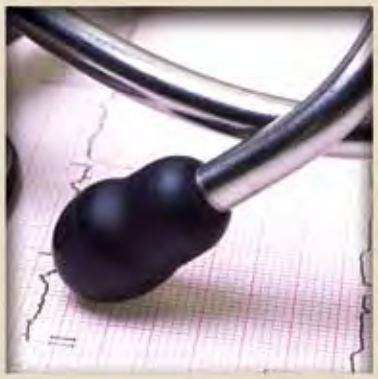
Department of Veterans Affairs
Health Administration Center
CHAMPVA

A Handbook for the CHAMPVA Program

Helping you take an active role in your health care









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 (**MbM**) (see page 17 for the number of the servicing center for your state)	**East 1-866-229-7389** **West 1-888-385-0235**
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**
SXC Beneficiary	**1-888-546-5502**

Published March 2009

Words that are in bold green print are defined on pages 60–64.

TABLE OF CONTENTS

TABLE OF CONTENTS

Department of Veterans Affairs
Health Administration Center
CHAMPVA

VA Health Administration Center
CHAMPVA
PO Box 469063
Denver CO 80246-9063

Phone: 1-800-733-8387
E-mail: Please go to this Web link and follow the directions for e-mail: http://www.va.gov/hac/contact

KEEP THIS HANDBOOK

This handbook provides important information about the CHAMPVA program. We also have a Web site where you can find *A Handbook for the CHAMPVA Program* 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 lists the topic areas by section, with corresponding page numbers.

The Index that begins on page 65 is an alphabetical listing of the topics addressed in this handbook, with corresponding page numbers.

Words and acronyms highlighted in green text in this handbook are defined on pages 60–64.

CHAMPVA APPLICATIONS

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

Words that are in bold green print are defined on pages 60–64.

CHANGE OF ADDRESS

It is very important that you notify us if your address or phone number changes by contacting us at:

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

Phone: **1-800-733-8387**

E-mail: Please go to this Web link and follow the directions for e-mail:
http://www.va.gov/hac/contact/

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. When you call us, we will ask our translation service to participate in the phone call.

We can also provide you, on request, 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.

HELPING YOU TAKE AN ACTIVE ROLE IN YOUR HEALTH CARE

Our number one priority is keeping you healthy. Numerous studies have shown that patients who are well informed about their care and effectively communicate with their health providers report better overall health. That's why we encourage you to take control of your health and become an active partner every step of the way.

Effective communication with your provider begins even before your first appointment. The time you take to prepare for your appointment will help you and your physician better manage your care. Make a list of any prescription or over-the-counter medications you take on a regular basis, as well as the dosages. It may also be helpful to make a note of symptoms you may be having, including duration, intensity and what, if anything, relieves the symptoms. Finally, be sure to make a list of any specific questions you may have and prioritize them so you are sure to get answers to your most urgent concerns.

During your appointment, be sure to ask your physician to fully explain any terminology or procedure you don't understand, and write down the answers, if necessary. If you are prescribed any medications, make sure that you know how much you are supposed to take and when you are supposed to take them.

Here is a list of questions that may also help you to gain understanding of your condition:

- 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 taking this medicine?
- What are the side effects of this medication?
- When should I schedule a follow-up appointment?

SUGGESTIONS FOR LONG-TERM CARE ASSISTANCE

As you read about the benefit package described 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.

Because neither CHAMPVA nor Medicare covers custodial long-term care, and it can be very expensive, we are providing you some options that you might want to consider as you plan ahead, before a crisis occurs.

Long-Term Care Insurance

This insurance is sold by private insurance companies and usually covers medical care and nonmedical care to help you with such personal needs 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 64108-2662.

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 469060
Denver CO 80246-9060
Attention: Communications

E-mail: Please go to this Web link and follow the directions for e-mail: **http://www.va.gov/hac/contact/**

Eligibility for CHAMPVA benefits can be impacted by changes to marriage status, eligibility for Medicare or TRICARE, and the student status of children ages 18 to 23. Such 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

SPOUSE STATUS

A spouse loses eligibility when:

There is a divorce or annulment from the **qualifying Veteran sponsor**. Eligibility for CHAMPVA ends on midnight of the effective date of the divorce decree or annulment.

