such as when traveling or receiving care from a non-participating provider. If you need to submit a claim:

1. Submit a claim form to TRICARE as soon as possible after receiving care.
    - **In the U.S. and its territories:** You must submit your claim within one year of the service date.
    - **All other overseas locations:** You must submit your claim within three years of the service date.
2. Submit claims of the following types:
    - Medical
    - Pharmacy
    - Dental
    - Third-Party Liability
3. Start your claim form:
    A. Download the TRICARE Claim Form, also known as the Patient's Request for Medical Payment, DD Form 2642.
    B. Fill out all 12 blocks of the form completely.
    C. Sign the form.



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

OMB No. 0720-0006
OMB approval expires 20241231

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.

TRICARE®

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1. PATIENT'S NAME *(Last, First, Middle Initial)*

2. PATIENT'S TELEPHONE NUMBER *(Include Area Code)*
Primary ( )
Secondary ( )

3. PATIENT'S ADDRESS *(Street, Apt. No., City, State, and ZIP Code)*

4. PATIENT'S RELATIONSHIP TO SPONSOR *(X one)*
☐ SELF ☐ STEPCHILD
☐ SPOUSE ☐ FORMER SPOUSE
☐ NATURAL OR ADOPTED CHILD ☐ OTHER *(Specify)*

5. PATIENT'S DATE OF BIRTH *(YYYYMMDD)*

6. PATIENT'S SEX *(X one)*
☐ MALE ☐ FEMALE

7. IS PATIENT'S CONDITION *(X both if applicable)*
If yes, see #7 in section below
ACCIDENT RELATED? ☐ Yes ☐ No
WORK RELATED? ☐ Yes ☐ No

8a. DESCRIBE ILLNESS, INJURY OR SYMPTOMS THAT REQUIRED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.

8b. WAS PATIENT'S CARE *(X one)*
☐ INPATIENT? ☐ PHARMACY?
☐ OUTPATIENT?
☐ DAY SURGERY?

9. SPONSOR'S OR FORMER SPOUSE'S NAME *(Last, First, Middle Initial)*

10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER OR DOD BENEFITS NUMBER (DBN)

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

b. TYPE OF COVERAGE *(Check all that apply)*
☐ (1) EMPLOYMENT *(Group)* ☐ (3) MEDICARE ☐ (5) MEDICARE SUPPLEMENTAL INSURANCE ☐ (7) OTHER *(Specify)*
☐ (2) PRIVATE *(Non-Group)* ☐ (4) STUDENT PLAN ☐ (6) PRESCRIPTION PLAN

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

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

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

C

a. SIGNATURE

b. DATE SIGNED *(YYYYMMDD)*

c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN US CURRENCY?
☐ No ☐ Yes

HOW TO FILL OUT THE TRICARE/CHAMPUS FORM

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

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

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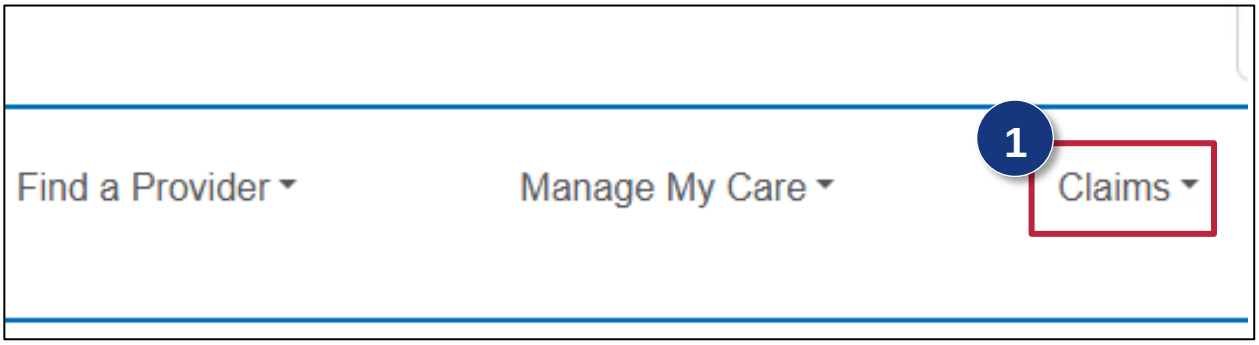
PREVIOUS EDITION IS OBSOLETE.

