Beneficiary claims Frequently Asked Questions (FAQ): General, self-filing claims and appeal submissions

GENERAL CLAIMS

What is an Explanation of Benefits (EOB), and how can I view mine?

A TRICARE EOB is an itemized statement that shows what action TRICARE has taken on your claims. It is not a bill. They are available in beneficiary self-service or the Humana Military mobile app.

How long does it take to process a claim?

Claims processing may take up to 90 days from the date of receipt.

Where can I view the claim's status?

Beneficiary self-service and the mobile app are an easy and convenient way to take control of your healthcare journey.

For more information visit tutorials, beneficiary self-service guide and mobile application FAQ.

Why is there limited access to some claims?

Access is limited based on these situations:

- If the dependent is 18 years old or older
- If there is no completed Personal Health Information (PHI) release consent between spouses on file
- If the claims are of a sensitive nature

How do I grant access for another person to be able to discuss these claims by phone?

State and federal laws may differ on definitions of PHI or sensitive nature, but commonly include information related to alcohol/drug treatment, abortion, venereal disease and AIDS. In some instances, information related to mental health and pregnancy/birth control.

Discussion of these types of claims may require written consent of the patient/beneficiary. Complete and return the TRICARE East Region authorization for general information form or the TRICARE East region authorization for release of sensitive information form.

Humana Military will follow all federal and state laws and regulations that are more stringent.

Return completed form to Humana Military:

Humana Military Privacy Office
PO Box 740062
Louisville, Kentucky 40201-7462
Fax: (877) 298-3407

Why would the TRICARE claims reimbursement amount differ from the total bill charges?

All TRICARE claims are subject to TRICARE Maximum Allowable Charge (TMAC). TMAC is the maximum amount TRICARE will pay a doctor or other provider for a procedure, service or equipment. This is connected to Medicare's allowable charges by law.

When can a provider bill for services above TMAC?

Non-participating providers can charge you up to 15% more than TMAC, known as balance billing. If you use a non-participating provider, the provider may bill the amount TRICARE allows for the service(s) plus an additional 15%. Make sure to review your TRICARE EOB to verify allowed amounts. Learn more about costs.

Note: If a provider is not TRICARE-authorized/certified on the date services are rendered, the claim will be denied. If the provider does not complete and submit certification paperwork, the beneficiary will be responsible for all charges.

How is Other Health Insurance (OHI) information updated?

Report or update OHI to minimize any delay in processing claims through the following methods:

1. Complete the OHI questionnaire.
2. Fax: (608) 221-7536 (Preferred method)

   or

   TRICARE East Region
   PO Box 8923
   Madison, WI 53708-8923

Note: Failure to update OHI details with your provider(s) or contractor may result in TRICARE denying claims.

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Why is a Third Party Liability (TPL) form (DD2527) requested?

The Federal Medical Recovery Act allows TRICARE to be reimbursed for its costs of treating you if you are injured in an accident that was caused by someone else. Claims submitted with ICD-10-CM S and T diagnosis codes or ICD-9-CM 800–999 diagnosis codes for professional services exceeding $500 and inpatient services often indicate an accidental injury or illness.

- Humana Military will send you the statement of personal injury-possible third party liability form (DD Form 2527) if a claim is received that appears to have third-party liability involvement.
- You must complete and sign this form within 35 calendar days.
- Follow the directions from Humana Military to return the form to your claims processor.

How do you determine if I utilized my Point of Service (POS) option?

Using the POS option, results in greater out-of-pocket expenses for beneficiaries. It applies when a TRICARE Prime beneficiary:

- Receives care from a network or non-network TRICARE-authorized provider without a referral from their Primary Care Manager (PCM)
- Receives care for clinical preventive services from a non-network provider
- Self-refers to a civilian specialty care provider after a referral has been authorized to a military hospital or clinic specialty care provider
- Self-refers to a non-network specialty care provider after a referral has been authorized to a network specialty care provider

What are non-covered services?

A non-covered service is a service that your healthcare plan does not cover. As the beneficiary, you are responsible for paying for those costs. Exclusions are all services and supplies related to a non-covered condition or treatment. Learn more at TRICARE: Q&A: Non-Covered Services from Network and Participating Non-Network Providers (East Region).

What are fraud and abuse?

Fraud is when a person or organization deliberately deceives others to gain some sort of unauthorized benefit.

Abuse is when providers supply services or products that are medically unnecessary or that do not meet professional standards.

- Learn how to report fraud or abuse.

SELF-FILING CLAIMS

How do I submit a claim for services or supplies provided by medical care personnel?

To process a beneficiary submitted claim, you must include:

- Beneficiary's first and last name (include on all attachments)
- Beneficiary's address
- Relationship to the sponsor
- Beneficiary's date of birth
- Beneficiary's sex
- Sponsor's name and ID (included on all attachments)
- OHI EOB
- Beneficiary or authorized person's signature
- Itemized bills with the provider information
- A description of the condition or diagnosis codes
- Procedures performed
- Proof of payment
- Signature of beneficiary or authorized party (Box 12a) is required for the claim to be processed. Please date all signatures on documentation to make sure that we can process claims in a timely manner.

Check out this step-by step guide on completing the claim form.

How do I submit a claim for a physical, occupational or speech therapy?

Follow the steps listed above. You must also include the provider's prescription and requested length of care. Please date all signatures on documentation to make sure that we can process claims in a timely manner.

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How long do I have to file a claim?

All claims must be filed within one year after the service took place. If a claim submission is returned for additional information, the re-submission of the claim must be received within the filing deadline or within 90 days of notice.

Where can I get more information on specific claim types?

- Banked Donor Milk (BDM) claims
- Breastfeeding supplies
- Durable Medical Equipment (DME)
- TRICARE East Region Authorization of Release for General Information
- TRICARE East Region Authorization for Release of Sensitive Information

APPEAL SUBMISSION PROCESS

Do I have the right to appeal a denied claim?

Yes. If you do not agree with a decision made about your benefit. Please see directions for appeals on your EOB.

How long do I have to submit a TRICARE claims appeal?

Claim appeal submission receipt is no later than 90 calendar days after the date of the initial denial determination letter or EOB.

Where do I submit a claim appeal?

Email: HMHSRECON@humana.com (preferred method)

Fax: (877) 850-1046

Humana Military appeals
PO Box 740044
Louisville, KY 40201-7444