Department of Veterans Affairs
Health Administration Center
CHAMPVA newsletter 2006

Fall 2006 Volume 1 Number 4

CHAMPVA Program Surveys

The Health Administration Center uses a variety of survey techniques in order to measure your satisfaction with various elements of the CHAMPVA Program. These techniques include quick surveys, listening and learning events, and program level surveys.

Quick surveys are done as the result of specific actions or events in the CHAMPVA program. These surveys help us gather information and gage satisfaction with specific pieces of the CHAMPVA program. Here is a short list of these surveys:

- At the completion of a phone call
- Upon entry into the CHAMPVA web site
- On receipt of a new authorization card
- On return of correspondence from one of your letters
- On the back page of our newsletters

The feedback we get helps us to fine-tune these services, and to identify when we are not meeting or exceeding your expectations.

Listening and learning events include all opportunities to gather information from events, forums, and our interaction with the public in our contact center. One of the key events in this area is our monthly discussion between senior managers and the front line staff in the contact center. This is an opportunity for us to gather input on the emerging issues that we are receiving from customers and stakeholders. Here is a short list of our listening and learning events:

- Participation at conference held by veterans organizations
- Delivering beneficiary and provider briefings in major cities
- Providing training to Veterans Service Officers at the state and local level
- Monthly sensing sessions with front line staff
- Interaction with our Customer Advisory Council
- Bi-monthly teleconferences with VA medical centers in the CITI program

The final method we use to assess overall program satisfaction is the CHAMPVA Program Survey. The program survey for 2007 is currently in development. We will send several hundred surveys out each quarter throughout 2007. These surveys will include questions on our current level of performance and on your perceptions of recent changes and improvements to the program. We need your input to measure the impact of recent improvements from the customer's perspective. If you receive a program survey in 2007, please take a few minutes to tell us how we are doing. Your input will make a difference!

Helpful Hints

What is an Appeal versus a General Correspondence Inquiry?

The Appeal Section at the Health Administration Center (HAC) often receives correspondence from you wanting us to re-examine a decision for a denied benefit, payment, or eligibility issue. However, upon review of the appeal, the issue doesn't always meet the criteria. Here's some helpful information that may assist you in identifying when an appeal may be requested for denied services.

Appeal Requests Include:

- Benefit coverage issues that are not specifically excluded by regulation or program policy.
- Authorization requests.
- Claims for services that were not submitted timely to the program.
- Second level mental health appeals (first level appeals are completed by our mental health contractor).
- Denied services when the bills are found to be incidental or unbundled [Explanation of Benefits (EOB) denial reason code numbers 1000 - 1008].

Non-Appealable Decisions

- The cost-share or deductible amounts; by law, this amount is payable by the beneficiary.
- Sanctioned or excluded medical providers by the Department of Health and Human Services or the Office of Inspector General.
- Veteran service-connected disability ratings, as they are decided by the local servicing Veterans Affairs Regional Office (VARO).

Appeal requests should be mailed to:

Department of Veterans Affairs
Health Administration Center
ATTN: APPEALS
PO Box 460948
Denver, CO 80246

General Correspondence Decisions

- Corrected claims.
- Recovery requests (check tracer or overpayment).
- Resubmission of a claim with a requested EOB.
- Requests for general information.
- Resubmission of a claim with medical documentation that was previously requested.
- Resubmission of a claim with codes that were missing when initially billed.
- Administrative errors by the HAC, i.e., incorrect date of service entered.

To ensure a prompt and timely response to general claim inquiries, requests for additional information, or resubmitted corrected claims, please send the inquiry directly to:

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

When submitting a corrected claim for payment, the correspondence should clearly indicate that the claim has been corrected or a stamp stating, "Corrected Claim" is very helpful. This approach is helpful in other situations such as, administrative errors by the HAC, recovery requests, resubmission of a claim with requested medical documentation, etc.

Benefit Reimbursement FAQ's

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a federal health benefits program administered by the VA's Health Administration Center (HAC) located in Denver, Colorado. The CHAMPVA program was designed to be the same as or similar to that of the TRICARE program administered by the Department of Defense (DoD).