4. Obtain a copy of the provider's bill. Make sure the bill contains the following:
    - Sponsor's ID Number or Department of Defense Benefits Number (DBN)
    - Provider's name and address
      Note: *If more than one provider's name is on the bill, circle the name of the person who treated you.*
    - Date and place of each service
    - Description of each service or supply furnished
    - Charge for each service
    - Diagnosis
      Note: *If the diagnosis is not on the bill, be sure to complete block 8a on the form.*
5. Mail your completed claim form and provider's bill to: **TRICARE West – Claims PO Box 202160 Florence, SC 29502**. Keep a copy of all paperwork for your records.
   Note: *If submitting a claim overseas, you can submit your claim online.*

Checking the Status of a Claim

To check the status of your TRICARE claim:

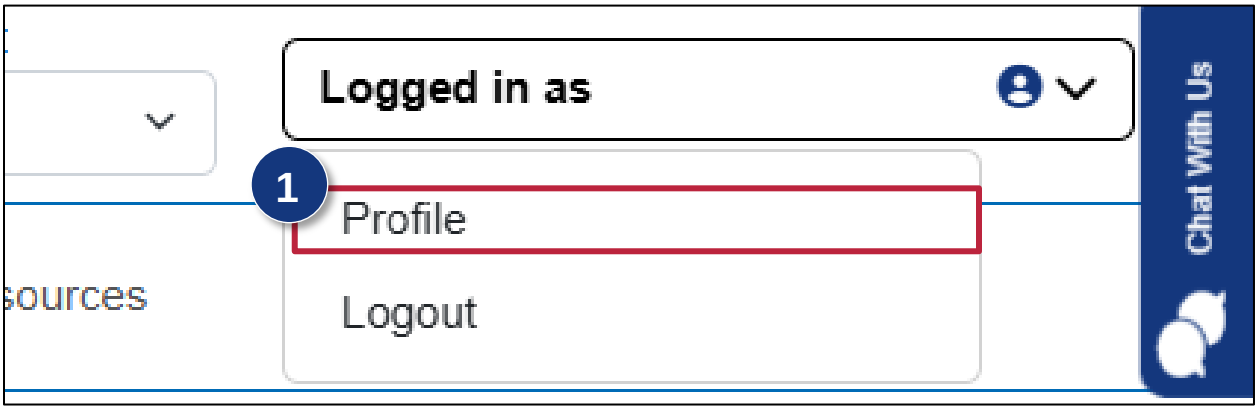
1. Within the secure, self-service West Region beneficiary portal, navigate to the **Claims** tab. Here you will be able to view the status of your submitted claims.
   Note: *If you prefer not to use online tools, you can contact TriWest customer service for assistance.*



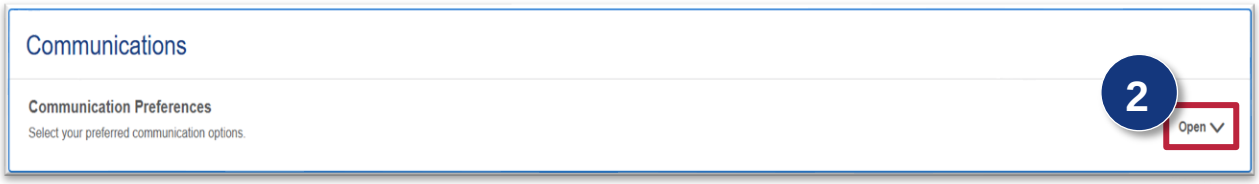
Selecting a Preferred Communication Method

To select a preferred communication method for your Explanation of Benefits (EOBs):

