Pharmacy Reimbursement for Guard and Reservist with Line of Duty (LOD) injuries or illness - DHA-GL

Who this is for
National Guard and Reservist

Background
Defense Health Agency Great Lakes DHA-GL in conjunction with Express Scripts Incorporated (ESI) began processing Retail Pharmacy reimbursements for National Guard and Reservist on 15 November 2004.

Eligibility
National Guard and Reservist who have pre-paid or have been billed for pharmaceuticals in conjunction with a Line of Duty Determination (LOD) injury or illness.

Note: Over-the-counter drugs and any non-covered pharmaceuticals will not be reimbursed.

Process for Reimbursement
Follow these steps to get reimbursed for authorized pharmaceutical items:

<table>
<thead>
<tr>
<th>Step</th>
<th>What Happens</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Member/Designated person with a Power of Attorney ONLY completes and signs a CHAMPUS Claim - Patient’s Request for Medical Payment DD Form 2642 (located at the end of this section).</td>
</tr>
</tbody>
</table>
| 2    | Member provides claim printout or paid civilian pharmacy invoice with the following information:  
  - Doctors Name  
  - Drug Name  
  - National Drug Code (NDC) number  
  - Quantity  
  - Cost share or amount charged  
  - Date of service, and  
  - Name of Retail Pharmacy and address (required) |
| 3    | Obtain eligibility documentation that covers the date of injury and/or pharmacy, i.e. orders, attendance roster, or LOD if not already sent to/ on file at DHA-GL. |
## Step 4
Complete DHA-GL Medical Eligibility Verification worksheet (DHAGL Worksheet 01 – (select from list under Request Worksheets). Write pharmaceutical reimbursement as well as diagnosis in block #11.

## Step 5
Forward the DD Form 2642, pharmacy invoice, eligibility documentation/LOD, and DHA-GL Medical Eligibility Verification Worksheet to the following FAX or address:

- **FAX:** 847-688-6460

**Mailing Address:**
Defense Health Agency Great Lakes (DHA-GL)
Attn: RC Retail Pharmacy Reimbursement
Bldg 3400 Ste 304
2834 Green Bay Road
Great Lakes IL 60088

---

### Results and Follow-up
If DHA-GL determines your pharmacy bill is related to your LOD injury or illness they will instruct ESI to process your claim for reimbursement. Within 30 working days, you will receive an Explanation of Benefits (EOB) statement with a reimbursement check from ESI.

### Website
TRICARE website for TRICARE Pharmacy Program - [http://www.tricare.mil/pharmacy](http://www.tricare.mil/pharmacy)

### Point of Contact
If you have questions or need additional assistance beyond the information provided here, contact:

<table>
<thead>
<tr>
<th>Section</th>
<th>Military Medical Support Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Customer Service Representative</td>
</tr>
<tr>
<td>Phone</td>
<td>888-647-6676</td>
</tr>
<tr>
<td></td>
<td>For questions about:</td>
</tr>
<tr>
<td>Billing/Claims</td>
<td>Dial option 2 then option 3</td>
</tr>
<tr>
<td>Pre-authorizations</td>
<td>Dial option 1 then option 3</td>
</tr>
<tr>
<td>Fax</td>
<td>847-688-6460 or 847-688-7394</td>
</tr>
</tbody>
</table>

---

**Privacy Act Statement:** This statement serves to inform you of the purpose for collecting information required by the Defense Health Agency Great Lakes (DHA-GL) and how it will be used. **AUTHORITY:** 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE program; and E.O. 9397 (SSN), as amended. **PURPOSE:** To collect information from Military Health System beneficiaries in order to determine their eligibility for coverage under the TRICARE Program. **ROUTINE USES:** Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 522a (b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: [http://dpclo.defense.gov/privacy/SORNs/blanket_routine Uses.html](http://dpclo.defense.gov/privacy/SORNs/blanket_routine Uses.html). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPPA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by 6025.18-R. Permitted uses and discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations. **DISCLOSURE:** Voluntary; however, failure to provide information may result in the denial of coverage.
**PRIVACY ACT STATEMENT**


**PRINCIPAL PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

**DISCLOSURE:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

**IMPORTANT - READ CAREFULLY**

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

**INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT**

**NONAVAILABILITY STATEMENT REQUIREMENTS:** If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a bona fide emergency. Without a necessary NAS your claim will be denied.

