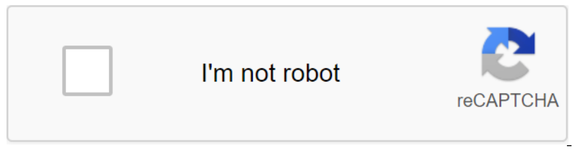
Dd form 2642 pdf



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Most providers will submit your TRICARE health care claim to you. However, under certain circumstances you can file your claims with us. You can file your own TRICARE claims for: Services from non-network providers received in office settings. Long-term medical equipment (DME) and materials (from network or in-carry suppliers). Your isp must file a claim on your behalf for: Services performed by a network provider (except DME). Services performed at the site (network or non-network), including laboratory work, radiology and outpatient surgery. Find out more on the TRICARE application page. What to include in the TRICARE Claim Beneficial Form of claim DD2642 Fill all the boxes on the form. Be sure to list your health status (s) (diagnosis) in box 8a. If the detailed supplier account does not contain your diagnoses and the information in this box does not describe your health condition (s) the claim cannot be processed. Sign the claim form. Make a copy of everything that is presented for your records. The claim must be filed within one year of the date when you received the medical care. Only one beneficiary can be listed in each claim form. To simplify processing, submit separate claims to different suppliers. The supplier's detailed bill Detailed supplier account should be on the provider's form and include: the beneficiary's name, the date of each service, the procedure code or the description of each service, the amount charged for each service, the vendor's name if the services were received from a separate provider (the name of the provider's name, if from a group or clinic with multiple vendor names on the account), and the address of the provider. Other Health Insurance (OHI) Explanation Benefits (EOB) If you have OHI, it is primary TRICARE (Exceptions: state Medicaid programs, government victim crime programs, Indian health care and TRICARE supplement plans). Make sure there is an appropriate EOB for each charge at the vendor's account. If your OHI has refused to charge as a duplicate, you will need to include the originally processed EOB for the same service. If your OHI refuses services as non-medically necessary you will need to contact OHI before TRICARE can consider the claim. For more information on how TRICARE works with OHI, visit us. Where to send the claim of TRICARE Medical Claims Health Net Federal Service, LLC c/o PGBA, LLC/TRICARE PO Box 202112 Florence, SC 29502-2112 Beneficiaries filing their own medical claims must use DD Form 2642. Be sure to attach a copy of the supplier's detailed bills to the claim form. Tip for Chrome users: If you can't open the form using the link above, hover over The View below, click the right button and Save the link as. Once you save it locally, you can open the form. Other health insurance questionnaires Use this document to update your other health insurance information. Tip for Chrome users: If you can't open the form using the link above, hover over The View below, click the right click and select Save the Link as. Once you save it locally, you can open the form. Form. Personal Injuries - Possible beneficiaries of third party liability may be asked to fill out a possible third party liability form if medical services received indicate an accident or injury. Email it or fax it: TRICARE West Claims - TPL PO Box 202103 Florence, SC 29502-2103 Fax: 1-844-869-2813 Tip for Chrome users: If you are unable to open the form using the link above, soar over the View qgt; below, select and save the link as a link. Once you save it locally, you can open the form. Costs and Fees (2020) TriCARE Costs and Fees sheet for 2020 lists the costs and fees associated with triCARE program options, including TRICARE Prime, TRICARE Select, Premium Health Options (TRICARE Reserve Select, TRICARE Retired Reserve, TRICARE Young Adults), TRICARE Pharmacy Program, and TRICARE Dental Program. For a better experience on this site, please turn off all pop-up blockers and use one of the following web browsers: Internet Explorer, Safari or Chrome. TRICARE is a registered trademark of the Ministry of Defense, the Ministry of Defense Health Agency. All rights are reserved. TRICARE DOD/CHAMPUS MEDICAL CLAIMPATIENT'S REQUEST FOR MEDICAL PAYMENTDay of public reporting for this collection of information, 0720-0006, is estimated at an average of 15 minutes per response, including time to review instructions, search for existing data sources, collect and store the necessary data, and complete and review the collection of information. At least for the time being, the Department of Defense, the Washington headquarters office, is commenting on this burden assessment or any other aspect of this information gathering, including proposals for whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. Respondents should be aware that, despite any other provision of the law, no person shall be penalized for non-compliance with the collection of information unless it displays the current OMB control number. RETURN THE COMPLETED FORM TO THE RELEVANT CLAIMS PROCESSOR. IF YOU DON'T KNOW WHO YOUR PROCESSOR processor, PLEASE VISIT: www.tricare.mil/ContactUs/CallUs.AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 C.F.R. 199 Civil Health and Health Care Program (CHAMPUS) and E.O. 9397 (SSN), as amended. PRINCIPAL PURPOSE (S): To determine eligibility for medical care under the TRICARE program, determine