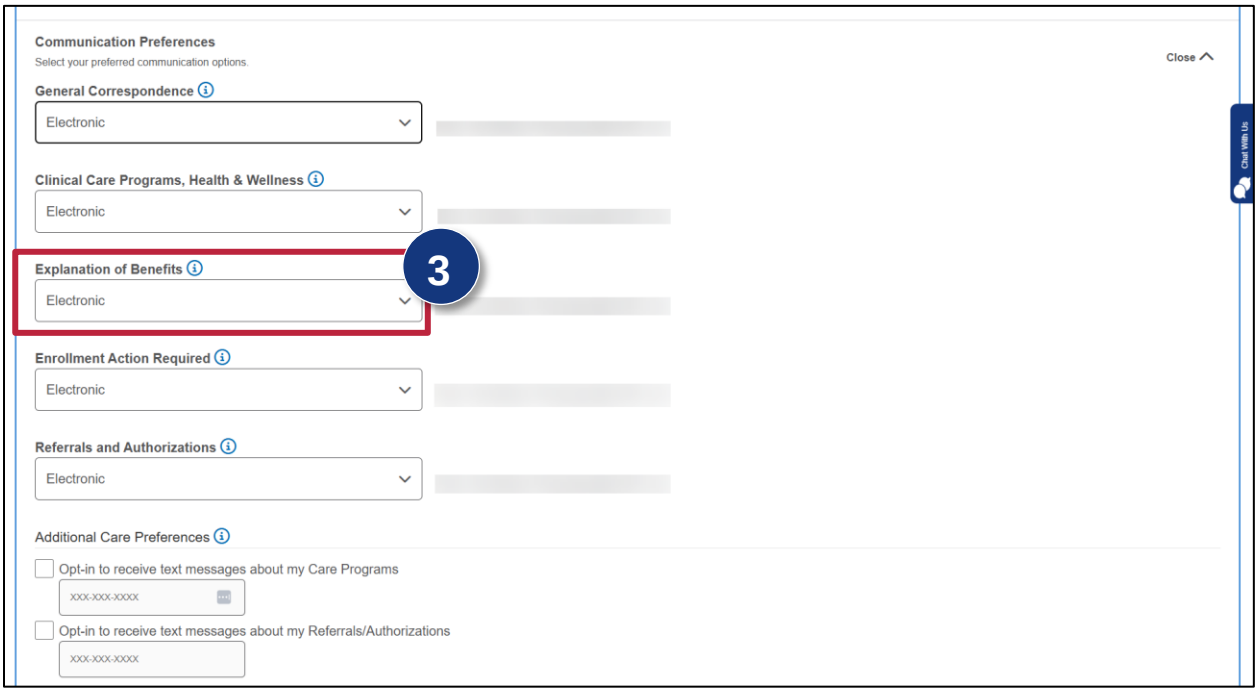
1. Select **Profile** from the **Logged in as** dropdown menu.



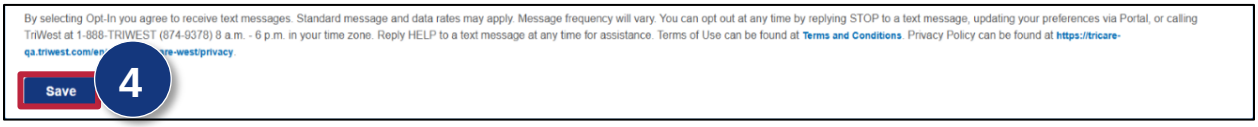
2. Select **Open** to expand the Communication Preferences section.



3. To select your preferred communication method for Explanation of Benefits notifications, use the **Explanation of Benefits** dropdown. Currently, the options are **Electronic** or **Hard Copy Mail**. ***Note:*** *An electronic version of the EOB will remain available, even if you choose to receive a hard copy by mail.*



4. Select **Save** to confirm your selection.



Understanding Your Explanation of Benefits (EOB)

TriWest will process your claim and send you an Explanation of Benefits (EOB). The EOB explains the medical treatments and services paid for on your behalf.

