Defense Health Agency Great Lakes

(DHA-GL)

Process Guide

December 2023

DEFENSE HEALTH AGENCY GREAT LAKES (DHA-GL) Process Guide

This guide was developed to assist active duty, reservist, guard members, unit medical and command representatives with commonly used DHA-GL services (or processes).

HOW TO …
Submit Medical Eligibility Documentation to DHA-GL
Submit a Request for Pre-authorization for Line of Duty Medical Care
Submit an Appeal
Submit Retail Pharmacy Reimbursement for Guard and Reservist with Line of Duty (LOD) injuries or illness
Obtain Assistance for Debt Collection
Frequently Asked Questions

How to Submit Medical Eligibility Documentation to DHA-GL

Who this is for

National Guard and Reservist

Purpose

Medical eligibility documents are used to document, establish, manage, and authorize civilian health care for eligible Reservist and National Guard members who incur or aggravate an injury, illness or disease in the line of duty.

Defense Health Agency Great Lakes (DHA-GL) is responsible for the authorization of civilian medical care for Reservist and National Guard members residing in the United States, District of Columbia and U.S. Virgin Island Only.

Eligibility

Reservist and National Guard members who incur or aggravate an injury, illness or disease in the line of duty on orders under 30 days.

Submitting Eligibility

Follow these steps to submit medical eligibility documentation to DHA-GL

Steps	Action
1	Unit medical representative **must** complete the DHA-GL Medical Eligibility Request DHA-GL Medical Eligibility Verification Worksheet DHA-GL Worksheet - 01, submit with a copy of certified orders/drill attendance sheet **and** ER/Urgent care notes (NOT discharge notes or after visit summary). Use email **(preferred),** mail or fax. **Do not send bills with eligibility, all billing must go to Tricare** ****Army Reserve and Army National Guard must submit eligibility through eMMPS/Medchart at** https://medchart.ngb.army.mil/MED-CHART **Email (Preferred):** dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil **Fax:** 847-688-6460 or 847-688-7394 **Mailing Address:** Defense Health Agency Great Lakes (DHA-GL) Attn: Reserve Eligibility Bldg 3400 STE 304 2834 Green Bay Road Great Lakes IL 60088

Step	
2	Ensure provider submits medical claims to appropriate region and uses the service members SSN as the member ID number on the claim forms, CMS1500 or UB04. **Tricare East** Tricare East Region Claims New Claims P.O. Box 7981 Madison, WI 53707-7981 **Tricare West** Tricare West Region Claims Submission Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 202112 Florence, SC 29502-2112

Note:

Do not send bills to DHA-GL, all claim forms must be submitted to Tricare

If a service member (SM) needs follow-up medical care, please see DHA-GL Process Guide for "How to Submit Pre-Authorization for Line of Duty(LOD) Medical Care"

The request must include a Service Approved Line of Duty. Any Claims for medical care rendered without a pre-authorization will be denied.

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. 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.

Defense Health Agency - Great Lakes
DHA-GL Worksheet-01
Rev. 12/05/2023

MEDICAL ELIGIBILITY VERIFICATION:
RESERVE COMPONENT

Instructions: Member or unit representative completes Sections I and II. **ONLY** Unit representative or Commanding officer completes and validates Section III; then email, mail, or fax this form & supporting documentation to DHA-GL.

Complete ALL Blocks

PRIVACY ACT STATEMENT

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AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE Program and, E.O. 9397 (SSN), as amended.

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DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of coverage.

REFERENCES: Governing Law- 10 U.S. Code § 1074a; and DODI 1241.01 - Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements

Defense Health Agency - Great Lakes
DHA-GL Worksheet-01
Rev. 12/05/2023

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RESERVE COMPONENT

Instructions: Member or current unit representative completes Sections I and II. **ONLY** Unit representative or Commanding officer completes and validates Section III; then email, mail, or fax this form & supporting documentation to DHA-GL.
COMPLETE ALL BLOCKS

Section I Member Data

1. Branch of Service: ◯ USAR ◯ USNR ◯ USMCR ◯ USAFR ◯ ARNG ◯ ANG ◯ USCGR

2. Name (Last, First, MI):	3. Rank or Grade:	4. SSN (full) / DOD ID:
5a. Address (street, apt #, city, state, & zip):		6. DOB (YYMMDD):
5b. Member Email Address:		7. Phone # (include area code):