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 Medicare 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 (along with the CHAMPVA **OHI** form, **VA Form 10-7959c** [see page 44]) immediately so we can take action to continue your CHAMPVA benefits without interruption.

How it works: When you have eligibility for both Medicare and CHAMPVA, billing for health care services must first be sent to Medicare and any Medicare supplement plans (usually referred to as Medigap plans) before the bill is sent to CHAMPVA. The claim can be submitted to CHAMPVA after Medicare pays its portion of the bill. We can process the remaining portion of the bill when we receive the provider's bill along with the **explanation of benefits** (**EOBs**) from Medicare and Medicare supplemental plans (if applicable).

We often receive questions regarding continued eligibility for CHAMPVA when there is Medicare entitlement as well as questions about coverage and payment. It can seem complicated, and we will try to reduce any confusion regarding the requirements to continue CHAMPVA eligibility if you are also eligible for Medicare and the benefits of using CHAMPVA with Medicare by providing you some of those questions and the answers.

Words that are in bold green print are defined on pages 60–64.

1

First, a brief overview of Medicare Parts A, B, C and D:

- **Part A:** Premium-free hospital insurance. You are eligible for Part A coverage if you are age 65 or older or if you are under age 65 with certain disabilities. There is a copayment.
- **Part B:** Outpatient insurance. There are copayments and premiums that apply. As of January 2007, Medicare Part B premiums are based on your yearly income.
- **Part C:** This is known as the Medicare Advantage Plan. It provides the benefits you would receive under both Parts A and B and is administered like an HMO. There are different copayments and deductibles, and you see an identified network provider. There is an additional premium for the Advantage Plan (beyond the premium you pay for Part B).
- **Part D:** Prescription coverage. Cost for this will vary depending on the plan. There is a copayment. Most plans also charge a monthly premium, and a yearly deductible might apply.

COMMON ELIGIBILITY QUESTIONS

If I am eligible for Medicare Part A, do I need Medicare Part B to also be eligible for CHAMPVA?

In almost all cases the answer is yes, however, the answer to this question varies based on the circumstances listed below.

- If you are under age 65 and eligible for Medicare Part A (to include the end stage renal disease [ESRD] program) you must always have Medicare Part B.
- If you are over age 65 and were never eligible for *premium-free* Medicare Part A, you do not need Part B.
- If you become eligible for CHAMPVA after June 5, 2001, regardless of your age when you become eligible, you must have Medicare Part B.
- If you were over age 65 and eligible for CHAMPVA when the law changed in 2001 to allow CHAMPVA benefits to continue, secondary to Medicare, you might have been "grandfathered in." That means that if you were CHAMPVA eligible as of June 5, 2001, and only had Medicare Part A, the law stated you could continue with CHAMPVA after that date and you did not have to purchase Part B. If you had purchased Part B, however, you could not discontinue your enrollment in it.

If I am enrolled in Medicare Part B, is there any time I can cancel Part B coverage and still be eligible for CHAMPVA?

If you have Medicare Part B, do not cancel it. If you cancel Medicare Part B coverage, your eligibility for CHAMPVA benefits will end on the same date your Part B coverage ends.

My husband just became permanently and totally disabled from a service-connected injury. He is 80 years old, and I'm 70. I have Medicare Part A, but not Part B. Will I be eligible for CHAMPVA?

Not at this time. If you are not covered under the Department of Defense TRICARE program, and you purchase Medicare Part B, you can become eligible for CHAMPVA as of the effective date of the Medicare Part B coverage.

I am enrolled in the Medicare Advantage Plan (Part C). Will that affect my eligibility for CHAMPVA?

The Medicare Advantage Plan is viewed the same as having Medicare Parts A and B, so there is no impact on your CHAMPVA eligibility.

How do I know if I have a Medicare Advantage Plan (Part C) or a Medicare supplemental plan (a Medigap plan)?

