Department of Veterans Affairs
Health Administration Center

Handbook

Published November 2006

Helpful Tips

KEEP THIS HANDBOOK

This handbook describes important information about the CHAMPVA program. We also have a great website where you can find the handbook in an electronic format. Go to **www.va.gov/hac** and check it out!

The handbook is not reprinted yearly. Occasionally, there will be a change that could impact your eligibility, benefits or costs. When that happens, we will send you a notification of the change and ask you to add it to your handbook. Please remember this handbook is only a guide. The law, regulations, and policy manual are the authoritative guidance for the CHAMPVA program.

FINDING INFORMATION IN THIS HANDBOOK

The Table of Contents on page 5 lists the topic areas by section, with page numbers.

The List of Topics that begins on page 7 is an alphabetical listing, with page numbers, of the topics discussed in this handbook.

You will also notice words highlighted in green in the text of this handbook. These highlighted words are defined on pages 62-65.

CHAMPVA APPLICATIONS

Information on how to apply for CHAMPVA can be found on our website at **www.va.gov/hac** or by calling us at 1-800-733-8387.

CHANGE OF ADDRESS

Notify us immediately of a change of address or phone number. You can do this by:

Mail: VA Health Administration Center
CHAMPVA
PO Box 469028
Denver, CO 80246-9028

Phone: 1-800-733-8387

Email: **hac.inq@va.gov**

SPECIAL NEEDS

Hearing impaired callers please use the Federal Relay Operator at 1-800-877-8339.

When English is not your first language, we can arrange for a third party translator to participate with you in a phone call. When you call us, we will ask you to hold and we will call our translation service to participate in the phone call.

We can also provide you, on request, with a copy of the CHAMPVA handbook in any language or Braille. It will take about six weeks to provide you the translated handbook from the time we receive your request.

TAKE AN ACTIVE ROLE IN YOUR HEALTH CARE

Studies have shown the benefits of positive patient-provider interaction. When you have increased control and are well informed about your health care, the studies support that your health status is improved.

There are a number of ways you can become actively involved in your health care. Before you go to your appointment, write down your questions and prioritize them. Sometimes you aren't able to cover all the questions in one office visit, so prioritizing them in advance will help you get the answers to your most urgent concerns first. If you aren't able to get through all your questions during the appointment, schedule a follow up office visit to go over the other questions. When you are in the doctor's office, ask for clarification of words or explanations your doctor provides that you don't fully understand. Write down the answers.

Here are some sample questions that you may want to use. The time you take to prepare for your medical appointment will often help you and your doctor to work together for the best management of your medical care.

- Why do I have this problem?
- How will this problem affect me in the future?
- What treatment is needed? Will the treatment require any changes to my diet or lifestyle?
- What will happen if I don't treat this condition right away?
- Do I need any tests?
- Why do I need this medicine and how long will I need to take it?
- Are there any foods or drinks I should avoid while take this medicine?
- What are the side effects of this medication?
- When should I see you for follow up?

SUGGESTIONS FOR LONG-TERM CARE ASSISTANCE

As you read the benefit package contained in this handbook, you will find that long-term care is not a covered CHAMPVA benefit. Long-term care is also known as custodial care and can be provided in nursing homes, assisted living facilities, adult day care or at a patient's home. It involves assistance with activities of daily living or supervision of someone who is cognitively impaired. That would include assistance with walking, personal hygiene, toilet, dressing, cooking/feeding, and medication.

Since CHAMPVA doesn't cover custodial long-term care, and it can be very expensive,

we are providing you some options that you may want to consider as you plan ahead, before a crisis occurs. We are providing this information as a service to you so that you are aware of the options because neither CHAMPVA nor Medicare provide coverage of this type of care.

- **Long-Term Care Insurance**

  This insurance is sold by private insurance companies and usually covers medical care and non-medical care to help you with your personal care needs such as bathing, dressing, using the bathroom, and eating.

  For more information about long-term care insurance, get a copy of "A Shopper's Guide to Long-Term Care Insurance" from your State Insurance Department or the National Association of Insurance Commissioners, 2301 McGee Street, Suite 800, Kansas City, MO 64108-3600. Medicare also has a publication entitled, "Choosing Long-Term Care: A Guide for People with Medicare" (CMS Pub. No. 02223). This publication is available by calling 1-800-633-4227 or by checking out their website at **www.medicare.gov**.

- **Life Insurance Policies**

  Some insurance companies may allow you to use your life insurance policy to pay for long-term care. Ask your insurance agent how this works.

- **Personal Resources**

  You can use your savings to pay for long-term care. You may qualify for Medicaid after most of your personal resources have been used.

COMMENTS?

We are always looking for your feedback. If you have suggestions on ways we can improve this handbook, please contact us at:

VA Health Administration Center
CHAMPVA
PO Box 65020
Denver, CO 80206-9020

Or email us at: **hac.inq@va.gov**

Important Phone Numbers

Name	Telephone Number
Your Doctor (primary care):	
Your Doctor:	
Your Doctor:	
Your hospital:	
Your Pharmacy:	
Your Medications	
CHAMPVA	1-800-733-8387
Magellan Mental Health	1-800-424-4018
Meds by Mail (see page 18 for the number of the service center for your state)	
Medicare Helpline For help with questions about Medicare	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Social Security Administration For help with questions about eligibility for and enrolling in Medicare, Social Security retirement benefits, or disability benefits	1-800-772-1213 TTY 1-800-325-0778

Table of Contents

List of Topics

Section 1: Eligibility Requirements

Remember, words in green text are defined on pages 62-65

Eligibility for CHAMPVA benefits can be impacted by changes such as the student status of children ages 18 to 23; your marriage, remarriage, divorce; or eligibility for Medicare or TRICARE. Changes must be reported to us immediately. Call us at 1-800-733-8387 or send the changes to:

VA Health Administration Center
CHAMPVA Eligibility
PO Box 469028
Denver, CO 80246-9028

CHILD STATUS	
A child loses eligibility when:	• a child (other than a helpless child) turns 18, unless enrolled in an accredited school as a full-time student, • a child, who has been a full-time student, turns 23 or loses full-time student status, • a child marries or • a stepchild no longer lives in the household of the sponsor.

CHILD STATUS
Requirements for Student (Age 18 – 23)
To establish student status, and retain CHAMPVA eligibility, an unmarried child between the ages of 18 and 23 must attend school full-time. Schools include, but are not limited to high school, vocational/technical, undergraduate, graduate, or postgraduate levels of study. Eligibility can be continued to the date of graduation or until the 23rd birthday, whichever comes first. Please read the following information carefully to avoid interruption in your benefits.

CHILD STATUS	
Requirements for Student (Age 18 – 23)	
First certification of full-time school attendance after age 18:	A letter will be sent to you 90 days prior to your 18th birthday. This letter will provide notification that you are about to lose eligibility and remind you to take the following actions to continue your eligibility for CHAMPVA. To avoid an interruption in your CHAMPVA benefits for the summer break between high school and the 1st semester/quarter of your education program, send us your acceptance letter from an educational institution as proof of intent to continue your education. When we receive that letter from the educational institution, we will cover the break between high school and the start of the 1st quarter/semester of the continuing full-time education program. You must then submit a school certification verifying enrollment within a month after the first semester/quarter begins. If this is not received, benefits will be terminated and any payments made by us after you turned 18 will be subject to recoupment. The certification letter should be on school letterhead and include: • student's full name, • student's Social Security number (SSN), • exact beginning date and projected graduation date, • number of semester hours or equivalent certification of full-time status, and • title and signature of a school official.
Recertification of full-time school attendance:	Each year you will need to recertify with us that you are still enrolled as a full-time student. We will send you a reminder when the annual update is needed. We will periodically check with the school to ensure you are a continuing full-time student. You can, if you wish, return the annual certification form with a copy of your school transcript attached to show that you are continuing your full-time education.

CHILD STATUS	
Requirements for Student (Age 18–23)	
School breaks:	Once your period of eligibility (which is the time from your entrance into the full-time educational program to the date of graduation or age 23, whichever is first) is established, your eligibility will not be interrupted for school breaks as long as you are a full-time student during both the semester/term prior to the break and after.
Withdrawal from school:	If you withdraw from school, your eligibility will be terminated. We must be notified of the change immediately.
Disabling illness:	If you incur a disabling illness or injury while enrolled as a full-time student and this prevents you from continuing as a student, eligibility may continue for six months after the disability ceases, for two years after the onset of the disability or until your 23rd birthday—whichever occurs first. Medical documentation is required to support that the illness or injury is of a disabling nature, prevents you from attending school, and the expected date you will be able to return as a full-time student.
Change in student status:	If you fail to notify us of the termination of full-time status, any claim paid by us after the date of loss of eligibility will be considered invalid, and you will be held financially responsible to repay the government and/or the health care provider in full for services.

CHILD STATUS
Requirements for Helpless Child Status
A child who, before reaching age 18, becomes permanently incapable of self-support may qualify as a helpless child. This determination is made by a VA Regional Office. Once helpless child status is determined, CHAMPVA benefits will continue without an age limitation unless the helpless child marries. If you believe your child may qualify as a helpless child, contact 1-800-827-1000 for assistance.

CHILD STATUS
Impact of Marriage
If you marry, regardless of whether you are under age 18, a full-time student or you have helpless-child status, you will lose CHAMPVA eligibility as of midnight on the date of marriage.

CHILD STATUS
Impact of the Divorce or Remarriage of Your Parent on Child/Student Status
If you are the birth or adopted child of the qualifying sponsor, your eligibility is not impacted. If you are a stepchild of the qualifying sponsor, your parents divorce, and you lose dependent status as determined by the Veterans Affairs Regional Office (VARO), you also lose CHAMPVA eligibility.

SPOUSE STATUS	
A spouse loses eligibility when:	There is a divorce or annulment from the qualifying sponsor. Eligibility for CHAMPVA ends on midnight of the effective date of the divorce decree or annulment.

WIDOW(ER) STATUS	
A widow(er) loses eligibility when:	There is a remarriage prior to age 55. NOTE: Prior to February 4, 2003, remarriage at any age terminated your CHAMPVA benefits. Because of a change to the law, widow(er)s who no longer qualified for CHAMPVA because of remarriage after age 55 could reinstate benefits if the application for benefits was received on or before December 31, 2004.
A widow(er) regains eligibility:	If you remarry prior to age 55, and the remarriage is later terminated by death, divorce, or annulment you may once again be eligible for CHAMPVA. To re-establish CHAMPVA eligibility, copies of the marriage certificate and death, divorce, or annulment documents (as appropriate) must be provided.
A widow(er) retains eligibility:	If there is a remarriage age 55 or later.

CHAMPVA AND MEDICARE

Your Medicare status has an impact on your eligibility for CHAMPVA benefits. Medicare automatically enrolls the vast majority of eligible beneficiaries 90 days prior to their 65th birthday. When you receive your initial information from Medicare, you also receive a Medicare card indicating both Medicare Part A and Part B coverage. To continue your CHAMPVA eligibility, you must enroll in, and remain enrolled in Medicare Part B. When you receive your Medicare card, send us a copy immediately

so we can take action to continue your CHAMPVA benefits without interruption. On the Medicare effective date, Medicare will become your primary insurer, and we will pay secondary (see page 48 for more information regarding payment).