1. Review the following details provided on the first page of the EOB:

   A. **Claim Number:** TRICARE's tracking number for this claim submission.

   B. **Services Provided By/Date of Services:** The provider's name and date they provided service.

   C. **Services Provided:** A brief description of the service.

   D. **Amount Billed:** The total amount charged by the provider.

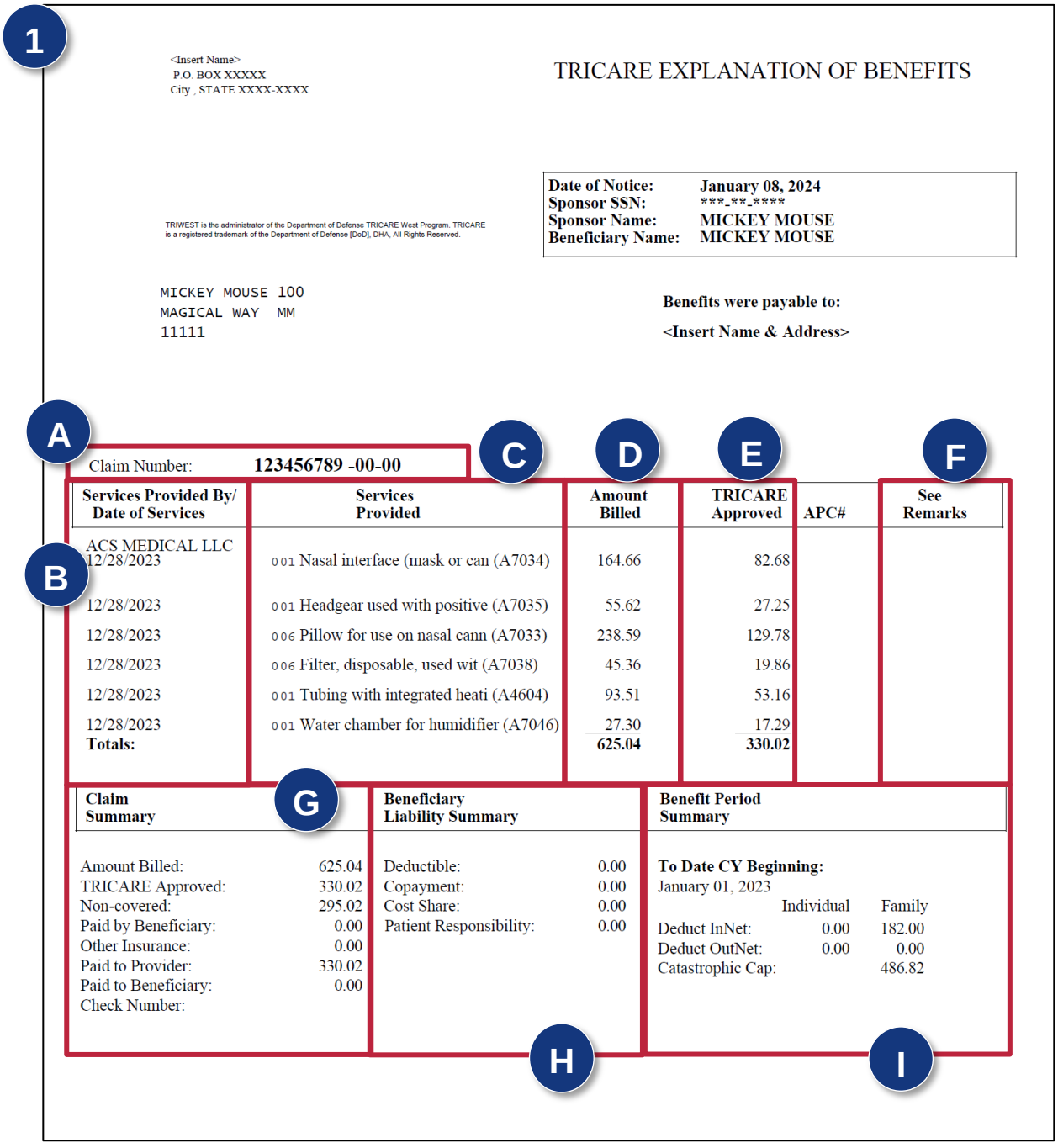
   E. **TRICARE Approved:** The amount paid by TRICARE.

