



Defense Health Agency PROCEDURES MANUAL

NUMBER 6015.01
October 24, 2017

J-1/8/RMD

SUBJECT: Military Medical Treatment Facility (MTF) Uniform Business Office (UBO) Operations

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedures Manual (DHA-PM), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (ah), establishes the Defense Health Agency's (DHA) procedures to:

a. Provide guidelines for the operation of MTF UBOs. It prescribes uniform billing procedures and accounting practices for the management and follow-up of patient accounts, including collecting, depositing, posting, and reconciliation.

b. Prescribe procedures for the Third Party Collections (TPCs), Medical Services Account (MSA), and Medical Affirmative Claims (MAC) programs, such as identification of beneficiaries who have other health insurance (OHI), coordination of benefits, and recovery of claims.

2. APPLICABILITY. This DHA-PM:

a. Applies to:

(1) OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General (OIG) of the DoD, the Defense Agencies, DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this DHA-PM as the "DoD Components").

(2) Any fixed medical asset billing pursuant to Reference (d).

b. Does not apply to:

- (1) Non-fixed deployed medical assets.
- (2) DoD Component facilities not involved in direct patient care, such as:
 - (a) Medical research facilities.
 - (b) DoD Component facilities for field service.
 - (c) DoD Component facilities afloat, such as hospital ships and sick bays aboard ships.
 - (d) DoD Component tactical casualty staging facilities, medical advance base staging facilities, and medical advance base components equipped with mobile-type units.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to Reference (e), that:

a. UBOs will be established and maintained to perform health care cost recovery under the TPC, MAC, and MSA programs and report performance metrics (i.e., billing, accounts receivable, claims adjustment and remittance, and collections data) to the DHA UBO. Reference (e), also states (in Enclosure 3) that under certain conditions the DoD may provide inpatient and outpatient medical and dental care, pharmaceuticals, or durable medical equipment (DME) on a space-available basis to foreign military personnel (FMP) and their dependents.

b. FMP care may be reimbursable or at no-cost, depending on the conditions described in Reference (e).

c. FMP, and their dependents, are not eligible to enroll in TRICARE Prime, TRICARE Prime Remote, or TRICARE Young Adult, or to purchase dental coverage under the TRICARE Dental Plan.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. INFORMATION REQUIREMENTS

a. DD Form 2569, "Third Party Collection Program/Medical Services Account/Other Health Insurance," referred to in paragraphs 3l(3), 3m(1), 3q(4)(b), 3r(5), 3s(3), 3t(3), 4c(4), and 4d(3) of Enclosure 3 and the appendix to Enclosure 3 in this DHA-PM, has been assigned Office of Management and Budget Control Number 0720-0055 in accordance with the procedures in Reference (g).

b. DD Form 2570, "Third Party Collection Program - Report on Program Results" referred to in paragraphs 4j(5), 4k(3)(h), and 4l(3) of Enclosure 3 in this DHA-PM has been assigned report control number DD-HA(Q)1986 in accordance with the procedures in Reference (f).

7. **RELEASABILITY.** Cleared for public release. This DHA-PM is available on the Internet from the DHA SharePoint site at: <http://www.health.mil/dhapublications>.

8. **EFFECTIVE DATE.** This DHA-PM:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with DHA-Procedural Instruction 5025.01 (Reference (c)).



R.C. BCNO
VADM, MC, USN
Director

Enclosures

1. References
2. Responsibilities
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Glossary

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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013
- (b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, "Publication System," August 21, 2015
- (d) United States Code, Title 10, Chapter 55
- (e) DoD Instruction 6015.23, "Foreign Military Personnel Care and Uniform Business Offices in Military Treatment Facilities (MTFs)," February 23, 2015
- (f) DoD 8910.01-M, Volume 1, "DoD Information Collections Manual: Procedures for DoD Internal Information Collections," June 30, 2014
- (g) DoD 8910.01-M, Volume 2, "DoD Information Collections Manual: Procedures for DoD Public Information Collections," June 30, 2014
- (h) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
- (i) DHA Uniform Business Office Website,
<https://info.health.mil/bus/brm/ubo/SitePages/Home.aspx>
- (j) Public Law 104-191, "Health Insurance Portability and Accountability Act of 1996 (HIPAA)," August 21, 1996, as amended
- (k) Assistant Secretary of Defense for Health Affairs Memorandum, "Revision of Compliance Audit Requirements in the Department of Defense 6010.15-M, "Military Treatment Facility Uniform Business Office Manual, November 9, 2006," February 27, 2008¹
- (l) National Archives' General Records Schedule (GRS) #16, "Administrative Management Records," August 2015
- (m) DoD 7000.14-R, "DoD Financial Management Regulation (FMR)," current edition
- (n) Assistant Secretary of Defense for Health Affairs Memorandum, "Defense Health Program Accounts Receivable Policy," May 2, 2008²
- (o) Assistant Secretary of Defense for Health Affairs Memorandum, "Medical Services Account Collections Recorded in Year Received," January 6, 2015³
- (p) DoD Forms Management Program Website,
<http://www.dtic.mil/whs/directives/infomgt/forms/>
- (q) Assistant Secretary of Defense for Health Affairs Memorandum, HA Policy: 05-020, "Policy for Cosmetic Surgery Procedures in the Military Health System," October 25, 2005
- (r) Assistant Secretary of Defense for Health Affairs Memorandum, "Outpatient Medical, Dental, and Elective Cosmetic Procedure Reimbursement Rates and Guidance," current year⁴

¹ Copies may be obtained from the DHA UBO Website at <https://info.health.mil/bus/brm/ubo/SitePages/PolicyGuidance.aspx>

² Copies may be obtained from the DHA UBO Website at <https://info.health.mil/bus/brm/ubo/SitePages/PolicyGuidance.aspx>

³ Copies may be obtained from the DHA UBO Website at <https://info.health.mil/bus/brm/ubo/SitePages/PolicyGuidance.aspx>

⁴ Copies may be obtained from the DHA UBO Website at <https://info.health.mil/bus/brm/ubo/SitePages/MHSUBORates.aspx>

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- (s) Assistant Secretary of Defense for Health Affairs Memorandum, HA Policy: 08-002, “Policy for Billing for Care Furnished by Military Treatment Facilities to Federal Employees for On-the-Job Injuries and for Occupational Health,” March 26, 2008
- (t) Assistant Secretary of Defense for Health Affairs Memorandum, “Direct Care Inpatient Rates Billing Update,” current fiscal year⁵
- (u) DoD 5105.38-M, “Security Assistance Management Manual (SAMM),” October 3, 2003⁶
- (v) Treasury Financial Manual Volume 1, Part 5, Chapter 2000, current edition
- (w) United States Code, Title 37, Section 1007(c)
- (x) Assistant Secretary of Defense for Health Affairs Memorandum “Defense Health Agency Write-Off of Aged Amounts Owed to MTFs Clarification of Procedures,” July 31, 2014⁷
- (y) Code of Federal Regulations, Title 32
- (z) Office of Management and Budget, Circular No. A-129, “Policies for Federal Credit Programs and Non-Tax Receivables,” Revised January 2013
- (aa) United States Code, Title 42, Chapters 7⁸ and 32⁹
- (ab) Code of Federal Regulations, Title 28, Part 43
- (ac) United States Code, Title 31, Chapter 37, Subchapter II
- (ad) Assistant Secretary of Defense for Health Affairs Memorandum, “Policy on New TRICARE Pharmacy Copayments and Elimination of Active Duty Family Member TRICARE Prime Copayments,” March 29, 2001
- (ae) Assistant Secretary of Defense for Health Affairs Memorandum, HA Policy: 07-026, “Policy for Billing Non-Department of Defense Beneficiary Newborns,” October 26, 2007
- (af) DoD Instruction 6025.23, “Health Care Eligibility Under the Secretarial Designee (SECDES) Program and Related Special Authorities,” October 2, 2013
- (ag) Assistant Secretary of Defense for Health Affairs Memorandum, “Termination of Subsistence Surcharge for Uniformed Services Personnel Who Are Hospitalized in Military Treatment Facilities,” October 24, 2007
- (ah) Office of the Under Secretary of Defense (Comptroller) Website, <http://comptroller.defense.gov/>

⁵ Copies may be obtained from the DHA UBO Website at <https://info.health.mil/bus/brm/ubo/SitePages/MHSUBORates.aspx>

⁶ Copies may be obtained from the Defense Security Cooperation Agency Website at <http://www.samm.dsca.mil/listing/esamm>

⁷ Copies may be obtained from the DHA UBO Website at <https://info.health.mil/bus/brm/ubo/SitePages/PolicyGuidance.aspx>

⁸ Also known as “The Social Security Act”

⁹ Also known as “The Federal Medical Care Recovery Act (FMCRA)”

ENCLOSURE 2

RESPONSIBILITIES

1. SECRETARIES OF THE MILITARY DEPARTMENTS AND DIRECTOR, DHA. The Secretaries of the Military Departments and the Director, DHA, will:

a. Establish and maintain a UBO operational center for each MTF. Pursuant to Reference (e), the UBO must encompass MSA, TPC, and MAC program activities.

b. Ensure appointment, in writing, of both a primary and an alternate MSA and TPC Officer. MSA and TPC Officer positions may be held by a commissioned officer, a non-commissioned officer (NCO), or a civilian equivalent of NCO or higher. Military Department and DHA-specific guidance may require that these positions be held only by these specified persons.

c. Where possible and as resources permit, a UBO Manager may be appointed to consolidate the management of MSA, TPC, and MAC activities.

(1) The UBO Manager position may be a commissioned officer, an NCO, or a civilian equivalent of NCO or higher. Military Department and DHA-specific guidance may require that these positions be held only by these specified persons. The UBO Manager may also serve as the TPC Officer or the MSA Officer, but not both.

(2) The UBO Manager position may not be held by a contracted employee. Contracted employees may not manage MSAs nor may they supervise government employees or perform inherently governmental functions.

d. Establish and maintain a compliance program in accordance with the provisions set forth in this DHA-PM.

e. Provide a copy of all Military Department and DHA-specific guidance issued to implement the provisions set forth in this DHA-PM to DHA UBO.

f. Maintain separation of medical record coding, billing, and collection activities.

g. Ensure development of a program to achieve maximum OHI capture.

h. Develop appropriate systematic backup and change-of-command procedures for all AIS to ensure protection of claims data.

i. Compromise, settle, or waive claims, as appropriate, in compliance with existing federal laws and regulations, as well as this DHA-PM.

j. Ensure participation in joint Military Department and DHA workgroups to facilitate the systematic evaluation of policy recommendations, program changes, and AIS changes.

k. Ensure development of training programs addressing all aspects of the MTF that affect UBO operations. Training should include patient interview techniques, identification and verification of OHI, claims processing, denials management, compliance, AIS usage, and relevant provisions of Reference (h).

l. Ensure amounts collected for health care services provided at or through a facility of the uniformed services are credited to the facility's operations and maintenance (O&M) appropriation. Amounts collected for health care services must not be taken into consideration in establishing the operating budget of the facility pursuant to section 1095 of Reference (d).

2. DIRECTOR, DHA. Under the authority, direction, and control of the Assistant Secretary of Defense for Health Affairs (ASD(HA)), the Director, DHA, will:

a. Issue supplemental Military Health System (MHS) level guidance to the Military Departments and the DHA and exercise management responsibility to ensure that MTF UBO operations are cost-effective, result in maximizing authorized collections, and comply with existing federal laws and regulations.

b. Facilitate effectiveness and efficiency by providing automated information systems (AIS) that support successful management of MTF UBOs.

c. Establish a systematic process by which the Military Departments and DHA can jointly evaluate and implement policy recommendations, program changes, and AIS thereby reducing inconsistency and facilitating standardization.

d. Maintain a database of all Military Department and DHA-specific guidance issued to implement this DHA-PM and ensure that such guidance is consistent with the provisions set forth in this DHA-PM.

3. DIRECTOR, DEFENSE MANPOWER DATA CENTER (DMDC). Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, the Director, DMDC, will:

a. Establish and maintain applications and databases that support storing and sharing of health care payer and coverage information.

(1) Authorized access to these applications and databases will be given to MTFs, managed care support contractors (including pharmacy contractors), designated providers, the Pharmacy Data Transaction Service, and other MHS-designated support and contractor staff.

(2) Tools will be given to designated DHA UBO staff for maintenance of these applications and databases.

b. Provide a basic reporting capability for health care payer and coverage information, including insurance carriers and OHI policies maintained by DMDC, to DHA (including the National Capital Region Medical Directorate/J-11 (NCR MD)) and the Military Departments.

ENCLOSURE 3

PROCEDURES

1. INTRODUCTION. This enclosure outlines procedures related to MSA, TPC, and MAC program activities at MTF UBOs.

a. MSA activities involve primary payer billing of individuals and other government agencies for health care services provided by MTFs.

b. TPC activities involve billing third party payers on behalf of uniformed services beneficiaries, excluding active duty, for health care services provided by MTFs.

c. MAC activities involve billing all areas of liability insurance, such as automobile, products, premises and general casualty, homeowners', renters', medical malpractice (by civilian providers), and workers' compensation (other than federal employees). MAC includes uniformed services beneficiaries, including active duty beneficiaries.

d. Additional guidance can be found at the DHA UBO Website (Reference (i)).

2. COMPLIANCE

a. General

(1) Implementation of an effective UBO compliance program supports the MHS's overall mission of providing quality health care and preventing health care billing fraud, waste, abuse, or mismanagement of government resources.

(2) This section serves as a tool to help MTF UBOs implement effective internal controls that promote adherence to applicable federal laws and regulations and DoD guidance relating to health care.

(3) This section applies to all MSA, TPC, and MAC activities, as well as any additional health care billing activities designated by the DoD, such as resource sharing agreements between the DoD and Department of Veterans Affairs (VA).

(4) Each MTF is responsible for implementation, maintenance, and oversight of an active compliance program whether the UBO program is staffed by government personnel or civilian contractor staff.

(5) Each MTF UBO Manager, if designated at an MTF, must submit documentation of its UBO compliance program implementation plans, policies, and procedures to its respective Military Department or the NCR MD/J-11 UBO Manager based on the guidance contained in this DHA-PM and additional resource material furnished by DHA UBO.

(6) Compliance program guidance in this section is adapted from guidance issued by the Department of Health and Human Services OIG for various provider groups. Additional resources for MTF UBO compliance are available in Reference (i).

b. UBO Compliance Program Minimum Requirements

(1) To ensure an effective compliance program, each MTF must designate a UBO Compliance Officer who must be responsible for all MTF UBO compliance activities and participate in any MTF-wide compliance program.

(2) The UBO Compliance Officer should have direct access to the MTF command group.

(3) The UBO Compliance Officer may be the Chief of the Patient Administration Division (PAD), the Chief of Resource Management (RM), or a member of the MTF's Internal Review and Audit Department. These individuals have the experience and training necessary to develop an effective compliance program.

(4) At a minimum, each MTF UBO compliance program must have:

(a) Written policies and procedures to validate the MTF's commitment to compliance including:

1. UBO standards of conduct.
2. A list of known billing risk areas.
3. Claims development and submission processes.

(b) Procedures to implement the Health Insurance Portability and Accountability Act's (HIPAA) administrative simplification, privacy, standardization, and security standards. Refer to References (j) and (h) for detailed guidance.

(c) Regularly monitored education and training programs for all affected employees.

(d) Effective and efficient lines of communication.

(e) Enforcement of standards by referencing disciplinary guidelines issued by the DoD OIG, civilian law enforcement, military personnel, as well as other documented and well-publicized regulations, directives, instructions, or guidelines.

(5) The UBO Compliance Officer must conduct periodic internal compliance audits as directed by the Military Departments, DHA, MTF commanders, or directors. At a minimum, the DHA UBO Compliance Audit Checklist and Post-Submission Review Worksheet, available at Reference (i), or similar tools that incorporate the minimum DHA UBO compliance checklist requirements, must be used to perform these internal audits.

c. UBO Compliance Officer. The UBO Compliance Officer must:

- (1) Be a member of the MTF's Compliance Committee.
- (2) Oversee and monitor implementation of the UBO compliance program.
- (3) Review the UBO compliance program annually to ensure relevance and compliance with current federal laws and regulations, DoD regulations, and Military Department or DHA-specific guidance. Tools for completing the required review, including the UBO Annual Review of Compliance Program Effectiveness Checklist, are available at Reference (i).
- (4) Ensure components of the UBO compliance program are implemented to reduce fraud, waste, abuse, or mismanagement of government resources within the UBO and throughout the revenue cycle.
- (5) Make the UBO compliance plan available to the entire MTF to aid in ensuring that contractors, vendors, and agents who furnish medical services on behalf of the MTF are aware of the MTF's compliance program and its respective coding and billing policies and procedures.
- (6) Have the authority to review all documents and other information relevant to billing compliance activities.
- (7) Assist the UBO and internal review committees in conducting internal compliance reviews, including reviews of other departments involved in the revenue cycle at the MTF.
- (8) Investigate issues related to billing compliance, take corrective action, and document compliance issues as necessary.
- (9) Notify employees through training and other means of communication of applicable regulations, procedures, and guidelines, and encourage reporting of suspected fraud, waste, abuse, or mismanagement of government resources without fear of retaliation.
- (10) Report the status of the UBO compliance program, at least annually, to the MTF commander or director, who will report through the appropriate chain-of-command to the UBO Manager. Similarly, report the results of any audits, investigations concerning fraud, waste, abuse, or mismanagement of government resources, and any resulting employee discipline.

d. Compliance Auditing and Monitoring Activities

- (1) The MTF commander or director must ensure the appointment of a Compliance Officer or equivalent, outside the UBO chain-of-command, who is charged with performing compliance audits and evaluating the MTF UBO at least once each quarter. The Compliance Officer may be a commissioned officer, an NCO at the grade of E-7 or above, or a civilian of comparable grade.