The following table summarizes when Medicare Parts A and B are needed for CHAMPVA eligibility:

If I am...	Do I need Medicare Part B for CHAMPVA Eligibility?
Under age 65 **AND** otherwise eligible for CHAMPVA, **AND** entitled to Medicare Part A coverage	Yes
Age 65 or older prior to June 5, 2001, **AND** met all other CHAMPVA eligibility requirements prior to June 5, 2001, **AND** entitled to Medicare Part A coverage	No
Age 65 or older prior to June 5, 2001, **AND** become CHAMPVA eligible **after** June 5, 2001, **AND** entitled to Medicare Part A coverage	Yes
Age 65 or older prior to June 5, 2001, **AND** otherwise eligible for CHAMPVA, **AND** entitled to Medicare Part A coverage, **AND** enrolled in Medicare Part B coverage as of June 5, 2001	Yes
Age 65 on or after June 5, 2001, **AND** CHAMPVA eligible, **AND** entitled to Medicare Part A coverage	Yes

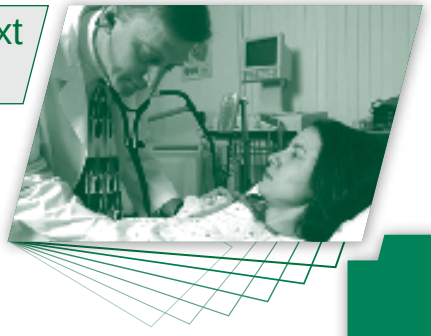
Additional Information About Medicare and CHAMPVA Eligibility

- If you are required to have both Medicare Parts A and B to establish CHAMPVA eligibility, and you did not obtain Medicare Part B previously, you will need to contact the Social Security Administration for Part B enrollment. Your CHAMPVA eligibility can then be established on the effective date of your Medicare Part B.
- Medicare Part D (Drug Plan) has no impact on your eligibility for CHAMPVA. However if you enroll in Medicare Part D, you will not be able to participate in our Meds by Mail program (see page 18).
- If you are 65 or over and live overseas, you must be enrolled in Medicare Part B even though Medicare does not provide benefits for medical care received overseas. CHAMPVA will be the primary payer for the benefits and you will receive the same level of coverage provided to those under age 65.

CHAMPVA AND TRICARE

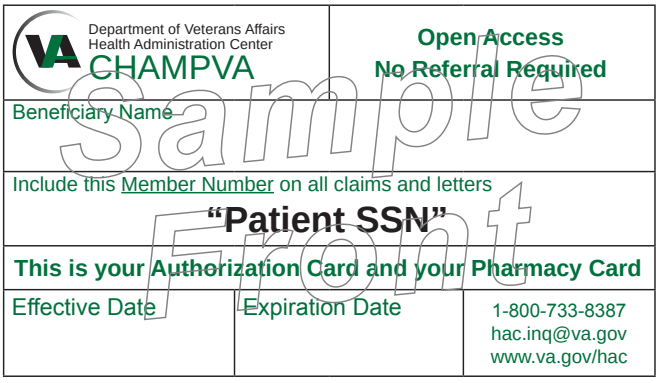
TRICARE is a health care program for active duty and retired uniformed services members and their families. If you become eligible for TRICARE benefits, you are no longer eligible for CHAMPVA and you must notify us immediately of this change in your status. You may, for example become TRICARE eligible when the qualifying sponsor is a retired reservist or National Guardsperson and begins to receive retired pay at age 60.

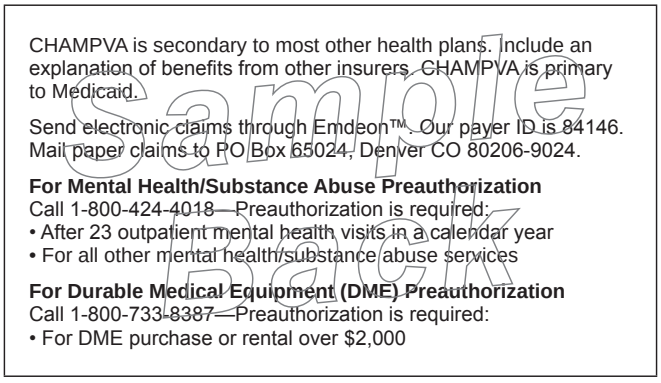
Remember, words in green text are defined on pages 62-65



Section 2: Obtaining Medical Care

Each CHAMPVA-eligible family member receives an authorization card. We changed our practice of displaying your Social Security number (SSN) as the Member Number on the Authorization Card due to the potential risk of identity theft if the card is lost or stolen. The sample below shows that cards are issued with the phrase "Patient SSN" rather than the actual number being displayed.





When you go to your doctor, make sure you take your CHAMPVA Authorization Card with you. Since your co-payment for care will be a percentage of the CHAMPVA-allowable amount rather than a specific, pre-determined dollar amount, talk to your doctor's office about how and when to pay your part of the bills. If you are getting outpatient care (to include prescriptions), and you have already paid your deductible or reached your catastrophic cap for the year, bring your most recent CHAMPVA Explanation of Benefits (EOB) with you that shows you have met one or both of these requirements for the year.

CHAMPVA covers most medically necessary health care. Though not a complete list, we cover ambulance, ambulatory surgery, durable medical equipment (DME), family planning and maternity, hospice, inpatient services, mental health services, outpatient services, pharmacy, skilled nursing care, and transplants.

We pay for covered services and supplies when medically necessary and received from an authorized provider. When providers are performing services within the scope of their license or certification, we consider them to be authorized. Although not all inclusive, these are the most common providers: anesthetist, audiologist, certified nurse midwife, certified registered nurse anesthetist (CRNA), certified nurse practitioner (NP or CNP), certified physician assistant (PA), certified psychiatric nurse specialist, clinical psychologist (Ph.D.), marriage and family counselor/therapist, licensed clinical social worker (LCSW or MSW), certified clinical social worker,

licensed clinical speech therapist (LCSP), licensed practical nurse (LPN), licensed vocational nurse (LVN), medical doctor (MD), occupational therapist (OT), doctor of osteopathy (DO), pastoral counselor, physical therapist (PT), podiatrist (DPM), psychiatrist, physiologist, registered nurse (RN).

You have many choices in selecting a provider. Medical services may be available to you at your local VA Medical Center through the CITI program, described in the following paragraph. You may also obtain medical services from non-VA providers.

VA MEDICAL PROVIDERS

Depending on whether your local VA Medical Center (VAMC) participates in the CHAMPVA Inhouse Treatment Initiative (CITI – pronounced city) program and the type of services a VAMC has available, you may be able to receive all or a portion of your medical care through the CITI program. The care may include inpatient, outpatient, pharmacy, durable medical equipment, and mental health services. Over half of all VA medical facilities participate in the CITI program so there is a good chance that a VAMC near you is a participant.

There is a benefit to you in checking out the availability of this program. The care you receive through this program is at **no cost to you!** There is no cost share and no deductible for the care you receive through CITI.

To find out if your local VAMC participates in this program:

Go to our website at **www.va.gov/hac**.

Select "For Beneficiaries" from the side tab, then select *"CHAMPVA"*

Scroll down to the *"CITI"* link. You will find a list of participating facilities and their phone numbers at this page.

Or you can call, email, or write us (see page 57 for contact information).

When you contact the VAMC, they will be able to tell you what services are available. If the services you need are available, and you choose to receive your care through the CITI program, the VAMC will ask you to process through the patient administration section. There they will review your CHAMPVA eligibility and other health insurance information. If you have Medicare or an HMO or PPO plan as your other health insurance, you will not be able to participate in the CITI program. Some VAMCs accept patients through the CITI program with other types of health insurance, but it is the VAMC's decision whether or not they will accept you into the CITI program. It is also the VAMC's decision if they can provide you the care you

need and this decision may change from time to time based on their patient workload.

If you are a veteran and a CHAMPVA beneficiary, you may be entitled to receive care through the VA health care system based on your veteran status rather than as CHAMPVA beneficiary. You will need to discuss this issue with the VA medical facility when you contact them about CITI participation.

NON-VA MEDICAL PROVIDERS

We do not have a network of medical providers. However, most TRICARE providers will also accept CHAMPVA. Go to the TRICARE website at **www.tricare.osd.mil/standardprovider** to locate a provider in your area and contact that provider to ask if they also accept CHAMPVA patients.

Most Medicare providers will also accept CHAMPVA patients. Medicare providers can be located through their website **www.medicare.gov**. Use the "*Search Tools*" at the bottom of that page to locate a Medicare provider.

Please call, email or write us (contact information on page 57) if you are having difficulty locating a provider and we will try to assist you in finding one.

Providers that accept "assignment" for CHAMPVA patients:

When you go to a medical provider, find out if the provider will accept CHAMPVA. Providers most often refer to it as accepting assignment. What that means is the provider will bill us directly for covered services, items, and supplies. Doctors or providers who agree to accept assignment are agreeing to accept the allowable amount and cannot collect additional amounts from you.

Important Note: All hospitals that participate in Medicare, and hospital-based health care professionals who are employed by, or contracted to, such hospitals, are required by law to accept CHAMPVA for inpatient hospital services.

Providers that do not accept "assignment" for CHAMPVA patients:

If assignment isn't accepted, you can still see the medical provider. But if you do, you need to know that you will likely have to pay the entire charge at the time of service. Additionally, you may be charged more than the CHAMPVA allowable amount. To obtain reimbursement, you will have to submit the itemized bill from the provider with a CHAMPVA claim form. When the claim is processed, we will send you our share of the allowable amount. What that means to you is that when the medical provider does not accept assignment, your cost will not only be for your share of our determined allowable amount, but also any charges over our allowable amount.

PHARMACY PROVIDERS

Meds by Mail

This is by far the most cost-effective way for you to receive your non-urgent, maintenance medications if you **do not have** another health insurance plan with pharmacy coverage (to include Medicare Part D). There are **no co-payments, no deductible requirements, and no claims to file!** Your maintenance medication is mailed to your home. This program is a great benefit and we highly encourage you to use it.

There are two pharmacy service centers and you are assigned to a service center based on the state in which you live. Your service center will help you with the status of your order, questions about drug availability, and patient profile updates.

If you live in these states, districts or territories:	Your Meds by Mail Pharmacy Service Center is:
Alabama, Connecticut, Delaware, District of Columbia, Florida, Georgia, Kentucky, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia	Meds by Mail Servicing Center Dublin, GA Monday–Friday 8:30 a.m. to 3:30 p.m. (Eastern Time) 1-866-229-7389 Email: **meds.mail@va.gov**
Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming	Meds by Mail Servicing Center Cheyenne, WY Monday–Friday 10:30 a.m. to 5:30 p.m. (Eastern Time) 1-888-385-0235 Email: **meds.mail@va.gov**

Important facts to keep in mind when using Meds by Mail:

- To begin using Meds by Mail, fill out the Meds by Mail Order Form and Patient Profile form available by visiting our website at **www.va.gov/hac/forms/forms.asp** or by calling 1-800-733-8387 and selecting the self-service option to request that forms be mailed to you.
- Tell your physician you are using a mail order prescription service. Request that the physician prescribe up to a 90 day supply with up to three (3) refills, if

possible. Certain medications may have a limit of 30 days for the supply amount. If you need to begin taking the medication right away, ask your provider to write two prescriptions—a one month supply that you can fill immediately at the local pharmacy and a longer-term supply to be filled through Meds by Mail.

- Original prescriptions must be sent to the service center (copied or faxed prescriptions cannot be filled).
- Maintenance medications (those you take for a longer period of time such as blood pressure, heart, arthritis, and chronic pain medication) are available through Meds by Mail.
- Certain controlled medications are also available through this program. For example, Tylenol No. 3, Valium, Klonopin, and Vicodin are available. These are medications in Schedules 3, 4, and 5 for controlled drugs (your physician can tell you if the medication prescribed to you is on one of these schedules). Medications such as Percocet, Percodan, Ritalin, and Oxycontin are NOT available and must be filled at your local pharmacy.
- Most prescriptions are filled with the generic equivalent.
- When the prescription does not have a generic equivalent, and the brand name drug prescribed is not on the VA's formulary, a pharmacist will contact your physician to obtain authorization to substitute the VA's formulary brand for the one prescribed by the physician.
- Over-the-counter medications are not covered by CHAMPVA and cannot be obtained through Meds by Mail. The ONLY exception is for insulin and insulin-related supplies.
- You can still use your local pharmacy for urgent care medications or any that are not available through Meds by Mail.
- If your other health coverage is Medicare and you have Medicare Parts A and B, but did not enroll in Medicare Part D, you can use Meds by Mail.
- If you obtain other health insurance that includes a pharmacy benefit (to include Medicare Part D, Prescription Drug Coverage Plan), you will no longer be eligible to use Meds by Mail.