Section II Illness/Injury Information

8. Date of injury/illness (YYMMDD):	9. Treated on (YYMMDD):	10. Duty Dates (YYMMDD): 10a. From: 10b.To:

11. Diagnosis or description of injury/illness: (include ICD-10 Code):

Section III Current Unit Certification of Eligibility

12. Type of ORDERS: ◯ Weekend Drill ◯ Annual Training ◯ Other

13. Name of the nearest Military Treatment Facility:_____which is_____miles from the member's **residence.**

14a. Unit Assignment (unit name, staff symbol, code, etc.):	14b. Unit UIC/OPFAC:
14c. Unit Address (street, bldg #, city, state, & zip):	14d. Unit Phone # (include area code):
15a. Unit POC - Medical Rep/Unit Administrator (name, rank and title):	15b. POC Phone # (include area code):
15c. Unit POC Department of Defense email address (.mil):	

16. **Certification**: I certify that this individual is eligible for care at government expense (CO or Unit Rep. Digital CAC signature ONLY):

Signature Printed Name: Date:

STOP Include all required documents!

You must include the following:

- **Drill Attendance Sheet or Certified Orders** (for initial date of medical care)
- **ER/Urgent Care Provider's Notes**

Documents must match or cover the dates in blocks 8-10 above.

Army Reserve and Army National Guard must submit eligibility through eMMPS/MedChart.

EMAIL, MAIL, or FAX INFORMATION

EMAIL this form/documents to: **(preferred)**
dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil
Note: this box can only accept emails from .mil addresses

MAIL this form/documents to:
Defense Health Agency Great Lakes (DHA- GL)
2834 Green Bay Road Ste 304
Great Lakes, IL 60088

FAX this form/documents to: **847-688-6460 or 7394**

How to Submit a Request for Pre-authorization for Line of Duty (LOD) Medical Care to DHA-GL

Who this is for National Guard and Reservist

Background and Purpose Defense Health Agency Great Lakes (DHA-GL) pre-authorizes civilian medical care for eligible National Guard and Reservist who have been injured or became ill in the line of duty during a period of qualified duty who resides greater than 50 miles/one hour drive time from a Military Treatment Facility (MTF).

Eligibility

You must meet the following criteria:

- National Guard or Reservist that has been issued a Line of Duty Determination (LOD) **and** resides outside 50 miles/one hour drive time of a MTF. MTF Locator link below:
  Find a Military Hospital or Clinic | TRICARE
- Have medical eligibility documentation on file at DHA-GL prior to requesting care (unless orders were greater than 30 days).

Submission Process Follow these steps to submit a pre-authorization request:

Step	Action
1	Unit medical representative completes a **Pre-Authorization Request or Medical Care** DHA-GL Worksheet-02 . Submit DHA-GL Worksheet-02, **service approved** LOD and clinical documentation by email (preferred), mail or fax. Clinical documentation should validate that the medical condition was incurred or aggravated while the member was in a qualified duty status. ****Army Reserve and Army National Guard must submit eligibility through eMMPS/Medchart. https://medchart.ngb.army.mil/MED-CHART** **Email Preferred:** dha.great-lakes.j-10.mbx.mmso-initial-lod-mma@health.mil **Fax:** 847-688-6369 or 7394 **Mailing Address**: Defense Health Agency Great Lakes (DHA-GL) Attn: Medical Pre-Authorizations 2834 Green Bay Road Bldg 3400 Ste 304 Great Lakes, IL 60088

Line of Duty (LOD) Episode of Care (EOC) Authorizations

- THP MMSO authorizes treatment of a specific LOD medical condition to which can include diagnostic tests, durable medical equipment support, treatment (to include surgery, if indicated) and any required/related follow-on care to include physical therapy, follow-on testing, etc. There is no longer a requirement for incremental requests to authorize care for each step in the treatment process. Episode of Care (EOC) authorizations result in a better coordinated treatment process for the RC service member and reduces delays in providing needed care.