Both CHAMPVA and TRICARE are federal programs, however, an individual eligible for TRICARE **is not** eligible for CHAMPVA benefits. CHAMPVA provides health care benefits to the family members of a veteran who has been rated by VA with a permanent and total disability.

Under the CHAMPVA program, the HAC occasionally receives inquiries on reimbursement asking why our payment or allowed amount is different from TRICARE or Medicare. The simple answer is that reimbursement is dependent on the type of service performed. In most instances the HAC allowed amount is identical or very close to the TRICARE allowed amount. Although CHAMPVA/TRICARE's payment methodologies are based on Medicare's model, there are differences between CHAMPVA and Medicare reimbursement methods to account for the distinct differences in the two programs beneficiary populations.

In the next couple of months, you'll see changes that will bring our payments in line with TRICARE in 2 areas. Payments for injectable medications that are billed in units (J-codes) and payment for anesthesia claims billed in units or minutes will be paid using the TRICARE allowable or CMAC.

Other common questions are:

Question: Is there a beneficiary cost share (co-payment) requirement?

Answer: Yes. CHAMPVA is a cost-sharing program. A cost share, or co-payment, is the portion of the CHAMPVA-determined allowable amount that the beneficiary is required to pay. With few exceptions, a beneficiary will pay something toward the cost of medical care. The CHAMPVA program has a beneficiary cost share of 25% of the CHAMPVA determined allowed amount.

Question: Is there a deductible requirement?

Answer: Yes. There is an annual (calendar year) deductible for covered outpatient medical services and supplies. The deductible is $50 per beneficiary or a maximum of $100 per family per year. The annual deductible must be paid prior to CHAMPVA paying 75% of the allowable amount.

Note: There is no cost share for hospice or for services received through VA medical facilities. This includes durable medical equipment items obtained through the VA, services received at VA facilities under the CITI program, or medications obtained through the Meds by Mail program.

Question: What is an allowable amount?

Answer: The allowable amount is the maximum payment that CHAMPVA will authorize for a covered medical service or supply. The allowable amount is determined prior to cost sharing and the application of the deductible and other health insurance payment.

Question: Is there catastrophic cap protection?

Answer: Yes. To provide financial protection against the impact of a long-term illness or serious injury, CHAMPVA has established an annual (calendar year) limit for out-of-pocket expenses for covered services paid by each CHAMPVA-eligible family. This is the maximum out-of-pocket expense a family can incur for CHAMPVA-covered services and supplies in a calendar year. The CHAMPVA catastrophic cap is $3,000 per calendar year. Upon meeting the limit, CHAMPVA pays 100% of the allowable amount for covered services for the remainder of the calendar year.

Question: What does CHAMPVA pay for inpatient services?

Answer: An inpatient service occurs when the admission to a hospital is for 24 hours or more, or when the admission was intended to last for more than 24 hours.

Facility Charges

CHAMPVA uses a Diagnostic Related Group (DRG) payment system to calculate the cost for most inpatient hospital services provided. This payment system is based on an episode of care. The DRG payment rates are based on an average cost of local care and the allowable amount may be either more or less than the billed amount. This is generally equivalent to the DoD rate.

Note: The DRG rate does not apply to all inpatient facilities such as: cancer hospitals, Christian Science sanitariums, foreign hospitals, long-term hospitals, non-Medicare participating hospitals, skilled nursing facilities, rehabilitation hospitals, sole community hospitals.

Professional Services

These services include physicians' fees and anesthesia services. The CHAMPVA-determined allowable is the lesser of the CHAMPVA established maximum allowable amount or the billed charge. CHAMPVA pays 75% of the allowed amount.

The HAC's goal is to eventually align our payment methodologies with those of Medicare. We are taking steps in that direction now. There will still be some differences between CHAMPVA's and Medicare's payment methodologies to account for the differences in the beneficiary populations.

If you have any questions concerning reimbursement or payment methodologies visit our website at **www.va.gov/hac**. Then go to fact sheets, under CHAMPVA –Information for Providers, Fact Sheet 01-11 (Payment Methodology).

Meet the HAC Medical Director, Dr. Anne Hazelton

Dr. Anne Hazelton, MD, MSPH

I began with my undergraduate degree in chemical engineering, and then worked as a biomedical engineer, with a year of graduate studies in that field. I then graduated from UC Davis School of Medicine, with postgraduate Family Practice and Internal Medicine training. After starting a family, I earned my Master of Science of Public Health, which qualified me to become Board Certified in Preventive Medicine.