If you need help with general information about Meds by Mail, eligibility or applications for Meds by Mail contact us at:

Phone: 1-800-733-8387

Email: **hac.inq@va.gov**

Website: **www.va.gov/hac** (select "*For Beneficiaries, Meds by Mail*")

Retail Network Pharmacy

Our network consists of over 45,000 pharmacies. If you do not have another health insurance plan that includes pharmacy coverage, you can use this network of pharmacies. The advantage to you is that you need only pay your cost share for the medication (after your outpatient deductible has been met) and there are **no claims for you to file**. To obtain information on local pharmacies in your area that are a part of the network of pharmacies, call the number below or go to our website and follow the instructions listed below.

Phone: 1-800-880-1377

Website: **www.va.gov/hac**

Click on "*For Beneficiaries"*

Select the "*Pharmacy Benefits"* link under the CHAMPVA program.

A paragraph will appear entitled, "*Pharmacies That Accept CHAMPVA*", go to the end of the paragraph and click on *"Pharmacy Network"*.

A page will appear with several boxes requesting information necessary to locate a network pharmacy near you.

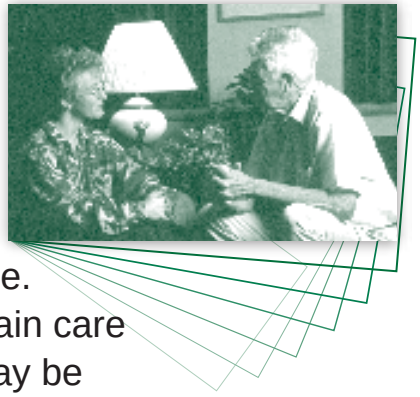
Follow the instructions on the page to get a list of pharmacies in or near your ZIP code that participate.

During 2007, expect some changes to the pharmacy program to include more network pharmacies and a specific pharmacy identification card.

Non-Network Retail Pharmacy

You can choose any pharmacy. The CHAMPVA Authorization Card is your proof of coverage. Advise the pharmacy that we currently do not have a special drug coverage card for prescriptions. When using a pharmacy that is not part of the network, the pharmacy most likely will ask you to pay the full amount of the prescription. In that case, you will need to request reimbursement from us by submitting a CHAMPVA Claim Form (VA Form 10-7959a) and the itemized pharmacy statement. If you have other health insurance, you will also need to submit the EOB showing what the other health insurance paid on the claim or showing what your copay was for that prescription. Please check the pharmacy information that you are submitting to make sure it includes the eleven-digit National Drug Code (NDC) for each prescription and the quantity of the medication. We cannot process the claim without this information.

Remember, words in green text are defined on pages 62-65



Section 3: Benefit Information

CHAMPVA does not cover all care that your physician may prescribe. Remember, the fact that your physician tells you that you need certain care does not mean that the care is covered under CHAMPVA. There may be limits on certain care, and some care is not covered at all. Additionally, we will cover only care that is medically necessary and appropriate.

Any type of care that goes on for a long time (over a period of weeks, months, etc.) such as physical therapy, medication, mental health services, skilled nursing services, may be medically reviewed periodically and medical documents will be requested during the course of treatment. We'll notify you when additional documentation or a treatment plan is needed from your medical provider.

The same benefits and limitations are applicable if you reside in the US or in another country. For example, if you reside or travel overseas, we will only cover medications that are FDA approved for use.

Authorization for Care

You do not need advance approval for care from us unless the care relates to one of the medical services listed below.

Although we may not require authorization for most medical services, it may be your physician's practice to obtain authorization for the care. In that case, ask the physician to call us regarding the service requested and we will provide information as to what will be needed to determine if it will be a covered benefit. You may also want to consider showing your provider this Section (Section 3) of the handbook as it describes the criteria for coverage of many services.

Required authorization

- Durable medical equipment with a purchase price or total rental price of $2,000 or more
- Mental health care (approval needed from our mental health contractor)
  - Inpatient mental health care
  - Care at Residential Treatment Facilities
  - Alcohol/substance abuse
  - Care in Partial Hospital Programs (PHP)

- Requests for extensions to our yearly limits on inpatient and outpatient mental health care.

- Dental care. Coverage is **very** limited and under most circumstances dental care is not covered under CHAMPVA.

Exceptions to the authorization requirement

- Mental health services and durable medical equipment provided through the VA CITI program do not require authorization.

- When Medicare is the primary payer and has authorized a service, we do not require authorization for those same services. If Medicare denies coverage because their rules for coverage were not followed or medical necessity was not established, we will also deny coverage.

To obtain authorization of durable medical equipment or dental services:

Mail: VA Health Administration Center
CHAMPVA
ATTN: Preauthorization
PO Box 65023
Denver, CO 80206-9023

Phone: 1-800-733-8387

To obtain authorization of mental health and substance abuse services:

Mail: Magellan Behavioral Health
CHAMPVA
PO Box 3567
Englewood, CO 80155

Phone: 1-800-424-4018 (domestic)
1-720-529-7400 (international)

Covered Benefits (not all inclusive)

To help you stay healthy and identify health problems early, the following is an alphabetical list of the preventive services we cover. In all cases, your physician will determine when it is medically necessary and appropriate for the medical service.

PREVENTIVE SERVICES	
Bone mass measurements	These measurements help determine if you are at risk for broken bones.
Cardiovascular screenings	Ask your doctor to test your cholesterol, lipid, and triglyceride levels so he/she can help you prevent a heart attack or stroke.
Cancer screening	Cancer screenings to include colorectal, oral cavity, prostate, skin, testicular, breast, and thyroid.
Cholesterol screening	As recommended by your physician, based your age, health, and risk factors.
Colonoscopy	Provided once every ten years after age 50, or at increased frequency when your physician determines you have an increased risk of colon cancer.
Diabetes screenings	We cover this screening when you have these risk factors: • high blood pressure, dyslipidemia (history of abnormal cholesterol and tryglyceride levels), obesity, or a history of high blood sugar. Or if you have two or more of the following characteristics: • age 65 or older; overweight; family history of diabetes (parents, brothers, sisters); and a history of gestational diabetes (diabetes during pregnancy), or delivery of a baby weighing more than nine pounds. Based on the results of these tests, you may be eligible for up to two diabetes screenings every year. Talk to your doctor for more information.
Genetic testing	When there is a history of breast cancer or sickle cell anemia.
HIV testing	When there has been HIV exposure or symptoms of possible infection.
Immunizations & vaccines	Your physician will advise you when it is appropriate for you or your child to have routine immunizations based on the Centers for Disease Control recommendations and other specific factors. We also cover post exposure rabies vaccines, and Rh immune globulin following the birth of an Rh positive child to an Rh negative woman.
Pap test and pelvic exam	These exams check for cervical and vaginal cancers. Pap screenings for patients age 18 and older or those younger than 18 when recommended by a clinician.

PREVENTIVE SERVICES	
Screening mammograms	These tests check for breast cancer before you or your doctor are otherwise aware of a problem. Age 35–40: • One baseline mammogram or • Yearly if you doctor determines you are at high risk Age 40+: • Yearly
Well child care	Up to the age of six to include physical exams; developmental and behavioral appraisal; sensory screening (vision/hearing); heredity and metabolic screenings; health guidance and counseling; and lab screening.

The following table provides an alphabetical listing of services that are covered when medically necessary, in addition to the preventive services listed above. These lists are NOT all inclusive. For additional information, review the CHAMPVA Policy Manual, Chapter 3, available on our web site at **www.va.gov/hac**. Please refer to the conditions of coverage below for limitations and to the non-covered services table that follows.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
ADD or ADHD	Attention Deficit Hyperactivity Disorder is considered a mental health condition.
Alcohol abuse (treatment for)	Preauthorization is required. Refer to “Substance abuse” for specific benefit coverage.
Allergy testing and treatment	All claims for allergy testing must indicate the type and number of tests performed. We cover RAST (Radio Allergosorbent Test), FAST (Fluro Allergosorbent Test), and IPA (Immunoperoxidase Assay Test) for inhalant or food allergy testing. PRIST (Paper Radioimmunosorbent Test) and RIST (Radioimmunosorbent Test) and Bronchial challenge testing.
Ambulance service	When life sustaining equipment is necessary for a medically covered condition or other means of transportation are contra-indicated. Ambulance service, other than land vehicles (such as boat or airplane) may be considered only when the pickup point is inaccessible by a land vehicle or when great distances or other obstacles are involved. Prior to payment, information to justify the use of a service other than a land vehicle will be required.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Ambulatory surgery	Performed on an outpatient, walk-in, or same-day basis in an appropriately equipped and staffed facility. Surgery is usually conducted under general anesthesia with no overnight stay required. Our coverage of ambulatory surgical procedures is dependent on where the surgery takes place. Most ambulatory surgical procedures performed in a hospital are covered when medically necessary. Certain procedures are also covered when performed in a Medicare-approved free-standing ambulatory surgical center.
Ankyloglossia (total or complete tongue-tie)	Surgery for tongue-tie is covered in cases where total or complete ankyloglossia is documented.
Autologous blood collection (blood transfusion)	Blood collection, processing, and storage are covered when there is a scheduled surgical procedure.
Barrier free lift	Claim should be accompanied by a CMN or doctor's order with diagnosis. Documentation is needed that shows a history of an inability to get out of bed; and that there is no care giver to get you in or out of bed. We will need the specifications for the lift. Home modifications are not covered.
Biofeedback	Certain types of therapy (electro thermal, electromyography, and electro dermal) are covered when there is medical documentation that there has been no response to other conventional forms of therapy.
Birth control	Intrauterine devices (IUDs), diaphragms, birth control pills, Norplant system long-term reversible contraceptive implants, sterilization (vasectomy or tubal ligation).
Blepharoplasty	Covered when significant impairment of vision is medically documented. Medical documentation is required to include two visual field studies; one with and one without lid elevation and photographs.
Bone growth stimulator electrical stimulation of bone	Claim should be accompanied by a CMN or doctor's order with diagnosis; documentation of a history of fracture with non healing for 3 months or more.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Breast reconstruction	Covered following a medically necessary mastectomy.
Breast reduction (reduction mammoplasty)	This is covered when there are signs and symptoms of macromastia or intractable pain, not amenable to other forms of treatment. Symptoms must be present for at least one year. Claims must include medical history along with operative report. This should include documentation of painful, persistent symptoms including back pain, neck and shoulder pain, poor posture, ulnar paresthesia, shoulder grooving, rash, restriction of physical activities, and estimated # of grams to be removed.
Cardiac rehabilitation programs	Limited to 36 sessions and normally completed within 12 months following a qualifying cardiac event.
Correction of a cleft palate	Claim must include a medical statement from the physician that includes the following information: brief medical history, condition, symptoms, length of time symptoms were present, other forms of treatment attempted, an operative report, and photographs, if available.
CT scans	Computerized tomography.
Dental (adjunctive)	Dental care can be considered for coverage only when it's adjunctive. That means the dental treatment MUST be completed as part of the appropriate treatment of the other (non-dental) covered medical condition. For example, an oral surgeon has to remove broken teeth to repair an injured jaw. Dental care requires preauthorization.
Dermatological procedures	For the treatment of covered conditions such as acne and for hypertrophic scarring and keloids resulting from burns, surgical procedures, or traumatic events.
Diabetes self-management training program (outpatient)	Prescribed by a physician for education about self-monitoring of blood glucose, diet, and exercise (limitations apply and medical documentation from the provider must accompany the billing).