- Under EOC, often referred to as "Primary Care Manager (PCM) evaluate and treat," the PCM manages the entire episode of care to include diagnostics, treatment, and follow-on care. **THP MMSO does not select PCMs, the TRICARE contractor does.** The PCM initiates the referral/preauthorization request directly to the respective TRICARE managed care support contractor through the provider referral/authorization portal. Once the TRICARE contractor receives the referral, they provide an authorization directly to a specialty provider for the specialty services requested by the PCM. This process occurs independently of THP MMSO and the Unit. The member and/or the unit may see these authorizations once completed on the TRICARE Contractor's authorization self-service portal (**East:** https://www.humanamilitary.com **West:** https://www.tricare-west.com). **It is the Service member's responsibility to keep the Unit informed on the status of their care throughout the entire EOC treatment process.**

- Most LOD follow-on care pre-authorizations issued by THP MMSO (Defense Health Agency, Great Lakes) are 365-day EOC authorizations. LOD care can only be approved for maximum of 12 months, if eligible, SM can seek additional care through VA. SM also should be referred to Disability Evaluation System (DES).

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. 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.

Defense Health Agency - Great Lakes
DHA-GL Worksheet-02
Rev. 12/5/2023

PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE: RESERVE COMPONENT

Instructions: Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then faxes or mails this form and supporting documentation to DHA-GL.
Complete ALL Blocks

PRIVACY ACT STATEMENT

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PURPOSE: To collect information from Military Health System beneficiaries to determine their eligibility for coverage under the TRICARE Program.

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DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of coverage.

REFERENCES: Governing Law- 10 U.S. Code § 1074a; and DODI 1241.01 - Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements

Defense Health Agency - Great Lakes
DHA-GL Worksheet-02
Rev. 12/05/2023

PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE: RESERVE

Instructions: Member or current unit representative completes Sections I and II. ONLY Unit representative or Commanding Officer completes and validates Section III; then email, mail, or fax this form and supporting documentation to DHA-GL.
COMPLETE ALL BLOCKS

Section I Member Data

1. Branch of Service: ◯ USAR ◯ USNR ◯ USMCR ◯ USAFR ◯ ARNG ◯ ANG ◯ USCGR

2. Name (Last, First, MI):	3. Rank or Grade:	4. Full SSN:
5a. Address (street, apt #, city, state, & zip):	6. DOB (YYMMDD):	7. Phone # (include area code):
5b. Member email address:	8. TRICARE Region ◯ East ◯ West ◯ Unknown	

Section II Pre Authorization Request

9. Date of injury/illness (YYMMDD):	10. Duty Dates (YYMMDD): 10a. From: 10b.To:

11. Diagnosis (Include ICD-10 Code):

12. Sent eligibility documents to DHA-GL on:_____.
If not sent, check which documents are attached (one or both): ◯ Line of Duty form (LOD) ◯ Orders/Attendance Roster.

13. List needed follow-up care or durable medical equipment (include CPT/HCPCS codes):

14. Is a Medical Board in Process? ◯ Yes ◯ No **If yes, note start date and Military Hospital/Clinic name:**

Section III Current Unit Certification of Eligibility

15. Name of the nearest Military Treatment Facility which is _____miles from the member's **residence.**

16a. Unit Name & Address (Unit name, staff symbol, code, etc.):	16b. Unit UIC/OPFAC:
17a. Unit POC - Medical Rep/Unit Administrator (Name, Rank and Title):	17b. POC Phone # (include area code):
17c. Unit POC United States Department of Defense email address (.mil):	

18. **Certification**: I certify this individual is eligible for this care at government expense (CO or Unit Rep. Digital CAC signature ONLY):
Signature: Printed Name: Date:

STOP Include all required documents!

You must include the following:

Service Approved LOD, Drill Attendance Sheet or Certified Orders **and** Clinical Documentation

Documents must match or cover the dates in blocks 9-10 above

Army Reserve and Army National Guard must submit Preauthorization through eMMPS/MedChart.