Occupational Medicine has been my field for over 20 years, including Compensation and Pension examinations for the Veteran's Administration. I have been consulting for Worker's Compensation and Medical Disability Case Management for large corporations, having been Medical Director for USWest (CO and WY) and Swedish Hospital Occupational Health. In September of 2000 I began expanding my practice to the legal arena, with Medical Record Reviews and testimony for employability issues in divorce cases. After completing The Biomechanics of Musculoskeletal Injury (a one-semester senior-level course at the School of Mines, completed in 5/04), I began performing Independent Medical Examinations, record reviews and testimony in the area of medical causality for car collisions and other trauma. I was accepted in Federal Court to provide expert testimony in the field of biomechanics, as well as occupational and preventive medicine.

In June 2006, I became the Medical Director for the Health Administration Center, a division of the VA, working at the international headquarters at Denver. This is a part time position that fits well with my other activities.

Health Care Fraud

Public confidence in the CHAMPVA program is essential to ensure its vitality in the decades ahead. Therefore, the Health Administration Center Program Integrity (PI) staff is dedicated to recognizing and deterring health care fraud.

The financial losses to government programs are staggering and the dollar loss alone does not tell the full story about the impact of health care fraud. Health care fraud and abuse take place in numerous arenas in the health care organization. Doctors, hospitals, nursing homes, laboratories, even the beneficiaries have been cited in scams to defraud the system. Fraud schemes include (but are not limited to):

- Phantom billing (fabricating claims for services that were not performed),
- Upcoding (charging to a more expensive service than the beneficiary actually received),
- Doctor shopping (going from one doctor to another in order to obtain multiple prescriptions for controlled substances),
- Misrepresenting services (performing uncovered services but billing for covered services),
- Providing unnecessary care that's not medically necessary,
- Delivering health care services without proper licenses, and
- Identity theft (using another beneficiary's health insurance card or identification to obtain health care).

The experienced, professional PI staff use fraud fighting tools to thoroughly research suspected claims to identify potential overpayments and major fraud schemes. They also monitor trends and recognize specific patterns of health care fraud and abuse. They work directly with the HAC Fiscal department in attempts to recover all dollars paid in cases of fraud and abuse through prompt administrative action, skilled negotiations and aggressive collections. They also coordinate on cases with the VA Office of Inspector General (OIG).

The financial costs of health care fraud are borne not only by taxpayers in the form of increased costs to government health care programs, but also to private businesses, insurance companies, and individual consumers. It is the responsibility of health care providers to police themselves by instituting well designed programs which call for promptly changing their billing systems to include internal controls which will catch overbilling or billing of services never rendered. It is the responsibility of the beneficiary to review their Explanations of Benefits (EOBs) and medical bills to ensure that the services billed were actually performed by the provider indicated and on the date specified.

Most doctors, hospitals and other health-care providers are honest and only want to be paid fairly for the essential services that they provide to the CHAMPVA beneficiaries. CHAMPVA continues to work to ensure that providers are paid appropriately while it protects beneficiaries and taxpayers from improper payments caused by both honest errors and unscrupulous activity. Consumers of health care should be the first line of defense against fraud. Therefore, CHAMPVA places a high priority on this kind of outreach and intends to increase its efforts to enhance public awareness of health care fraud. Please notify CHAMPVA if you suspect health care fraud and abuse by using the following resources:

Mail

Please mail any fraud & abuse issues to the following address:

VA Health Administration Center
CHAMPVA

ATTN: Program Integrity
PO Box 65020
Denver CO 80206-9023

FAX

Fax us at 303-331-7830.