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Drug abuse (treatment for)	Preauthorization is required. Refer to "Substance abuse" for specific benefit coverage.
Drugs and medications	Drugs and medications must be approved by the Department of Health and Human Services' Food and Drug Administration (FDA) for the treatment of the condition for which it is administered; prescribed by an authorized provider; and dispensed in accordance with state law and licensing requirements.
Durable medical equipment (DME)	DME is equipment that can withstand repeated use; is primarily used to serve a medical purpose; is generally not useful in the absence of an illness or injury; and is appropriate for use in the home. DME includes such items as a wheelchair or a hospital bed. The DME must be ordered by a physician and be preauthorized by us if the total cost (for rental or purchase) exceeds $2,000. Requests for preauthorization must include the CMN or doctor's DME order. This information can be submitted in the form of a letter or by using a Medicare CMN form. In either case, the following information must be included: the name, address, and tax identification number of the provider; the required equipment (the make and model number, cost and specifications for any customization); diagnosis; medical necessity; and the anticipated duration that the item is needed. Coverage may be authorized for customization, accessories, or supplies that are essential to provide a therapeutic benefit and to ensure proper functioning of the equipment; duplicate item of DME when it is essential to provide a fail-safe, in-home, life-support system; maintenance by a manufacturer's authorized technician; repair and adjustment; replacement needed as a result of normal wear or a change in the medical condition; temporary rental when the purchased DME is being repaired; and/or a vehicle wheelchair lift (detachable).
Eating disorders	Covered when preauthorized by the CHAMPVA mental health contractor.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Eyeglasses, spectacles, contact lenses	When required after intraocular surgery, ocular injury, or congenital absence of a human lens.
Family planning and maternity	We cover most treatment related to prenatal, delivery, and postnatal care, to include complications associated with pregnancy such as miscarriage, premature labor, and hemorrhage. Services provided to the mother and those provided to the child must be billed separately.
Fetal fibronectin enzyme immunoassay	Services provided to the mother and those provided to the child must be billed separately.
Foot care services	Covered when it is not for routine treatment, but medically necessary treatment for a specific diagnosis such as diabetes.
Genetic testing during pregnancy	We cover this for any of the following: • women 35 or older • one parent has had a previous child with a congenital abnormality • one parent has a history (personal or familial) of congenital abnormality • mother contracted rubella during first trimester • history of cystic fibrosis or recessive genetic disorder
Gingival hyperplasia	When caused by prolonged medication therapy for conditions such as epilepsy or seizure disorders
Home health care	To include skilled nursing and rehabilitative care, as part of a physician's treatment plan and provided by a licensed or registered caregiver. Home health care is intermittent skilled care in a home setting when you are homebound.
Hospice	We cover hospice care for terminally ill patients who have a life expectancy of six months or less. The CHAMPVA benefit closely resembles Medicare's hospice benefit. The program is designed to provide care and comfort to our beneficiaries and emphasizes supportive services such as pain control, home care, and patient comfort. (continued on the next page)

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Hospice (continued from the previous page)	Your hospice caregiver will be asked to provide the following information for authorization: Hospice tax identification number, Medicare hospice provider number, address of hospice, county in which hospice is located, remit to address (where the payment is to be mailed), name of attending physician, name of hospice physician, diagnosis, whether request is for inpatient, home care, or respite care, physician certification of terminal illness, patient's election of hospice (signed by patient or patient's representative based on a health care power of attorney), Medicare hospice per diem (daily) reimbursement rate, itemized list of medications or any other services not included under the hospice per diem.
Implants (surgical)	Must be approved by the FDA. There are limitations so check with us before the surgery. For example, breast implants are covered for reconstructive surgery following removal of the breast, but not for breast augmentation.
Infertility testing and treatment	Services include diagnostic testing, surgical intervention, hormone therapy and other covered procedures to correct the cause of infertility.
Insulin and diabetic related supplies	Covered even though a prescription may not be required by state law. Insulin pumps are covered when claim is accompanied by a CMN or doctor's order with diagnosis of Diabetes Mellitus.
Kidney (renal) dialysis	Limited to periods of Medicare ineligibility (Medicare coverage of individuals with end stage renal disease (ESRD) begins 90 days from the date maintenance dialysis treatment begins at which time we become a secondary payer)
Laser surgery	Covered when the surgical procedure is medically necessary, considered acceptable medical practice for the condition, the laser is FDA-approved, and the laser is merely used as a substitute for the scalpel.
Loss of jaw substance	Covered when due to direct trauma or treatment of neoplasm. A medical statement is required that provides the diagnosis, history of the trauma or treatment of a neoplasm, and the patient's age. Include a detailed description of the prosthetic treatment plan when applicable.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
MRA, MRI, MRS	Magnetic resonance angiography (MRA), magnetic resonance imaging (MRI), and magnetic resonance spectroscopy (MRS). Claims for both an MRI and CT scan of the same body area for the same episode of care will require documentation of need and will be reviewed for medical appropriateness.
Mastectomy bras and prostheses	Up to seven bras every 12 months; replacement of breast prostheses every 24 months.
Mental health inpatient care	Acute care to include room, board, and other hospital services. Benefit: 30 days for beneficiaries ages 19 and over, per year or during a single episode of care; 45 days per fiscal year for acute inpatient care for beneficiaries ages 18 or younger; one psychotherapy session per day not to exceed seven sessions per week (more than seven sessions per week requires authorization from the mental health contractor). Preauthorization is required from the mental health contractor. The CHAMPVA mental health contractor may consider a waiver of the 30/45 day limit.
Mental health outpatient care	Benefit: 23 outpatient psychotherapy sessions per year when medically necessary, not to exceed two psychotherapy sessions per week in any combination of individual, family, collateral or group. More than 23 visits per year can be allowed and more than two visits per week when preauthorized by the CHAMPVA mental health contractor. Individual psychotherapy (limited to 60 minutes unless for crisis intervention) and individual psychotherapy sessions in excess of 50 minutes that have been preauthorized by the CHAMPVA mental health contractor are covered. Multiple sessions on the same day to allow for crisis intervention and preauthorized by the CHAMPVA mental health contractor are covered.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Mercury hypersensitivity	The removal of dental amalgam mercury source is covered under the following conditions: Independent diagnoses by a physician allergist based upon generally accepted test(s) for mercury hypersensitivity. Documentation, which reasonably rules out sources of mercury exposure other than the dental amalgam.
Morbid obesity	Surgical procedures are limited to gastric bypass, gastric stapling, gastroplasty (including vertical banding gastroplasty), Roux-en-Y gastrojejunostomy, adjustable silicone gastric banding (LAP-BAND), and medically necessary revisions. Claims must be accompanied by the body mass index (BMI), current height, weight, history of other medical conditions and history of other treatments tried and failed. Surgical correction of morbid obesity may be covered when one of the following conditions is met: • Patient's BMI is over 40 or, • BMI over 35 with serious medical conditions exacerbated or caused by obesity or, • Second surgery (takedown) due to complications of previous surgical correction.
Myofascial pain dysfunction syndrome	Treatment of this syndrome may be considered a medical problem only when it involves immediate relief of pain. Treatment beyond four visits or any repeat episodes of care within a six (6) month period must be documented by the provider of services and medically reviewed by us.
Newborn care	The baby's care is paid for as part of the maternity care of the mother for the first three days. After three days, the baby's care is subject to separate cost sharing.
Occupational therapy	Training and assessment cannot relate primarily to employment.
Orthopedic braces and other appliances	For the neck, arm, back and leg to assist you in movement or to provide support to a limb.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Orthotic shoes for diabetics	One pair of custom molded shoes (including inserts) per calendar year. One pair of extra-depth shoes (not including inserts provided with such shoes) per calendar year. Three pairs of multi-density inserts per calendar year.
Oxygen and related equipment (to include oxygen concentrators)	A CMN is required that includes the oxygen flow rate with frequency and duration of use, estimated length of time oxygen will be required, and the method of delivery. A Medicare CMN can be used or the physician can provide this information on his/her letterhead. If the initial certificate of medical necessity shows an indefinite or lifetime need, a new prescription is not required with each billing as long as the diagnosis supports a continued need.
Panniculectomy	Medical documentation should be submitted with the claim that documents the complications experienced as a result of the enlarged pannus such as skin rashes/infection, conservative treatments that were tried & failed and/or low back pain.
Penile implant/ testicular prosthesis	For organic impotence, correction of a congenital anomaly, or correction of ambiguous genitalia.
Physical therapy	Physical therapy services must be prescribed by a physician and professionally administered physical therapy to help you attain greater self-sufficiency, mobility, and productivity is covered when the exercises and other modalities improve muscle strength, joint motion, coordination, and endurance.
Positron emission tomography (PET)	A covered benefit when used to identify complex partial seizure disorders, evaluation of ischemic heart disease, and for identifying unknown primary tumors. The PET scan is considered experimental or investigational for the diagnosis of a number of other conditions. For additional information, access the CHAMPVA Policy Manual, Chapter 2 Benefits, Section 26.9 available at our website (**www.va.gov/hac**).

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Plastic surgery	This benefit is very limited. It can be covered to correct a serious birth defect such as a cleft lip/palate, to restore body form or function after an accidental injury, to improve appearance after severe disfiguration or extensive scarring from cancer surgery or breast reconstructive surgery after a mastectomy that is covered by CHAMPVA.
Prosthetic devices	Artificial limbs, eyes, voice prostheses, and FDA approved surgical implants.
Psychiatric partial hospitalization program (PHP)	Benefit: 60 days per year. To qualify as a PHP, the program must be at least three hours per day, and available five days per week (day, evening, or weekend program). The facility must be a TRICARE-approved provider or a Medicare-certified facility. Preauthorization is required from the CHAMPVA mental health contractor except when Medicare is the primary payer. In that case, when Medicare has authorized the care, the service does not require preauthorization through our mental health contractor.
Pulmonary rehabilitation programs	Limited to pre- and post-operative lung or heart/lung transplants and cardiopulmonary disease.
Radiation therapy	Brachytherapy, fast neutron, hyperfractionated, and radioactive chromic phosphate synviortheses are covered.
Residential treatment center (RTC)	Benefit: 150 days per year. Preauthorization is required by the CHAMPVA mental health contractor at least three days before admission. Care must be provided in a TRICARE-authorized facility. Care in an RTC is for adolescents ages 18 and younger (or under the age of 21 if a full-time student). Care may be authorized when a psychiatrist recommends admission for a diagnosable psychiatric disorder and a psychiatrist or clinical psychologist directs the treatment plan. Note: the treatment plan must include a provision for family therapy. Geographically Distant Family Therapy (GDFT) is also covered when preauthorized by the mental health contractor.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Single photon emission computed tomography (SPECT)	A covered benefit when used to identify myocardial perfusion, evaluation of seizure disorders, monitoring metastatic prostate cancer after surgery. The SPECT scan is considered experimental or investigational for the diagnosis of a number of other conditions. For additional information access the CHAMPVA Policy Manual, Chapter 2 Benefits, Section 26.11 available at our website (**www.va.gov/hac**).
Skilled nursing care	Skilled care may be provided by a variety of licensed professional care givers. This may include a Registered Nurse (RN), Licensed Practical/Vocational nurse (LPN/LVN), Physical Therapist, Occupational Therapist, Respiratory Therapist, or Social Worker. The skilled care can be provided in different settings such as the patient's residence, or rehabilitation facility. Where the care is provided depends on the amount and frequency of care and the severity of the illness.
Skilled nursing facility care	A skilled nursing facility (SNF) provides skilled nursing or rehabilitative care to patients who need 24 hour per day care under the supervision of a registered nurse or physician. A service is considered skilled care when it **cannot** be done by a non-medical person. Skilled care may be provided in a facility that is separate from a hospital or it may be a distinct part of a hospital. Skilled nursing does not require preauthorization, but all claims are subject to medical review. Claims should be accompanied by medical documentation that justifies that level of care on a daily basis.
Speech therapy	For physical impairments to include: • brain injury (i.e., traumatic brain injury, stroke/ cerebrovascular accident, etc.), • congenital anomalies (i.e., cleft lip and cleft palate), • neuromuscular disorders such as cerebral palsy, • congenital sensory disorders. (The Individuals with Disabilities Education Act (IDEA) requires schools to provide speech therapy services for children to age 21. If services are not available through the state, documentation from the state is required.)