EMAIL, MAIL, or FAX INFORMATION

EMAIL this form/documents to**: (Preferred)**
dha.great-lakes.j-10.mbx.mmso-initial-lod-mma@health.mil
Note: this box can only accept emails from .mil addresses

MAIL this form/documents to:
Defense Health Agency Great Lakes (DHA-GL)
2834 Green Bay Road Ste 304
Great Lakes, IL 60088

FAX this form/documents to: **847-688-7394 or 6369**

How to Submit a Formal Appeal to Defense Health Agency Great Lakes DHA-GL

Who this is for

National Guard and Reservist

Purpose

This explains how an eligible member submits a formal appeal to the Defense Health Agency Great Lakes (DHA-GL) to request:

- Payment of a denied authorized medical care claim
- Approval of a pre-authorization for medical care previously denied

Eligibility

To be eligible to submit a formal appeal to DHA-GL you must have been either denied a payment of medical care claim(s), or denied pre-authorization request(s) for authorized medical care, and meet the following criteria:

If …	Then on date of care, MUST …
National Guard or Reservist	Have an approved Line of Duty (LOD) on file at DHA-GL for the illness or injury.

Definition: Authorized medical care: A medical treatment or procedure which is medically necessary.

*****Appeals are not a guarantee of Claim Payment or Pre-Authorization Approval *****

Appeal Process Follow these steps to submit a formal appeal to DHA-GL:

Steps	Who does it	What Happens
1	Member	Contacts Medical/Unit Representative for clarification, guidance, and assistance with denial of claim or pre-authorization request.
2	Member/Unit Representative	Contacts appropriate DHA-GL point of contact below via telephone for further information regarding the reason for denial. Assists member in developing appeal. **Note**: If the member's care is managed by an MTF, contact that MTF for appeal process.
3	Member/Unit Representative	Submit the following appeal request package to DHA-GL at the below email address: • Copy of the Explanation of Benefits (EOB), if applicable • Eligibility should be on file at DHA-GL **Claims Appeal – Email** dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil **Phone:** 888-647-6676, option 2, option 3 **Pre-Auth Appeal – Email** dha.great-lakes.j-10.mbx.mmso-initial-lod-mma@health.mil **Phone:** 888-647-6676, option 1, option 3

Examples when appeals do not apply:
Non-covered services, non-certified provider, expired authorization, no service approved, LOD, SM no longer in military (not limited to this list). If the appeal is denied, the decision will be provided by phone call or email.

Defense Health Agency - Great Lakes
DHA-GL Worksheet-03
Rev. 12/5/2023

FORMAL APPEAL REQUEST
Defense Health Agency Great Lakes DHA-GL

Instructions: Complete this form when submitting a formal appeal for denied medical care claim(s), denied pre-authorization request by the Defense Health Agency Great Lakes (DHA-GL) ONLY. See the DHA-GL website for detailed instructions at http://www.health.mil/greatlakes

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Defense Health Agency -
Great Lakes
DHA-GL Worksheet 03
Rev. 12/5/2023

FORMAL APPEAL REQUEST
Defense Health Agency Great Lakes DHAGL

Instructions: Complete this form when submitting a formal appeal for denied medical care claim(s), denied pre-authorization request by the Defense Health Agency Great Lakes ONLY. See the DHA-GL website for detailed instructions at http://www.health.mil/greatlakes/

1. Branch of Service *(select one)* ☐ USAR ☐ USAFR ☐ USNR ☐ USMCR ☐ ANG ☐ ARNG

2. Name (Last, First, MI):	3. Rank or Grade:	4. SSN (full) / DOD ID

5. Duty Location (Unit name and location)	6. Daytime Phone # & Personal Email

7. Type of Appeal *(select one)*: ☐ Denied Claim ☐ Denied Pre-authorization Request

8. Date of Injury/Illness (YYMMDD):	9. Date(s) of Care/Pre-authorization request (YYMMDD):

10. Unit/Command Medical POC:	10A. POC Phone # (include area code)

11. Appeal: Briefly state why the claim should be paid, or the denied pre-authorization should be approved:

Service Member's Signature:	Date Signed:

Please include necessary documentation and email, mail OR fax all documents to:

EMAIL this form/documents to **(Preferred):**
dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil
Note: this box can only accept emails from .mil addresses

FAX this form/documents to:
847-688-6460 or 7394

MAIL this form/documents to:
Defense Health Agency Great Lakes (DHA-GL)
2834 Green Bay Road Ste 304
Great Lakes, IL 60088

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

Who this is for

National Guard and Reservist on a Line of Duty residing in the CONUS, DC, Alaska, Hawaii

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 prescriptions in conjunction with a Line of Duty Determination (LOD) injury or illness.