(2) The Compliance Officer must use, at a minimum, the DHA UBO Compliance Audit Checklist template to perform UBO audits. The DHA UBO Compliance Audit Checklist template is available at Reference (i).

(a) Standardized key performance indicators, such as error registration rates and identified underpayments, may be used to monitor compliance and assist in the reduction of identified risks.

(b) The compliance audit must verify:

1. Internal controls have been implemented as identified in this DHA-PM and on the UBO Compliance Audit Checklist.

2. Requirements for storage and deposit of funds are met.

3. MTFs have billed insurance providers for patient encounters where OHI information exists in DoD systems (e.g., Defense Enrollment Eligibility Reporting System (DEERS), Composite Health Care System (CHCS), future electronic health records (EHRs) pursuant to Reference (k).

4. MTFs have adequately followed up on collections from insurance providers (Reference (k)).

(c) MTFs must correct deficiencies that are found during compliance audits.

(3) The Compliance Officer must maintain the original copy of the quarterly Compliance Audit Checklist and provide a copy to the UBO Manager or MSA Officer if no UBO Manager has been appointed. The UBO must maintain copies of the completed quarterly Compliance Audit Checklist for at least 5 years pursuant to Paragraph 14(f)(1) of Reference (l).

e. Responding to Detected Offenses and Developing Corrective Action Initiatives. DoD Components, the Military Departments, and DHA have procedures in place for investigating alleged noncompliance, violations of applicable federal laws, and other types of misconduct in accordance with established federal guidelines, and for reporting any offenses to the appropriate authorities. Staff responsible for conducting these investigations must send copies of all reports and subsequent actions taken to the UBO Manager or MSA Officer if no UBO Manager has been appointed.

3. MSA

a. General

(1) MSA activities include billing, recording accounts receivable, and collecting funds for medical and dental procedures furnished to uniformed services beneficiaries, civilian emergency patients, and other non-beneficiary patients authorized to receive care in an MTF.

(2) MSA activities provide a complete and reliable financial record of billing transactions, including: collections control, accounts receivable, and deposits.

(3) The MTF Treasury/Cashier office must be located in an area that is easily accessible and clearly identifiable by all patients.

(4) At branch clinics where the volume of cash transactions does not support an MSA office, the parent MTF must take collections and make deposits to the local or supporting financial services officer, defense accounting officer, disbursing officer (DO), or authorized banking facility.

(5) The MSA office must adhere to Reference (m), the same regulation directed to MSA Officers, alternate MSA Officers, collection agents, treasurers, cashiers, change fund custodians, and all other positions within the MSA office involved in collecting, recording accounts receivable, and depositing cash and other forms of negotiable instruments.

b. Appointment of the MSA Officer

(1) Pursuant to Volume 5, Chapter 2 of Reference (m), for each fixed-facility MTF where an MSA Office is established, the MTF commander or director must appoint an MSA Officer and an alternate MSA Officer in writing using DD Form 577, "APPOINTMENT/TERMINATION RECORD - AUTHORIZED SIGNATURE". The appointed MSA Officer must sign DD Form 577 in which he/she acknowledges that he/she is strictly liable to the United States for all public funds under his/her control. The appointment letter, DD Form 577, also includes a statement confirming that the individual has been counseled regarding pecuniary liability.

(2) The MSA Officer and alternate must be commissioned officers, NCOs, warrant officers, or civilian employees not otherwise accountable for appropriated funds or government property. The functions of these positions may not be performed by an individual under contract with the U.S. Government.

c. Responsibilities of the MSA Officer

(1) The MSA Officer is a collection agent of the local DO responsible for billing, recording accounts receivable, and collecting fees for health care services, materials, and subsistence provided at the MTF.

(2) Additionally, the MSA Officer must:

(a) Provide necessary information to PAD staff so that patients are adequately informed of expected inpatient hospitalization or outpatient visit charges through the initial interview, admissions process, clinic check-in, discharge interview, and marketing materials, such as inpatient and outpatient handbooks.

(b) Make every effort to collect accounts receivable before they become delinquent. Also, notify the RM officer (as required by Military Department or DHA-specific guidance) when accounts receivable become delinquent. See paragraph 3ac of this enclosure for procedures for transferring delinquent accounts receivable.

(c) Safeguard funds and controlled forms from loss or theft pursuant to Volume 5, Chapter 3 of Reference (m) if appointed as a Change Fund Custodian.

(d) Ensure storage of safeguarded forms and accuracy of records when MSA duties are delegated to other individuals.

(e) Obtain and administer a change fund if appointed as a Change Fund Custodian. The MSA Officer may not use or permit the use of undeposited collections or personal money as a change fund.

(f) Provide and maintain a change fund for dining hall collections and deposit collections to the proper appropriation in accordance with Military Department or DHA-specific guidance and if appointed as a Change Fund Custodian.

(g) Maintain an accounting record of all applicable medical and dental service charges and collections. Deposit collections as reimbursements to the proper appropriation pursuant to Reference (o).

(h) Prepare and submit financial reports in accordance with References (m) and (n).

(i) Validate deposits by a cash control machine or voucher number and the signature of the servicing finance officer.

(j) Ensure deposits agree with the automated system.

(k) Ensure postings to patient accounts equal amounts received and deposited.

(l) Establish internal controls and a separation of duties to ensure security of funds. When feasible, separate persons should be responsible for:

1. Recognizing and recording accounts receivable.

2. Collecting payments.

3. Depositing cash funds.

(m) Deposit all collections received for administrative services (e.g., copy charges) to the proper O&M appropriation (Reference (m)).

(n) Ensure billing audit controls are established to accurately bill all applicable patients for services rendered, including pay patients overseas, civilians in remote locations, and civilian emergencies.

d. Permanent Transfer of MSA Officer Responsibilities

(1) Unless otherwise directed by Military Department or DHA-specific guidance, to transfer responsibilities from one MSA Officer to another, the incumbent MSA Officer must:

(a) Post and update accounting records for all transactions up to the end of the day before the transfer and document the status in the files.

(b) Deposit all cash collections on hand in accordance with Reference (m) and guidance from the servicing accounting and finance office.

(c) Return all cash change funds to the servicing accounting and finance office, or effect transfer pursuant to DO requirements.

(d) Close the books as of the day before the transfer.

(e) Prepare and verify a statement listing all outstanding accounts receivable and a transfer certificate showing the inclusive numbers of all unused numbered or controlled forms (See Figure 1.)

<p>“I certify that, to the best of my knowledge and belief, the attached is an accurate and complete summary of all outstanding accounts receivable and an accurate listing of all forms on hand as of [time and date]. All transactions within the MSA since the last billing audit report on [date] are accurately reflected in the accounts and records of the MSA, documented by the retained and currently available copies of cash collection vouchers, accounts receivable records, cash meal logs, or other authorized vouchers. All records of the MSA are hereby transferred to my successor.”</p> <p style="text-align: right;">Signature [full name and grade of outgoing MSA Officer]</p> <p>“I hereby certify that I have examined the records of the MSA and accept accountability as of [time and date].”</p> <p style="text-align: right;">Signature [full name and grade of incoming MSA Officer]</p> <p>APPROVED: Signature [full name and grade of MTF commander or director]</p>

Figure 1. Sample Permanent Medical Services Account Officer Transfer Certificate

(2) The incumbent MSA Officer must retain a copy of the completed statements and certificates and distribute the original to the MSA files, one copy to the incoming MSA Officer, and one copy to the MTF commander or director.

(3) The incumbent MSA Officer is responsible for briefing the incoming MSA Officer.

e. Temporary Absence of the MSA Officer

(1) Unless otherwise directed by Military Department or DHA-specific guidance, when the appointed MSA Officer is absent from duty for a period of fewer than 30 calendar days, the MTF commander or director must decide if transfer of MSA responsibilities is warranted. If a transfer is warranted, the duties of the appointed MSA Officer must be either assumed by the alternate MSA Officer or delegated by the MTF commander or director to the responsible RM Officer, Comptroller, PAD Officer, or other designated representative.

(2) The appointed individual must be fully responsible and must assume the same responsibilities as the existing MSA Officer during his or her period of absence.

(3) A Temporary MSA Officer Transfer Certificate must be completed (See Figure 2.)

(4) When the designated MSA Officer will be absent for 5 calendar days or less, his or her direct supervisor assumes the MSA duties. Strict accountability of funds and controlled forms must be maintained.

<p>“I hereby certify that, to the best of my knowledge and belief, the records, balances, and supporting documents pertaining to the MSA are both true and correct. The records and accounts are hereby temporarily transferred to the Acting MSA Officer.”</p> <p style="text-align: right;">Signature [full name and grade of regular MSA Officer]</p> <p>“I hereby certify that I have examined the records of the MSA and accept accountability as of [time and date].”</p> <p style="text-align: right;">Signature [full name and grade of temporary MSA Officer]</p> <p>APPROVED: Signature [full name and grade of MTF commander or director]</p>
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Figure 2. Sample Temporary Medical Services Account Officer Transfer Certificate

f. Change Funds

(1) The MSA Officer’s change fund is provided by the local DO and all collections are deposited to the treasury account belonging to the local DO. The MSA Officer must request, in writing, initial authority from the responsible DO to maintain a change fund.

(2) The MSA Officer must request, in writing, a new and certified fund cite each fiscal year.

(3) The MSA Officer must be responsible for the change fund and for issuing required amounts to cashiers by hand receipt or a Military Department or DHA-specific form.

(4) The minimum amount of funds required to provide a separate internal MSA change fund must be maintained for each assigned, alternate, and relief cashier.

(5) The MSA Officer must ensure change funds are not used to cash personal checks, postal money orders, or other negotiable instruments for the convenience of individuals.

(6) Personal checks must only be accepted for the amount due.

(7) Change funds must not be recorded in the cash and sales journal, nor included as a part of daily receipts.

g. Minimum MSA Internal Controls

(1) The MSA Officer must establish minimum internal control procedures as listed below. The RM Officer, Comptroller, or PAD Officer responsible for UBO functions may establish additional controls as deemed necessary.

(a) Cashiers must record all accounts receivable accurately and promptly pursuant to References (m), (n), and (o).

(b) The MSA Officer must reconcile subsidiary records (e.g., invoice and receipts (I&Rs) and DD Form 1131, "Cash Collection Voucher") to the MTF Monthly Medical Services Activity Report (MMSAR).

1. The MMSAR must be forwarded to the servicing accounting and finance office, if requested.

2. System limitations may require creation and maintenance of a manual report since the MMSAR does not reflect current collections.

(c) A manual process must be used to provide receipts for collections if the billing and collection application is not functional.

3. Receipts to patients or sponsors. A manual receipt must be provided to patients or sponsors for the amounts collected. The manual receipt must identify:

a. The date of receipt.

b. The patient's name.

c. Register or account number.

d. The sponsor's patient Internal Entry Number.

e. The patient's family member prefix.

f. The amount collected (may not be blank).

g. The signature (handwritten or digital) of the MSA office cashier or collector of funds.

4. Receipts for dining facility collector of funds. A manual receipt must be provided to the dining facility collector of funds for the amount collected. The manual receipt must identify:

- a. The date of receipt.
- b. The name of the dining facility collector of funds.
- c. The meal for which the collection was made.
- d. The amount collected.
- e. The signature of the MSA office cashier or collector of funds.

5. Posting manual receipts. Post all manual receipts immediately as soon as the billing and collection application is functioning.

a. A copy of all manual receipts must be attached to the Cash Collection Detail Report reflecting that the collection has been posted to the billing and collection application and retained by the MSA Officer.

b. If the billing and collection application is not functional at the end of the workday, all manual receipts must be held in the cashier's safe or lock box until the application is functional and the collection can be properly posted.

c. When feasible, the MSA Officer may not also be the cashier. A separation of duties is necessary to ensure the integrity of the accounts. When feasible, separate persons should be responsible for:

1. Recognizing and recording accounts receivable.
2. Collecting payments.
3. Depositing cash funds.

d. Cashiers and alternates must be assigned, in writing, and approved by the responsible RM Officer, Comptroller, or PAD Officer.

e. The MSA Officer must advance a change fund to each cashier and ensure that appropriate documentation is signed by the cashier and retained by the MSA Officer as evidence of accountability for the cash.

1. The MSA Officer must assign separate change funds and lock boxes to alternate or relief cashiers.

2. The MSA Officer must obtain receipt for permanent change funds issued to permanent cashiers.

3. All cashiers must ensure change funds are secured in a location where unauthorized persons cannot access them.

4. If more than one person has access to the safe where funds are kept, each responsible person must have an individual lock box for storage inside the safe.

f. Each cashier must retain and safeguard I&Rs and other voucher forms generated for the collection transactions he/she processes.

g. The MSA Officer must maintain documentation when transferring cash and vouchers to a cashier and account for returned vouchers.

1. New receipts must be used whenever a change of cashier takes place during the day.

2. Numbered vouchers transferred to the cashier must be identified by serial or account numbers.

h. Cashiers must settle the account with the MSA Officer by turning over the cash collections and receipt vouchers at the end of the day or when relieved during the day. The MSA Officer must verify that the change fund remaining in the cashier's cash box agrees with the receipt for the fund.

i. Cashiers must use separate I&Rs for foreign currency.

j. Collections and settled accounts must be handled as outlined in this section. However, daily verification of change funds is not required.

k. At least once a month, the MSA Officer must perform an unannounced audit of all funds entrusted to permanent cashiers.

h. Responsibility for Loss of Funds and Action to Be Taken

(1) MSA Officers must not procure surety bonds with appropriated funds.

(2) MSA Officers must not be required to provide bonds at their personal expense.

(3) The absence of bond coverage does not relieve custodians of responsibility for funds, patient valuables, or financial liability in case of loss.

(4) Anyone discovering a loss or deficiency of government funds, vouchers, or papers must immediately advise the MTF commander or director in writing.

(a) The MTF commander or director will submit a request for an investigation from the base or post.

(b) If a loss occurs, the appropriate action to be taken will be consistent with the procedures outlined in Volume 5, Chapter 6 of Reference (m).

i. Commingling of Funds

(1) MSA funds and records may not be mixed with other patient account funds and records, including, but not limited to, TPC and MAC.

(2) Charity drive funds, lost and found currency, and imprest funds must not be held by the MSA Officer.

j. Appropriation Reimbursements and Rates

(1) The O&M account of the MTF or another appropriation account must be reimbursed for the cost of providing medical services and subsistence to patients.

(2) Refer to the patient category (PATCAT) table (or future EHR solution) for appropriate rates and modes of payment and validate the correct PATCAT (or future patient classification) is assigned. The current PATCAT table (or future EHR solution) is available in Reference (i).

(3) Depending on the patient, a subsistence rate (SR), family member rate (FMR), interagency rate (IAR), international military education and training (IMET) rate, interagency/other federal agency sponsored rate (IOR), full outpatient reimbursement rate (FOR), full reimbursement rate (FRR), or other rates specified in the PATCAT table (or future EHR solution) for patient encounters will be charged. See paragraphs 6 and 7 of this enclosure for more detail on UBO rates. Current medical, dental, and elective cosmetic surgery rates and related policies are available at Reference (i).

(4) Use DD Form 7, "Report of Treatment Furnished Pay Patients – Hospitalization Furnished (Part A)," DD Form 7A, "Report of Treatment Furnished Pay Patients – Outpatient Treatment Furnished (Part B)" or Standard Form (SF) 1080, "Voucher for Transfer Between Appropriations and/or Funds" for interagency billing. The forms may be collected locally by the MSA office or centrally by the Military Department or NCR MD/J-11. Current versions of all forms are available at the DoD Forms Management Program Website, <http://www.dtic.mil/whs/directives/infomgt/forms/> (Reference (p)).

k. Accounts Receivable

(1) Pursuant to Volume 4, Chapters 1 and 3 of References (m) and (n), the MSA office must ensure an accounts receivable is recognized (i.e., established) and recorded (i.e., posted) for all health-related services and goods provided requiring payment from others. If payment is not received when a right to payment is established, all accounts receivable must be aged pursuant to

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provisions provided by the Under Secretary of Defense (Comptroller)/Chief Financial Officer (USD(C)/CFO), DoD. See References (m) and (n) for more detailed information.

(2) Payments to the MTF must be received only via acceptable forms of payment as described in paragraph 3y of this enclosure.

(3) Pursuant to sections 1079(a) and 1095 of Reference (d), as well as Reference (o), all monies collected from non-Federal entities, including refunds, must be credited to the appropriation available for the fiscal year in which the amount is collected.

(4) A separation of duties is required for processing and recording accounts receivable activities. When feasible, separate persons should be responsible for:

(a) Recognizing and recording accounts receivable.

(b) Collecting payments.

(c) Depositing cash funds.

1. General Billing Procedures

(1) MSA staff must ensure a bill is generated for each MSA billable patient.

(2) The PATCAT table (or future EHR solution) indicates appropriate patient billing categories, mode of payment, billing rates, and applicable billing forms for certain categories of patients. The current PATCAT table (or future EHR solution) is available at Reference (i).

(3) Patient OHI data (e.g., completed and signed DD Form 2569 or approved 2569 compliance card) must be captured immediately upon arrival for an outpatient appointment, ambulatory procedure visit (APV), or inpatient admission.