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Substance abuse (treatment of)	Benefit: three (3) substance use disorder treatment benefit periods in your lifetime. A benefit period begins with the first date of covered treatment and ends 365 days later (regardless of the total services actually used within that one-year benefit period). • **Outpatient rehabilitation** 60 group therapy sessions for outpatient rehabilitation, when medically necessary, per benefit period (individual therapy is not covered for Substance Use Disorder Rehabilitation) 15 sessions per benefit period for family therapy provided on an outpatient basis Preauthorization for outpatient services is required if you exceed 60 group therapy sessions or 15 family therapy sessions during a benefit year. • **Detoxification** Inpatient services for detoxification. Preauthorization is required by the CHAMPVA mental health contractor Limited to seven days per admission and counts toward the 30/45 inpatient mental health day limit. Detoxification can only be approved if care is under general medical supervision. • **Inpatient and Partial Hospitalization Rehabilitation** Preauthorization is required. Limited to no more than one inpatient stay during a single benefit period of 21 days. Limited to three benefit periods or rehabilitation stays per lifetime. The facility must be a TRICARE-approved provider or be a Medicare-certified facility.
Surgical sterilization	Tubal ligation and vasectomy.
Temporomandibular joint (TMJ)	Initial radiographs, up to four office visits, physical therapy for acute phase treatment only, and construction of occlusal splint.
TENS, Neurostimulator	Claim should be accompanied by a CMN or doctor's order with the diagnosis.

OTHER COVERED SERVICES	
Covered Service	**Conditions of Coverage**
Transplants	A summary from the transplant team indicating the medical necessity for the procedure must be provided. These transplants are covered (as well as donor costs): Allogeneic bone marrow transplantation Autologous bone marrow transplantation Corneal transplantation Heart transplantation Heart-kidney transplantation Heart-lung transplantation Kidney transplantation Liver transplantation Liver-kidney transplantation Lung transplantation Multivisceral transplantation Pancreas transplantation Pancreas after kidney transplantation Pancreas-kidney simultaneous transplantation Peripheral stem cell transplantation Small intestine transplantation Small intestine-liver transplantation Umbilical cord blood stem transplantation
Ultrasound	Ultrasound procedures for diagnosis, guidance, and post-operative evaluation of surgical procedures may be cost shared. Maternity related ultrasound is limited to the diagnosis and management of a high-risk pregnancy or when there is a reasonable probability of neonatal complications.
Wheelchair or scooter (motorized)	Claim should be accompanied by a CMN or doctor's order with the diagnosis. Seating evaluation must be performed with indication that vehicle can be used inside the home.
Wig or hairpiece	As a result of treatment for cancer (one per lifetime).
Wound vac	Claim should be accompanied by a CMN or doctor's order. We will need the wound measurements (length/width/depth), the starting date, and length of need.

Non-Covered Services (not all inclusive)

This table provides an alphabetical listing of services that are not covered. For additional information, review the CHAMPVA Policy Manual, Chapter 3, available at our website. Claims submitted for these services are denied.

NON-COVERED SERVICES
Acupuncture
Air conditioners, humidifiers, dehumidifiers, and purifiers
Abortion counseling
Abortions except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term
Anabolic steroids
Artificial insemination
Autopsy and post-mortem examinations
Aversion therapy
Biliopancreatic bypass
Biofeedback treatment of ordinary muscle tension, psychosomatic conditions, hypertension or migraine headaches
Bone marrow transplants for treatment of ovarian cancer
Bridges (adding or modifying)
Camps
Care for which you are not obligated to pay, such as services obtained at a health fair
Care or supplies furnished or prescribed by a person in the immediate family
Care provided outside the scope of the provider's license or certification
Chemical peeling for facial wrinkles
Chiropractic services
Christian Science "absent treatment" also called "treatment through prayer and spiritual means"
Chronic fatigue syndrome
Contraceptives not requiring a physician's prescription such as condoms, spermicidal foams, and jelly
Cosmetic drugs (i.e., Retin A, Botox)
Cosmetic surgery performed to improve physical appearance or for psychological purposes

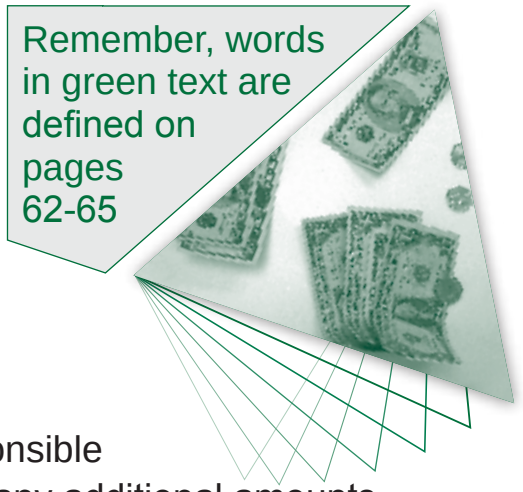
NON-COVERED SERVICES
Counseling services related to tobacco use, safe sexual practices, dental health, nutritional counseling, stress management, lifestyle modifications, or for socioeconomic purposes
Court-ordered treatment in which the patient is directed to a specific treatment provider, and the treatment program is available at no cost to the beneficiary
Custodial care (such as bathing, feeding), retirement or rest homes, halfway houses, and domiciliaries (house or permanent residence)
Dental caries (decay)
Dentures or partial dentures (adding or modifying)
Diagnostic tests to determine the sex of a child
Diagnostic tests to establish a child's paternity
Domiciliary care/services including halfway houses and rest cure facilities
Drug maintenance programs where one addictive drug is substituted for another (such as methadone for heroin)
Drugs that are not FDA approved
Durable medical equipment denied as not medically necessary by Medicare
Educational counseling
Electrolysis (hair removal)
Electroshock therapy (EST) as negative reinforcement
Embryo transfer
Employment required examinations
Exercise equipment
Exercise programs (general)
Experimental, investigational or unproven drugs that are not approved by the FDA for commercial marketing
Eye and hearing examinations (routine)
Eye movement desensitization reprocessing (EMDR)
Eyeglasses, contact lenses, spectacles or other optical devices except as noted above in *Covered* benefits
Family furnished care or supplies
Foot care services of a routine nature, such as removal of corns and calluses
Group C drugs for terminally ill cancer patients (these medications are available free from the National Cancer Institute through its registered physicians)

NON-COVERED SERVICES
Guided imagery
Hair transplants
Health club membership
Hearing aids or hearing aid exams
Hearing examinations unless in connection with a covered illness/injury
Holistic therapy (such as bioenergetics and orthomolecular therapies)
Hot tubs
Housekeeping, homemaker, and attendant services
Hypnosis
Immune globulin
Immunizations for travel
Injuries (trauma) to teeth only
Inpatient stay to primarily control or detain a runaway child
In vitro fertilization
Investigational drugs
Learning disorders such as reading disorders or dyslexia, mathematics disorders, disorders of written expression/and or learning disorders not otherwise specified
Light therapy for seasonal affective disorder (SAD)
Long-term care
Luxury or deluxe equipment (we cover only the cost of basic equipment that meets your medical needs)
Maintenance agreements/contracts
Marathon therapy
Marriage counseling
Medical photography
Megavitamin therapy
Mind expansion or elective psychotherapy, i.e., Z therapy and transcendental meditation, environmental ecological treatments, primal therapy
Multi family group therapy
Modifications to home or vehicle
Natural childbirth classes
Naturopathic services

NON-COVERED SERVICES
Orthodontia care (braces)
Orthomolecular psychiatric therapy
Orthoptics (eye exercises or visual training)
Orthotic shoe devices, such as heel lifts, arch supports, shoe inserts, etc., unless associated with diabetes
Outpatient psychotherapy provided while a beneficiary is participating in an inpatient program
Over-the-counter contraceptives such as condoms and spermicidal foams
Over-the-counter medications that do not require a prescription (except for insulin and diabetic related supplies which are covered even when a physician's prescription is not required under state law)
Penile implant/testicular prosthesis for a psychiatric cause
Personal comfort items such as telephones and televisions
Postpartum home visits for non-medical reasons
Postpartum inpatient stay of an infant for purposes of staying with the mother (when the mother requires continued treatment, but the newborn does not)
Postpartum inpatient stay of a mother for purposes of staying with the newborn (when the newborn requires continued treatment, but the mother does not)
Pre-employment physicals
Premenstrual syndrome treatment
Private hospital rooms
Radial keratotomy
Rest cure
Retirement homes
Reversal of sterilization
Rolfing
Root canals
Self-help courses
Services by providers suspended or sanctioned by any federal agency. To obtain a listing or search for an excluded provider, use the Medicare exclusions link at the Health Administration Center website at **www.va.gov/hac** or access this information directly from the Department of Health and Human Services Office of Inspector General website at **http://exclusions.oig.hhs.gov**.
Services and supplies obtained as part of a grant, study, or research program.

NON-COVERED SERVICES
Services and supplies not provided in accordance with accepted professional medical standards or related to experimental/investigational or unproven procedures or treatment regimens.
Services or supplies above the appropriate level required to provide the necessary medical care.
Services provided by a member of your immediate family or person living in your household.
Services and supplies that could have been (and are) performed routinely on an outpatient basis
Services or advice provided by telephone
Sex changes
Sex therapy counseling or sexual behavior modification
Sexual dysfunction, paraphilias and gender identity disorders
Smoking cessation medication and products
Spas
Staff consultations required by the policies of a hospital or other institution
Stress management
Surgery for psychological reasons
Swimming pools
Tattoo removal
Telephone consultations, services, advice
Therapeutic absences
Transportation services that do not require life sustaining equipment
Treatment of generally poor dental health
Treatment of dry mouth (xerostomia)
Vehicle lifts that are non-detachable and cannot be removed from one vehicle and used on another
Vitamins, except for formulations of folic acid, niacin, and vitamins D, K, and B12 (injection)
Vocational counseling
Weight control medication or reduction programs
Whirlpools
Workers' Compensation injuries

Section 4: Your Costs



Remember, words in green text are defined on pages 62-65

There are two parts to your costs. First, for outpatient care (for example, pharmacy and doctor's appointments), there is an annual deductible. Second, most medical services and supplies have a cost share (co-payment).

If your provider does not accept assignment, you are responsible for your deductible and cost share (described below), and any additional amounts between our total allowable amount (our portion of the allowable and your cost share) and the provider's billed amount.

For care that is not covered by us, you pay the full bill.

If your provider accepts assignment the provider is agreeing to accept our allowable amount as payment in full. A provider cannot balance bill you in this situation. That means the provider cannot bill you for the difference between their billed amount and the CHAMPVA allowed amount.

ANNUAL DEDUCTIBLE

The annual (calendar year) outpatient deductible is the amount that you must pay before we pay for a covered outpatient medical service or supply. The deductible is $50 per beneficiary or a maximum of $100 per family per year. The annual deductible must be paid prior to our paying 75% of the allowable amount. As claims are processed for covered services, charges are automatically credited to individual and cumulative family deductible requirements for each calendar year. **DO NOT** send checks to us to satisfy your deductible requirement.

There is **no deductible** for inpatient services, ambulatory surgery facility services, partial psychiatric day programs, hospice services, or services provided by VA medical facilities (CITI, Meds by Mail).

COST SHARE

A cost share, or co-payment, is the portion of the CHAMPVA allowable amount that you are required to pay. With few exceptions, you will pay something toward the cost of your medical care. For covered outpatient services, we pay up to 75% of the CHAMPVA allowable amount after the deductible is met. For your inpatient service cost share, please refer to the chart in this section entitled *Cost Summary*, starting on page 44.

There is **no cost share** for hospice or for services received through VA medical

facilities. This includes services received at VA facilities under the CITI program or medications obtained through the Meds by Mail program.