the liability of other health insurance, certify that thematic care has been received, and reimbursement for medical services obtained by law. ROUTINE USE (S): The use and disclosure of your records outside of the DoD may occur under the Amended Privacy Act 1974 (5 U.S.C. 552a(b)). The information collected can be passed on to organizations, including departments and social services, Veterans Affairs and other federal, state, local or foreign government agencies or authorized private commercial entities. Any protected health information (PHI) in can be used and disclosed under the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as is done under the DOD. Permitted use and disclosure of PHI information include, but are not limited to, treatment, payment, medical operations and the containment of certain infectious diseases. For a full listing of applicable RoutineUses for this system, refer to the applicable SORN. SOURCE HEALTH: EDTMA 04, Medical/Dental Claims History Files (October 27, 2015, 80 FR65720); Voluntary. If you choose not to provide your information, a fine may not be imposed, but the lack of information requested may result in payment or may result in a denial of the claim. FRAUD NOTICE - READ CAREFULLYFederal Laws (18 U.S.C. 287 and 1001) criminalize the knowingly submitting or filing of any false, fictitious or fraudulent statements on any matter in the jurisdiction of any Department or institution in the United States. Examples of fraud are situations in which persons who are not eligible for an identity card knowingly use an unauthorized identification card when filing a TRICARE/CHAMPUS claim; or where service providers file treatment claims, ore shipments not provided to or used by TRICARE DOD/CHAMPUS beneficiaries; Or where the participating provider of the beneficiary/patient account (or sponsor) foramounts over TRICARE/CHAMPUS is determined to pay a valid fee; or where the beneficiary/patient (or sponsor) does not disclose other medical benefits or insurance coverage. IMPORTANT - READ CAREFULLY Use this form if your supplier does not file a claim for you. If you are getting help abroad, you can register on the Safe Claims portal to file your overseas claimonline at www.tricare-overseas.com/beneficiaries/claims/claims-portal-login.ITEMIZED BILL: Polish this form and attach a detailed bill that should be on the supplier's billing form. The bill should include the following.1 The name/address of the doctor or health care provider (the one that actually provided your treatment). If there is more than one supplier in the account, circle3. The location of each service;4. Description of each surgical or medical service or furnished delivery;5. Fee for each service;6. The diagnosis should be included in the bill. If not, make sure you have completed block 8a on the form. PRESCRIPTION DRUGS: Prescription claims require a patient's name; name, strength, filled date, days delivery, amount of dispensed, and the drug price theeach; NDC for each drug, if any; Prescription number of each drug; The name and address of the pharmacy; and the name and address of the doctor-prescriptive. Billing statements showing only general expenses, or cancelled receipts, or cash registers of a similar type are not acceptable as detailed statements unless the receipt contains the details required above. TIMELY FILING REQUIREMENTS: In the United States and the United States, claims claim be filed within one year of the date of service, or one year from the date of discharge for inpatient treatment. The timely deadline for applications abroad is three years from the date of service. If the claim is returned for additional information, you must re-submit the claim within a timely filing period, or within 90 days of notification - depending on the date later. WHERE TO OBTAIN ADDITIONAL FORMS: You can get additional claims forms by calling your regional contractor (phone numbers are available atwww.tricare.mil/contactus) or by www.tricare.mil, mytricare.com or tricare4u.com. All 12 blocks on the form have been completed. If the claim is not signed, it will be returned2. Checked that the SSN sponsor is correct.3. Attached is your supplier's account or provider, which specifically identifies the doctor/supplier who provided your treatment. Attached is the Explanation of Benefits if there is another health insurance, Medicare, or additional Medicare.5 insurance. Attached is DD Form 2527, Personal Injury Statement - Possible liability of third party TRICARE management activities if an accident work is related. See instruction number 7 on the back.6. Ensured that the patient's name, sponsor's name and sponsor's name are SSN or DBN are on all attachments.7. Made a copy of this claim and attachments for your entries8. Included is evidence of payment of all out-of-pocket expenses/services received abroad. TRICARE accepts the following as proof of payment: a cancelled check, a credit card receipt, or an electronic transfer record (EFT) showing that the beneficiary has paid the provider. THE PREVIOUS EDITION IS OUT OF DATE. TRICARE DOD/CHAMPUS MEDICAL CLAIMPATIENT'S REQUEST FOR MEDICAL PAYMENTDay of public reporting for this collection of information, 0720-0006, is estimated at an average of 15 minutes per response, including time to review instructions, search for existing data sources, collect and store the necessary data, and complete and review the collection of information. At least for the time being, the Department of Defense, the Washington