(4) Upon discharge, inpatients with charges due (e.g., subsistence or the FMR) must have the opportunity to pay their bill or elect other payment arrangements. The MTF must advise active duty family members not enrolled in TRICARE Prime, family members of retirees, and survivors, in writing, of their obligation to pay the FMR (if they do not pay upon discharge). The MSA office must ensure procedures are in place for patients discharged after normal duty hours.

(5) Payment arrangements for pay patients may be made in accordance with Military Department or DHA-specific guidance implementing References (m) and (n).

m. Billing Procedures – I&R

(1) The I&R serves as an invoice and subsequent receipt for patients, and due process begins on the date printed on the I&R. It shows the charges billed for health care services

rendered and subsistence, as well as payments made on the account (See Figure 3 of this enclosure for a sample I&R).

(a) The I&R serves as a record of cash receipts and as an accounts receivable record for local collections.

UNIFORM BUSINESS OFFICE										
AMC WILLIAM BEAUMONT 5005 N PIEDRAS EL PASO TX 79920 915-742-4342 NPT 2:1295838787				I&R #: G0108-16-000036 Date: 05/11/2016		Tax ID: 741146946				
Invoice & Receipt										
SPONSOR NAME 1234 MAIN STREET EL PASO TX 79938			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Payment</td> <td>WILLIAM BEAUMONT ARMY MEDICAL CENTER 5005 N. PIEDRAS ST</td> </tr> <tr> <td>Remittance Address</td> <td>ATTN: MCHM-RMD-HT EL PASO TX 79920</td> </tr> </table>				Payment	WILLIAM BEAUMONT ARMY MEDICAL CENTER 5005 N. PIEDRAS ST	Remittance Address	ATTN: MCHM-RMD-HT EL PASO TX 79920
Payment	WILLIAM BEAUMONT ARMY MEDICAL CENTER 5005 N. PIEDRAS ST									
Remittance Address	ATTN: MCHM-RMD-HT EL PASO TX 79920									
Patient IEN: 987654 FMP/Patient Name: 20/Patient Name			Balance Due: <u>06/10/2016</u> Amt: <u>\$57.47</u>							
Date of Service	Description	Qty	Charges	Payment/ Adjustment Date	Payment/ Adjustment	Running Balance				
09/17/2015	AMC WILLIAM BEAUMONT/160108S0000398 EMERGENCY SERVICES	1	57.47			57.47				
Balance Due: 06/10/2016						\$57.47				
<p>According to our records, you, or a person assigned under your sponsorship, received health care services as listed above. Payment of this invoice is due upon receipt. If you or your family member has Health Insurance or information concerning a third party payer of your services, please complete DD Form 2569 (http://www.dtic.mil/whs/directives/forms/eforms/dd2569.pdf) and submit it to the Uniform Business office (UBO) within 10 business days.</p> <p>You have the right to inspect and copy government records related to these charges and request a review of how we determined your charges; however, this request does not alleviate your financial responsibility. U.S. Code of Federal Regulation (CFR), Title 45, Part 164 permits the use and disclosure of Protected Health Information to carry out treatment, payment, or health care operations. The Military Health System (MHS) Notice of Privacy Practices (NoPP) can be found at: http://www.health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/HIPAA-Compliance-within-the-MHS/Notice-of-Privacy-Practices. Your Personally Identifiable Information is protected under the U.S. Code (USC), Title 5, Section 552a. If you make or provide any knowingly false or frivolous statements, representations, or evidence, you may be liable for penalties under the False Claims Act, USC, Title 31, Sections 3729-3731 and criminal penalties under USC, Title 18, Sections 286-287 & 1001-1002, and/or other applicable statutes.</p> <p>In accordance with the Debt Collection Improvement Act (DCIA) of 1996 and CFR, Title 31, Part 901, the Department of Defense (DoD) medical treatment facility (MTF) UBO is required to promptly collect any debt owed to the United States. Any unpaid balances are subject to referral to a higher authority for collection action; in order to avoid interest, penalty and administrative fees, this invoice must be paid in full no later than the date listed above. If you are unable to pay the debt in full by the date shown, please contact the UBO to discuss any possible payment agreement options.</p> <p>Payment Options for the UBO are listed below: Pay.gov – https://www.pay.gov/public/form/start/68775422 Check – please make checks payable to U.S. TREASURER and mail to the remittance address above. Credit/Debit Cards – please call 915-742-2159 PayPal – https://www.pay.gov/public/form/start/68775422</p>										

Figure 3. Sample Invoice and Receipt (See Above)

(b) For the hospital dining facility or Nutritional Medicine Service officer, the I&R serves as a receipt for cash collected and is turned into the MSA office.

(c) The I&R may also serve as a receipt for completed cash meal logs and dining hall signature records returned to the MSA office.

(2) The MSA office must ensure that an I&R is on file or established in the automated system for each patient who has been charged for medical services or subsistence. The MSA office must compare I&Rs on file or in the automated system with the admissions and dispositions report.

n. DD Form 139, "Pay Adjustment Authorization". The MSA office must always attempt to collect payment from the patient at time of the outpatient appointment or upon hospital discharge.

(1) Voluntary Pay Deduction. If a Military Service member voluntarily consents to payroll deduction, MSA staff must prepare a DD Form 139 with the following statement: "The charges are for [outpatient health care services or hospitalization] of [Patient Name] for the period [outpatient date of service or admission and discharge dates and times]." The most current version of DD Form 139 is available at Reference (p). (See Figure 4 below for a sample consent statement for voluntary pay deduction.)

<p>I hereby certify that I am not able to make payment directly to the military treatment facility for charges in the amount of [\$ total amount due]. I am requesting and consenting to immediate collection of these medical care charges from my pay and understand the collection must be a one-time deduction.</p> <p>Patient's Name _____</p> <p>Date and Time of Admission _____</p> <p>Date and Time of Discharge _____</p>

Figure 4. Sample Consent Statement for Voluntary Deduction from Pay

(a) The DD Form 139 and a signed consent statement must be forwarded to the Service member's servicing accounting and finance office no later than the next duty day.

(b) If the member is scheduled to separate from military service within 30 calendar days of inpatient hospital discharge or outpatient date of service, notify the servicing accounting and finance office of the projected separation date.

(2) Involuntary Pay Deduction. If the Service member does not elect voluntary payroll deduction, the MSA Officer must advise the Service member that charges owed will be deducted from his or her pay if payment is not received by the due date on the I&R.

(a) No consent statement is required if pay deduction is involuntary due to account delinquency in accordance with guidance provided in Reference (m).

(b) Volume 16, Chapter 2 of Reference (m), provides guidance on how to proceed with a deduction from pay without a Service member's consent.

(3) Receipt of Funds from Payroll Deduction. The payroll office will remit funds collected via payroll deduction to the MSA office by check (or composite check for several deductions) that the MSA office must deposit in the appropriate O&M account. Alternatively, if a complete fund cite is provided on the DD Form 139, the appropriate O&M account will be credited via payroll voucher. In the case of deposit via payroll voucher, the MSA office will only receive a list of deductions credited.

o. Elective Cosmetic Surgery

(1) Pursuant to Reference (q), only TRICARE eligible beneficiaries who will not lose TRICARE eligibility for at least 6 months may receive elective cosmetic surgery in an MTF.

(2) Reference (q) does not pertain to medically necessary or reconstructive surgery procedures.

(3) Elective cosmetic surgery rates are included in Reference (r). Charges for each procedure must be calculated by MSA staff using the DHA UBO Cosmetic Surgery Estimator for the current year.

(4) Only the procedures listed on the DHA UBO Cosmetic Surgery Superbill associated with the Cosmetic Surgery Estimator for the current year may be billed as elective cosmetic surgery. The current version of the DHA UBO Cosmetic Surgery Superbill is available at Reference (i).

(5) All patients, including active duty, are responsible for the cost of implant(s), cosmetic pharmaceuticals, and elective cosmetic surgery procedures at the rate applicable at the time of payment.

(6) Charges for all elective cosmetic surgery services must be paid in advance. Procedures may not be scheduled until the total estimated charges are paid and the patient has signed a letter acknowledging financial responsibility for any additional charges. The original letter must be maintained in the patient's file in the MSA office with all other relevant documentation.

(7) Records for each elective cosmetic surgery encounter must be reconciled after the date of surgery to ensure that advance payments made match services rendered. Patients must be billed for any additional procedures, supplies, pharmaceuticals and applicable ancillary services rendered that were not part of the patient's initial prepayment. Similarly, a refund may be necessary if reduced services are provided.

(8) Additional elective cosmetic surgery information and resources are available in Reference (i).

p. Billing Patients Who Do Not Present Authorized Proof of Eligibility for Care

(1) If a patient does not present an identification card or authorized proof of eligibility for care, a statement of eligibility form must be completed for the patient before treatment is rendered and then forwarded to the MSA office.

(2) For any treatment, the patient has 30 calendar days from inpatient hospital discharge or outpatient date of service to present documentation of eligibility for care. Otherwise, the MSA office must bill the patient as a non-uniformed services beneficiary at the appropriate FOR or FRR using an I&R.

(3) If the patient or sponsor furnishes proof of eligibility for care to the PAD office or MSA office after the bill is generated and within 30 calendar days of inpatient hospital discharge or outpatient date of service, void the I&R.

q. Billing for Trauma Care and “Other Medical Care” Provided to Civilians

(1) Except in cases where another government agency is the payer and circumstances involving IMET, foreign military sales, or the North Atlantic Treaty Organization as provided in paragraphs 3v and 3x of this enclosure, MTFs must charge civilian patients who are not eligible beneficiaries (or as a courtesy their insurers on behalf of these patients) reasonable charges, as determined by the Secretary of Defense, for trauma and other medical care provided. (See Figure 5 for an example of “other medical care.”)

A civilian visiting a military installation suffers a broken leg while on the installation; the patient would receive stabilizing medical care.

Figure 5. Example of “Other Medical Care”

(2) MTFs retain and use the amounts collected for trauma consortium activities, readiness training, and administrative, operating, and equipment costs.

(3) A “reasonable charge” is a fee that usually covers the cost of medical care but does not generate a profit.

(4) The TPC program does not apply to civilian patients who are not eligible beneficiaries.

(a) Civilian emergency patients are treated at their own expense and billed at the appropriate FOR or FRR using an I&R.

(b) The MSA Officer should ensure that either a hard copy or electronic version of a DD Form 2569 (see the appendix to this enclosure), or an approved DD Form 2569 compliance

card is completed and signed, or evidence of OHI discovery is available for non-uniformed services beneficiary patients to identify whether or not the patient has OHI/other health care coverage. DD Form 2569 serves as both an assignment of benefits and authorization to release medical information. The most current version of DD Form 2569 is available at Reference (p). DoD may conduct OHI/other health care coverage discovery on non-uniformed services beneficiary patients, but a signed DD Form 2569 (hard copy or electronic version) is still required as the assignment of benefits and authority to release medical information for these patients.

(c) The MTF is not required to file a claim directly with the civilian patient's insurance company but may do so as a courtesy to the patient at his/her request, unless the Military Department, or NCR MD/J-11, responsible for the MTF providing the care has directed otherwise.

(d) If the MTF files an insurance claim as a courtesy on the civilian patient's behalf, the MSA office must:

1. Send a follow-up letter after 30 calendar days from the date the I&R was generated.
2. Advise the patient that he or she is personally liable for any amounts not paid by the third party payer within 60 calendar days of the due date on the payer's I&R.
3. Transfer the account to the patient, upon completion of due process pursuant to Reference (m), if no payment is received from the third party payer. If payment is received from the third party payer after transfer, the MSA Officer must immediately contact the appropriate office in accordance with Military Department or DHA-specific guidance to discuss reimbursement options.

r. Billing Patients Who Are Not Uniformed Services Beneficiaries But Are Eligible to Receive Care

(1) A statement of eligibility form must be completed before the patient receives treatment and then forwarded to the MSA office.

(2) For a complete listing of patients eligible to receive care, refer to the PATCAT table (or future EHR solution). The current PATCAT table (or future EHR solution) is available at Reference (i).

(3) Examples of patients who are not uniformed services beneficiaries but are eligible to receive care to the extent specified in the action creating that eligibility are:

- (a) State Department employees and their dependents.
- (b) Contractors and some federal employees overseas and in remote areas.

(c) Civilian employees and their dependents paid from non-appropriated funds (NAFs).

(d) United States Family Health Plan enrollees.

(e) Civilian emergencies as a result of natural or national disasters in accordance with policies promulgated by the Federal Emergency Management Administration (FEMA). During a natural or national disaster, MTFs may be required to furnish health care to patients not otherwise authorized to receive care in an MTF. These patients may be directed to the MTF by the National Disaster Medical System, or they may be part of a FEMA mission assignment.

(4) Medical record coding must be completed before the patient receives the final bill.

(5) The MSA Officer should ensure that either a hard copy or electronic version of a DD Form 2569 (see the appendix to this enclosure), or an approved DD Form 2569 compliance card is completed and signed, or evidence of OHI discovery is available to identify whether or not the patient has OHI/other health care coverage. DD Form 2569 serves as both an assignment of benefits and authorization to release medical information. DoD may conduct OHI/other health care coverage discovery on non-uniformed services beneficiary patients who are eligible to receive care, but a signed DD Form 2569 (hard copy or electronic version) is still required as the assignment of benefits and authority to release medical information for these patients.

(a) The MTF is not required to file a claim directly with the patient's insurance company but may do so as a courtesy to the patient at his/her request; unless the Military Department, or NCR MD/J-11, responsible for the MTF providing the care has directed otherwise.

(b) If the MTF files an insurance claim as a courtesy on the patient's behalf, the MSA office must:

1. Send a follow-up letter after 30 calendar days from the date the I&R was generated.

2. Advise the non-uniformed service beneficiary that he or she is personally liable for any amounts not paid by the third party payer within 60 calendar days of the due date on the payer's I&R.

(c) The MTF should obtain a signed statement from the patient acknowledging his or her indebtedness to the MTF. The patient must be asked to notify the MSA office of any change of address.

(d) The MSA Officer must retain the signed statement acknowledging a debt with the I&R in the active accounts receivable file until the account has been paid in full.

(6) If no payment is received from the third party payer, the MSA Officer must transfer the account to the patient, upon completion of due process pursuant to Reference (m). If

payment is received from the third party payer after transfer, the MSA Officer must immediately contact the appropriate office in accordance with Military Department or DHA-specific guidance to discuss reimbursement options.

s. Billing for Emergency Services on Behalf of Non-Uniformed Services Medicare Enrollees

(1) MTFs may bill non-uniformed services Medicare enrollees directly for emergency treatment at the appropriate FOR or FRR based on Military Department and NCR MD/J-11-specific guidance. In the alternative, they may participate in Medicare or elect to enroll as nonparticipating providers for certain emergency care and submit claims to Medicare for care provided to these Medicare enrollees within the Continental United States based on Military Department and NCR MD/J-11-specific guidance. In either case, participating or electing to submit claims to Medicare: the MTF must follow Medicare rules; bill Medicare at the IAR/IOR; submit all claims for Medicare patients to Medicare for the calendar year; and agree to accept Medicare reimbursement. Also, in either case, the MTF should bill the patient for any Medicare authorized deductibles and co-payments.

(2) Except for the cases of participating providers, Medicare will not cover non-emergency follow-up treatment furnished by an MTF.

(3) All non-uniformed services Medicare enrollees should complete either a hard copy or electronic version of a DD Form 2569 (see the appendix to this enclosure), which contains his/her assignment of benefits required for the MTF to receive Medicare reimbursement. DoD may conduct OHI/other health care coverage discovery on Medicare enrollee patients, but a signed DD Form 2569 (hard copy or electronic version) is still required as the assignment of benefits and authority to release medical information for these patients. If the MTF determines that the patient is insured by a third party payer in addition to Medicare, that payer should be billed at the appropriate FOR or FRR before billing Medicare at the IAR/IOR.

(4) The MSA office must prepare the appropriate claim format (Uniform Bill (UB)-04/837I or Centers for Medicare and Medicaid Services (CMS) Form 1500/837P) and submit it to the appropriate Medicare carrier or fiscal intermediary (FI). Submission is based on the MTF's geographical location and must be completed in accordance with Medicare rules and Military Department or DHA-specific guidance.

t. Billing State Agency-Sponsored Programs

(1) MTFs may bill non-uniformed services State Agency-Sponsored Program beneficiaries (e.g., Medicaid enrollees) directly for emergency treatment at the appropriate FOR or FRR based on Military Department and NCR MD/J-11-specific guidance. In the alternative, they may participate in these programs (e.g., Medicaid, Victims of Crime) or elect to enroll as nonparticipating or out-of-network providers for certain emergency care and submit claims to the State Agency based on their Military Department and NCR MD/J-11-specific guidance. In either case, participating or electing to submit claims as nonparticipating or out-of-network providers, MTFs must follow State Agency and Military Department or DHA-specific guidance for filing claims.

(2) The MSA office must bill the non-uniformed services State Agency enrollee patient, or State Agency-Sponsored Program on his/her behalf at the appropriate FOR or FRR.

(3) All non-uniformed services patients eligible for compensation by State Agency programs should complete either a hard copy or electronic version of a DD Form 2569 (see the appendix to this enclosure), which contains his/her assignment of benefits required for the MTF to receive reimbursement. DoD may conduct OHI/other health care coverage discovery on State Agency-Sponsored patients, but a signed DD Form 2569 (hard copy or electronic version) is still required as the assignment of benefits and authority to release medical information for these patients. If the MTF determines that the patient is insured by a third party payer in addition to a State Agency program, that payer should be billed at the appropriate FOR or FRR before billing the State Agency program at the FRR or FOR.