CATASTROPHIC CAP

Your catastrophic cap is $3,000 per calendar year. To provide financial protection against the impact of a long-term illness or serious injury, we have established an annual limit for out-of-pocket expenses for covered services paid by you. This is the maximum out-of-pocket expense you and your family can incur for CHAMPVA-covered services and supplies in a calendar year. Credits to the catastrophic cap are applied starting January 1st of each year and run through the end of the calendar year, December 31st. Upon meeting the limit, you or your family's cost share for covered services for the remainder of the calendar year is waived, and we pay 100% of the CHAMPVA allowable amount for covered services for the remainder of the calendar year.

Each time we pay a bill, your deductible and cost share are calculated and credited to your catastrophic cap. The cumulative amount credited to your catastrophic cap is shown on the explanation of benefits (EOB) you receive after services are paid. If you find an error, let us know quickly.

CHAMPVA ALLOWABLE AMOUNT

The allowable amount is the most we will pay for a covered medical service or supply. We determine the allowable amount before we calculate your cost share, the deductible, or the OHI payment. The CHAMPVA allowable amount is generally the same as TRICARE's or Medicare's allowable amount.

COVERAGE OUTSIDE THE UNITED STATES

If you live or travel overseas, we provide the same benefits as if you were in the US. Your deductible and cost share will be the same amount of the allowed amount, which for foreign countries is the reasonable and customary billed amount. Claims received in English (billing and medical documentation) will be processed faster as we will not need to arrange for the translation. But, if the billing and medical documentation is received in a foreign language, translation will be arranged at no cost to you. Our payments are made in US dollars.

COST SUMMARY–WHEN YOU HAVE NO OTHER HEALTH INSURANCE

BENEFITS	DEDUCTIBLE?	YOU PAY
Ambulatory surgery	NO	25% of CHAMPVA allowable
Ambulatory surgery (CITI program-VAMC)	NO	$0
Professional services	YES	25% of CHAMPVA allowable amount after deductible
Professional services (CITI program-VAMC)	NO	$0
Durable medical equipment (DME): non-VA source	YES	25% of CHAMPVA allowable amount after deductible
Durable medical equipment (DME): VA source	NO	$0
Emergency room charges	DEPENDS—whether the emergent care becomes part of inpatient charges or remains as an outpatient charge	The charges will be included in the inpatient charge if once you stabilize you are admitted to the hospital. Your payment will then be based on "inpatient services." If you are not admitted, your payment is based on "outpatient services."
Inpatient services: DRG based	NO	Lesser of: 1) per day amount X number of inpatient days; 2) 25% of billed amount; or 3) DRG rate
Inpatient services (CITI program-VAMC)	NO	$0
Inpatient services: non-DRG based	NO	25% of CHAMPVA allowable amount
Inpatient mental health: High Volume and residential treatment centers	NO	25% of CHAMPVA allowable amount

BENEFITS	DEDUCTIBLE?	YOU PAY
Inpatient mental health: Low Volume	NO	Lesser of: 1) per day amount X number of inpatient days; or 2) 25% of billed amount
Outpatient services (i.e. doctor visits, lab/radiology, home health, mental health services, skilled nursing visits, ambulance)	YES	25% of CHAMPVA allowable amount after deductible
Outpatient services (i.e. doctor visits, lab/radiology) (CITI program—VAMC)	NO	$0
Pharmacy services (retail)	YES	25% of CHAMPVA allowable amount after deductible
Pharmacy services (Meds by Mail or CITI)	NO	$0

WHEN CHAMPVA PAYS INCORRECTLY

Sometimes, in the processing of millions of claims each year, there may be an inadvertent overpayment to you or your provider, depending on who submitted the claim. This might happen when we aren't aware that you have other health insurance that should have paid before the bill was submitted to us, when a provider bills us twice for the same service, or if we mistakenly pay for services for you or a family member during a period of ineligibility. No matter whose fault the incorrect payment was, we are required to take action to get the money back from whoever received the erroneous payment. That's called recoupment and it is done to help ensure that your tax dollars are spent properly, according to the law.

Here's what will happen if you are the one who was overpaid. You will receive a written request for repayment of the amount and the letter will explain your rights under the law. You should respond to the request within 30 days. Make sure you answer it promptly. If you can't afford to pay the money all at once, you may be able to make monthly payments. You will be asked for financial information if you request a waiver of the overpayment. Depending on the outcome of the review of that information, the debt may be reduced or waived. If you do not respond to our notification, action to collect the amount owed to the VA will begin.

Section 5: Other Health Insurance

Remember, words in green text are defined on pages 62-65

OHI CERTIFICATION

When you first applied for CHAMPVA we asked you to complete a CHAMPVA OHI Certification Form (VA Form 10-7959c). Any time there is a change in your OHI status, **you must inform us of the change**. Periodically we will ask for you to recertify your OHI status by completing the form and submit it to us at the address listed in *"Where to send completed forms"*, page 60. Or, you can call our toll free number and provide the information to a customer service representative.

If your OHI is Medicare, include a copy of your Medicare card.

If your OHI is a health maintenance organization (HMO) or preferred provider organization (PPO) plan, include a copy of the plan's co-payment information and schedule of benefits.

CHAMPVA AS PRIMARY PAYER

If you also qualify for one of the three types of health insurance listed below, we will still pay first (as the primary insurer). Those plans are:

Medicaid

If you are eligible for Medicaid, we pay first. In those instances where Medicaid may have made payment for medical services and supplies first, we will reimburse the appropriate Medicaid agency for the amount we would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less.

State Victims of Crime Compensation Program

We always pay first if you are eligible under a State Victims of Crime Compensation Program.

CHAMPVA Supplemental Health Insurance

There are a number of companies that offer CHAMPVA supplemental policies. After we make a payment for health care services, your remaining out-of-pocket expenses such as deductibles and co-payments often are payable by the supplemental insurance policy. If you have a policy that was specifically obtained for the purpose of supplementing CHAMPVA, we will compute the allowable amount, pay the claim, and then you can submit the balance due on the claim to your supplemental insurer.

We do not endorse one policy over another and you should carefully consider your family's needs for the additional coverage. Information on supplemental insurance is available on the HAC website at **www.va.gov/hac**. Further information about supplemental health plans can also be obtained from Federal Publishing at **www.federalpublishing.com**. Federal Publishing is not affiliated with the government and we do not endorse their products or services.

CHAMPVA AS A SECONDARY OR TERTIARY PAYER

In all other cases, CHAMPVA is a secondary or tertiary payer; we pay after your OHI and, if you have more than one OHI (such as Medicare and Medicare supplemental plan), we pay after both plans. Having OHI complements the CHAMPVA program; it does not prevent anyone from using it. You may have another health plan through your employer, your spouse's employer, or other government program such as Medicare. In most cases when you have OHI and CHAMPVA, there is no cost to you at all. When there is a cost to you, it is most often because you have exhausted your other health insurance benefits so the OHI is no longer making payment for a service or benefit period. In that case, when the medical service or supply is a covered benefit under CHAMPVA, we would again cost share the expense of the care with you.

You or the provider must file the claim with the other insurance plan before submitting it to us for payment. Upon receiving the explanation of benefits (EOB) statement from the other insurer, you or the provider may file a CHAMPVA claim for any remaining balance. In addition to the EOB from the other health insurance, claims (billings) must include the provider's itemized billing statement.

CHAMPVA AND HEALTH MAINTENANCE ORGANIZATION (HMO) OR PREFERRED PROVIDER ORGANIZATION (PPO) PLANS

If you have an HMO or PPO plan, we will pay your out-of-pocket expenses (your co-payments under the HMO/PPO) for covered services up to CHAMPVA allowable amount.

We will not pay for medical services that were available through your HMO/PPO plan if you choose to obtain care outside the plan without authorization from the HMO/PPO (for example, you choose to go to a doctor that is not part of your plan) or you do not follow the rules and procedures of your HMO/PPO to obtain the care.

COST SUMMARY—WHEN YOU HAVE OHI (OTHER THAN MEDICARE)

SERVICE	OTHER HEALTH INSURANCE PAYS	CHAMPVA PAYS	YOU PAY
All medical services and supplies that are covered by both the OHI and CHAMPVA.	Their plan allowable	What you owe up to the CHAMPVA allowable amount	In most cases, $0
Medical services covered by your OHI, and **NOT** covered by CHAMPVA.	Their plan allowable	$0	Your OHI plan co-payment
Medical services **NOT** covered by your OHI, but covered by CHAMPVA (**NOTE:** We do **NOT** pay for services that were determined non-covered by your OHI because you failed to follow the OHI plan requirements.)	$0	The CHAMPVA allowable amount (see page 44)	Your cost share for the type of service (see table on page 44)

CHAMPVA AND MEDICARE

When payment for covered services and supplies can be made under both Medicare and CHAMPVA, Medicare is the primary payer. For health care services covered under both plans, you most often have no out-of-pocket expense. The amount of the Medicare co-payment is published yearly in your Medicare handbook.

Information to keep in mind if you have Medicare:

It is important to be aware that when you have Medicare and CHAMPVA, you must follow Medicare's rules and procedures for covered services. If you do not follow their rules, or if Medicare determines the service is not medically necessary or appropriate, we will not pay for that care.

If you or your provider do not agree with the Medicare decision regarding payment or non-payment, an appeal of the decision should be made with Medicare.

In most cases, when you are eligible for Medicare Part A, you must enroll in Medicare Part B to also have CHAMPVA eligibility (refer to page 13 regarding eligibility).

You are not required to enroll in Medicare Part D (drug plan) in order to receive or retain CHAMPVA benefits. CHAMPVA is a creditable drug plan. So if you lose your CHAMPVA coverage at a later date, Medicare will not charge a penalty for enrollment into Part D.

We do not pay your Medicare Part B or Part D premiums.

COST SUMMARY WHEN YOU HAVE MEDICARE

SERVICE	MEDICARE PAYS	CHAMPVA PAYS	YOU PAY
Part A – Hospital			
Hospital Stay 1-60 days	All but the Medicare co-payment	Your Medicare co-payment	$0
Hospital Stay 61-90 days	All but the Medicare co-payment	What you owe up to the CHAMPVA allowable amount	In most cases, $0
Hospital Stay 91-150 days	All but the Medicare co-payment	What you owe up to the CHAMPVA allowable amount	In most cases, $0
Hospital Stay >150 days	$0	75% of the CHAMPVA allowable amount	25% of the CHAMPVA allowable amount
Part A - Skilled Nursing Facility (SNF)			
	There must be a 3-day inpatient stay prior to admission to the SNF	There must be a 3-day inpatient stay prior to admission to the SNF	
1-20 days	100% of Medicare allowable	What you owe up to the CHAMPVA allowable amount	In most cases, $0
21-100 days	All but the Medicare co-payment	What you owe up to the CHAMPVA allowable amount	In most cases, $0
>100 days	$0	75% of the CHAMPVA allowable amount	25% of the CHAMPVA allowable amount

SERVICE	MEDICARE PAYS	CHAMPVA PAYS	YOU PAY
Part B – Outpatient			
	(after $100 deductible met)	(after $50 deductible met)	
Outpatient medical care to include:			
• Office visits (doctor) • Durable Medical Equipment • Cancer screenings • Mammograms • PAP smears • Immunizations (including flu shots) • Diabetes supplies (test strips, monitors, etc.) • Diabetes self-mgmt training • Bone mass measurements	80% of Medicare allowable amount	What you owe up to the CHAMPVA allowable amount	In most cases, $0
Clinical laboratory	100% of Medicare allowable	What you owe up to the CHAMPVA allowable amount	$0
Mental Health Visit	50% of Medicare allowable	What you owe up to the CHAMPVA allowable amount	In most cases $0
Hospice Outpatient Medications Respite care	100% of Medicare allowable All but $5 per prescription 95% of Medicare allowable	What you owe up to the CHAMPVA allowable amount	$0
Pharmacy (without Medicare Part D)	$0 (with a few exceptions)	Retail: 75% of allowable amount Meds by Mail: 100%	25% of CHAMPVA allowable amount $0

SERVICE	MEDICARE PAYS	CHAMPVA PAYS	YOU PAY
Part B – Outpatient			
Pharmacy (with Medicare Part D)			
The first $250	$0	75% of the allowable amount, after you pay your $50 deductible	25% of the allowable amount
Between $250 and $2,250	25% of total drug costs	75% of the CHAMPVA allowable amount	Typically, you pay $0
Between $2,250 and $5,100	100% of total drug costs	CHAMPVA pays nothing	$0
After $5,100 in total drug costs	The greater of $2 for generics, $5 for brand drugs, or 5%	75% of the remaining cost, until your expenses reach $3,000. Then we pay 100%	25% of the remaining cost, until your expenses reach $3,000. Then you pay nothing

CHAMPVA AND WORKERS' COMPENSATION

We do not pay for medical care for the treatment of a work-related illness or injury when benefits are available under a workers' compensation program. You must apply for workers' compensation benefits. If you exhaust your workers' compensation benefits, we will then pay for covered services and supplies. Provide a copy of the final decision of the workers' compensation claim to avoid any delay in payment of future claims.