   F. **See Remarks:** The remarks will include the payment or denial code, if applicable. Look for a full description at the bottom of the page. You'll see what has or has not been paid on your behalf.

   G. **Claim Summary:** The total calculations for the amount billed to TRICARE. You'll see what has been paid.

   H. **Beneficiary Liability Summary:** The amount you may need to pay.

   I. **Benefit Period Summary:** The remaining totals for deductibles and catastrophic cap.



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<Insert Name>
P.O. BOX XXXXX
City , STATE XXXX-XXXX

TRICARE EXPLANATION OF BENEFITS

Date of Notice:	**January 08, 2024**
Sponsor SSN:	***-**-****
Sponsor Name:	**MICKEY MOUSE**
Beneficiary Name:	**MICKEY MOUSE**

MICKEY MOUSE 100
MAGICAL WAY MM
11111

Benefits were payable to:

<Insert Name & Address>

A

Claim Number: **123456789 -00-00**

C D E F

Services Provided By/ Date of Services	Services Provided	Amount Billed	TRICARE Approved	APC#	See Remarks
B ACS MEDICAL LLC 12/28/2023	001 Nasal interface (mask or can (A7034)	164.66	82.68		
12/28/2023	001 Headgear used with positive (A7035)	55.62	27.25		
12/28/2023	006 Pillow for use on nasal cann (A7033)	238.59	129.78		
12/28/2023	006 Filter, disposable, used wit (A7038)	45.36	19.86		
12/28/2023	001 Tubing with integrated heati (A4604)	93.51	53.16		
12/28/2023	001 Water chamber for humidifier (A7046)	27.30	17.29		
Totals:		**625.04**	**330.02**		

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Claim Summary

Amount Billed:	625.04
TRICARE Approved:	330.02
Non-covered:	295.02
Paid by Beneficiary:	0.00
Other Insurance:	0.00
Paid to Provider:	330.02
Paid to Beneficiary:	0.00
Check Number:	

Beneficiary Liability Summary

Deductible:	0.00
Copayment:	0.00
Cost Share:	0.00
Patient Responsibility:	0.00

Benefit Period Summary

To Date CY Beginning:
January 01, 2023

	Individual	Family
Deduct InNet:	0.00	182.00
Deduct OutNet:	0.00	0.00
Catastrophic Cap:		486.82

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2. Refer to the back of your EOB for in-depth information about the following:

   A. **TRICARE Eligibility:** The requirements to be eligible for TRICARE benefits.

   B. **Timely Filing:** An overview of guidelines of the timeframe for claims to be submitted.

   C. **Grievances**: How to submit grievances regarding quality of care and service.

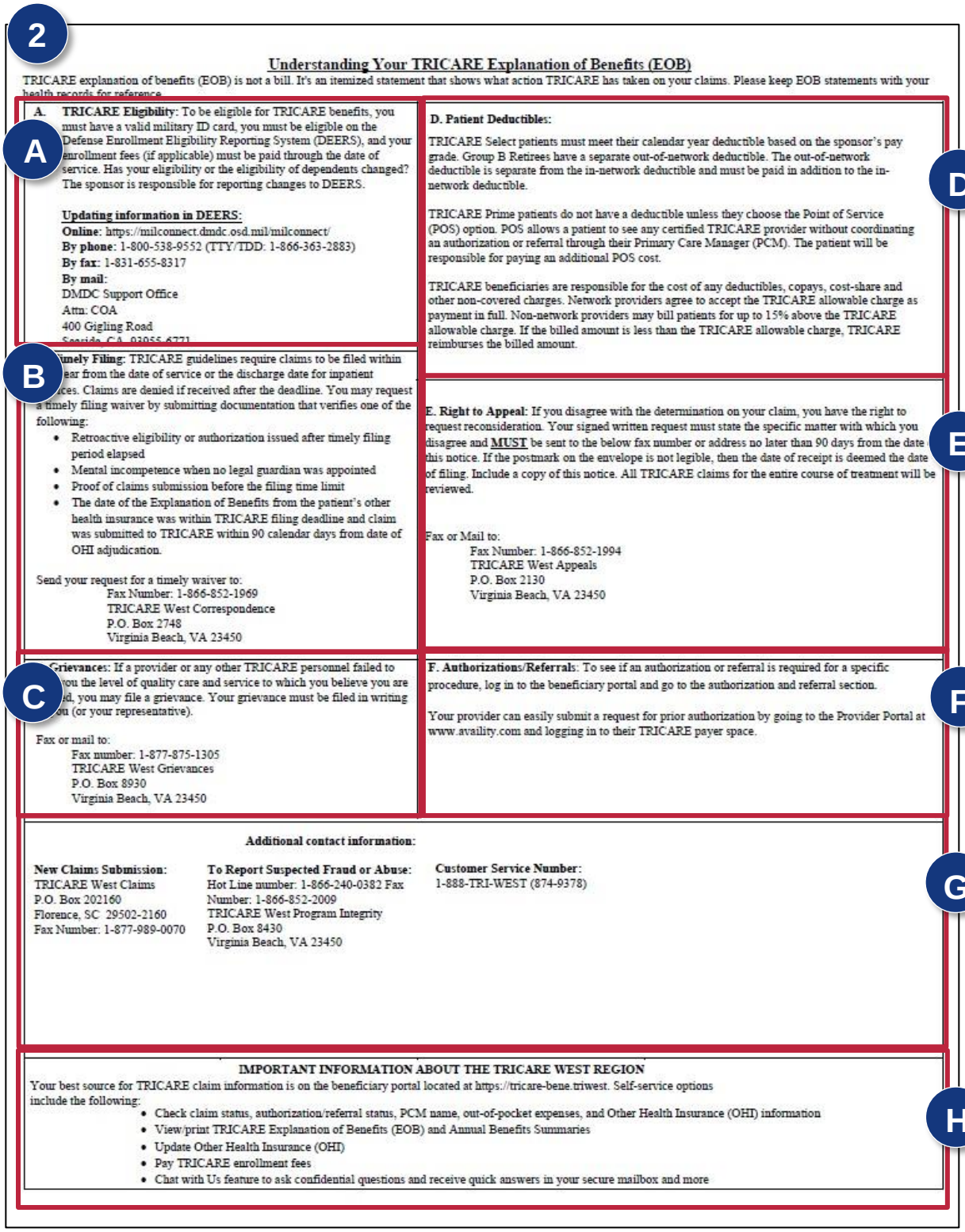
   D. **Patient Deductibles:** The rules and responsibilities of meeting deductibles for patients and beneficiaries.

   E. **Right to Appeal:** The steps to requesting a reconsideration when you disagree with the determination of your claim.

   F. **Authorizations/Referrals:** Where to view if an authorization or referral is required for a procedure.

   G. **Additional contact information:** The different methods of contact for additional support.

   H. **Important Information about the TRICARE West Region:** The link to the beneficiary portal with self-service option listed.



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Understanding Your TRICARE Explanation of Benefits (EOB)

TRICARE explanation of benefits (EOB) is not a bill. It's an itemized statement that shows what action TRICARE has taken on your claims. Please keep EOB statements with your health records for reference.

A

A. TRICARE Eligibility: To be eligible for TRICARE benefits, you must have a valid military ID card, you must be eligible on the Defense Enrollment Eligibility Reporting System (DEERS), and your enrollment fees (if applicable) must be paid through the date of service. Has your eligibility or the eligibility of dependents changed? The sponsor is responsible for reporting changes to DEERS.

Updating information in DEERS:
Online: https://milconnect.dmdc.osd.mil/milconnect/
By phone: 1-800-538-9552 (TTY/TDD: 1-866-363-2883)
By fax: 1-831-655-8317
By mail:
DMDC Support Office
Attn: COA
400 Gigling Road
Seaside, CA 93955-6771

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Timely Filing: TRICARE guidelines require claims to be filed within one year from the date of service or the discharge date for inpatient services. Claims are denied if received after the deadline. You may request a timely filing waiver by submitting documentation that verifies one of the following:

- Retroactive eligibility or authorization issued after timely filing period elapsed
- Mental incompetence when no legal guardian was appointed
- Proof of claims submission before the filing time limit
- The date of the Explanation of Benefits from the patient's other health insurance was within TRICARE filing deadline and claim was submitted to TRICARE within 90 calendar days from date of OHI adjudication.