(4) In the case of State Agency-Sponsored Programs, if the program's allowable payment is less than the billed amount, payment received equal to the program's allowable payment must be accepted as payment in full. Do not bill the patient for the difference between the program's allowable payment and the billed amount.

(5) The MSA office must provide the patient a bill for services rendered.

(6) The MSA office must follow guidance for uncollected debt as outlined in References (m) and (n).

u. Billing for Care Furnished for On-the-Job Injuries

(1) Workers' Compensation in General. The MSA office must refer to State or other applicable Federal regulations governing workers' compensation.

(a) The individual with oversight of MSA, TPC, and MAC programs must ensure the timely completion of forms required by the health care provider on a workers' compensation claim, as required by the insurer, payer, and Workers' Compensation Board.

(b) Refer to Reference (s) for detailed information regarding billing procedures for workers' compensation and occupational health services. A summary of billing procedures for workers' compensation and occupational health services is provided in Table 1 of this enclosure.

(2) Workers' Compensation Involving DoD Beneficiaries. Workers' compensation cases are covered under both MSA and MAC programs.

(a) Civilians are covered under MSA.

(b) Uniformed services active duty, retired members, and all eligible family members are covered under MAC.

(3) Workers' Compensation Involving DoD Employees

Table 1. Workers' Compensation Patient Category (or future patient classification) Billing Process

	DoD NAF Employee (Non-Uniformed Services Beneficiary)	DoD NAF Employee (Uniformed Services Beneficiary)	Appropriated Fund DoD Employee (Non-Uniformed Services Beneficiary)	Appropriated Fund DoD Employee (Uniformed Services Beneficiary)	Other Federal Agency (Non-Uniformed Services Beneficiary)	Other Federal Agency (Uniformed Services Beneficiary)
Occupational Health (Initial Care)	Bill NAFIs at IAR	Bill NAFIs at IAR	No Bill	No Bill	Bill NAFIs at IAR	Bill NAFIs at IAR
Occupational Health (Follow-up Care)	Bill NAFIs at IAR	Bill NAFIs at IAR	No Bill	No Bill	Bill NAFIs at IAR	Bill NAFIs at IAR
Workers' Compensation (Initial Care)	Bill NAFIs at IAR	Bill NAFIs at IAR	No Bill	No Bill	Bill NAFIs at IAR	Bill NAFIs at IAR
Workers' Compensation (Follow-up Care)	Bill NAFIs at IAR	Bill NAFIs at IAR	No Bill	No Bill	Bill NAFIs at IAR	Bill NAFIs at IAR
Non-Work-Related Care	Bill Employee	Do Not Bill Employee (Collect OHI Information and Bill Accordingly)	Bill Employee	Do Not Bill Employee (Collect OHI Information and Bill Accordingly)	Bill Employee	Do Not Bill Employee (Collect OHI Information and Bill Accordingly)

(a) Do not bill appropriated funds for initial or follow-up medical care for work-related injuries or illnesses.

(b) Bill the non-appropriated fund instrumentality (NAFI) at the IAR for initial and follow-up medical care for work-related injuries or illnesses, unless the Secretary of the Military Department or Director, DHA, responsible for the MTF concerned has designated NAF employees as eligible for care without reimbursement (see Reference (s) for more information).

(c) Do not bill the Department of Labor (DOL) for DoD federal employees because Congress appropriates DoD funds to provide care for DoD federal employees in the case of occupational injuries and illnesses. If DoD billed DOL (which it must not in this case), DoD would have to pay the cost of medical care plus a surcharge for administrative costs to DOL.

(d) DoD employees may elect to receive their follow-up care at an MTF. However, follow-up care must be appropriately authorized.

(e) Refer to paragraph 3(u)5 of this enclosure, for guidance governing the administration of workers' compensation claims for non-DoD employees who are uniformed services beneficiaries.

(4) Workers' Compensation Involving Civilian Emergency Patients or Contractor Employees. For non-uniformed services patients (including contractors who are not uniformed services beneficiaries or DoD employees), the MSA office must bill the workers' compensation carrier, patient, or patient's employer if the injury or illness is work-related, in accordance with State law and Military Department or DHA-specific guidance. If it is determined that the injury or illness was not work-related, and therefore not covered under workers' compensation, the patient's status reverts to civilian emergency using the applicable PATCAT (or future patient classification) and billing rule.

(5) Workers' Compensation Involving Other (non-DoD) Federal Employees. SF 1080 must be used pursuant to paragraph 3v of this enclosure for interagency billing if the Military Department or NCR MD/J-11 has entered into an agreement with the employee's agency. Ensure the appropriate agency is billed at the IAR. If there is no interagency agreement, bill the patient at the FRR/FOR rate.

v. Billing Other Federal Government Agencies, VA, Department of State, and Other Special Categories

(1) This section does not apply to federal employees treated for work-related injuries or illnesses (see paragraph 3u of this enclosure) or to agencies, departments, or others with agreements that specify another reimbursement process.

(2) Collect from other government agencies, departments, and other special categories based on the PATCAT (or future patient classification) and appropriate billing rate as specified on the PATCAT table (or future EHR solution). The current PATCAT table (or future EHR solution) is available at Reference (i).

(3) The MSA Officer must transmit bills as soon as possible after services are provided and at least monthly in accordance with the guidance provided in this DHA-PM supplemented by Military Department or DHA-specific guidance.

(4) For non-DoD interagency billing, use the SF 1080 supported by a DD Form 7 or 7A or other approved commercial claim form with adequate detail to adjudicate a bill if the Military Department or NCR MD/J-11 has entered into an agreement with the employee's agency. Follow Military Department or DHA-specific guidance.

(5) If the patient has been granted eligibility under the Secretarial Designee Program, bill in accordance with the guidance provided in the designee letter.

(6) For MTFs in DoD/VA resource sharing agreements, bill in accordance with the most current guidance provided for inpatient and outpatient services available at Reference (i) unless there is a local sharing agreement in place that modifies national guidance.

(7) Memorandums of Understanding or Agreements detailing procedures for interagency billing between the DoD and other government agencies, executed at the DHA-level or higher, may supersede billing guidance in this section.

w. Billing Contractors During Contingency Operations. Guidance in this DHA-PM does not apply to procedures necessary to bill non-fixed deployed medical assets. DHA UBO establishes global rates and separate billing guidance for non-fixed deployed medical assets. While these facilities are expected to charge contractors for health care services rendered during contingency operations, billing procedures differ from the provisions cited in this DHA-PM.

x. Health Care Billing for IMET, foreign military sales, and North Atlantic Treaty Organization

(1) The MTF must obtain a copy of the Invitational Travel Orders for health care billing for international military.

(2) Information on the charges for health care for IMET students and their dependents is included in References (r) and (t), which are available at Reference (i).

(3) Additional guidance regarding reciprocal agreements is provided by Reference (u), and related policy memorandums are available on the Defense Security Cooperation Agency Website.

y. Forms of Acceptable Payment. The MSA office must only accept payment of amounts due to the MTF in these authorized forms:

(1) Cash: U.S. currency and coin.

(2) Credit cards (where applicable).

(3) Foreign currency.

(a) Transactions affected by military payment certificates and foreign currency are governed by directives of the overseas command concerned.

(b) The MSA Officer must use separate I&Rs for foreign currency and military payment certificates.

(4) Negotiable instruments. Authorized negotiable instruments may not be accepted in amounts larger than the amount due. Negotiable instruments made payable or endorsed to the servicing accounting and finance office, as prescribed locally, are acceptable in these forms:

(a) U.S. Treasury checks.

(b) Certified checks, cashier's checks, and bank drafts.

(c) Personal checks. Personal checks for more than the amount due must not be accepted. Personal checks for partial payments must not be accepted if they carry any conditional endorsement such as "payment in full."

(d) Traveler's checks.

(e) U.S. Postal money orders or money orders issued by banks or other financial establishments.

(f) Military payment certificates. Military payment certificates must be accepted outside the continental United States where such certificates are required for use as currency.

(5) Electronic payments.

z. DD Form 1131, "Cash Collection Voucher"

(1) The MSA Officer must use DD Form 1131 to transfer monies received to the local or supporting accounting and finance office or local banking institution and to document deposits in the accounting records pursuant to Chapter 5, Volume 5 of Reference (m).

(a) The designated billing and collection application generates pre-numbered DD Form 1131s. An electronic PDF version of DD Form 1131 is also available at Reference (p).

(b) If forms are used, the MSA Officer must assign a standard document number series of consecutive numbers by fiscal year to the DD Form 1131.

(c) The MSA Officer must transfer all proceeds from sales to the local or supporting accounting and finance office, or make deposit to the Federal Reserve Bank or designated depository using SF 215, "Deposit Ticket" or a Military Department or DHA-specific form pursuant to requirements of the MTF's local or supporting accounting and finance office.

(d) Depending on the requirements of the Defense Finance and Accounting Service (DFAS) office servicing an MTF, confirmed copies of the SF 215 must be:

1. Sent to the servicing accounting and finance office with the original DD Form 1131 and a copy of all checks included in the deposit, or

2. Processed through the Over the Counter Channel (OTCnet) web-based application hosted by the Department of Treasury and copies of DD Form 1131 and checks kept on file, or

3. Sent to DFAS with the original DD Form 1131 and a copy of all checks included in the deposit; except at MTFs where DFAS electronically retrieves SF 215s from the Collections Information Repository, MTFs will submit only the signed DD Form 1131 to DFAS, citing the applicable Collections Information Repository Voucher Number.

(e) Checks must be retained and stored via OTCnet per Volume I, Part 5, Chapter 2000 Section 2040 of Reference (v), (e.g., store physical checks for up to 5 days after deposit and check copies for up to 10 days after deposit) and Volume 5, Chapters 8 and 11 of Reference (m). After scanning items in OTCnet, the scanned checks must be retained until they are verified

that they reside within OTCnet and a good image is on file. This verification must take place within 14 calendar days. Items that have been scanned and are awaiting approval must be secured in an approved manner. Once verified, checks must be shredded and destroyed.

(f) If funds are stored overnight, the MSA Officer must ensure storage meets the requirements of Volume 5, Chapter 3 of Reference (m) and Military Department or DHA resource protection guidelines. The MSA Officer must obtain approval for fund containers.

(2) MSA Officer must prepare a separate DD Form 1131 for each fiscal year.

(a) Credit each collection from a non-Federal entity to the fiscal year received pursuant to Reference (o) and Military Department or DHA-specific guidance.

(b) The accounting classification block shows the full listing of major accounting classifications.

(3) Sales codes must be appropriately reported as part of the fund cite and different sales codes must be reported as necessary.

(4) The MSA Officer must use a separate line for each accounting classification, if appropriate.

(5) The appropriate agent must sign each DD Form 1131. The MSA Officer must retain a copy of the DD Form 1131 with supporting documentation containing the disbursing office voucher number and must record the collection into the finance system (if authorized).

(6) The MSA Officer must use a separate DD Form 1131 to transfer foreign currency to the servicing accounting and finance office. The MSA Officer must indicate the units and quantities of foreign currency and the equivalent value in U.S. currency, based on the actual rate on the date of receipt or transfer.

aa. Uncollectible or Dishonored Checks

(1) The MSA Officer must handle uncollectible and dishonored checks in accordance with Military Department or DHA-specific guidance implementing Reference (m). Refer to the procedures provided in Reference (m), if Military Department or DHA-specific guidance is not available.

(2) When a recorded cash collection is rendered null and void by a dishonored check, the MSA Officer must follow either these manual or automated procedures:

(a) Manual Procedures

1. Pull the original I&R copies from the files and adjust them by striking the collection entry, deducting the voided amount from the payment column, and adding the voided amount to the balance due.

2. Initial the adjustment and explain the adjustment in a footnote.
3. File the forms in the unpaid section of the accounts receivable file.
4. Immediately follow up on the payment status on these accounts.

(b) Automated Procedures

1. Zero out collections in the automated system by printing a DD Form 1131.
2. Post a negative amount corresponding to the original payment and print a negative final DD Form 1131.
3. Immediately follow up on the payment status on these accounts.

(3) The MTF may impose an administrative fee if the MTF processes dishonored checks (Reference (m)).

ab. Settling Outstanding Accounts Receivable

(1) The MSA office must make every effort to collect accounts receivable before they become delinquent. Delinquent accounts receivable are receivables that are not paid within 30 calendar days of the date the I&R was generated. MTFs that use U.S. Treasury debt management and collection programs (e.g., Centralized Receivables Service) should settle accounts according to those U.S. Treasury program policies and procedures.

(2) In the case of active duty Service members and other patients subject to salary offset (e.g., federal employees), if charges are not paid by the due date on the I&R, the MSA Officer should prepare a DD Form 139, "Pay Adjustment Authorization" (active duty Service members) or DD Form 2481, "Request for Recovery of Debt Due the United States by Salary Offset" (other patients), with this statement in the remarks section: "The patient named above was notified in writing on [date] concerning these unpaid charges. The charges are for health care services for [name of patient] for the period of [admission and discharge date or outpatient date of service]. The patient has not paid as of this date."

(a) Additionally, the MSA Officer must include a statement on the DD Form 139 or DD Form 2481 certifying that the patient was provided due process for payment of the debt pursuant to Volume 16, Chapter 2 of Reference (m) and a reference to the statutory authority in section 1007(c) of Reference (w).

(b) The MSA office must forward the DD Form 139 or DD Form 2481 to the Service member's or other patient's servicing accounting and finance office.

(c) Current versions of both DD Form 139 and DD Form 2481 are available at Reference (p).

(3) The MSA office must not close out accounts receivable so long as any collection effort is being made on the account in accordance with Volume 16, Chapter 2 of Reference (m).

(4) Accounts receivable sent to DFAS or the Department of Treasury should be classified as currently not collectible (CNC) and continue to be reported in the monthly accounts receivable reports in accordance with Volume 16, Chapter 2 of Reference (m).

(5) The MSA office must process unpaid accounts of Service members who have been found mentally incompetent in accordance with applicable guidance from the servicing accounting and finance office and Military Department and DHA-specific guidance.

(6) If the MSA office determines that a patient is deceased, it should forward the account to the appropriate DFAS or other federal collection program office (i.e., FedDebt) and cease further collection efforts.

(7) Military Departments and DHA must follow procedures outlined in References (m), (n), and (o) to record intragovernmental and public accounts receivable.

ac. Procedures for Transferring Delinquent Accounts

(1) The MSA office must transfer accounts receivable from third party payers totaling \$25 (if payer has a Taxpayer Identification Number)/\$100 (if the payer does not have a Taxpayer Identification Number) or more and individual accounts receivable totaling \$25 or more that are over 120 days' delinquent to the DFAS or the Department of Treasury for further collection action, pursuant to Volume 4, Chapter 3 of Reference (m). Follow ASD(HA)'s Memorandum, "Defense Health Agency Write-Off of Aged Amounts Owed to MTFs Clarification of Procedures," (Reference (x)), for the handling of delinquent third party payer accounts less than \$25/100 and individual delinquent accounts less than \$25.

(2) The MSA office must follow DFAS and Department of Treasury policies and procedures to transfer delinquent accounts receivable to those agencies if the MSA office is using those federal programs for billing services. In general, the following procedures should be performed:

(a) Review the account to ensure patient identification data is complete, charges are accurate, and past collection efforts are fully documented.

(b) Include copies of follow-up letters, records of phone calls or personal contacts made to generate collection, and any other information that may assist in further collection efforts.

(c) The UBO, as the office of record, must maintain copies of all related documents and pertinent correspondence as "Proof of Debt" and submit them upon request to DFAS or the Department of Treasury.

(d) Include in the Proof of Debt package the following which substantiates the status of the account:

1. Patient's name and Social Security number (SSN).
2. Sponsor's name and SSN.
3. Sponsor's grade.
4. Sponsor's organization.
5. Patient's address.
6. Dates of service and subsistence provided.
7. The amount of collections, if any, applied against the charge.
8. The outstanding balance.
9. The complete fund citation of the specific program and appropriation to which collections must be deposited as reimbursements.
10. A record of follow-up actions.
11. Any other identifying data or pertinent information.
12. Corresponding I&R.
13. Corresponding delinquent letters and final notices.

(3) After performing these actions and transferring the account to DFAS or the Department of Treasury, the MSA office must write off the associated accounts receivable in the billing and collection application using the financial classification "CNC". If DFAS or the Department of Treasury return a debt as uncollectible, the MSA office must take appropriate actions to terminate collection action and reclassify the account as "closed out" in accordance with Volume 4, Chapter 3 of Reference (m).

ad. Corrections in Accounting Records. The procedures described in paragraphs 3ad(1) and (2) contain both automated and manual procedures. Manual procedures are provided for instruction when automated systems are not available to perform these procedures.

(1) Processing Refunds

(a) Submit a claim for reimbursement of overcharges to the servicing accounting and finance office using the SF required by the MTF's supporting DFAS office ("the DFAS SF").

(b) The DFAS SF must show the appropriation number and the DD Form 1131 under which the funds were deposited with the servicing accounting and finance office.

(c) Attach a copy of the DFAS SF to the back of the patient's I&R after entries are made on the front of the I&R adjusting the accounts referenced in the DFAS SF.

(d) Cash refunds or refunds with purchased money orders are not authorized.

(2) Processing Undercharges

(a) When a patient has been undercharged, the MSA office must contact the patient or sponsor to collect the balance due the U.S. Government.

(b) The MSA Officer must make the necessary adjusting entries on the I&R and other appropriate MSA records.

ae. Procedures for Handling Fees Collected for Medical Records Copying, Etc.

(1) The PAD or medical records office must process requests for clinical information received from non-government agencies.