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

Process for Reimbursement

Follow these steps to get reimbursed by Express Scripts for authorized prescriptions:

Steps	What Happens
1	Member/Designated person with a Power of Attorney ONLY completes and signs a CHAMPUS Claim - Patient's Request for Medical Payment DD Form 2642. **Ensure SM's SSN is on the form**
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	Eligibility and/ or Line of Duty documentation should already be on file at DHA-GL. **Army Reserve and Army National Guard must submit eligibility through eMMPS/MedChart.**

Step	What Happens
4	Submit the DD Form 2642, pharmacy invoice, eligibility documentation/LOD, and DHA-GL Medical Eligibility Verification Worksheet to the following email (preferred), fax or address: • **Email:** dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil • **Fax: 847-688-6460** **Mailing Address**: Defense Health Agency Great Lakes (DHA-GL) Attn: RC Retail Pharmacy Reimbursement 2834 Green Bay Road Bldg 3400 Ste 304 Great Lakes, IL 60088

Note:
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 business days, you should receive an Explanation of Benefits (EOB) statement with a reimbursement check from ESI. Website: https://www.express-scripts.com/

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. 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.

- PATIENT'S COPY -

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

OMB No. 0720-0006
OMB approval expires
Aug 31, 2009

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

AUTHORITY: 44 U.S.C. 3101; 10 U.S.C. 1079 and 1086; 38 U.S.C. 1781; E.O. 9397.
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 deadiline, 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.

- PATIENT'S COPY -

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 ☐ STEPCHILD
☐ SPOUSE ☐ FORMER SPOUSE
☐ NATURAL OR ADOPTED CHILD ☐ OTHER *(Specify)*

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

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

7. IS PATIENT'S CONDITION *(X both if applicable)*
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? ☐ PHARMACY?
☐ OUTPATIENT?
☐ DAY SURGERY?

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

10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER

11. OTHER HEALTH INSURANCE COVERAGE

a. Is patient covered by any other health insurance plan or program to include health coverage available through other familymembers? If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements. ☐ YES ☐ NO

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

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

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

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

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT

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.

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

How to Obtain Debt Collections Assistance by DHA-GL

Who this is for

National Guard and Reservist

Purpose

To assist members with resolving debt collection issues, the Under Secretary of Defense established Debt Collection Assistance Officer (DCAO) Programs at every Lead Agent Office and Military Treatment Facility worldwide.

DCAOs assist by providing the correct regional contractor's billing information to the provider(s)/collection agency.

Note: While DCAOs cannot provide legal advice or act as beneficiary advocates, they will take all measures necessary to ensure each case is thoroughly researched and that beneficiaries are provided with written findings and assistance in the minimum time possible. DGA-GL cannot remove debt in collections from credit reports.

Eligibility

Remote service members may seek assistance via the DHA-GL DCAOs to resolve debt collection issues:

If …	Member MUST …
National Guard or Reservist	Have been issued a Line of Duty Determination (LOD) at the time of care/debt incurred. Note: The LOD must be on file at DHA-GL prior to requesting assistance. See "How to Submit Medical Eligibility Documentation (Line of Duty Determination LOD) to DHA-GL" process guide for complete instructions. * If service member resides in a Prime Service Area (catchment) of a Military Treatment Facility (MTF); Service member should seek assistance from the MTF via Patient Admin/TOPA Flight/BCAC.