Phone

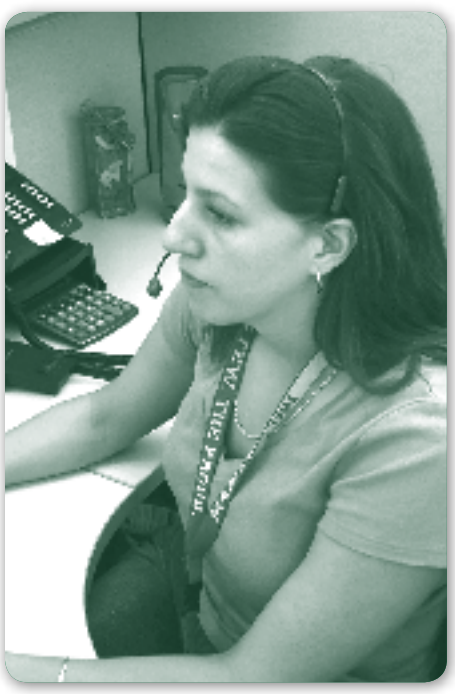
You can call us at 800-733-8387. All calls are confidential and can be made Monday through Friday from 6:05 a.m. to 5:30 p.m. ET.

By reporting suspicious or questionable activity, we guarantee a thorough and timely review of all relevant information. Please remember to:

- Identify the type of correspondence as Fraud & Abuse,
- Explain the reason for the correspondence to include why you believe fraud & abuse occurred, and
- Submit copies of all relevant documentation.

Please be aware that all reports/ suspicions of fraud & abuse remain confidential.

Phone Center Update



We have extended our call-in time by one hour (8:05 a.m.–7:30 p.m. Eastern Time)

- 1-800-733-8387

We have opened our on-line "Live Chat" service one hour earlier (10:00 a.m. - 6:30 p.m. EST)

- **http://www.va.gov/hac/contact/contact.asp**
- Select "Chat Live"!

Also, telephone wait times are improving and we're able to answer your questions completely and accurately faster than we have in recent months. Telephone wait-times averaged 17 minutes in April 2006 and we're down to 10 minutes for August 2006!

Also, we continue to fill vacancies, improve upon existing, and implement new technologies and process improvements all to better serve you, our customer. Although we are getting better, it will be approximately 6 months before we're where we want to be with service levels, however, please rest assured that we're working hard to offer you the highest quality of customer service possible. Stay tuned, there are more exciting improvements coming!

BENEFICIARY

Speed Up Your Claims!

There are a few simple things that ***you,*** the beneficiary, can do in order to expedite the processing of your claim. Here are a few suggestions:

- **Submit pharmacy summaries, not labels.**

  Submit pharmacy summaries. Your pharmacy can give you a printout for the date range you specify. If it is necessary to submit prescription labels, send *copies only*, making certain they are on pages that are 8-1/2 inches by 11 inches in size. Retain the originals for yourself. It is also unnecessary to send drug descriptions.

- **Do not staple your claims.**

  Staples jam machines we use to scan your claims. Do not staple your claims together. It is not necessary as our employees meticulously ensure that claims and all pertinent paperwork will stay together.

- **Make sure all papers are 8-1/2 inches by 11 inches.**

  It is easier for us to process your claims if all of the papers you submit are a full 8-1/2 inches by 11 inches. If you have continuous feed documents, separate them along the perforated lines. Additionally, try to ensure that there are no torn or frayed edges.

- **Do not tape papers.**

  If a paper is small, frayed, or torn, do not tape it to another paper. Instead, make a copy and submit that. Also, do not submit sticky notes with your claims.

- **Make certain that the *patient's* name and Social Security number is on the claim.**

  Make certain that it is the name and Social Security number of the person *receiving* the medical services that appears on the claim. If a dependent receives medical services, their name and Social Security number should appear on the claim, not the sponsors. In addition, if two or more people in your family have similar first and last names, have the middle name spelled out on the claim form. It would also be beneficial if you inform whoever is providing the medical services of this so they can bill us correctly.

By following these few simple hints, you can greatly increase the speed in which your claims get processed. Following this advice will help us when we process your claim, although we will always do our best to rapidly process any claim that you submit.

Understanding the Difference between Custodial Care and Skilled Care

There is often confusion with the terms Custodial Care and Skilled Care. Understanding the difference between custodial care and skilled care is crucial when determining your health care coverage under CHAMPVA (Civilian Health and Medical Program of Veterans Affairs).

Skilled care may be provided by a variety of licensed professional care givers. This may include a licensed professional such as Registered Nurses (RNs), Licensed Practical/Vocational Nurses (LPNs/LVNs), Physical Therapists, Occupational Therapists, Respiratory Therapists, or Social Workers. The skilled care can be provided in different settings such as the patient's residence, a nursing home or rehabilitation facility. Where the care is provided depends on the amount and frequency of care and the severity of the illness.