(2) MSA office staff must use a locally developed transmittal letter or a copy of the transmittal letter from the insurance company to release this information pursuant to Volume 11A, Chapter 4 of Reference (m).

(3) When payment is received, the PAD or medical records office will send the payment to the MSA office with a copy of the locally developed transmittal letter or the transmittal letter from the insurance company. The MSA office must indicate on the receipt of funds transmittal: "Received [\$ dollar amount received] on [date]."

(4) The medical records office must retain a copy of the locally developed transmittal letter or the transmittal letter from the insurance company as a source document attached to the DD Form 1131.

(5) The MSA office must post collections to the billing and collection application, deposit the funds with the servicing accounting and finance office via OTCnet and/or local bank, and attach all related papers to the receipt copy of the DD Form 1131 for filing. (See Volume 11A, Chapter 4 of Reference (m)).

(6) These processes and charges apply for both hard copy and electronic images.

af. Safeguarding Patient Valuables. At MTFs where the UBO has been designated by the appropriate authority as the agent responsible to safeguard patient valuables, the agent must comply with the Volume 5, Chapters 2, 3, and 16 of Reference (m). Reference (m) does not mandate that this agent be the UBO.

ag. MSA Reports

(1) The MSA Officer must type the word “Initial” or “Final” in the top margin of all reports covering the first or last month’s operation or portion thereof resulting from activation, redesignation, opening operations at a new station, or completion of operations at a station before moving to a new station.

(2) A corrected report automatically and entirely cancels any previous report for the same period of time, subject, and data.

(a) For automated systems, corrections made to a previous month’s report must be reflected in the current report.

(b) For manual systems, the MSA Officer must produce all corrected reports from 3 months previous as well as subsequent reports for submission, unlike the automated system, which automatically updates subsequent reports.

(c) Place an asterisk (“*”) by each corrected entry on the corrected report.

(d) Type “Corrected – [date of corrected copy]” in the top margin of all corrected reports.

(e) Enter the month and year of the initial report in the block provided for the date on the report.

(f) Corrected DD Form 7 and DD Form 7A reports must indicate only the differences from what was originally submitted.

(3) The MSA office must prepare the following reports:

(a) DD Form 7, “Report of Treatment Furnished Pay Patients — Hospitalization Furnished (Part A)”

1. At the end of each calendar month, the MSA Officer must prepare a report of inpatient care on DD Form 7 for each PATCAT (or future patient classification) listed in the PATCAT table (or future EHR solution).

2. A person who has received inpatient care and for whom a bed is maintained in the MTF must be reported as a pay patient on DD Form 7.

3. The MSA Officer must prepare a separate report for each major category of patient (e.g., active duty, active duty dependent, retired member, or retired member dependent, or other).

4. The MTF must issue a report no later than calendar day 7 of the following month.

5. The MSA Officer must send the original and one additional copy of the report to the respective Military Department, or NCR MD/J-11, if required by the Military Department or DHA.

6. The most current version of DD Form 7 is available at Reference (p).

(b) DD Form 7A, "Report of Treatment Furnished Pay Patient – Outpatient Treatment Furnished (Part B)"

1. At the end of each calendar month, the MSA Officer must prepare a report of outpatient care on DD Form 7A for each pay PATCAT (or future patient classification) listed in the PATCAT table (or future EHR solution).

2. The MTF must issue a report no later than calendar day 7 of the following month.

3. The MSA Officer must prepare a separate report for each major category of patient (e.g., active duty, active duty dependent, retired member, or retired member dependent).

4. The MSA Officer must send the original and one additional copy to Military Department, or NCR MD/J-11, if required.

5. The most current version of DD Form 7A is available at Reference (p).

(c) MMSAR

1. At the end of each month, the MSA Officer must produce a summary of MSA activity showing billing and collections for reimbursable services and subsistence.

2. The MSA Officer must submit a separate report for the current and prior fiscal years until all prior years' outstanding accounts receivable have been resolved.

3. The MSA Officer must report these separate sections by sales code:

a. Subsistence;

b. Medical services; and

c. Food service rate collections.

ah. Disposition of Records

(1) The MSA Officer must retain all accounting forms and records used to operate the MSA office, including but not limited to collection vouchers, monthly reports, and deposit records, for 10 years after the final invoice or Intra-Governmental Payment and Collection or other similar documentation.

(2) Data may be retained electronically or in hard copy. Follow Military Department or DHA-specific guidance.

(3) The MSA Officer must dispose of records in accordance with Military Department or DHA-specific guidance and requirements for handling sensitive material.

4. TPC

a. General

(1) Each MTF must establish a TPC office. The TPC program is a congressionally mandated program that authorizes MTFs to bill private health insurance plans for health care services furnished by MTFs to uniformed services beneficiaries. This section provides guidelines for billing, recording accounts receivable, and collecting payments under the TPC program.

(a) Section 1095 of Reference (d), as implemented by part 220 of Title 32, CFR (Reference (y)), authorizes MTFs to collect from third party payers' reasonable charges for medical services provided to uniformed services beneficiaries.

(b) The TPC program applies to members of the uniformed services (excluding active duty), retired members of the uniformed services, and their dependents as outlined in sections 1072, 1074, and 1076 of Reference (d).

(c) Civilian emergency patients and DoD civilian employees are not beneficiaries and therefore not covered under the TPC program. Refer to paragraph 3 of this enclosure for further guidance.

(2) TPC staff must:

(a) Identify uniformed services beneficiaries with OHI (e.g., private third party payer health insurance plans, Medicare supplemental insurance, and other contractual coverage for medical expenses).

(b) Document OHI coverage in the patient's medical record and CHCS (or future system).

(c) Submit insurance claims to third party payers for reimbursement in compliance with all third party payer submission requirements.

(d) Follow up to ensure collection activities are processed in accordance with applicable federal laws, regulations, and policies.

(e) Document and report collection activities.

- (f) Implement and apply TPC program compliance guidelines.
- (g) Follow guidance provided in this DHA-PM and Reference (m).
- (h) Maintain TPC claims on file for at least 10 years.

(3) Pursuant to Enclosure 2 of this DHA-PM, each MTF must designate an individual responsible for TPC management (who may also serve as the UBO Manager) whose duties must include:

- (a) Programing marketing and education.
- (b) Overseeing identification and collection of third party plan or policy information.
- (c) Filing claims with third party payers.
- (d) Posting funds.
- (e) Reporting TPC program status.

(f) Referring outstanding claims for further action pursuant to this DHA-PM, Reference (m), and applicable Military Department or DHA-specific guidance.

(4) Implementing an effective TPC program requires a review of all aspects of the revenue cycle as it pertains to the UBO. The following functions are important for an efficient TPC program:

- (a) Accounts receivable management.
- (b) MTF accounting and finance offices.
- (c) Physician and nursing staffs.
- (d) Admissions.
- (e) Medical records (e.g., encounter documentation and accurate coding).
- (f) The legal office.
- (g) Utilization and quality assurance review.
- (h) Ancillary departments (e.g., laboratory, radiology, and pharmacy).
- (i) Information management.
- (j) Patient access (including appointments).

b. Health Care Plans Not Subject to the TPC Program. Health care plans not subject to the TPC program include:

- (1) TRICARE;
- (2) TRICARE supplemental plans; and
- (3) Income or wage supplemental plans.

(4) Plans administered by subchapters XVIII and XIX (Medicare and Medicaid, respectively) of Chapter 7 of Title 42, United States Code (Reference (aa)), also known and referred to in this DHA-PM as the “Social Security Act.”

(5) Certain existing health care plans:

(a) The TPC program is not applicable to third party payer plans which have been in continuous effect without amendment or renewal since prior to April 7, 1986. Plans entered into, amended, or renewed on or after April 7, 1986, are subject to the TPC program pursuant to section 220.6(c) of Reference (y).

(b) The TPC program is not applicable to third party payer plans in connection with outpatient care that have been in continuous effect without amendment or renewal since before November 5, 1990 and specifically exclude payment for services rendered. Plans entered into, amended, or renewed on or after November 5, 1990, and those prior plans that do not specifically exclude payment for services rendered, are subject to the TPC program pursuant to section 220.6(d) of Reference (y).

(c) An amendment to a policy or plan may include, but is not limited to, premium rate changes, benefit changes, insurance carrier changes, or conversion from an employer insured plan to a self-insured plan or the reverse.

(6) Refer to section 220.6 of Reference (y) for additional details regarding third party payer plans not subject to the TPC program.

c. Identifying Beneficiaries Who Have OHI

(1) Timely and accurate identification of beneficiaries with OHI is crucial to a successful TPC program. To achieve 100 percent contact rate, each MTF must establish a process to verify whether or not a patient has OHI (including pre-admitted inpatient and APV patients).

(2) If the patient enters the MTF through the emergency department, OHI information may not be obtained until after the patient is stable.

(3) TPC staff are responsible for educating staff to ensure that patients receive adequate explanations about the requirements and benefits of the TPC program, the types of policies and plans subject to collection, and the patient’s responsibility in this process.

(4) There must be a signed hard copy or electronic version of a DD Form 2569 (see the appendix to this enclosure), an approved DD Form 2569 compliance card or evidence of OHI discovery for each eligible beneficiary, excluding active duty. The form or evidence of OHI discovery must be retained in hard copy or electronic format for the requisite time period for claims processing. The most current version of DD Form 2569 is available at Reference (p). Although evidence of OHI discovery in general may be retained in lieu of a signed DD Form 2569 (hard copy or electronic version), the MTF must provide payers with a signed copy upon request.

(a) The patient, or patient's responsible party, must be asked to complete, sign, and date a DD Form 2569 (hard copy or electronic version) at least annually—unless evidence of discovered OHI was obtained within a year of either the last signed DD Form 2569 or OHI discovery update—or when there are changes to the patient's information.

(b) If the patient states that he or she has health coverage other than TRICARE and has an insurance card, the MTF may make a copy of the front and back of the card and attach the copy to the DD Form 2569. In this instance, the patient may not be required to complete questions related to specific health insurance coverage on the form. However, all other applicable sections of the form must be completed and signed accordingly.

(5) In the absence of an insurance card, the beneficiary must list, at a minimum:

(a) Name of the policyholder or subscriber.

(b) Plan or policy number.

(c) Effective date(s) of coverage and, if the policy or plan is listed as expired, the end date of coverage.

(d) For group insurance policies (e.g., employer sponsored plans), the name of the group and the group number.

(e) Names of dependents if the plan or policy covers them.

(f) Benefits covered under the plan (including pharmaceuticals), amount of deductible (dollar amount), co-insurance (percentage of costs), or co-payment (charge at time of encounter) required under the policy or plan.

(g) If pre-certification is required for an inpatient stay, the phone number needed to call for pre-certification.

(h) The third party payer's mailing address. This includes the addresses and phone numbers for each coverage type (e.g., pharmacy, hospital, and mental health).

(6) If the third party payer information is already in the CHCS, billing and collection application or future EHR solutions, verify the information, and enter the date of verification in the pre-certification or utilization review free text fields.

(a) Where necessary, MTF staff must make required changes.

(b) MTF staff must verify information for billable plans or policies and input into CHCS, the billing and collection application or future EHR solutions in accordance with Standard Insurance Table guidelines. MTF staff must not enter TRICARE supplemental plans, income (or wage) supplemental policies, or any other non-billable policies. (See paragraph 4b of this enclosure for a list of health care plans not subject to the TPC program.)

(7) For all newly identified billable OHI, MTF staff should check applicable medical records, CHCS, the billing and collection application and future EHR solutions, for prior billable events and verify that claims were filed and payment was received for all services provided during the plan or policy effective dates.

(8) All patients, including active duty, who have sustained an injury, must be asked if the injury is accident or work-related. If the patient states that his or her inpatient admission or outpatient visit is accident or work related, the interviewer must obtain relevant accident insurance or workers' compensation plan information. (See paragraph 3 of this enclosure for guidance regarding workers' compensation involving civilian patients and paragraph 5 for all other patients.)

d. Mandatory Compliance by Third Party Payers

(1) Third party payers are required to abide by the provisions of section 1095 of Reference (d) and part 220 of Reference (y). Third party payers may not require an MTF to enter into a participation agreement or other contractual vehicle as a condition of payment, nor may they deny claims or reduce payment based on the fact that care was rendered in a government facility.

(2) MTFs may reach understandings with third party payers on claims procedures and other administrative matters if these understandings are not pre-conditions to complying with federal, State, or local statutory and regulatory requirements.

(3) Third party payers may not require beneficiaries to sign an assignment of benefits form with the MTF as a condition of payment to the MTF. The DD Form 2569, signed by the patient (hard copy or electronic version), serves as evidence of assignment of benefits as well as the patient's insurance declaration form, and a signed copy will be furnished to the third party payer upon request.

(4) Third party payers may not deny or reject full reimbursement of claims based on the premise that they reimburse only the amount the patient would have been liable for had the plan or policy not existed. Denial of claims for this reason, or for any other invalid reason, must be followed up on in accordance with Military Department or DHA-specific guidance.

(5) MTFs must have denial management protocols and processes to review and adjudicate all OHI denials. Follow Military Department or DHA-specific guidance.

e. Authorization to Release Medical Information in Support of the TPC Program

(1) Upon request by representatives of third party payers, MTFs must make available health care records of patients for whom payment is sought.

(2) MTFs must adhere to all privacy and security laws and Military Department or DHA-specific guidance applicable to releasing medical information for claims payment purposes.

(3) The MTF may not bill the third party payer for copying records.

f. Medical Services Billed. Third party payers should be billed for all services rendered, including multiple visits on the same day to different clinics. Billable services include:

(1) Inpatient hospital care (including institutional fees and charges for inpatient professional services);

(2) APV or same day surgery;

(3) Outpatient services (including institutional fees and charges for professional services);

(4) Ancillary services, including but not limited to, laboratory, pathology, and radiology procedures;

(5) Prescription drugs;

(6) Observation services;

(7) Immunizations and injections;

(8) Dental care;

(9) Ambulance services;

(10) DME and durable medical supplies; and

(11) Anesthesia services.

g. Medical Services Not Billed

(1) Medical services not billable are those for which DHA UBO has not established a rate or where DHA UBO has set the rate to zero. MTFs may not establish rates under any circumstances, except where there is a valid DoD/VA resource sharing agreement.

(2) The TPC office must notify its UBO Manager of any services rendered for which there is not a DHA UBO established rate. The UBO Manager must ensure that this information is communicated to DHA UBO.

h. Billing Activities

(1) MTFs must bill third party payers' reasonable charges, as established by DHA UBO and approved by the ASD(HA), for services furnished to uniformed services beneficiary patients at or through an MTF.

(2) In accordance with section 220.8 of Reference (h), a third party payer may submit evidence to an MTF demonstrating that the charges billed are too high for the geographic area for the same or similar groups of services.

(a) The MTF UBO must forward the request and the accompanying evidence to the UBO Program Manager who will forward the request to DHA UBO for a decision to approve or disapprove.

(b) Any decision by DHA UBO must be limited to the applicable calendar or fiscal year.

(3) Pursuant to section 1095 of Reference (d), an MTF may not require uniformed services beneficiaries to pay the MTF any deductible, co-payment, or co-insurance amounts imposed by the third party payer.

(4) For inpatient hospital care, institutional rates are determined as described in Reference (i). Refer to paragraph 6 of this enclosure for additional guidance.

(5) For inpatient claims, the FMR may not be billed to the patient when billing OHI. These amounts are considered covered by the third party payer. If no payment is received or expected from the third party payer and the patient is not a TRICARE Prime member, the MSA office must then bill the patient the appropriate FMR. Refer to paragraph 6 of this enclosure for additional information.

(6) Under TRICARE resource sharing agreements, the MTF contracts with contractors who may assign an individual or individuals to work in the MTF. Under such an arrangement, the MTF must file third party claims using appropriate established rates, or follow the guidance in the resource sharing agreement.

(7) The TPC office must bill health maintenance organization (HMO) plans to the extent the MTF may reasonably expect to be reimbursed. Typically, HMOs only pay for emergency care, urgent care, opt-out (or point-of-service), and out-of-service area care. The TPC office must:

(a) Identify patients with HMO (or other managed care organization products) coverage.

- (b) Certify admissions, file, and pursue all claims with HMO (inpatient and outpatient), opt-out, or point-of-service provisions.
- (c) Certify all admissions for emergency, urgent, and out-of-service area care.
- (d) Identify all outpatient treatment for emergency, urgent, and out-of-service area care.
- (e) File and pursue resultant claims with HMOs.

(8) Every MTF that performs billing functions must establish and maintain billing records pursuant to this DHA-PM and Reference (m), which may be supplemented by Military Department or DHA-specific guidance. Each record must, at a minimum, include:

- (a) Action taken on each claim and date(s);
- (b) Amount billed and date(s);
- (c) Amount collected and date(s);
- (d) Account balance;
- (e) Amount in dispute and date(s) of appeal;
- (f) Claim adjustment reason(s) with amounts, including rationale for write-off;
- (g) Delinquent amount and date(s) of response(s) to appeal; and
- (h) Final account disposition, including documentation of the denial management/follow up process on outstanding claims, timeframe to conduct follow up on outstanding claims, and date transferred to the Department of Treasury.

(9) The TPC office must accurately prepare and submit claims, either electronically or via paper claim format (until no longer accepted by the payer), to third party payers using:

- (a) UB-04/837I. To ensure proper payment is made, it is necessary to annotate “Y” for “yes” in Form Locator 53 of the UB-04/837I. By indicating a “Y” or defaulting to “Y” in Form Locator 53, the third party payer must reimburse the MTF, as opposed to the patient.
- (b) CMS 1500/837P;
- (c) Universal claim form/National Council for Prescription Drug Programs; and
- (d) The American Dental Association claim form.