CHAMPVA AND ACCIDENTAL INJURIES

If you are involved in an accident (such as an auto accident), you are required to file a medical claim with your (or the other person's) insurance before submitting it to us. This is called third-party liability and means that someone else is legally responsible for your medical care. When we receive the explanation of benefits (EOB) statement from the insurance company, you may file a CHAMPVA claim for any remaining balance. To ensure your medical needs are met, we will provide payment for medically required services while a determination of third party liability is being made. If another party is determined to be responsible for covering the bills, we will request reimbursement for our payments from you or the other party (often their insurance company).

Section 6: Claim Filing Instructions

Remember, words in green text are defined on pages 62-65

It is important to fill out a claim form correctly. In most cases, the provider will complete and send in the claim form for you. There are times, though, that you will have paid for the medical service or supply and need to request reimbursement from us. A mistake, forgotten signature, or other missing information can slow down your claim or result in an initial rejection of the claim. We can't process the claim until we have all the information.

WHEN YOU SUBMIT THE CLAIM

You'll need to send in three items:

1. CHAMPVA Claim Form, VA Form 10-7959a (available by phone or on the web)
2. The provider's itemized billing statement to include all information listed under the section below titled: *Provider Submitted Claims*.
3. When you have other health insurance (OHI), an explanation of benefits (EOB) from the other health insurer.

Tips for when you file claims

- Your name must be listed on the claim form exactly as it is on the CHAMPVA Authorization Card.
- Your CHAMPVA Member Number (**your** Social Security number) must be on the claim.
- Keep copies of all receipts, invoices, etc.
- Separate claim forms are required for each CHAMPVA beneficiary in your household.
- If you do ***NOT*** use CHAMPVA VA Claim Form 10-7959a, payment will be made directly to the health care provider instead of to you.
- After billing your other health insurance, you can file with CHAMPVA for any remaining balance.

PROVIDER SUBMITTED CLAIMS

If your provider submits the claim, they will either send it electronically or on a standardized paper form (HCFA-1500, CMS-1500, UB-92, or UB-04).

Tips for when your provider files claims

- Claims submitted electronically are processed more quickly. If your providers can send the claims electronically, provide them these instructions:

Electronic Filing Instructions: Providers can submit electronic claims

through our clearinghouse, Emdeon™. Our EDI payer ID number at Emdeon™ is 84146 for medical claims and 84147 for dental claims.

- An itemized billing statement on a HCFA-1500, CMS-1500, UB-92, or UB-04 form is required with the following information:
  - Full name, address, and tax identification number of the provider
  - Address where payment is to be sent
  - Address where services were provided
  - Provider professional status (doctor, nurse, physician assistant, etc.)
  - Specific date of each service provided. Date ranges are acceptable only when they match the number of services/units of services
  - Itemized charges for each service
  - Appropriate medical code (ICD-9, CPT, HCPCS) for each service
- If other health insurance was billed, provide a copy of their EOB detailing what they paid. Sometimes the definition or explanation of their codes is on the reverse of their explanation of benefits (please include a copy of that as well).
- Medical records or notes must be submitted with the bill in some cases. The handbook notes many of those services that require the medical documentation such as for skilled nursing, home health, and some surgical procedures.

PHARMACY CLAIMS

Most pharmacies submit claims to us electronically. The following information is required for pharmacy claims regardless of whether submitted electronically or on paper and regardless of whether submitted by the pharmacy or by you:

- An invoice/billing statement that includes:
  - Name, address, and phone number of the pharmacy
  - Name of prescribing physician
  - Name, strength, quantity for each drug
  - Eleven-digit National Drug Code (NDC) for each drug
  - Charge for each drug
  - Date prescription was filled
- If you send us a claim, use CHAMPVA Claim Form (VA Form 10-7959a). Also provide the sales receipt (cash register receipt) with the date and dollar amount that corresponds to the date and dollar amount on the pharmacy invoice/billing statement.
- If you send us a claim and you have other health insurance, your co-payment amount must be included on your receipt.

WHERE TO MAIL CLAIMS

VA Health Administration Center
CHAMPVA
PO Box 65024
Denver, CO 80206-9024

CLAIM FILING DEADLINES

You have one year after the date of service in which to file any claims. In the case of inpatient care, the claim must be filed within one year of the discharge date. Claims submitted after the claim filing deadline will be denied.

EXPLANATION OF BENEFITS (EOB)

After a claim is filed for your health care service, you will receive an EOB from us in the mail. The EOB lists the details of the services you received and the amount you may be billed by your provider. If you had paid for the service and submitted a claim for reimbursement, it will tell you how we calculated your cost share. The EOB contains the following information:

- amount billed by the provider
- amount allowed by CHAMPVA
- amount not covered
- amount paid by other health insurance plan or program
- annual catastrophic cap accrual
- beneficiary and family deductible accrual
- CHAMPVA payment(s)
- date(s) of service
- description of service
- provider name
- remarks

When a provider files a claim, the EOB is sent to both you and the provider. When you file a claim, the EOB is sent only to you. When your health care service is received through a VA source (such as Meds by Mail or CITI), an EOB is not sent to you.

Section 7: Appeal Requests

You may appeal denials of:

- Eligibility determinations
- Benefit coverage
- Authorization requests
- Denied services
- Second level mental health appeals (Note: first level appeals related to mental health care are completed by our mental health contractor—address on page 22 of the handbook).

For an appeal to be considered, you must:

- Submit the request in writing within one year of the date of the Explanation of Benefits (EOB) in the case of a denial of a service or benefit or one year from the date of the letter notifying you of a denial of eligibility or service to us at:

  VA Health Administration Center
  CHAMPVA
  ATTN: Appeals
  PO Box 460948
  Denver, CO 80246-0948

- Identify why you believe the original decision is in error,
- Include a copy of the EOB or other determination letter, and
- Submit any new and relevant information not previously considered.

After reviewing your appeal and supporting documentation, a written decision will be sent to you advising of the decision. If you still disagree with the decision, you may request a second review. That request for review must be received within 90 days of the date of the first decision. Your request must be submitted in writing, identify why you believe the decision is in error, and include any additional relevant information. Second level appeal determinations are final decisions and cannot be appealed again.

Note: If the reason for the appeal is not identified, the request will be returned back to you with no further action.

We will not consider appeals submitted regarding:

- The cost-share or amount of an individual or family's deductible. By law, this amount is payable by you.

- Sanctioned or excluded medical providers by the Department of Health and Human Services or the Office of Inspector General.
  - Providers may be sanctioned for failure to maintain proper medical credentials, fraud and abuse, default on public loans, or other various reasons. Only the sanctioned provider or appointed representatives can appeal this decision and that appeal must go to HHS-OIG.
- Benefits that are specifically excluded by regulation.

Appeal requests that relate to the following situations will not receive a formal review, but will be reprocessed when the missing information is received or when you notify us the billing is resubmitted with a correction.

- Claim denials for missing code information (Current Procedural Terminology (CPT), Health Care Common Procedure Coding System (HCPCS), Internal Classification of Diseases (ICD9), and National Drug Codes (NDC)).
- Decisions on claims where we are requesting more information before an action is taken on your claim. Examples of this may include claim denials requesting medical documentation, operative reports, treatment plans, or a certificate of medical necessity.
- Claim denials requesting an Explanation of Benefits (EOB).
- Billing errors (i.e., incorrect date of service, incomplete or missing procedure codes, and/or billed charges) where a corrected bill is submitted to modify the original claim.
- Corrected claims

Appeal requests regarding the service-connected disability rating must be submitted to the local servicing Veterans Administration Regional Office (VARO). The VARO determines the service-connected rating, and a challenge regarding their determination must be submitted to them.

Section 8: When You Need Help or Information

Remember, words in green text are defined on pages 62-65

Customer Service

At CHAMPVA we are always working to improve our service to you. We are committed to getting you accurate and timely information about your benefits and giving you a variety of ways to obtain the needed information.

If this handbook doesn't provide you with the answers to your questions or the information you need, we have the sources listed below to assist you. Please review the entire section to help you decide the best way available for you to get in touch with us.

INTERACTIVE VOICE RESPONSE SYSTEM
Phone Toll Free: 1-800-733-8387
Hours of Availability: 24 Hours a Day, 7 Days a Week
You can obtain information and request forms through our interactive voice response system, without waiting to speak to a customer service representative. **Services available through this system are:** Ordering CHAMPVA forms and applications. Press 1 to use the self service system to request forms. The prompts will instruct you to leave a voicemail request by leaving your CHAMPVA member number (Social Security number), full name and address. You can check on your eligibility, claims status, annual deductible, and annual catastrophic cap. Your providers can check on your eligibility or the status of a payment.
TALK TO A CUSTOMER SERVICE REPRESENTATIVE
Phone Toll Free: 1-800-733-8387
Hours of Availability: 8:05 a.m. to 7:30 p.m. (Eastern Time) Monday through Friday (excluding holidays)
You'll find it easier to reach our customer service representatives during "non-peak hours." Our non-peak hours are Thursday and Friday, from 12:00–2:00 p.m. and 4:00–5:00 p.m. (Eastern Time).

WEB: WWW.VA.GOV/HAC

The following information is available on the web 24 hours a day, 7 days a week:

- The CHAMPVA handbook and policy manual
- Frequently asked questions
- Fact sheets on all aspects of the CHAMPVA program

WWW.MYCHAMPVA.COM

This is a secure website where you can retrieve information about claim status, current period of eligibility and other health insurance (OHI) information the HAC has on file for you. It is available 24 hours a day, seven days a week. To register for the automated web service, access **www.mychampva.com**. After completing the HAC On-Line registration screen, please print the required VA Form 10-5345, Request for Authorization to Release Medical Records or Health Information, that is also available on this page. Print the form by clicking the link titled *Written Request Form* at the bottom of the page, and follow the instructions to complete the form. Mail the completed form to:

VA Health Administration Center
HAC On-Line
PO Box 469028
Denver, CO 80246-9028

We will notify you by email when your account has been activated. In that email you will receive a log-in identification and temporary password. You will not be able to access the site for 48 hours after activation. After the 48 hours have passed, log in and then you will be asked to change your password. For your protection, keep your password in a safe place.

EMAIL: HAC.INQ@VA.GOV

Typically you will receive a response to your question within one working day. To protect your privacy, we do not recommend that you include sensitive or personal information in the message. We do ask that you include your full name in the body of the message. We will not return information containing personal identifiers or medical information on email. If you are requesting that type of information, we will call you or send the information through regular mail.

CHAT LINE

Your CHAMPVA questions can be answered live, on-line by a customer service representative 11:00 a.m. to 6:30 p.m. Eastern Time, Monday through Friday (excluding holidays). To access the chat line, go to **www.va.gov/hac/contact/contact.asp** and select "*Chat Live!*".