While a patient is receiving skilled care, they may also be getting custodial care. Custodial care can be provided by a licensed professional or a non licensed person such as a Certified Nursing Assistant (CNA), Personal Care Attendant (PCA) or a family member. Skilled service that can be safely performed by a non-skilled person is considered custodial. When a skilled service is provided infrequently in a facility then the care can be considered custodial. Custodial care also includes behavioral monitoring, safety monitoring, and activities of daily living, such as, toileting, bathing, eating, dressing, and walking.

Alternative care settings exist for patients in need of custodial care. Custodial care can be provided in an Assisted Living Setting, Nursing Home, residence, and/or facilities specializing in the care of patients with diseases such as Alzheimer's disease and dementia.

Skilled care is a covered CHAMPVA benefit however; custodial care is not a covered CHAMPVA benefit. This does not imply that the care being rendered is not required by the patient, it only means that the care is not covered by CHAMPVA.

Save Money with Generic Medications!

There has always been an uncertainty about using generic medications. Did you know that the generic has to be approved by the Food and Drug Administration (FDA) just like all of the brand name medications? Generics have to match the brand in dosage, safety, strength, quality, performance and intended use. All of the active ingredients have to be the same, work in the same way and in the same amount of time.

Generics can save you money because the generic manufacturer doesn't have to invest in the cost of the development of the original brand name drug. Why don't all medications have generics? This is because of the patent protection. Once a drug begins being developed, the patent is submitted. The patent generally lasts for 20 years from this date. Once the patent runs out, the generic manufacturers can start making the same medication.

You may notice that the generic has a different color or flavor. This is because the law does not require that the generic look or taste exactly the same. Rest assured that by selecting a generic medication you are receiving the same active ingredients that work just as effectively as the brand name medication. By selecting the generic, you can save some money and receive the same quality as your brand name medication!

Social Security Numbers

Lately, there has been a lot of attention on the use of an individual's Social Security number (SSN) and the possibility that this use may create a risk for identity theft. As you may know, the Health Administration Center (HAC) has used the individual's SSN for the past decade to control and coordinate the delivery of benefits in the CHAMPVA program. While it is necessary for us to continue to request and use your Social Security number for our internal activities, we have recently come to the conclusion that we could reduce the risk of identity theft if your Social Security number was not printed on documents that leave our facility.

The following changes are currently being deployed across the CHAMPVA program (as well as the other health plans that the HAC manages).

Your CHAMPVA Authorization Card

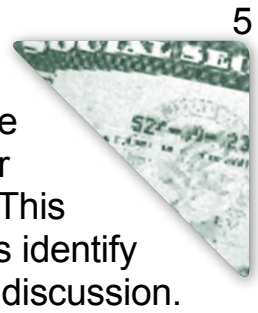
The Center will begin issuing CHAMPVA Authorization Cards in September of 2006 that replace the individual's Social Security number with the phrase "Patient SSN". When you present your new CHAMPVA Authorization Card, it may now be necessary for you to present a second form of identification, or to verbally provide your SSN.

Your CHAMPVA Explanation of Benefits (EOB) form

The Center also removed the "SSN:" section of the EOB form, and replaced your Authorization Card number with the phrase "Patient SSN". Since this form already displays your name and address, as well as the provider's billing control number, we determined that it was no longer necessary to include your SSN on this document.

CHAMPVA Outgoing Correspondence

In the past, it has been our practice to place the veteran SSN or VA Case File number or the beneficiaries SSN in the upper right-hand corner of all correspondence. This was intended to help us identify the document in future discussion. Since we now maintain an image of every document that we produce, this is no longer necessary.



The Department of Veterans Affairs is in the process of creating an agency-wide standard for the identification of all veterans and family members VA-wide. When this new identification system is approved for implementation, we will issue every CHAMPVA beneficiary a new Authorization Card, and this unique identifier will appear on all of the documents mentioned above.

For now, we hope that these actions will reduce the risk of identity theft associated with the use of the SSN in our programs. We look forward to the day when the Center can operate without the use of any individual's SSN.

