Timely Filing Waiver Form

Use this form to determine if you qualify for a Timely Filing Waiver.

All TRICARE claims for benefits must be filed with TriWest Healthcare Alliance (TriWest) no later than one year after the date the services were provided.

Exceptions

- Were you active duty at the time of service?
- Was a retroactive eligibility/preauthorization claim determined?
- Did an administrative error occur at the time of service?
- Did you have an inability to communicate or mental incompetency without an appointed legal guardian at the time of service?
- Was there a delayed adjudication by your primary insurance?
- Did you have dual eligibility with Medicare in which Medicare accepted the claim as timely?

If you answered yes to any of the above questions you may qualify for a Timely Filing Waiver. TriWest considers claim payment for services or supplies received six years immediately after the request is submitted. TriWest will deny services or supplies claimed after the six-year period.

Fill out and submit a Timely Filing Waiver request if you qualify for one of the exceptions above. Additional information regarding filing a claim can be found at www.tricare.mil/west.

Submit Timely Filing Waiver and Claim Form

Send this waiver request with the completed claim form (DD Form 2642) via fax to 866-852-1969 or mail to:

TriWest TRICARE West Region

Beneficiary Correspondence

P.O. Box 2130

Virginia Beach, VA 23450

Agreement

Please submit a separate form for each claim review. Submission of this form is not a guarantee of claim processing or payment.

Important: Incomplete or missing information on form could result in a denial for not meeting timely filing requirements.

Patient name: _____ Patient Date of Birth (MM/DD/YYYY): _____

Patient SSN (XXX-XX-XXXX): _____ or DoD Benefits Number (DBN) (XXXXXXXXX - XX): _____

Sponsor SSN (XXX-XX-XXXX): _____ or DoD Benefits Number (DBN) (XXXXXXXXX - XX): _____

Date of Service (MM/DD/YYYY): _____ End of Service (MM/DD/YYYY): _____

Provider Name: _____

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Reason for late claim submission:

Signature of Patient/Legal Guardian

Date (MM/DD/YYYY)