IMPORTANT NOTICE

1. THIS NOTICE CAN BE USED:

A. As a deductible certificate to show your providers the amount of the outpatient deductible met as of the date of this notice.
B. As a record of bills paid or denied (if you submitted other medical expenses not shown on this form, you will receive a separate notice).
C. To collect other insurance. This notice may be used to claim benefits from a secondary insurance policy. Since the insurance company may keep this notice, it is advisable that you keep a record of this information.

IF YOU NEED MORE INFORMATION:

- Check your TRICARE handbook.
- See the Health Benefits Advisor or Health Care Finder at the nearest Uniformed Services medical facility.
- Always give your Sponsor's Social Security number when writing about your claim.
- If inquiring about this claim, please provide the claim number located on the front of this form.
- Contact us at the telephone number shown on the front of this form.
- Written inquiries except Appeals (see #4) and Grievances (see #10) should be mailed to the following address:

WPS TRICARE
P.O. Box 7992
Madison, WI 53707-7992

2. TIME LIMIT FOR FILING CLAIMS:

Example:	For services received:	File Claims By:
	1 Jan 92-31 Dec 92	31 Dec 93
	1 Jan 93 & after	1 year after Date of Service

All claims for benefits submitted under TRICARE for dates of service prior to January 1, 1993 must be filed with the appropriate TRICARE contractor no later than December 31 of the calendar year immediately following the year in which the service or supply was provided. For services on and after January 1, 1993, all claims must be filed with the appropriate TRICARE contractor no later than one year from the date of service, or the date of discharge in the case of inpatient care.

If your claim was denied because it was not filed on time and you believe you were not at fault, contact us or your Health Benefits Advisor for assistance. In limited circumstances, exceptions may be made.

3. TYPE OF SERVICE CODES:

First Position:

A = Ambulatory surgery cost-shared as inpatient (Active duty family members only)
I = Inpatient
M = Outpatient maternity care cost-shared as inpatient
N = Outpatient cost-shared as inpatient
O = Outpatient Care Other
P = Outpatient partial psychiatric hospitalization care cost-shared as inpatient

Second Position:

1 = Medical Care
2 = Surgery
3 = Consultation
4 = Diagnostic/Therapeutic X-Ray
5 = Diagnostic Laboratory
6 = Radiation Therapy
7 = Anesthesia
8 = Assistance at Surgery
9 = Other Medical Service
A = DME Rental/Purchase
B = Drugs
C = Ambulatory Surgery
D = Hospice
E = Second Opinion on Elective Surgery
F = Maternity
G = Dental
H = Mental Health Care
I = Ambulance
J = Program for Persons with Disabilities

4. YOUR RIGHT TO APPEAL THIS INITIAL DETERMINATION:

If you disagree with the determination on your claim, you have the right to request a reconsideration. Your **SIGNED** written request must state the specific matter with which you disagree and **MUST** be mailed to the following address no later than ninety (90) days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

WPS TRICARE
ATTN: APPEALS
P.O. Box 7992
Madison, WI 53707-7992

5. IF PAYMENT NOT BASED ON THE FULL AMOUNT BILLED:

The amount TRICARE may pay is limited by law to the **lowest** of:
A. The CHAMPUS Maximum Allowable Charge: i.e. the charge made 80 percent of the time by physicians or suppliers in the country for similar services during the base year adjusted by where the services were rendered; or
B. Prevailing charge: i.e. the charge made 80 percent of the time by physicians or suppliers in the state for similar services during the base year; or
C. The amount the provider actually charges for the service or supply; or
D. The fiscal year 1988 prevailing charge adjusted by the Medicare Economic Index (MEI); or
E. The discounted charge that a provider has agreed to accept under a special program approved by the Director, TRICARE Management Activity.

6. PATIENT'S SHARE OF THE COST FOR AUTHORIZED CARE:

Inpatient Benefits	*See remarks on front.
Outpatient Benefits	
Active duty family members of sponsor E-4 and below:	First $50 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $100 per family plus 20% of allowable charges after deductible has been paid.
Active duty family members of sponsor E-5 and above:	First $150 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $300 per family plus 20% of allowable charges after deductible has been paid.
Former spouses, Non-active duty members and their families:	First $150 of allowable charges incurred by a patient each fiscal year (1 October-30 September) not to exceed $300 per family plus 25% of allowable charges after deductible has been paid.

Claim payments are subject to the provision that the beneficiary cost-share is collected by the provider. The provider's failure to collect the cost-share can be considered a false claim and/or may result in reduction of payment.

7. SPONSOR, PATIENT, OR DEPENDENT NOT ENROLLED OR NOT ELIGIBLE ON DEERS:

If the Defense Enrollment Eligibility Reporting System (DEERS) indicates that the sponsor, patient and/or dependent is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Future claims will be denied if you are not enrolled in DEERS. If the sponsor is deceased, report to any service personnel office to get enrolled or call the appropriate number listed below.

8. IDENTIFICATION CARD (ID) OR ELIGIBILITY EXPIRED ON DEERS:

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to any parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. In an emergency, call the appropriate number listed below.

FOR DEERS INFORMATION CALL:
CALIFORNIA .....1-800-334-4162 HAWAII & ALASKA.... 1-800-527-5602
ALL OTHER STATES..... 1-800-538-9552

9. BENEFICIARY NOTICE:

Please review the services shown on the front side of this TRICARE Explanation of Benefits. If you find that payment consideration has been made for any services that you did not receive, or that services were provided by a health care professional that you did not see, please contact your Regional Director at 1-888-777-8343.

10. TO FILE A GRIEVANCE:

If you are dissatisfied with the ability of WPS personnel to provide appropriate health care services, access to care, timeliness of care, quality of care or service, or level of care or service, you may file a grievance. Mail your written grievance with supporting information to:

WPS TRICARE
ATTN: Priority / Grievances
P.O. Box 7992
Madison, WI 53707-7992