Denied Claims Service

Are you new to CHAMPVA and looking for some assistance on how to respond to a denied claim? It can often be difficult to read a health plan Explanation of Benefits (EOB) form for the first time, and figure out exactly what we are trying to tell you about the claim(s) that we denied. Due to technical requirements, we are limited to 80 characters when we send you the claim denial explanations at the bottom of our EOB form.

Wouldn't it be nice if you had some way to get a more comprehensive explanation of why we denied a claim and what you could do (if anything) to get us to reconsider the claim for payment? Are you worried about waiting on hold for an extended period of time just to get some advice or assistance?

Your worries are over! We have recently created a new service to provide additional guidance on how to respond to a claim denial, based on our ten most frequent used denial codes. If you have the EOB form available, you can use the denial code on the form to get detailed instruction about how to respond to the claim denial. We also offer an email address to submit questions on our less common claims denial.

Visit us at **www.va.gov/hac**, and click on the "for beneficiaries" or the "for providers" links to access important information on our programs. The first announcement that you will see is a quick link to this new service.

Tell Us Your Story

The Health Administration Center would like to tell your story to our employees. We feel it is extremely important for us to know and understand those that benefit from the CHAMPVA program. As a result, we are dedicating one wall of our facility to post the stories of those that we serve.

In the space provide, we ask that you provide a brief history of your service to our great country. Include the branch and/or units in which you served. We also want to know the various duty stations and conflicts you or your loved one experienced. Anything that you feel would help us understand the sacrifices you have made for our freedom. We would also gladly accept photos (maximum size should be 4" X 6") of our veterans and their families.

Help us honor you. Please send us your story and become a permanent part of our "Beneficiary Profiles - Wall of Honor!"

This is the story of:

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Free Medication Mailed to Your Home!

Would you like?

- *Medications delivered (mailed) to your home or post office box in the United States, Guam and Puerto Rico*
- *No Copay*
- *No claim forms*
- *Regionally located servicing centers to best serve your pharmacy needs*
- *Your prescriptions promptly, accurately and professionally filled*
- *Your maintenance prescription and drug needs handled by one pharmacy*
- *Refills initiated by you simply sending a refill slip back to us*

Through the Meds by Mail program this can all happen for you.

Eligibility Requirements

- *You must have no other pharmacy insurance (Medicare parts A and B are OK to have with this program)*
- *Other restrictions may apply to you*

If this is the kind of prescription service you want, give us a call or email us.

Phone: 1-800-733-8387

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

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

PROVIDER

Have you applied for your National Provider Identifier?

Who?
All individuals and organizations who meet the definitions of "Health care Provider" as described in CFR 160.103 are eligible to obtain a National Provider Identifier (NPI). If you are a Health Insurance Portability and Accountability Act (HIPAA) covered provider and if you submit your claims electronically you will need to take action and obtain an NPI.

What?
The NPI is a 10 digit intelligence free numeric identifier that will be used to identify you and your health care partners in all HIPAA standard transactions. The NPI will replace the legacy identifiers currently used by Medicare and many health care plans such as OSCAR and UPIN numbers.

When?
The NPI will be required in all electronic claim transactions you send to the Health Administration Center (HAC) as of the compliance date of May 23, 2007. The HAC will need your NPI for the providers identified in your electronic claims transactions (837). In addition, you must send your Tax Identification Number (TIN) for the "Pay To" provider identified in the electronic claims transactions (837) for tax purposes in addition to the NPI, for the electronic claims to be accepted and processed.

Why?
The NPI is an Administrative Simplification mandate of HIPAA. This is another step being taken to improve electronic transactions for health care.

How?
There are three ways that you can obtain an NPI:

- Complete the online application at the National Plan Provider Ennumeration System (NPPES) website (**https://nppes.cms.hhs.gov/nppes/welcome.do**) or
- Download the paper application form at **www.cms.hhs.gov.nationalprovidentstand/** or call the enumerator at 1-800-465-3203 for a paper copy and mail to address of the form or,
- After asking for your permission, authorize an employer or other trusted organization to obtain an NPI for you through bulk enumeration.

Regardless of how you obtain your NPI, it is important that you retain the notification document that NPPES sends to you that contains your NPI. You will need to share this information with other health care partners who may provide electronic billing services to you or your organization.