(10) MTFs must comply with the data elements and code specifications of:

- (a) The National Uniform Billing Committee;
 - (b) The National Uniform Claim Committee;
 - (c) The National Council for Prescription Drug Programs for both paper and electronic claim formats; and
 - (d) American National Standards Institute X12, which is responsible for establishing data content and format for electronic claims submission pursuant to the HIPAA (Reference (j)).
- (11) The TPC office must prepare and send inpatient claims to the third party payer immediately upon completion of the medical record and coding.
- (12) Outpatient claims must be prepared and sent to the third party payer within 15 business days after the outpatient encounter information and coding for billing is obtained.
- (13) The TPC Officer must check the report of discharged patients with OHI for the coding status of their medical record and coordinate with the PAD or Medical Records Officer to confirm that records are complete prior to the generation of a bill.
- (14) The TPC office must prepare separate claims for the mother and a newborn in an inpatient delivery case. (See also paragraph 6c of this enclosure for guidance regarding billing for newborn care.)
- (15) MTFs must have denial management protocols and processes to review and adjudicate all OHI denials. Follow Military Department or DHA-specific guidance.
- (16) Refer to Tables 2 and 3 to determine what types of services must be billed based on beneficiary category and type of OHI:

Table 2. Type of Services Billed by Beneficiary Category

Beneficiary Category	Inpatient Hospital Billing	Outpatient Visit Billing	Ancillary Services Billing	No-Fault Accident Billing
Active Duty	NO	NO	NO	YES
Retiree	YES	YES	YES	YES
Dependent	YES	YES	YES	YES

Table 3. Type of Services Billed by Type of Insurance Plan or Policy

Type of Policy or Plan to be Billed	Inpatient	Outpatient	Ancillary
Private Insurance Policy	YES	YES	YES
Employer Group Health Plan	YES	YES	YES
Association or Organization Health Plan	YES	YES	YES
No-Fault Automobile Insurance	YES	YES	YES
Third Party Automobile Liability	YES	YES	YES
Medicare Supplemental Plan	YES	YES	YES
Workers' Compensation Plan (non-federal employee)	YES	YES	YES
Workers' Compensation Plan (federal employee)	NO	NO	NO
TRICARE Supplement	NO	NO	NO
Income (wage) Supplement	NO	NO	NO

i. Medicare Supplemental Insurance (Medigap) Plans. MTFs may collect from Medicare supplemental policies for covered inpatient, outpatient, institutional, and professional services.

(1) Obligation to Pay. The obligation of a Medigap plan to pay must be determined as if the MTF were a Medicare-eligible provider and the services rendered as if they were Medicare-covered services.

(a) The insurer may not deny a TPC claim on the grounds that a claim had not been submitted previously by the provider or beneficiary to Medicare.

(b) In general, Medigap plans are responsible for paying the Medicare enrollee's Medicare Part A and Part B out-of-pocket costs under normal operation of the Medicare program to the extent covered by the plan provisions. Medigap plans typically do not supplement the patient's cost-sharing under Medicare Part C or Part D. Refer to section 220.10 of Reference (y) for additional information regarding special rules for Medigap plans.

(2) Medicare Part A. The obligation to pay the Medicare inpatient deductible amount only applies to Medigap policies covering the inpatient deductible.

(a) The Medigap insurer may not be obligated to pay the MTF if the benefit is required to satisfy a patient's inpatient deductible in a Medicare certified civilian hospital arising from the same admission within the same Medicare benefit period. If the patient is entitled to both DoD retiree benefits and Medicare benefits and the Medicare Part A deductible has already been paid to an MTF, and within 60 days of discharge from the MTF the patient is admitted to a Medicare certified hospital, the MTF shall refund the deductible payment to the Medicare supplemental

insurer so that it may pay the deductible to the Medicare certified hospital pursuant to section 220.10 of Reference (y).

(b) A Medicare benefit period begins the first day the patient receives covered inpatient hospital services and extends until the Medicare enrollee has been out of the hospital or skilled nursing facility for 60 consecutive calendar days. A person may be hospitalized several times during a benefit period; but the Part A deductible is charged only once per admission during any benefit period. There is no limit to the number of benefit periods a beneficiary may have.

(c) In all cases when the Medigap payment is refunded, the patient is to be billed the appropriate subsistence amount. Refer to paragraph 7 of this enclosure for additional guidance regarding subsistence.

(3) Medicare Part B. Collection of the Medicare Part B deductible is limited to outpatient and professional services.

(a) The Medicare Part B deductible is a calendar year deductible.

(b) The MTF may be required to refund or offset the annual Medicare Part B deductible amount if the patient was also treated by a civilian Medicare certified provider for similar services provided by the MTF and the amount paid to the MTF by the insurer has already been applied previously to pay the civilian provider. Pursuant to Section 220.10(c)(iii) of Reference (y), Medigap insurers are not required to pay more than one deductible charge per benefit period in cases in which beneficiaries receive similar services from both an MTF and a Medicare-certified civilian hospital.

(c) MTFs must keep track of refunds and reconcile accounts for financial auditing and compliance purposes.

(d) As part of the basic benefits, all Medigap plans reimburse for the Medicare Part B coinsurance (generally 20 percent of the Medicare approved amount) after the calendar year deductible amount is met.

(e) Because MTFs in general do not bill Medicare for uniformed services beneficiaries, MTFs may bill the Medigap plan based on the actual charge(s) of the outpatient or professional service.

(f) MTFs may bill for the Medicare Part B coinsurance amount based upon the professional component of the inpatient claim.

(g) MTFs may bill prescription drugs to a Medigap company for those policies covering prescription drugs.

j. Collection Activities

October 24, 2017

(1) Authority to Collect Payments. The authority to collect from third party payers authorized by section 1095 of Reference (d), includes contractual payments such as automobile liability and no-fault insurance policies. For these types of cases, this authority extends to active duty members as well (see paragraph 5 of this enclosure for information related to MAC).

(2) Follow-up Claims Inquiries. TPC staff must conduct either a written or telephone follow-up if reimbursement is not received within 30 calendar days of the date the claim was generated or other intervals as specified by Military Department or DHA-specific guidance.

(3) Referral of Outstanding Claims. When all efforts to collect on a valid claim have been exhausted, the responsible TPC office must refer accounts receivable to its local Judge Advocate General or the Department of Treasury for action if over 120 days' delinquent.

(4) O&M Account Deposits. All collections made by the Staff Judge Advocate, Judge Advocate General or external agent must be deposited into the MTF O&M account.

(5) Closing Claims. The MTF must close outstanding TPC claims that fall into one of the listed categories for valid adjustment reasons, in accordance with standard reporting requirements, such as the DD Form 2570:

- (a) Amount of coverage.
- (b) Patient not covered, care provided not covered, or policy expired.
- (c) TRICARE or income supplemental plans.
- (d) Medicare supplemental plans if paid within policy limitations.
- (e) HMO paid in accordance with policy provisions. (See paragraph 4h of this enclosure for additional information.)
- (f) MTF did not comply with utilization review procedures.
- (g) Outstanding claim represents amount equal to the patient's co-pay or deductible.
- (h) Other valid reasons as described by the payer or as determined by the MTF commander or director.

(6) Documenting Closure. The records of closed accounts must be clearly documented and must state the reason for closure without collection or collection of less than 100 percent of the billed amount, minus appropriate discounts (e.g., in network) deductibles, co-insurance, co-payments, etc.

(7) Uncollectible Debts. Refer to Volume 16, Chapter 2 of Reference (m) and guidance in Reference (z).

(8) Deposits. Deposit TPC funds for the current year in the local O&M appropriation of the MTF providing the medical services. Deposit collections in the year received, not in the year in which medical care was rendered or billed pursuant to section 1095 of Reference (d) and Military Department or DHA-specific guidance.

(9) Validating Accuracy of Payments. The TPC office is responsible for ensuring the accuracy of third party payer payments and must validate the payer's explanation of benefits (EOB) to ensure the third party payer has processed the claim properly. At a minimum, the TPC office must verify that:

(a) All charges on the claim are listed on the EOB.

(b) All deductibles, co-payments, co-insurance, and any other pertinent factors affecting payments have been considered and comply with applicable federal laws and regulations.

(c) A valid explanation is given for unpaid or unprocessed charges.

(d) Diagnosis and procedure codes listed on the EOB match the diagnosis and procedure codes on the claim.

k. Minimum TPC Internal Controls

(1) The MTF commander or director will ensure that the TPC office maintains an appropriate separation of duties to minimize the risk of misappropriation of funds.

(2) The MSA office must:

(a) Receive and open mail including mail containing checks or payments from all sources, including MSA, TPC, and MAC pursuant to Volume 5, Chapter 10 in Reference (m). All mail remittances must be opened by a person independent of the collection function.

(b) Ensure checks are posted (i.e., recorded) and deposited pursuant to Volume 5, Chapter 5 in Reference (m), and Military Department or DHA resource protection guidelines.

(3) The TPC office must:

(a) When feasible, ensure separation of duties between billing and posting of amounts received. When feasible, separate persons should be responsible for:

1. Recognizing and recording accounts receivable.

2. Posting payments.

(b) Forwarding TPC checks or payments received in the mail to the MSA Officer or collection agent immediately upon receipt.

(c) Maintaining separate accounting records for TPC billing and receipts to provide adequate billing audit trails.

(d) Recording collections accurately.

(e) Reconciling insurance policy or plan documents indicating amounts paid with total charges to validate payment of the full amount less appropriate discounts (e.g., in network), deductibles, and co-payments.

(f) Ensuring payments are validated and posted to the correct patient account in accordance with Military Department or DHA-specific guidance regarding claim closure and disputed claims.

(g) Ensuring documents indicating amounts paid or collected equal amounts deposited.

(h) Ensuring TPC records are reconciled with TPC deposits and TPC reports, including DD Form 2570 reports. TPC records must be reconciled monthly with accounting and finance office records.

1. TPC Program Quarterly and Annual Reports

(1) DHA UBO will set annual TPC program collection goals for each Military Department and the NCR MD/J-11.

(2) Each Military Department and the NCR MD/J-11 must set annual individual MTF collection goals.

(3) Each Military Department and the NCR MD/J-11 must enter into the DHA UBO Metrics Report, no later than 30 calendar days following each quarter, the performance metrics required by the DD Form 2570 and as shown in Figure 6. The most current version of DD Form 2570 is also available at Reference (p).

THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS		SEGMENT REPORTED (<i>X one</i>)		REPORT CONTROL SYMBOL	
		<input type="checkbox"/> INPATIENT		DD-HA(Q)1986	
		<input checked="" type="checkbox"/> OUTPATIENT			
1. QUARTER ENDING (YYYYMM)	2. REPORTING MEDICAL TREATMENT FACILITY (MTF)	3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NO.			
201204	MTF, Anywhere USA	1234			
PART I					
4. REPORTING PERIOD (<i>See Note 1</i>)					
FISCAL YEAR (FY) (1)	NO. OF NON-ACTIVE DUTY INPATIENT DISPOSITIONS/VISITS (2)	NO. OF CLAIMS (3)	NO. OF COLLECTIONS (4)	NO. CLAIMS DIVIDED BY DISPOSITIONS/ VISITS (%) (5)	TOTAL \$ AMOUNT BILLED/CHARGES (6)
a. CURRENT FY	1,000	100	75	10	100,000.00
PRIOR YEAR (PY)					
b. PY 1	700	55	40	8	70,000.00
c. PY 2	500	30	25	6	50,000.00
	\$ ADJUSTMENTS AND REFUNDS (<i>See Note 2</i>) (7)	\$ AMOUNT COLLECTED PY 2 (8)	\$ AMOUNT COLLECTED PY 1 (9)	\$ AMOUNT COLLECTED CURRENT FY (10)	\$ AMOUNT REMAINING UNCOLLECTED (<i>See Note 3</i>) (6)-(7) + (8) + (9) + (10) (11)
a. CURRENT FY	5,000.00			25,000.00	70,000.00
b. PY 1	10,000.00		15,000.00	15,000.00	30,000.00
c. PY 2	15,000.00	10,000.00	15,000.00	5,000.00	5,000.00
PART II					
REASON CODES	5. DISTRIBUTION OF REMAINING UNCOLLECTED AMOUNTS		6. UNCOLLECTED AMOUNTS SUBDIVIDED BY FY (\$) (<i>See Notes 1 and 4</i>)		
			a. FY 2012	b. FY 2011	c. FY 2010
1	OPEN CLAIMS (<i>Requires additional follow-up action by Medical Treatment Facility for resolution</i>)		69,000.00	14,000.00	0.00
2	TRANSFERRED TO EXTERNAL AGENT (<i>e.g., JAG</i>) (<i>Excluding Third Party Liability Cases</i>)			15,000.00	4,000.00
REASON CODES 3-7. THIRD PARTY REDUCED / DENIED PAYMENT FOR INVALID REASONS (<i>Requires additional debt collection/legal action</i>)					
3	MTF NOT A PARTICIPATING HOSPITAL		0.00	0.00	0.00
4	PLAN EXCLUDES MILITARY HOSPITALS OR BENEFICIARIES		0.00	0.00	1,000.00
5	PATIENT HAD NO OBLIGATION TO PAY		0.00	0.00	0.00
6	INSURER PAID PATIENT DIRECTLY		1,000.00	1,000.00	0.00
7	OTHER (<i>Explain</i>)				
TOTAL OF ALL OPEN CLAIMS (<i>Reason Codes 1 through 7</i>)			70,000.00	30,000.00	5,000.00
REASON CODES 8-16. CLOSED CLAIMS. THIRD PARTY PAID IN FULL OR REDUCED/DENIED PAYMENTS (<i>No further action required because unpaid amount is not a valid claim</i>)					
8	AMOUNT OF COVERAGE (<i>i.e. plan pays less than 100%</i>)		1,000.00	1,000.00	2,000.00
9	PATIENT NOT COVERED, CARE PROVIDED NOT COVERED, OR POLICY EXPIRED		2,000.00	3,000.00	5,000.00
10	CHAMPUS AND/OR INCOME SUPPLEMENTAL PLANS		0.00	0.00	0.00
11	MEDICARE SUPPLEMENTAL PLANS		0.00	1,000.00	1,000.00
12	HEALTH MAINTENANCE ORGANIZATION (HMO) (<i>i.e. nonemergency out-of-plan care not covered</i>)		0.00	0.00	0.00
13	MTF DID NOT COMPLY WITH UTILIZATION REVIEW PROCEDURES (<i>i.e. pre-admission screening, concurrent review, second surgical opinions, etc.</i>)		1,000.00	1,000.00	2,000.00
14	REFUNDS		0.00	0.00	0.00
15	PATIENT COPAYS AND DEDUCTIBLES		1,000.00	4,000.00	5,000.00
16	OTHER (<i>Explain</i>) (<i>Example - third party provided lower prevailing rate vs. amount billed</i>)				
TOTAL OF ALL CLOSED CLAIMS (<i>Reason Codes 8 through 16</i>)			5,000.00	10,000.00	15,000.00
NOTES:					
1. All activity for amounts claimed and collected shall be reported in the fiscal year that the services were rendered (<i>i.e. care provided in FY 1989 will be reported as an FY 1989 claim and collection, regardless of the year payment is received</i>). This requires cut-off billing for all inpatients at fiscal year end.					
2. Amounts reported in Part I, Column (7) for each fiscal year shall equal the subtotal for Reason Codes 8-16 in Part II, for the respective fiscal years.					
3. Amounts reported in Part I, Column (11) for each fiscal year shall equal the subtotal for Reason Codes 1-7 in Part II, for the respective fiscal years.					
4. Each quarterly report shall be cumulative for the current and two prior fiscal years.					

DD FORM 2570, JUN 2001

PREVIOUS EDITION IS OBSOLETE.

Reset

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Figure 6. Sample DD Form 2570

5. MAC

a. General

(1) MAC activities involve billing all areas of liability insurance, such as automobile, products, premises and general casualty, homeowners', renters', medical malpractice by civilian providers, and workers' compensation other than federal employees. MAC includes active duty beneficiaries.

(2) Pursuant to Chapter 32 of Reference (aa), also known as the "Federal Medical Care Recovery Act (FMCRA)," the United States may recover the reasonable cost of care in any case in which the United States is authorized or legally required to furnish or pay for hospital, medical, surgical, or dental care, and treatment (including DME and durable medical supplies) to a person who is injured or suffers an illness under circumstances creating tort liability in a third party.

(3) This program is based primarily upon the authority granted by Chapter 32 of Reference (aa), as implemented by part 43 of Reference (ab), and sections 3711-3720E of Reference (ac). See also section 1095 of Reference (d), as implemented by part 220 of Reference (y).

(4) MAC includes collections from all forms of tort liability or contractually based insurance, such as:

- (a) Automobile;
- (b) Motorcycle;
- (c) Boat and airplane;
- (d) Product and manufacturers' liability (e.g., defective products);
- (e) Premises or general casualty (e.g., slip and fall) or umbrella;
- (f) Homeowners' and renters'; and
- (g) Medical malpractice (other than federal providers).

(5) MAC also includes all types of contract-based medical or health indemnity insurance or coverage reimbursable without regard to fault, such as:

- (a) Workers' compensation other than federal employees.
- (b) No-fault and personal injury protection (PIP) policies (e.g., automobile accidents).

(c) Medical payments (e.g., automobile, motorcycle, boat, and plane accidents or premises and general casualty, homeowners', and renters' insurance).

(6) MAC also covers collecting accrued pay for lost time of Service members due to circumstances creating tort liability upon a third party.