headquarters office, is commenting on this burden assessment or any other aspect of this information gathering, including proposals for whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. Respondents should be aware that, despite any other provision of the law, no person shall be penalized for non-compliance with the collection of information unless it displays the current OMB control number. RETURN THE COMPLETED FORM TO THE RELEVANT CLAIMS PROCESSOR. IF YOU DON'T KNOW WHO YOUR PROCESSOR processor, PLEASE VISIT: www.tricare.mil/ContactUs/CallUs.AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 C.F.R. 199 Civil Health and Medical Program (CHAMPUS) and E.O. 9397 (SSN), as amended. PRINCIPAL PURPOSE (S): To determine eligibility for health care under the TRICARE program, identify other other responsibility of insurance, to certify that thematic care has been received, and reimbursement for medical services received by law. ROUTINE USE (S): The use and disclosure of your records outside of the DoD may occur under the Amended Privacy Act 1974 (5 U.S.C. 552a(b)). The information collected may be passed on to organizations including the Departments of Health and Human Services, Veterans Affairs, and other federal, state, local or foreign government agencies, or authorized private businesses. Any protected health information (PHI) in your records can be used and disclosed in accordance with the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented in DoD. Permitted use and disclosure of PHI information include, but are not limited to, treatment, payment, medical operations and the containment of certain infectious diseases. For a full listing of applicable RoutineUses for this system, refer to the applicable SORN. SOURCE HEALTH: EDTMA 04, Medical/Dental Claims History Files (October 27, 2015, 80 FR65720); Voluntary. If you choose not to provide your information, a fine may not be imposed, but the lack of information requested may result in payment or may result in a denial of the claim. FRAUD NOTICE - READ CAREFULLYFederal Laws (18 U.S.C. 287 and 1001) criminalize the knowingly submitting or filing of any false, fictitious or fraudulent statements on any matter in the jurisdiction of any Department or institution in the United States. Examples of fraud are situations in which persons who are not eligible for an identity card knowingly use an unauthorized identification card when filing a TRICARE/CHAMPUS claim; or where service providers file treatment claims, ore shipments not provided to or used by TRICARE DOD/CHAMPUS beneficiaries; Or where the participating provider of the beneficiary/patient account (or sponsor) foramounts over TRICARE/CHAMPUS is determined to pay a valid fee; or where the beneficiary/patient (or sponsor) does not disclose other medical benefits or insurance coverage. IMPORTANT - READ CAREFULLY Use this form if your supplier does not file a claim for you. If you are getting help abroad, you can register on the Safe Claims portal to file your overseas claimonline at www.tricare-overseas.com/beneficiaries/claims/claims-portal-login.ITEMIZED BILL: Polish this form and attach a detailed bill that should be on the supplier's billing form. 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INTERVIEWER - In the U.S. and the United States, claims must be filed within one year of the date of service or one year from the date of discharge for inpatient treatment. The timely deadline for applications abroad is three years from the date of service. If the claim is returned for additional information, you must re-submit the claim within a timely filing period, or within 90 days of notification - depending on the date later. WHERE TO OBTAIN ADDITIONAL FORMS: You can get additional claims forms by calling your regional contractor (phone numbers are available atwww.tricare.mil/contactus) or by www.tricare.mil, mytricare.com or tricare4u.com. All 12 blocks on the form have been completed. If the claim is not signed, it will be returned2. Checked that the SSN sponsor is correct.3. Attached is your supplier's account or provider, which specifically identifies the doctor/supplier who provided your treatment. Attached is the Explanation of Benefits if there is another health insurance, Medicare, or additional Medicare.5 insurance. Attached is DD Form 2527, Personal Injury Statement - Possible liability of third party TRICARE management activities if an accident work is related. See instruction number 7 on the back.6. Ensured that the patient's name, sponsor's name and sponsor's name are SSN or DBN are on all attachments.7. Made a copy of this claim and attachments for your entries8. Included is evidence of payment of all out-of-pocket expenses/services received abroad. TRICARE accepts the following as proof of payment: a cancelled check, a credit card receipt, or an electronic transfer record (EFT) showing that the beneficiary has paid the provider. THE PREVIOUS EDITION IS OUT OF DATE. 1. NAME PATIENT (last, first, middle initial)2. PATIENT TV (turn on the area code)3. PATIENT'S ADDRESS (street, apt. No., city, state and postcode)4. PATIENT'S RELATIONSHIP TO SPONSOR (X one)7. IS PATIENT'S CONDITION (X both, if applicable)5. PATIENT'S DATE OF BIRTHIf yes, see #7 section below8a. DESCRIBE ILLNESS, INJURY OR SYMPTOMS THAT REQUIRE TREATMENT, SUPPLYING ORMEDICATION. IF THERE IS AN INJURY, NOTE HOW IT HAPPENED. CHECK THE INSTRUCTIONS BELOW.9. SPONSOR'S OR FORMER SPOUSE'S NAME (last, first, middle initial)10. SPONSOR