HAC Electronic Commerce Information

Submit your claims electronically and save time and get your payment in less time. Check with your clearinghouse or billing service to see if you can submit claims to us electronically!

Electronic Claims (837)
The Health Administration Center can receive your electronic medical and dental claim submissions using the HIPAA mandated 837 transactions through our clearinghouse Emdeon®, formerly known as WebMD. Registration is NOT required. Our Payer IDs at Emdeon are 84146 for Medical Claims and 84147 for Dental claims. If you are not connected to Emdeon, contact your clearinghouse, billing service or electronic claim submitter to be sure our payer IDs have been added to their software system. If you are interested in submitting claims through Emdeon, you can contact them at: **http://www.emdeon.com/claimsadministration/payers_ecommerce.php**

Electronic Remittance Advice (835)
For all compliant electronic claims sent to us through Emdeon we can provide a HIPAA mandated electronic 835 Remittance Advice to you through our clearinghouses Emdeon®. Providers must complete the ERA Provider setup form at Emdeon to receive the HAC 835's. The form and additional information about the ERA can be found at the following link: **http://www.emdeon.com/PayerLists/payer_enrollment_forms.php** to receive the 835.

New Paper Claim Formats

If you are a paper claim submitter you might want to review the information in regard to new forms that will be required for use in 2007. Both forms have been changed and will have new instructions. Check with your software vendor to see when your billing service or office manager will receive an update for your current software.

For institutional providers the National Uniform Claim Committee (NUBC) has a new UB 04 paper form that will replace the current UB 92 form. This new form includes some new fields including the National Provider Identifier (NPI).

(See our article on the NPI in this newsletter). The final instructions for the new form are expected in September 2006. Additional information about the UB 04 can be found at: **http://www.nubc.org/public/whatsnew/ub-04proofs.pdf**

For Non-Institutional and professional providers the CMS 1500 (12/90) has also been changed by the National Uniform Claim Committee (NUCC) to clarify some fields and accommodate the NPI and has a new format the CMS1500 (08/05). The current CMS 1500 (12/90) form will be replaced after approval for use from the Office of Management and Budget (OMB). Additional information can be found at: **http://www.nucc.org/ or http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm4293.pdf**

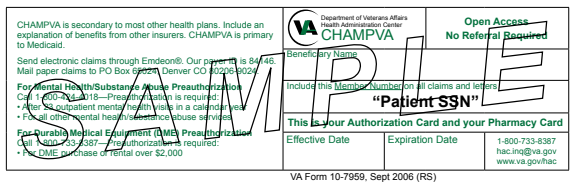
Important Notice to Providers

In order to process a claim in this office, the patient must be a CHAMPVA beneficiary. CHAMPVA beneficiaries are issued Card A (as shown). The **U.S. Military ID Card** (B–as shown) and the **Veterans Universal Access ID Card** (C–as shown) do not identify the holder as a CHAMPVA beneficiary. Please contact TRICARE (Card B) or your nearest VA Medical Center (Card C) in those instances. We have provided alternate contact information for your convenience.

Card A ►
CHAMPVA Authorization Card
Phone: (800) 733-8387
Website: **www.va.gov/hac/champva/champva.asp**

Card B ►
U.S. Military Identification Card
Phone: (800) 538-9552
Website: **www.tricare.osd.mil**

Card C ►
Veterans Universal Access Identification Card
Phone: (877) 222-8387
Website: **www.va.gov**



Do You Have a New Address? Please Let Us Know

If you have had a recent change of address please write or type it in below, cut out this section and mail it to the address following the questions below.

Write your name and new address here: _____

_____

_____

_____

Help Us Serve You

If you are registered with CHAMPVA, but have never used the program, can you tell us why?

_____

_____

_____

Would you prefer your handbook as a **hard copy book**, or as an **electronic copy** on a **CD-ROM**? Please check one of the boxes at the right.

☐ Hard Copy

☐ Electronic copy (CD-ROM)

Department of Veterans Affairs
Health Administration Center
CHAMPVA
2006 newsletter
Fall 2006 Volume 1 Number 4

CHAMPVA Newsletter
ATTN: HAC Communications
PO Box 65020
Denver, CO 80206-9020