Send your request for a timely waiver to:
Fax Number: 1-866-852-1969
TRICARE West Correspondence
P.O. Box 2748
Virginia Beach, VA 23450

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Grievances: If a provider or any other TRICARE personnel failed to provide you the level of quality care and service to which you believe you are entitled, you may file a grievance. Your grievance must be filed in writing by you (or your representative).

Fax or mail to:
Fax number: 1-877-875-1305
TRICARE West Grievances
P.O. Box 8930
Virginia Beach, VA 23450

D

D. Patient Deductibles:

TRICARE Select patients must meet their calendar year deductible based on the sponsor's pay grade. Group B Retirees have a separate out-of-network deductible. The out-of-network deductible is separate from the in-network deductible and must be paid in addition to the in-network deductible.

TRICARE Prime patients do not have a deductible unless they choose the Point of Service (POS) option. POS allows a patient to see any certified TRICARE provider without coordinating an authorization or referral through their Primary Care Manager (PCM). The patient will be responsible for paying an additional POS cost.

TRICARE beneficiaries are responsible for the cost of any deductibles, copays, cost-share and other non-covered charges. Network providers agree to accept the TRICARE allowable charge as payment in full. Non-network providers may bill patients for up to 15% above the TRICARE allowable charge. If the billed amount is less than the TRICARE allowable charge, TRICARE reimburses the billed amount.

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E. Right to Appeal: If you disagree with the determination on your claim, you have the right to request reconsideration. Your signed written request must state the specific matter with which you disagree and **MUST** be sent to the below fax number or address no later than 90 days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. All TRICARE claims for the entire course of treatment will be reviewed.

Fax or Mail to:
Fax Number: 1-866-852-1994
TRICARE West Appeals
P.O. Box 2130
Virginia Beach, VA 23450

F

F. Authorizations/Referrals: To see if an authorization or referral is required for a specific procedure, log in to the beneficiary portal and go to the authorization and referral section.

Your provider can easily submit a request for prior authorization by going to the Provider Portal at www.availity.com and logging in to their TRICARE payer space.

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Additional contact information:

New Claims Submission:
TRICARE West Claims
P.O. Box 202160
Florence, SC 29502-2160
Fax Number: 1-877-989-0070

To Report Suspected Fraud or Abuse:
Hot Line number: 1-866-240-0382 Fax
Number: 1-866-852-2009
TRICARE West Program Integrity
P.O. Box 8430
Virginia Beach, VA 23450

Customer Service Number:
1-888-TRI-WEST (874-9378)

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IMPORTANT INFORMATION ABOUT THE TRICARE WEST REGION

Your best source for TRICARE claim information is on the beneficiary portal located at https://tricare-bene.triwest. Self-service options include the following:

- Check claim status, authorization/referral status, PCM name, out-of-pocket expenses, and Other Health Insurance (OHI) information
- View/print TRICARE Explanation of Benefits (EOB) and Annual Benefits Summaries
- Update Other Health Insurance (OHI)
- Pay TRICARE enrollment fees
- Chat with Us feature to ask confidential questions and receive quick answers in your secure mailbox and more

Special Considerations

Depending on the type of data, state and federal laws protect the privacy of individuals aged twelve and older. For individuals under the age of 18, the sponsor or authorized parent will have access to their records on the portal regarding immunizations, vitals, and allergies. The non-sponsor parent can only see this information if they submit an Authorization to Disclose form and the request is approved by TriWest.

For individuals between the ages of 13 and 17, neither the sponsor nor authorized parent will be able to view the following sensitive diagnoses:

- Abortion
- Reproductive services (including contraception)
- Sexually transmitted diseases (STDs)
- Gender dysphoria
- Alcohol/substance abuse
- Substance use disorders (SUDs)
- Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)

Note: *If requested, TriWest will send a hard copy of the Explanation of Benefits (EOB) by mail if there are any sensitive diagnoses included on the EOB.*