* * * * * *

**ITEMIZED BILL:** Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

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

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

* * * * * *

**TIMELY FILING REQUIREMENTS:** All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice -- whichever date is later.

* * * * * *

**WHERE TO OBTAIN ADDITIONAL FORMS:** You may obtain additional claim forms from your claims processor, the TRICARE Service Center at the nearest military treatment facility or TRICARE Management Activity, 16401 E. Centreftech Pkwy., Aurora, CO 80011-9066.

*** REMINDER ***

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

1. Completed all 12 blocks on the form. If not signed, the claim will be returned.
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance.
5. Obtained a Nonavailability Statement if required (see information above).
6. Attached DD Form 2527, “Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity” if accident or work related. See instruction number 7 on reverse side.
7. Ensured that patient's name, sponsor's name and sponsor's SSN are on all attachments.
8. Made a copy of this claim and attachments for your records.
1. **PATIENT’S NAME** (Last, First, Middle Initial)  
2. **PATIENT’S TELEPHONE NUMBER** (Include Area Code)  
   - **DAYTIME** ( )  
   - **EVENING** ( )  
3. **PATIENT’S ADDRESS** (Street, Apt. No., City, State, and ZIP Code)  
4. **PATIENT’S RELATIONSHIP TO SPONSOR** (X one)  
   - SELF  
   - SPOUSE  
   - NATURAL OR ADOPTED CHILD  
   - STEPCHILD  
   - FORMER SPOUSE  
   - OTHER (Specify)  
5. **PATIENT’S DATE OF BIRTH**  
   (YYYYMMDD)  
6. **PATIENT’S SEX**  
   - MALE  
   - FEMALE  
7. **IS PATIENT’S CONDITION** (X both if applicable)  
   - ACCIDENT RELATED? YES NO  
   - WORK RELATED? YES NO  
8a. **DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.**  
8b. **WAS PATIENT’S CARE** (X one)  
   - INPATIENT?  
   - OUTPATIENT?  
   - DAY SURGERY?  
9. **SPONSOR’S OR FORMER SPOUSE’S NAME** (Last, First, Middle Initial)  
10. **SPONSOR’S OR FORMER SPOUSE’S SOCIAL SECURITY NUMBER**  
11. **OTHER HEALTH INSURANCE COVERAGE**  
   a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members?  
   - YES  
   - NO  
   If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements.  
   b. **TYPE OF COVERAGE** (Check all that apply)  
   - (1) EMPLOYMENT (Group)  
   - (2) PRIVATE (Non-Group)  
   - (3) MEDICARE  
   - (4) STUDENT PLAN  
   - (5) MEDICARE SUPPLEMENTAL INSURANCE  
   - (6) PRESCRIPTION DISCOUNT PLAN  
   - (7) OTHER (Specify)  
   c. **NAME AND ADDRESS OF OTHER HEALTH INSURANCE**  
   - (Street, City, State, and ZIP Code)  
   d. **INSURANCE IDENTIFICATION NUMBER**  
   e. **INSURANCE EFFECTIVE DATE**  
   (YYYYMMDD)  
   f. **DRUG COVERAGE?**  
   - YES  
   - NO  
12. **SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.**  
   a. **SIGNATURE**  
   b. **DATE SIGNED** (YYYYMMDD)  
   c. **RELATIONSHIP TO PATIENT**  
   - YES  
   - NO  
13. **OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?**  
   - YES  
   - NO  

**HOW TO FILL OUT THE TRICARE/CHAMPUS FORM**  
You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.  
11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICARE/CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.  
NOTE: All other health insurance except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. The claims processor cannot process claims until you provide the other health insurance information.  
12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a and sign the claim.  
Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.  
13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment available only in some local currencies.
TRICARE DoD/CHAMPUS MEDICAL CLAIM
PATIENT’S REQUEST FOR MEDICAL PAYMENT

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0720-0005). 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 THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A BENEFICIARY COUNSELING AND ASSISTANCE COORDINATOR (BCAC) OR TRICARE MANAGEMENT ACTIVITY (303) 676-3400.