MAIL
When writing us, please include your name, your CHAMPVA Member Number (your Social Security number), and your phone number. Send your inquiry to: VA Health Administration Center CHAMPVA PO Box 65023 Denver, CO 80206-9023

Where to Get Forms and Publications

Forms and publications are available to you through these options. When you use any of these options, make sure you provide your name, address, and CHAMPVA Member Number.

INTERACTIVE VOICE RESPONSE SYSTEM
Phone Toll Free: 1-800-733-8387 **Hours of Availability:** 24 Hours a Day, 7 Days a Week
TALK TO A CUSTOMER SERVICE REPRESENTATIVE
Phone Toll Free: 1-800-733-8387 **Hours of Availability:** 8:05 a.m. to 7:30 p.m. (Eastern Time) Monday through Friday (excluding holidays)
WEB
www.va.gov/hac
EMAIL
hac.inq@va.gov
MAIL
When writing us, please include your name, your CHAMPVA Member Number, and your phone number. VA Health Administration Center CHAMPVA PO Box 65023 Denver, CO 80206-9023

Note: To view and print forms, you must have Adobe Acrobat Reader version 6.0. This is available to download for free from the website, if you do not currently have it loaded on your computer.

Where to Send Completed Forms

CHAMPVA Applications	VA Health Administration Center CHAMPVA Eligibility PO Box 469028 Denver, CO 80246-9028
School Certifications	
Other Health Insurance (OHI) Certification Forms **Note**: you can also provide OHI information by calling a customer service representative at 1-800-733-8387.	VA Health Administration Center CHAMPVA PO Box 65023 Denver, CO 80206-9023
Completed Claims for Medical Services and Supplies	VA Health Administration Center CHAMPVA PO Box 65024 Denver, CO 80206-9024

Section 9: Help Fight Fraud

Combating fraud and abuse takes a cooperative effort from each of us. One way for you to help is by reviewing your Explanation of Benefits (EOB) to be sure that the services billed to us were reported properly. If you should see a service and/or supply billed to us that you did not receive, please report that immediately in writing. Indicate in your letter that you are filing a potential fraud complaint and document the following facts:

- The name and address of the provider,
- The name of the beneficiary who was listed as receiving the service or item,
- The claim number,
- The date of the service in question,
- The service or item that you do not believe was provided,
- The reason why you believe the claim should not have been paid, and
- Any additional information or facts showing that the claim should not have been paid.

DETECTION TIPS

You should be suspicious of practices that involve:

- Providers who routinely do not collect your cost share (co-payment).
- Billing by your provider for services that you did not receive.
- Providers billing for services or supplies that are different from what you received.

PREVENTION TIPS

- Always protect your CHAMPVA Authorization Card. Know to whom you are giving your CHAMPVA Member Number. Do not provide your member number to someone over the phone if they call you.
- Be skeptical of providers who tell you that a particular item or service is not usually covered by us, but knows how to bill for the item or service to get it paid.

Who do I contact if I suspect fraud, waste, or abuse?

Mail: VA Health Administration Center
ATTN: Program Integrity
PO Box 65020
Denver, CO 80206-9020

Phone: 1-800-733-8387

Email: **hac.inq@va.gov**

Section 10: Definitions of Common Words and Acronyms Used in the Handbook

Word/Acronym	Definition
Adjunctive	The treatment is a necessary part of approved care for a covered medical condition.
Allowable Amount	The term includes both the amount we pay and your cost share.
Assignment	When you go to a medical provider, find out if the provider will accept CHAMPVA. Providers most often refer to it as accepting assignment. What that means is the provider will bill us directly for covered services, items, and supplies. Doctors or providers who agree to accept assignment cannot try to collect more than the CHAMPVA deductible and cost share amounts from you.
Balance Billing	Balance Billing is inappropriate. When the provider accepts assignment that is an agreement to accept the VA allowable amount as payment in full. You are not responsible for paying the difference between the provider's billed amount and our determined allowable amount.
Beneficiary	A CHAMPVA-eligible spouse, widow(er), or child. Beneficiaries may also be referred to as dependents.
CDC	Centers for Disease Control
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
Child	Includes birth, adopted, stepchild, or helpless child as determined by a VA regional office (VARO).
Certificate of Medical Necessity (CMN)	A Certificate of Medical Necessity, or CMN is a document provided by your physician that indicates the medical necessity for the care or services prescribed as part of your treatment plan.
Coordination of Benefits	We must be aware of other health insurance to know when there may be double coverage. Knowing this, we can ensure that there is not a duplication of benefits paid between the other health insurance coverage and CHAMPVA. The explanation of benefits from the OHI provides the documentation for us to coordinate benefits and pay your claim appropriately.

Word/Acronym	Definition
Custodial Care	Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to: • Personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing; • homemaking, such as preparing meals or special diets; • moving the patient; • acting as companion or sitter; • supervising the medication that can usually be self-administered; or • treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respiration, or administration and monitoring of feeding systems.
Diagnosis Related Groups (DRG)	A system that hospitals use to classify the resources used to treat a specific condition or related condition based on the clinical needs of the patient. The DRG Group determines the reimbursement to the hospital.
Explanation of Benefits (EOB)	After the bill is processed, you will receive this form that provides details of what was paid and the amount of payment.
FDA	Food and Drug Administration
Formulary	A health plan's list of preferred drugs based on evaluations of the effectiveness, safety, and cost.
HAC	Health Administration Center. Administers the CHAMPVA program.
HCPCS	Healthcare Common Procedure Coding System
Helpless Child	A child who, before the age of 18, became permanently incapable of self-support and was rated as a helpless child by a VA Regional Office (VARO).
High Volume	Facilities with 25 or more mental health discharges in a year
HMO	Health maintenance organization
Low Volume	Facilities with less than 25 mental health discharges in a year
MbM	Meds by Mail

Word/Acronym	Definition
Medical Necessity	Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that we determine: • are appropriate to diagnose or treat the patient's condition, illness or injury; • are consistent with standards of good medical practice in the United States; • are not primarily for the personal comfort or convenience of the patient, the family, or the provider; • are not a part of or associated with the scholastic education or vocational training of the patient, and; • in the case of inpatient care, cannot be provided safely on an outpatient basis.
NDC	National Drug Code used to identify pharmaceuticals.
Non-peak Hours	Period of time that call volume is most often less than other times of the day.
OHI	Other health insurance
Over-the-counter Medications	Medications that do not require a prescription.
PPO	Preferred Provider Organization
Primary Payer	A health insurance plan that will pay first on the bills for service. These are typically major medical health plans.
Qualifying Sponsor	A veteran who is in receipt of a VARO award that establishes eligibility for CHAMPVA benefits for his/her dependents. These dependents can not be entitled to DoD TRICARE benefits.
Recoupment	Collection of a debt owed to the government.
Secondary Payer	A health insurance plan that pays after the primary payer has determined what they will pay on the claim.
Service-connected	A VARO determination that a veteran's illness, injury, or death is related to military service.
Spouse	The wife or husband of a qualifying sponsor.
Supplemental Insurance	A health insurance plan that pays after the primary payer has determined what they will pay on the claim. We will pay before a CHAMPVA supplemental policy, but will pay after a Medicare supplemental policy.

Word/Acronym	Definition
Survivors	Widows and dependent children
Tertiary Payer	A payer that provides coverage after the primary and secondary payer have made payment on a claim.
VA	Department of Veterans Affairs
VARO	Veterans Affairs Regional Office
Widow(er)	The surviving spouse of a qualifying sponsor.

Section 11: Notice of Privacy Practices

We, the Veterans Health Administration (VHA), are providing you with the VA Notice of Privacy Practices. This Notice provides a summary of VA privacy practices and briefly states:

- How your health information may be used and disclosed;
- Your rights regarding your health information; and
- Our legal duty to protect the privacy of your health information.

For a more complete description of our privacy practices, you should carefully review the Detailed Notice of Privacy Practices that is available at our website, or can be requested by calling 1-877-222-8387 (VA Health Benefits Call Center). This notice does not modify or limit the VA Detailed Notice of Privacy Practices.

Your Health Information

Health information is any information we create or receive about you and your past, present, or future:

- Physical or mental health condition
- Health care
- Payment for medical services

How We May Use and Disclose Your Health Information

In most cases, your written authorization is needed for us to use or disclose your health information. However, federal law allows us to use and disclose your health information without your permission for the following purposes:

- Treatment
- Eligibility and Enrollment for VA Benefits
- Public Health
- Research (with strict limitations)
- Abuse Reporting
- Workers' Compensation
- Patient Directories
- Payment
- Law Enforcement
- Judicial or Administrative Proceedings
- Services
- Correctional Facilities
- When Required by Law
- Family Members or Others Involved in Your Care (with limitations)
- Health Care Operations
- Coroner or Funeral Activities (with limitation)
- National Security
- Health Care Oversight
- Military Activities
- Health or Safety Activities

Department of Veterans Affairs Summary Notice

All other uses and disclosures of your health information will **not** be made without your prior written authorization.

Your Privacy Rights

- Review your health information;
- Obtain a copy of your health information;
- Request your health information be amended or corrected;
- Request that we not use or disclose your health information;
- Request that we provide your health information to you in an alternative way or at an alternative location in a confidential manner;
- An accounting or list of disclosures of your health information; and
- Receive our VA Notice of Privacy Practices upon request.

Changes

We reserve the right to change the VA Notice of Privacy Practices. The revised privacy practices will be effective for all health information we already have about you, as well as information we receive in the future. We will send to your last address of record, and otherwise make available to you, a copy of the revised Notice within 60 days of any change.

Complaints

If you are concerned that your privacy rights have been violated, you may file a complaint to VHA or to the Secretary of the U.S. Department of Health and Human Services. To file a complaint with VHA you may contact your VA health care facility Privacy Officer, the VHA Privacy Officer, or VHA via "Contact the VA" at **www.va.gov** or dial 1-877-222-8387. Complaints do not have to be in writing, though it is recommended. You will not be penalized or retaliated against for filing a complaint.

REQUESTING OR RELEASING INFORMATION FROM MY RECORD

How do I get a copy of my record?

Use VA Form 10-5345a, *Individual's Request for a Copy of their own Health Information*, (available by phone or on the web) to obtain a copy of your record or a copy of a document in your record if you want the information to be sent directly to you.

Use VA Form 10-5345, *Request for and Authorization to Release Medical Records or Health Information*, if you want us to send a copy of your record or a copy of a

specific document in your record to a person or entity other than yourself. This is normally used if you want your information to go to a legal office.

How do I let the HAC know that I want to allow them to discuss claims and eligibility information from my file with an individual of my choosing?

Use VA Form 10-5345, *Request for and Authorization to Release Medical Records or Health Information*, with the words "Recurring Disclosure Authorization" printed in the *Authorization* block, if you want us to discuss claim and eligibility information about you with a person who regularly assists you in handling your medical care needs, such as your spouse, adult child, or friend.

How do I get access to online information about my file?

Use VA Form 10-5345a, *Individual's Request for a Copy of their own Health Information*, with the words "HAC ON-LINE" printed in the block above the signature line to obtain access to selected information from your CHAMPVA record about yourself through an on-line secure Internet connection. Additional information about HAC On-Line is at our website under *For Beneficiaries*, *CHAMPVA*.

Where do I mail these requests?

Mail: VA Health Administration Center
CHAMPVA
PO Box 469028
Denver, CO 80246-9028

Notice of intent to conduct computer matching: Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches. Pursuant to 5 USC 552a, the Privacy Act of 1974, as amended, and the Office of Management and Budget Guidelines on the Conduct of Matching Programs, notice is hereby given of the VA's intent to conduct computer matches with Centers for Medicare and Medicaid Services (CMS). Data from the proposed matches will be utilized to verify Medicare entitlement for applicants and recipients for CHAMPVA benefits, whose eligibility for CHAMPVA is based upon entitlement for Medicare.

Department of Veterans Affairs
Health Administration Center
CHAMPVA
PO Box 65023
Denver, Colorado 80206-9023