OR EX-SPOUSE PROVIDE A NUMBER OR DOD ALLOWANCE NUMBER (DBN)11. OTHER HEALTH INSURANCE COVERAGEA. Is the patient covered by any other health plan or program to include health insurance insurance through other family members? For patients abroad, this includes national health insurance. If so, check block Yes and fill blocks 11 and 12 (see instructions). If not, you should check block No and complete Block 12. Do not provide TRICARE/CHAMPUS with additional insurance information, but does report Medicare supplements. (5) MEDICARE ADDITIONAL INSURANCEC. THE NAME AND ADDRESS OF ANOTHER HEALTH INSURANCED. INSURANCE IDENTIFICATION (street, city, state, and postcode) REMINDER: Attach an explanation of benefits or a pharmacy receipt, which indicates the actual cost of the drug, the amount paid by OHI, and the amount you paid.12 THE SIGNATURE OF THE PATIENT OR THE AUTHORIZED PERSON CONFIRMS THE CORRECTNESS OF THE CLAIM AND13. OVERSEAS CLAIMS ONLY:AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.C. RELATIONSHIP TO PATIENTHOW TO FILL OUT THE TRICARE/CHAMPUS FORMYou must attach a detailed invoice (see before form) from your doctor/supplier to CHAMPUS to handle this claim.1. Enter the patient's surname, name and middle initial as he appears on the11. By law, you must report if the patient is covered by any other health insurance tomilitary ID card. Do not use nicknames.include health insurance available through other family members. If the patient has two. Enter the patient's primary phone number and TRICARE/CHAMPUS secondary insurance, don't tell us. You need, however, a number to include the area code.report Medicare additional coverage. Block 11 allows space to message 23. Enter the full address of the patient's residence at the time of the insurance. If there is additional insurance, report the information as a service (street number, street name, apartment number, city, state, postcode). required by block 11 on a separate sheet of paper and attach to the claim. Do not use the mailbox number, except for rural routes and numbers. NOTE: All other health insurance, excluding Medicaid and TRICARE/CHAMPUSDo, do not use the APO/FPO address unless the patient actually lived in restocking plans before TRICARE/CHAMPUS pays. With theoverseas, when care has been provided.exception of Medicaid and CHAMPUS additional plans, you must first submit the4. Check the field to indicate the patient's relationship to the sponsor. If the other is a claim to another health insurer and the insurance has since determined their check, specify how it relates to the sponsor; for example, parent.payment, attach another benefit insurance explanation (EOB) or worksheet to5. Enter the patient's date of birth (YYYYMMDD). The claims processor cannot process a claim until you provide another one6. Check the box for men or women (patient). Check the field to indicate if the patient's condition is related to the accident, work related12. The patient or other authorized person must sign If the patient isor both. If an accident or work is related, the patient is required to complete DDunder 18 18 Old, any parent can sign if the services are confidential and form 2527, Personal Injury Statement - Possible third party liability that the patient must sign a claim. If the patient is 18 years of age or older, but he cannot know what management is. Download the form on claim, the person who signs must be either a legal guardian, or in the8a. Describe the condition of the patient for whom the treatment was provided, such as the broken physical protection of the legal guardian, spouse or parent of the patient. If except for weapons, appendicitis, eye infection. If the patient's condition is the result of an injury, the signatory patient must print or enter his/her name in block 12a. and sign a claim.report as it happened, such as a fallen on the stairs at work, a car accident. Attach a claim to the claim by giving the full name and address of the signature,8b. Check the box to indicate where the care was given.relationship to the patient and the reason the patient cannot sign. Turn on9. Enter the name of the sponsor or ex-spouse, the name and intermediary appointments signed as a legal guardian, or provide yourinitial as it appears on the military ID card. If the sponsor and the patient are the state that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.10. Enter the Social Security number of the Sponsor or Ex-Spouse (SSN) or Patients13. If it is a claim for treatment received abroad, indicate whether you want to pay usDoD Benefits (DBN). THE PREVIOUS EDITION IS OUT OF DATE. Popular Articles DD Form 2896-1, Reserve Component Health Insurance Request Form DD 2896-1, Reserve Component Health Insurance Request Form USCIS Form I-551, Permanent Resident Card USCIS Form I-551, Permanent Resident Card of the Washington State Patrol Inspection Request Form Of Washington Patrol Form FORMa MV-4ST, Vehicle Sale and Use of Tax Return / Application for Registration Form MV-4ST, Vehicle Sale and Use of Tax Return/ Application for Registration Form Notice of Action USCIS Form I-797C Notice of Action Form REG 124, Application for designated vehicle identification number Form REG 124, Application for designated vehicle identification number Form VSD 190, Application for Vehicle Transaction (s) Form VSD 190, Application for Vehicle Transaction (s) Form DOS-1246, Security Extension Service Form DOS-12466 , App Extension Security dd form 2642.pdf download. dd form 2642 tricare pdf