PRIVACY ACT STATEMENT


PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim.

IMPORTANT - READ CAREFULLY

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

INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT

NONAVAILABILITY STATEMENT REQUIREMENTS: If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a bona fide emergency. Without a necessary NAS your claim will be denied.

ITEMIZED BILL: Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

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

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

TIMELY FILING REQUIREMENTS: All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice -- whichever date is later.

WHERE TO OBTAIN ADDITIONAL FORMS: You may obtain additional claim forms from your claims processor, the TRICARE Service Center at the nearest military treatment facility or TRICARE Management Activity, 16401 E. Centretech Pkwy., Aurora, CO 80011-9066.

*** REMINDER ***

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

1. Completed all 12 blocks on the form. If not signed, the claim will be returned.
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance.
5. Obtained a Nonavailability Statement if required (see information above).
6. Attached DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity" if accident or work related. See instruction number 7 on reverse side.
7. Ensured that patient's name, sponsor's name and sponsor's SSN are on all attachments.
8. Made a copy of this claim and attachments for your records.
1. PATIENT'S NAME (Last, First, Middle Initial)  
2. PATIENT'S TELEPHONE NUMBER (Include Area Code)  
   DAYTIME ( )  
   EVENING ( )

3. PATIENT'S ADDRESS (Street, Apt. No., City, State, and ZIP Code)  
4. PATIENT'S RELATIONSHIP TO SPONSOR (Xone)  
   SELF  
   SPOUSE  
   NATURAL OR ADOPTED CHILD  
   STEPCHILD  
   FORMER SPOUSE  
   OTHER (Specify)

5. PATIENT'S DATE OF BIRTH (YYYYMMDD)  
6. PATIENT'S SEX  
   MALE  
   FEMALE

7. IS PATIENT'S CONDITION (X both if applicable)  
   ACCIDENT RELATED? YES NO  
   WORK RELATED? YES NO

8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.  
8b. WAS PATIENT'S CARE (X one) INPATIENT? YES NO  
   OUTPATIENT? YES NO  
   PHARMACY? YES NO  
   DAY SURGERY? YES NO

9. SPONSOR'S OR FORMER SPOUSE'S NAME (Last, First, Middle Initial)  
10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER

11. OTHER HEALTH INSURANCE COVERAGE  
   a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? YES NO  
      If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements.  
   b. TYPE OF COVERAGE (Check all that apply)  
      (1) EMPLOYMENT (Group)  
      (2) PRIVATE (Non-Group)  
      (3) MEDICARE  
      (4) STUDENT PLAN  
      (5) MEDICARE SUPPLEMENTAL INSURANCE  
      (6) PRESCRIPTION DISCOUNT PLAN  
      (7) OTHER (Specify)

   c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE  
      (Street, City, State, and ZIP Code)

   d. INSURANCE IDENTIFICATION NUMBER

   e. INSURANCE EFFECTIVE DATE (YYYYMMDD)

   f. DRUG COVERAGE?
      YES NO

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

   a. SIGNATURE

   b. DATE SIGNED (YYYYMMDD)

   c. RELATIONSHIP TO PATIENT
      YES NO

13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?

HOW TO FILL OUT THE TRICARE/CHAMPUS FORM  
You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.

11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICARE/CHAMPUS insurance, do not report. You must, however, report Medicare supplemental insurance. Block 11 allows space to report two other health insurances. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim. NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. The claims processor cannot process claims until you provide the other health insurance information.

12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a. and sign the claim. Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.

13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment available only in some local currencies.