(7) Deposits for all MAC reimbursements must be made into the MTF's appropriation or supporting O&M account in the year collected pursuant to sections 1095 and 1079a of Reference (d) and Chapter 32, section 2651 of Reference (aa). Follow Military Department or DHA-specific guidance.

(8) MAC accounts receivable must be posted (i.e., recorded) in accordance with guidance provided in References (m) and (n).

b. Role of the Recovery Judge Advocate (RJA)

(1) The Military Department designated RJA is responsible for the assertion and compromise, waiver, or settlement of disputed claims, dictated by Military Department or DHA-specific guidance, arising from a recoverable injury or illness. The RJA is responsible for determining if a patient's treatment represents a potentially recoverable claim.

(2) MTFs must cooperate and collaborate with their supporting RJA and execute or adhere to Memorandums of Understanding as applicable.

(a) Each MTF must establish and implement procedures in accordance with applicable Military Department or DHA-specific guidance, to facilitate the exchange of information necessary to support MAC recovery activities.

(b) MTFs and RJAs must coordinate to ensure inpatient and outpatient records, including emergency department, physical therapy, outpatient or APVs, and ancillary services, are screened to identify potential MAC cases.

(c) MTFs and RJAs must also screen requests for information from third parties to identify potential MAC cases.

(d) The RJA will ensure that MTF comptroller, UBO, clinic, and PAD records are screened to identify potential MAC cases.

(e) The RJA must also coordinate with the other uniformed service claims offices and MTFs to identify potential related claims involving care provided to the injured party at other MTFs.

(3) The RJA must furnish the treating MTF with copies of the final DD Form 1131 showing collections deposited to the MTF's O&M or appropriation account or a monthly report containing pertinent information regarding the patient(s) and the amount(s) deposited to the MTF's account.

(4) RJAs must furnish the referring MTF with a monthly list of claims that were closed without recovery as well as claims that were transferred to another claims jurisdiction.

(5) Before settlement of a MAC case, the RJA must contact the MTF and TRICARE managed care support contractor to ensure all amounts paid by the U.S. Government are included in the claim assertion.

(6) To the extent possible, the RJA must review civilian police accident reports, military police blotters, news reports, court proceedings, line of duty investigations, and similar sources to identify other potential MAC cases.

c. MTF Responsibilities

(1) MTFs must make all records, including electronic records, available to the RJA for use in identifying, asserting, and collecting MAC claims.

(2) MTFs must use existing TPC procedures and documents to the greatest extent possible to ensure accident and injury information (e.g., who, what, when, where, and how) is obtained. The MTF must interview patients:

(a) At point of entry (e.g., outpatient care, APV, ancillary services such as pharmacy, radiology and laboratory, and inpatient care).

(b) During an inpatient stay.

(c) At discharge.

(d) By follow-up conversations with the patient and family.

(3) The procedures and documents used to obtain and record accident information include, but are not limited to:

(a) Pre-admission, admission, concurrent stay, and discharge follow-up interviews.

(b) Outpatient encounter forms.

(c) Emergency room logs.

(d) Admitting and discharge summaries.

(e) Other pertinent medical treatment documents, such as:

1. Admitting, emergency room, physical therapy, and outpatient clinic records.

2. Insurance disclosure forms.

3. Supplemental care payments.

4. Patient, attorney, third party coverage, medical record, or other requisite information or notices.

5. Other hospital or provider notes.

6. Work release requests.

7. Other requests concerning potential MAC cases.

(4) The MTF commander or director will ensure the MTF does not release bills or medical records or respond to requests for assistance with workers' compensation forms without coordinating with the RJA.

(5) Additionally, the MTF must:

(a) Forward copies of all accident-related daily treatment logs and completed third party liability questionnaires using Military Department or DHA-specific forms to the responsible RJA no later than 48 hours after treatment.

(b) Promptly notify the RJA regarding treatment.

(c) Provide claim forms with accurate and complete cost computation.

(d) Provide copies of supporting medical records (e.g., admitting and discharge physician narratives or summaries, outpatient and ancillary service records), as requested by the RJA.

(e) Provide copies of paid vouchers for patients treated in civilian facilities (e.g., MTF-referred treatment) or other DoD MTFs, as requested by the RJA.

(6) MTFs must establish internal controls for cases sent to the RJA for recovery. These controls must cover at a minimum:

(a) Dispositions of claims.

(b) Deposits of funds to the MTF's account.

(c) Timely reporting of information about potential or ongoing MAC cases.

(d) Accurate and complete cost computations for care provided at or through the MTF.

(e) Copies of supporting medical records.

(f) Updated appropriation for depositing funds at the start of each fiscal year.

d. Multiple Sources of Recovery

(1) Often a patient is covered by one or more group health plan or insurance policy (for TPC claims) and one or more automobile liability, no-fault, PIP, or medical payment policy (for MAC claims). State insurance regulations require coordination of employer or group health plans and casualty or liability insurance benefits. Therefore, TPC and MAC claims must be pursued simultaneously.

(2) The U.S. Government may not collect more than the total charge of medical care from any one source or combination of sources. If total payment received exceeds the amount billed, the MTF must refund the overage to the insurer.

(3) MTFs must establish procedures to ensure coordination with, and timely notification of, the supporting legal office on any TPC claim and subsequent collection or denial in cases where the legal office has a concurrent MAC claim. The MTF may not wait until payment is received from the insurer to notify the supporting legal office about a potential MAC claim because the legal office must assert the MAC claim in a timely manner to preserve the U.S. Government's right to recovery.

(4) For uniformed services beneficiaries who are non-federal employees or contractor employees, the MTF may not file a TPC claim with the patient's third party payer when the employee is covered by workers' compensation benefits. The legal office must file the workers' compensation claim as a MAC claim.

6. CHARGES FOR MEDICAL SERVICES

a. General

(1) MSA. Section 1078 of Reference (d), allows for the establishment of fair charges for medical and dental care furnished to active duty family members not enrolled in TRICARE Prime and family members of retirees under section 1076 of Reference (d).

(2) TPC. Section 1095 of Reference (d), allows for the collection of reasonable charges from third party payers for health care services provided at or through an MTF. The MTF may not bill a covered beneficiary for any deductible, co-payment, or other amount denied by a third party payer.

(3) Resource Sharing Agreements. When a civilian provider, under a TRICARE resource sharing agreement, furnishes services at an MTF to a beneficiary, the MTF must bill third party payers the same way as it would bill for any similar services provided at the MTF. See section 220.8(h) of Reference (y).

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b. Inpatient Billing. When reimbursement is required for hospitalization, the MTF must bill using the rates published in Reference (t), plus the FMR, if applicable. Refer to Reference (t), as well for detailed inpatient charge calculation guidance. Additional information regarding inpatient rates is also available at Reference (i). The FMR is an inpatient per diem rate charged to active duty family members not enrolled in TRICARE Prime (see ASD(HA) Memorandum, “Policy on New TRICARE Pharmacy Copayments and Elimination of Active Duty Family Member TRICARE Prime Copayments,” (Reference (ad))) and all retiree family members whose care is not reimbursed by a third party payer. The FMR does not apply to uniformed services beneficiary patients with OHI. Pursuant to section 1095 of Reference (d) and section 220.9 of Reference (y), these amounts are considered covered by the third party payer. The FMR differs from the SR. See paragraph 7 of this enclosure for details. Additional information regarding the FMR is available at Reference (t).

c. Billing for Newborn Care

(1) Generate a bill for all newborns with OHI from the time of birth.

(2) A separate charge must be made for each newborn when there is a multiple birth.

(3) For MSA and TPC accounts, newborns are charged the applicable rate pursuant to his or her PATCAT (or future patient classification). The current PATCAT table (or future EHR solution) is available at Reference (i).

(4) For civilian emergencies, charges must be generated for both the mother (starting from date of admission) and infant (starting from the time of birth).

(5) Newborns of dependent daughters of uniformed services beneficiaries, former Service members, and spouses of former Service members must be billed separately from the time of birth in accordance with ASD(HA) Policy: 07-026, “Policy for Billing Non-Department of Defense Beneficiary Newborns,” (Reference (ae)). An MTF may elect to use Secretarial Designee authority in accordance with Military Department or DHA-specific guidance as stated in paragraph 4.j. of Reference (af).

d. Billing for Transient Patients

(1) A transient patient is one who is in transit through aero medical evacuation channels. This includes any delay or layover during evacuation, such as remaining overnight, unless the patient is removed from the aeromedical evacuation system by the medical authority and admitted to an MTF, either en route or at the final destination. A patient ceases to be a transient patient once he or she is admitted to an MTF.

(2) Air in-flight medical care reimbursement charges are determined by the status of the patient (ambulatory or litter) and are per patient per trip during a 24-hour period. A trip encompasses the time from patient pickup to drop off at the appropriate facility. These charges are only for the cost of providing medical care, a separate charge for transportation may be generated by the Global Patient Movement Requirements Center.

e. Outpatient Billing

(1) Outpatient charges are based on the type of services or procedures provided. Outpatient Billing rates are established by DHA UBO and approved by ASD(HA) annually or as needed.

(2) When reimbursement for outpatient services is required, rates are determined as described in Reference (r). See Reference (r), as well for detailed outpatient charge calculation guidance and Reference (i) for additional information on rates for outpatient medical services.

(3) The MTF must only submit claims for services that have an approved rate. If a reimbursement rate has not been established for a particular service, the MTF may not bill the patient for the service rendered unless the charge is a pass-through from another organization.

(a) MTFs must alert the UBO Manager of any services provided for which there is not an established rate.

(b) This information must be communicated to DHA UBO in accordance with the responsibilities outlined in Enclosure 2 of this DHA-PM.

(4) The MTF must charge patients for services furnished such as office visits, APVs, and follow-up visits for evaluation and management services, as well as referral visits to other clinics within the MTF or paid for by the MTF.

(5) When otherwise already supported by an existing eligibility for non-reimbursable care the following is a partial list of services provided without charge:

(a) Check-in at “sick call” to make an appointment for a visit on a subsequent day.

(b) Weight checks.

(c) Blood pressure checks when requested by the physician as follow-up treatment.

(d) Follow-up visits for the sole purpose of checking bandages, dressings, sutures, and casts.

(e) Removal of casts if the cast was applied at an MTF.

(f) Vision tests for military driver’s licenses.

(g) Dependent school children’s visits to public health nurses who are employees of the MTF and located at the school.

(h) Follow-up visits for contact lens adjustment. A new refraction or prescription would result in a chargeable visit.

(i) Physical examinations provided to prospective dependents (pre-adoptive) of uniformed services beneficiaries.

(j) Pre-employment physicals provided to civilian employees if required for DoD positions. If the individual is hospitalized for further examination, prior notice must be submitted and approved.

(k) Physical examinations required for enlistment or induction into military service or application to one of the Military Department academies.

(l) Follow-up visits for suture removal, bandage check, blood pressure check, etc., by outside the continental United States civilian employees on official temporary duty orders overseas.

(m) Telephone consults or assessments.

(n) Confidential medical care and advice provided at authorized teen clinics and youth health centers to adolescent dependents of federal civilian employees.

(o) Patient education, such as plaque control, family planning, or expectant parent classes.

(p) Organized group examinations or evaluations, such as school or sports physicals, conducted in schools, community centers, or medical facilities.

(q) Public health measures requested by the military base or post commander upon the recommendation of the principal medical staff officer in the interest of the health of the community, including:

1. Immunizations.

2. Interviews.

3. Examinations.

4. Outpatient treatment.

5. Follow-up of cases dealing with communicable diseases.

6. Biological tests associated with epidemiological surveys.

7. Collection of specimens for blood or alcohol tests legally performed at the request of security police.

f. Overseas Outpatient Charges

(1) Certain categories of non-DoD beneficiaries are authorized to receive care at fixed MTFs overseas. Refer to the PATCAT table (or future EHR solution) for a list of these individuals (generally categories K and R) who are authorized to receive care at MTFs. The current PATCAT table (or future EHR solution) is available at Reference (i).

(2) Overseas patients are required to pay for the services they receive. However, if the non-DoD beneficiary patient has OHI, the MTF may as a courtesy bill the third party payer directly pursuant to Military Department or DHA-guidance, and establish accounts receivable.

7. SUBSISTENCE CHARGES

a. General

(1) Subsistence charges cover the basic cost of food. The PATCAT table (or future EHR solution) identifies the patient categories that are billed for subsistence charges.

(2) Subsistence charges do not apply to:

(a) Active duty or retired members of the uniformed services (see Reference (ag)).

(b) Patients whose OHI covers any portion of the hospitalization or any other amount paid by a third party payer to the MTF.

(c) Cadets and midshipmen while they are inpatients.

(3) MTF dining hall charges, not subsistence charges, must apply to any individual in a non-inpatient status (e.g., observation, APV) unless otherwise accepted.

(4) Subsistence charges are different from the FMR (see paragraph 6 of this enclosure for additional information on the FMR).

b. Collection and Disposition of Subsistence Charges

(1) The SR is a standard rate established by the Office of the USD(C). It is available from the Office of the USD(C)'s Website (Reference (ah)) in the "DoD Reimbursable Rates" section at the "Food Services charges at Appropriated Funded Dining Facilities Tab G." The effective date for this rate is prescribed by the Comptroller. To calculate the subsistence charge, determine the number and type of meals provided to the patient and apply the applicable reimbursable rates published by the Office of the USD(C).

(2) Subsistence charges must be collected and deposited locally.

(a) The MSA office must attempt to collect all subsistence accounts receivable at the time of discharge.

(b) If the per diem subsistence charges are not paid within 30 calendar days of inpatient hospital discharge or outpatient date of service, the MSA office must follow up on the account with a letter of delinquency (see Figure 7), or by documented contact with the patient or patient's sponsor, pursuant to Volume 16, Chapter 2 of Reference (m).

(c) Letters of delinquency may be generated through the billing and collection application.

(3) The MSA office must collect monies from trustees or sponsors for mentally incompetent patients.

(4) If medical activities are supported by the base food service function, the MSA office must deposit collections of the SR to the appropriate fund indicated by the base or post food service officer and the servicing accounting and finance office.

UNIFORM BUSINESS OFFICE BILLING MTF NAME Street Address City, State Zip Phone NPI 2: 1234567890 Tax ID: 74-25486659	REPRINT (Used after initial print) I&R #: G0109-14-12345 Date: 02/01/2014																
Notice of Past Due Account																	
Sponsor Name Street Address City / State / Zip	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Payment Remittance Address</td> <td>Remittance MTF Name Address 1 Address 2 City/State/Zip</td> </tr> </table>	Payment Remittance Address	Remittance MTF Name Address 1 Address 2 City/State/Zip														
Payment Remittance Address	Remittance MTF Name Address 1 Address 2 City/State/Zip																
Patient IEN: 123456789 FMP/Patient Name: 30/Patient Name Balance Due [Due Date of Original I&R]: _____																	
<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #e1eef6;"> <th style="width: 15%;">Date of Service</th> <th style="width: 45%;">Description</th> <th style="width: 20%;">Charges</th> <th style="width: 20%;">Delinquent Balance</th> </tr> </thead> <tbody> <tr> <td>12/01/13</td> <td>Treating DMIS Name/Account Control #</td> <td>175.00</td> <td>165.00</td> </tr> <tr> <td>12/03/13</td> <td>Treating DMIS Name/Account Control #</td> <td>75.00</td> <td>75.00</td> </tr> <tr> <td>12/05/13</td> <td>Treating DMIS Name/Account Control #</td> <td>100.00</td> <td>100.00</td> </tr> </tbody> </table>		Date of Service	Description	Charges	Delinquent Balance	12/01/13	Treating DMIS Name/Account Control #	175.00	165.00	12/03/13	Treating DMIS Name/Account Control #	75.00	75.00	12/05/13	Treating DMIS Name/Account Control #	100.00	100.00
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12/05/13	Treating DMIS Name/Account Control #	100.00	100.00														
Balance Due Upon Receipt: \$340.00																	
<p>The above balance is past due and because payment was due no later than 30 days from the date of billing, it is now classified as delinquent. This is our second request for payment of your outstanding balance. Please refer to the above referenced invoice number for details concerning your balance. We understand medical billing is not always simple to understand; if you have a question regarding your bill, please contact the Uniform Business Office (UBO) and we'd be happy to help.</p> <p>Our ability to continue providing medical services to our nation's warriors diminishes if we are unable to collect in full for services provided, in a timely manner. To ensure we are successful at collecting the debts owed to us, the U.S. Department of Treasury's Bureau of the Fiscal Service has mandated that we follow the provisions of the Debt Collection Improvement Act (DCIA) of 1996. In addition, the Digital Accountability and Transparency Act (DATA Act) requires Federal Agencies to refer non-tax debts to the Treasury within 120 days of delinquency. Information concerning Debt Collection Authorities can be found at: http://fiscal.treasury.gov/fservices/gov/debtColl/rsrscTools/debt_dca.htm. Neither the UBO nor the Military Treatment Facility where you received your services has the authority to grant a waiver to collect the charges related to these services.</p> <p>You have the right inspect and copy government records related to these charges and request a review of how we determined your charges; however this request does not alleviate your financial responsibility. Your Personally Identifiable Information (PII) is protected under the U.S. Code (USC), Title 5, Section 552a. If you make or provide any knowingly false or frivolous statements, representations, or evidence, you may be liable for penalties under the False Claims Act, USC, Title 31, Sections 3729-3731 and criminal penalties under USC, Title 18, Sections 286-287& 1001-1002, and/or other applicable statutes.</p> <p>If you receive any type of pay from the DoD, your outstanding debt will be referred to the Defense Finance & Accounting Service (DFAS), for Salary Offset. If you are not an employee of the DoD, your debt will be referred to the Department of Treasury and will be subject to interest, penalties and administrative fees calculated from the due date. The following site lists the collection techniques utilized by the Treasury: http://www.fiscal.treasury.gov/fsprograms/fs_debt.htm.</p> <p>If your payment is already on its way, we thank you and ask that you contact the UBO to insure it was received. If not, in order avoid further aggressive collection action, payment is required no later than 15 days from the date of this letter, as it is already past due. If you are unable to make payment in full, please contact us to discuss payment plan options.</p>																	
ABACUS DLQ 2.0	Print Date																