How to Request Assistance Follow these steps to receive assistance from the DHA-GL Debt Collection Assistance Office (DCAO)

Step	What Happens
1	Member completes the following forms: • Authorization For Disclosure of Medical or Dental Information DD Form 2870 • Notice of the Role of the DCAO form Note: DHA-GL must have these forms to legally contact the collection agencies involved.
2	Member or Unit Rep should email **(preferred)** or fax the following documentation to DHA- GL DCAO: • DD Form 2870 • Notice of the Role of the DCAO form • Copy of the final notice letter from the collection agency/credit bureau, stating this information has been noted on the member's credit report • LOD (if appropriate) **Email:** dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil **Fax: 847-688-6460** Mailing Address: Defense Health Agency Great Lakes Attn: Debt Collection Action Officer 2834 Green Bay Road Bldg 3400 Ste 304 Great Lakes, IL 60088 Note: If the DHA-GL DCAO does not receive all the information listed above, the DCAO will send the member a letter requesting information needed for the case.

Results and Follow-up

Once the claim(s) are paid by TRICARE, the provider receives a check and a copy of Explanation of Benefits (EOB). It is the providers responsibility to notify collection agency and remove the debt from SM's credit report.

SM should be actively involved and reaching out to the providers/collection agency to ensure the debt(s) have been resolved. SM should also be registered for the online beneficiary portal to track claim status. If the care in question is not covered by TRICARE, or the member was ineligible, the DHA-GL DCAO will send a letter to the member stating the facts.

Website

Contact information for DCAOs located at Military Treatment Facility's (MTFs) can be found on the TRICARE web site at: https://tricare.mil/bcacdcao. If the BCAC is not located on the website, the SM needs to call the MTF directly for the information.

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. 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.

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

Section	Military Medical Support Office
Position	Customer Service Representative
Phone	888-647-6676
	For questions about:
Eligibility/Claims	Dial option 2 then option 3
Pre-authorizations	Dial option 1 then option 3

DEFENSE HEALTH AGENCY – GREAT LAKES

DEBT COLLECTION RESOLUTION PACKET

INSTRUCTIONS FOR COMPLETING THE DD2870 FOR DEBT COLLECTION

1. **On the DD Form 2870 complete Section I in its entirety.**
2. **In Section II please indicate the name of the collection agency in Block #6.**
3. **In Block #9 please use today's date.**
4. **Leave Block #10 blank**
5. **In Section III, Sign and date the form**
6. **Please attach a copy of the collection notice or credit report as well as any medical claims for this episode of care.**

Debt Collection Checklist (Please check what you are returning)

☐ **This coversheet completed**
☐ **Acknowledgement Sheet of Debt Collection Assistance Officer**
☐ **DD Form 2870… Completed as stated above**
☐ **Copy of Collection notice or Credit Report showing the delinquency**
☐ **Medical Claims/bills for this episode of care**
☐ **Documents substantiating the duty status of the service member**
☐ **Other supporting documentation that may support the claim**

Email: dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil **Fax Number: 847-688-6460** **Phone number: 888-647-6676 opt 2, opt 3**	**Submitted by:** **Phone Number:**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104 -191; E.O. 9397 (SSAN); DoD 6025.18 -R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER

4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)*
	[ ] OUTPATIENT [ ] INPATIENT [ ] BOTH

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS *(Street, City, State and ZIP Code)*
Defense Health Agency - Great Lakes	2834 Grccn bay Rd, BLDG 3400, Ste 304 Great Lakes IL 60088
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

[ ] PERSONAL USE	[ ] CONTINUED MEDICAL CARE	[ ] SCHOOL	[ ] OTHER *(Specify)*
[X] INSURANCE	[ ] RETIREMENT/SEPARATION	[ ] LEGAL	

8. INFORMATION TO BE RELEASED

Medical claims and supporting documents

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION DATE *(YYYYMMDD)*	
	[ ]	[X] ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR **s** 164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE:	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
[ ] AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	
	SPONSOR NAME: **SPONSOR RANK:** **FMP/SPONSOR SSN:** **BRANCH OF SERVICE:** **PHONE NUMBER:**

Reset

NOTICE OF THE ROLE OF THE DEBT COLLECTION ASSISTANCE OFFICER

ACKNOWLEDGEMENT

I**,_____**,understand that the role of the Debt Collection Assistance Officer (DCAO) is one of researching TRICARE claims that are the basis for an underlying debt. The DCAO has my consent to contact all necessary agencies – including military personnel offices, military treatment facilities (MTF), TRICARE Lead Agent offices, the TRICARE Management Activity (TMA), managed care support contractors, creditors who have issued bills, even debt collection agencies if appropriate – in order to research the TRICARE claim involved. The DCAO will assist me in understanding the basis for the underlying debt. The DCAO will coordinate with TMA to provide an official determination as to the appropriate resolution of a TRICARE claim.

I acknowledge and understand that the DCAO is NOT acting as my advocate in assisting me regarding the pending debt collection action. In addition, I acknowledge that the DCAO is NOT acting as my legal representative in this matter. In the event the DCAO determines that the debt appears to be valid, I have the right to continue to challenge the correctness of the debt, including exercising my TRICARE appeal rights. I understand I have the right to seek legal assistance through my legal assistance officer or private attorney.

_____Date: _____

_____

PRINTED NAME AND SOCIAL SECURITY NUMBER

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Defense Health Agency Great Lakes (DHA-GL)

Frequently Ask Questions (FAQs)

Eligibility

Q: I am Reservist and went to ER while I was on drill/Annual Training, what do I do now?

A: Have your unit representative submit DHA-GL Worksheet 1, certified orders/roster and ER/Urgent care provider's notes. This is to validate you were eligible to receive medical care at government expense. If eligible, TRICARE contractors will pay the provider for care with zero cost share/ co pay to you.

Q: If my unit representative does not submit the documentation to validate my eligibility, can I submit it?

A: No, your eligibility validation package must come from your unit /unit representatives.

Q: I am a Reservist; how does my unit submit my eligibility documentation?

A: USNR, USMCR, USAFR and ANG can send required documents to our specified organization email box dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil (Do not send bills)

******Army: If you are ARNG/USAR your unit must use eMMPs via MedChart to submit your eligibility.

Q: I am a Reservist/National Guard in the Army, why does my unit have to use MedChart?

A: This is not a DHA-GL mandate, ALL ARNG/USAR requests are required by the National Guard Bureau and Office of the Chief of Army Reserve (OCAR) to be submitted by the Electronic Medical Processing System (eMMPS/MedChart). DHA-GL will NOT accept Army Reserve Component eligibility packages submitted by mail, FAX or email.

** If you are a Unit Administrator looking for further information on getting MEDCHART access or instructions, please contact your chain of command.

Q: I am a Reservist on orders over 31+ days, when should I submit eligibility?

A: Your unit does not need to submit eligibility; your DEERS should reflect your time as Active Duty which will communicate with TRICARE to pay your claims as Tricare Prime/Remote. If you need follow up care after your orders end, your unit should submit a pre-authorization request along with the required documentation.

Q: Why is DHA-GL requiring CAC verified digital signatures?

A: To verify signatures are still valid, and to confirm the Unit Representative/Commanding Officer listed is the one who signed the document.

Q: I am a Reservist and went to ER/Urgent care while on drill status, why was my eligibility denied?

A: DHA-GL reviews each case and if the eligibility your unit rep submitted on your behalf did not meet incurred or aggravated criteria, the government is not obligated for the payment. Some examples are but limited to: Existed prior to (drill) service (EPTS), gross negligence, misconduct, drug use, STIs, Annual Health Assessments, Behavioral Health, Alcohol abuse/withdrawal, medication refills, MRI, etc.

Q: What does "eligibility on file" mean?

A: This means we have verified and approved the eligibility documents and claims sent to Tricare will be authorized for payment that are associated with your eligibility/LOD.

Q: How can I get reimbursed for claims I paid out of pocket?

A: DHA-GL does not reimburse. You must have providers bill Tricare and once providers receive payment from Tricare, it is up to the provider's office to refund you for anything out of pocket.

Q: I live in Puerto Rico, why aren't my claims getting paid?

A: All information for eligibility/LODs is processed by Rodriguez Army Health Clinic Fort Buchanan in Puerto Rico, please forward all necessary documentation there.

Q: What are your phone hours?

A: DHA-GL phone hours are 0830-1100 and 1300-1530, Monday thru Friday, excluding holidays.

Additionally, you can try to submit a claim for reimbursement to Tricare by going to https://www.tricare.mil/FormsClaims/Claims for more information.

For more FAQs, please visit our homepage at:

https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/TRICARE-Health-Plan/MMSO