Figure 7. Sample Delinquent Letter

Payment Options for the UBO are listed below: **(Configurable Text)**

- 1) Pay.gov MTF Pay.gov URL
Pay.gov Instructions per MTF
- 2) Check Make checks payable to MTF NAME and mail to the MTF Remittance Address above.
- 3) Credit Card Please call Business Office Cashier at 555-555-5555

Configurable Signature Block **(No Signature)**

Name

Title

APPENDIX TO ENCLOSURE 3

SAMPLE DD FORM 2569, "THIRD PARTY COLLECTIONS PROGRAM/MEDICAL SERVICES ACCOUNT/OTHER HEALTH INSURANCE," PAGE 1

THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE <i>(Read Privacy Act Statement before completing this form.)</i>		OMB No. 0720-0055 OMB approval expires 31 Aug. 2019
<p>The public reporting burden for this collection of information is estimated to average 4 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, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350-3100 (0720-0055). 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. PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.</p>		
<p>PRIVACY ACT STATEMENT</p> <p>AUTHORITY: Title 10 USC, Sections 1079b, Procedures for charging fees for care provided to civilian; retention and use of fees collected; 1095, Health care services incurred on behalf of covered beneficiaries; collection from third party payers; 42 USC, Chapter 32, Third Party Liability For Hospital and Medical Care; EO 9397 (SSN) as amended.</p> <p>PURPOSE(S): Your information is collected to allow recovery from third parties for medical care provided to you in a Military Treatment Facility. ROUTINE USE(S): Your records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurance providers, and other third parties in order to collect amounts owed to the Department of Defense. Your records may also be used and disclosed in accordance with 5 USC 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcid.defense.gov/Privacy/SORN/index/BlanketRoutineUses.aspx.</p> <p>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, and healthcare operations.</p> <p>DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.</p>		
PATIENT INFORMATION		
1. PATIENT NAME (Last, First, Middle Initial)	2. SSN	3. DATE OF BIRTH (YYYY/MM/DD)
Doe, Jane, M.	222-34-5678	1965/01/15
4a. MAILING ADDRESS (Include ZIP Code)	b. HOME TELEPHONE NO.	
424 Maplewood Lane Harvest Town, VA 22455	(703) 555-2222	
	5a. FAMILY MEMBER PREFIX	b. SPONSOR SSN
	30	111-23-4567
6a. PATIENT'S EMPLOYER'S NAME	b. EMPLOYER TELEPHONE NUMBER	
Virginia Department of Education	703 555-3434	
INSURANCE INFORMATION		
7. ARE YOU ELIGIBLE FOR VETERANS AFFAIRS BENEFITS?		
<input checked="" type="checkbox"/> a. YES. (If you have an insurance card (e.g., Veterans Health Identification Card (VHIC), Veterans Choice Card), that can be copied or scanned by the MTF representative, please provide it and proceed to Item 8; otherwise, please complete items 7.a.(1) through (5) below.)		
(1) Member ID	(2) Plan ID	(3) Expiration Date (YYYY/MM/DD)
1234567890	123 45 67890	2026/12/31
(4) VA Facility Name (e.g., primary care/specialty clinic) that assists in coordinating your care		
Washington DC VA Medical Center		
(5) VA Facility Address and Telephone Number		
50 Irving Street, NW, Washington DC 20422 (202) 745-8000		
<input type="checkbox"/> b. NO. (Proceed to Item 8.)		
8. DO YOU HAVE OTHER HEALTH INSURANCE? (This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)		
<input checked="" type="checkbox"/> a. YES. (Complete Item 9 and the remaining sections below.)		
<input type="checkbox"/> b. NO, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. (Proceed to Item 13.)		
<input type="checkbox"/> c. NO, but I am not a DoD beneficiary. (Proceed to Item 12.)		
9. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.		
a. NAME OF POLICY HOLDER (Last, First, Middle Initial)	b. DATE OF BIRTH (YYYY/MM/DD)	c. RELATIONSHIP TO POLICY HOLDER
Doe, John, R.	1960/06/06	Spouse
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER	e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER	
Department of Defense, Defense Health Agency 7700 Arlington Blvd., Falls Church, VA 22042 (703) 681-0000	Virginia Blue Cross Blue Shield P.O. Box 105080, Richmond, VA 23234 (800) 555-0000	
f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID
111-23-9645	ABC123A567800	423456B101
i. GROUP PLAN NAME	j. ENROLLMENT/PLAN CODE	
BCBS Federal	051	
k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE (YYYY/MM/DD)	m. POLICY END DATE (YYYY/MM/DD)
Medical	2017/01/01	2016/12/31
n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number		
Virginia Blue Cross Blue Shield P.O. Box 105080, Richmond, VA 23234 (800) 555-0000		
(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number
ABC123A567800	610575	2323

DD FORM 2569, SEP 2016

PREVIOUS EDITION IS OBSOLETE.

Adobe Professional XI

SAMPLE DD FORM 2569, "THIRD PARTY COLLECTIONS/PROGRAM MEDICAL SERVICES ACCOUNT/OTHER HEALTH INSURANCE," PAGE 2

10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.					
a. NAME OF POLICY HOLDER (Last, First, Middle Initial) Doe, John, R.		b. DATE OF BIRTH (YYYY/MM/DD) 1960/06/06		c. RELATIONSHIP TO POLICY HOLDER Spouse	
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER Department of Defense, Defense Health Agency 7700 Arlington Blvd., Falls Church, VA 22042 (703) 681-0000					
e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER Delta Dental Insurance Company P.O. Box 1818, Baltimore, MD 21215 (800) 555-0000					
f. CARD HOLDER ID 111-23-9645		g. POLICY ID 111-23-9645		h. GROUP POLICY ID 045	
i. GROUP PLAN NAME Delta Dental Federal		j. ENROLLMENT/PLAN CODE 045		k. INSURANCE TYPE Dental	
l. POLICY EFFECTIVE DATE (YYYY/MM/DD) 2017/01/01		m. POLICY END DATE (YYYY/MM/DD) 2017/12/31			
n. (1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number Delta Dental Insurance Company P.O. Box 1818, Baltimore, MD 21215 (800) 555-0000					
(2) Rx Policy ID 111-23-9645		(3) Rx Bin Number 610382		(4) Rx PCN Number 9898	
11. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?					
<input checked="" type="checkbox"/> a. YES (Complete 11c.-f. and proceed to Item 13.)					
<input type="checkbox"/> b. NO (Proceed to Item 13.)					
c. NAME (Last, First, Middle Initial)		d. SSN		e. DATE OF BIRTH (YYYY/MM/DD)	
f. RELATIONSHIP TO POLICY HOLDER		c. NAME (Last, First, Middle Initial)		d. SSN	
e. DATE OF BIRTH (YYYY/MM/DD)		f. RELATIONSHIP TO POLICY HOLDER		e. DATE OF BIRTH (YYYY/MM/DD)	
Doe, Robert, K.		333-56-8789		1996/04/04	
child		Doe, Mary, J.		444-12-7456	
1999/12/11		child			
12. MEDICARE OR MEDICAID INFORMATION					
a. MEDICARE PART A NUMBER		b. MEDICARE PART B NUMBER		c. MEDICARE MANAGED CARE PLAN NAME	
d. MEDICARE PART D NUMBER AND PLAN NAME				e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE	
13. CERTIFICATION, RELEASE, AND ASSIGNMENT					
a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of \$250,000 or imprisonment for five years, or both.					
b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.					
c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.					
d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles.					
e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided to me and/or my family member.					
f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.					
14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE				b. DATE (YYYY/MM/DD)	
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE				b. DATE (YYYY/MM/DD)	
16. ANNUAL PATIENT INSURANCE VERIFICATION					
a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.					
b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.					
17a. SIGNATURE (Patient or Adult Family Member)				b. DATE (YYYY/MM/DD)	
18. VERIFICATION		(2) Initials		(2) Initials	
a. (1) Date (YYYY/MM/DD)		b.(1) Date (YYYY/MM/DD)		c.(1) Date (YYYY/MM/DD)	

DD FORM 2569 (BACK), SEP 2016

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AIS	automated information systems
APV	ambulatory procedure visit
ASD(HA)	Assistant Secretary of Defense for Health Affairs
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCS	Composite Health Care System
CMS	Centers for Medicare and Medicaid Services
DFAS	Defense Finance and Accounting Service
DHA	Defense Health Agency
DHA-PM	Defense Health Agency-Procedures Manual
DMDC	Defense Manpower Data Center
DME	durable medical equipment
DO	disbursing officer
DOL	Department of Labor
EHR	electronic health record
EOB	explanation of benefits
FEMA	Federal Emergency Management Administration
FI	fiscal intermediary
FMP	foreign military personnel
FMR	family member rate
FOR	full outpatient reimbursement rate
FRR	full reimbursement rate
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	health maintenance organization
I&R	invoice and receipt
IAR	interagency rate
IMET	international military education and training
IOR	interagency/other federal agency sponsored rate
MAC	Medical Affirmative Claims
MHS	Military Health System
MMSAR	Monthly Medical Services Activity Report
MSA	Medical Services Account
MTF	medical treatment facility

NAF	non-appropriated fund
NAFI	non-appropriated fund instrumentality
NCO	non-commissioned officer
NCR MD	National Capital Region Medical Directorate/J-11
O&M	operations and maintenance
OHI	other health insurance
OIG	Office of the Inspector General
OTCnet	Over the Counter Channel
PAD	Patient Administration Division
PATCAT	patient category
PIP	personal injury protection
RJA	Recovery Judge Advocate
RM	Resource Management
SF	Standard Form
SR	subsistence rate
SSN	Social Security number
TPC	Third Party Collection
UB	Uniform Bill
UBO	Uniform Business Office
USD(C)/CFO	Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD
VA	Department of Veterans Affairs

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are provided for the purposes of this DHA-PM.

accounts receivable. Receivables arise from claims to cash or other assets against another entity. At the time revenue is recognized and payment has not been received in advance, a receivable must be established. Receivables include, but are not limited to, monies due for the sale of goods and services and monies due for indebtedness as described in Volume 4, Chapter 3 of References (m) and (n). Accounts receivable arising from claims to another government agency are referred to as intragovernmental accounts receivable, and accounts receivable arising from claims to a nonfederal entity are referred to as public accounts receivable. Revenue is recognized (posted and recorded) and an account receivable is established at the time services are rendered.

APV. Formerly referred to as same day surgery. A type of outpatient visit in which immediate pre-procedure and immediate post-procedure care requires an unusual degree of intensity and

care and is provided in an ambulatory procedure unit. Care is required in the facility for less than 24 hours.

automobile liability insurance. Insurance covering legal liability for health and medical expenses resulting from personal injuries arising from the operation of a motor vehicle. Automobile liability insurance includes:

Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

Uninsured and underinsured coverage, in which there is a third party tort-feasor who caused the injuries (i.e., benefits are not paid on a no-fault basis), but the insured party is not the tort-feasor.

billable visit. A billable visit must meet the Medical Expense and Performance Reporting System definition of a visit. (See the definition for "visit.")

claim. Any request for payment for services rendered related to care and treatment of a disease or injury that is received from a beneficiary, a beneficiary's representative, or an in-system or out-of-system provider by a Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) FI or managed care contractor on any CHAMPUS-approved claim form or approved electronic media. Types of claims and/or data records include institutional, inpatient professional services, outpatient professional services (ambulatory), drug, dental, and program for the handicapped.

DME. Equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, and generally is not useful to an individual in the absence of an illness or injury (e.g., wheelchairs, home hospital beds).

elective cosmetic surgery. Defined in Reference (q).

facility of the uniformed services. Defined in section 220.14 of Reference (y).

fund cite. An account or reference number identifying a specific appropriation or line of accounting.

Global Patient Movement Requirements Center. A joint activity reporting directly to the Commander, U.S. Transportation Command, the DoD single manager for the regulation of movement of uniformed services patients. The Global Patient Movement Requirements Center authorizes transfers to MTFs or the VA and coordinates in theater and inside continental United States patient movement requirements with the appropriate transportation component commands of U.S. Transportation Command.

health care services. Inpatient, outpatient, and designated ancillary and prescription drug services.

inpatient. A patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

inpatient hospital care. Treatment provided to an individual other than a transient patient, who is admitted (i.e., placed under treatment or observation) to a bed in an MTF of the uniformed services that has authorized beds for inpatient medical or dental care.

insurance, medical service, or health plan. Any plan (including any policy, program, contract, or liability arrangement) that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for health or medical services, items, products, and supplies.

intragovernmental receivables. Receivables due from DoD Components or other federal entities are intragovernmental receivables and must be reported separately from receivables due from public entities.

Medicare supplemental insurance plan (Medigap). An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" as provided in section 220.10 of Reference (y).

MTF. A DoD facility that provides medical and/or dental services.

NCR MD/J-11. Defined in Reference (b).

no-fault insurance. An insurance contract providing compensation for health and medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes PIP and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

non-uniformed services beneficiary. This PATCAT (or future patient classification) includes federal employees, overseas State Department employees and their dependents (while overseas), and contractors.

observation services. Those services furnished by a hospital on the hospital's premises, including the use of a bed and periodic monitoring by the hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Most observation care services do not exceed 1 day. Some patients may

require a second day of services. Only in rare and exceptional cases do observation services span more than 2 calendar days.

occupational health. Preventive health care, health promotion, curative health care, first aid, rehabilitation and compensation, where appropriate, as well as strategies for prompt recovery and return to work.

outpatient care. Visits to a separately organized clinic or specialty service made by patients who are not currently admitted to the reporting MTF. Patient receives health care services for an actual or potential disease, injury, or lifestyle-related problem.

PATCAT. A legacy CHCS classification that tells whether a patient is billable or not billable, and if billable, the appropriate payment mode and rates to apply. The future EHR solution may utilize a new patient classification nomenclature and structure.

pay patient. An individual eligible to receive care in an MTF on a reimbursable basis.

Secretarial Designee Program. A program established under section 1074(c) of Reference (d) to create eligibility for health care services in MTFs for individuals who have no such eligibility under Reference (e). When used, medical care provided on a reimbursable basis, unless non-reimbursable care is specifically authorized by section 108 of Reference (y) or reimbursement is waived by the Under Secretary of Defense for Personnel and Readiness, or the Secretaries of the Military Departments or Director, DHA, when they are the approving authority.

staff. Includes all personnel – active duty, government, civilian contractor – working in an MTF.

third party payer. An entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a workers' compensation program or plan, and any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies. For purposes of the definition of "third-party payer," an insurance, medical service, or health plan includes a preferred provider organization, an insurance plan described as Medicare supplemental insurance, and a PIP plan or medical payments benefit plan for personal injuries resulting from the operation of a motor vehicle.

TRICARE is secondary payer to all third-party payers. Under limited circumstances described in section 199.8(c)(2) of Reference (y), TRICARE payment may be authorized to be paid in advance of adjudication of the claim by certain third-party payers. TRICARE advance payments will not be made when a third-party provider is determined to be a primary medical insurer under section 199.8(c)(3) of Reference (y).

TRICARE. Formerly known as CHAMPUS. TRICARE is the health care program of the DoD MHS that provides civilian health benefits for military personnel, military retirees, and their dependents, including some members of the Reserve Component. The TRICARE program is managed by DHA under the authority of the ASD(HA).

TRICARE supplemental plan. An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under TRICARE. No insurance, medical service, or health plan provided by an employer or employer group may qualify as a TRICARE supplemental plan (see also section 220.10 of Reference (y)).

tort-based insurance. Indemnification for physical injuries and property damage resulting from a person's negligence established through legal processes or adjudication. For example, automobile liability and uninsured and/or underinsured motorist coverage; commercial and/or public premises ("slip and fall") or general casualty and umbrella (covering a variety of real or personal properties such as business, home, farm, boat, car, airplane, etc.) insurance; product (manufacturer's) liability insurance; homeowners' and/or renters' insurance; medical malpractice coverage; and boat or airplane casualty insurance.

uniformed services beneficiary. Any person eligible for benefits and authorized treatment in a uniformed services facility pursuant to sections 1074, and 1076 (a) and (b) of Reference (d).

visit. Health care characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen. For a visit to be counted, there must be interaction between an authorized patient and a health care provider, independent judgment about the patient's care, and documentation, including, at a minimum, the date, clinic name, reason for visit, patient assessment, description of the interaction between the patient and the health care provider, disposition, and signature of the provider of care, in the patient's authorized record of medical treatment.

workers' compensation. Any program or plan that provides compensation for loss, to employees or their dependents, resulting from the injury, disablement, or death of an employee due to an employment related accident, casualty or disease. The common characteristic of such a plan or program is the provision of compensation regardless of fault, in accordance with a delineated schedule based upon loss or impairment of the worker's wage earning capacity, as well as indemnification or compensation for medical expenses relating to the employment related injury or disease. Workers' compensation law varies from State to State. Federal employees are covered by the Federal Employees Compensation Act for workers' compensation purposes.