If you are uncertain, and it is not clear from the information you have from the plan, contact Medicare and ask if the coverage you have with them is a Medicare Advantage Plan.

I am a CHAMPVA beneficiary and will soon have my 65th birthday. What do I need to do so that my CHAMPVA benefits continue uninterrupted?

In most cases, you can have all the paperwork done for enrollment into Medicare 90 days before your 65th birthday. *Make sure you enroll in Medicare Part B*. As soon as you receive your Medicare card that shows the dates your Medicare Parts A and B will begin, send a copy of the card to us along with an **other health insurance** (**OHI**) certification form (**10-7959c**). The form is available on our Web site at: **http://www.va.gov/hac/forms/champva/10-7959c.pdf**. We will update your records when this information is received and issue you a new CHAMPVA Identification Card with an extended expiration date.

Can I use a VA Medical Center under the CHAMPVA In-house Treatment Initiative (CITI) program to obtain my care if I am Medicare eligible?

CHAMPVA beneficiaries with Medicare cannot use a VA Medical Center under our CITI program, because Medicare will not pay the VA Medical Center for the services it provides. If you are currently being seen at a VA Medical Center, but will become entitled to Medicare soon, you will need to find a different provider.

Must I enroll in Medicare Part D, the prescription drug plan, to be eligible for CHAMPVA?

No, you do not need to enroll in Part D to maintain your CHAMPVA eligibility. In fact, there are some benefits of the CHAMPVA prescription programs you would no longer be able to use if you enrolled in Part D. You would not be able to use the **Meds by Mail** program, through which you can obtain your maintenance medications at no cost to you (no premiums, no deductible and no copayments). You would also not be able to use our network retail pharmacies.

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 to enroll in Part B. 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 page17).
- 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.
- VA is considered a "creditable prescription drug plan." CHAMPVA beneficiaries who chose not to enroll in a Medicare Part D plan before May 15, 2006, will not have to pay a late enrollment penalty if they choose to enroll in a Medicare drug plan during a later enrollment period.

CHAMPVA AND TRICARE

TRICARE is a health care program for active duty and retired uniformed service 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 Veteran sponsor** is a retired reservist or National Guard member and begins to receive retired pay at age 60.

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.
- a stepchild no longer lives in the household of the sponsor.

Impact of the Divorce or Remarriage of Parent on Child/Student Status

The eligibility of a birth or adopted **child** of the **qualifying Veteran sponsor** is not impacted by the parents' divorce or remarriage.

However, a stepchild of the **qualifying Veteran sponsor** will lose CHAMPVA eligibility if the parents divorce, and that stepchild loses dependent status as determined by the **VARO**.

Requirements for Students (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 maintained to the date of graduation or until the 23rd birthday, whichever comes first. Please read the following information carefully to avoid interruption of benefits.

First certification of full-time school attendance after age 18: A letter will be sent to the student 90 days prior to his or her 18th birthday, providing notification of the impending change in CHAMPVA eligibility. This letter will also outline the necessary actions for extending CHAMPVA eligibility:

- To avoid an interruption of CHAMPVA benefits for the summer break between high school and the first term of the continuing education program, the student must send us proof of intent to continue his or her education (e.g., a letter of acceptance). When we receive that letter from the educational institution, we will cover the break between high school and the start of the first term of the continuing full-time education program.
- Within one month after the first term begins, the student must submit a school certification verifying enrollment. If CHAMPVA does not receive verification, benefits will be terminated and any payments made by CHAMPVA after the student 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:

The student will need to recertify their full-time enrollment status on an annual basis. We will send a reminder each year before the update is due. In addition, we will periodically check with the school to ensure the student is enrolled as a full-time student. CHAMPVA will accept a copy of the student's school transcript attached to the certification form as verification of full-time enrollment.

School breaks: Once a student's CHAMPVA eligibility has been established, it will not be interrupted during school breaks, as long as the student is enrolled as a full-time student during the terms prior to and following the break.

Withdrawal from school: If the student withdraws from school, their eligibility will be terminated. We must be notified of the change immediately.

Disabling illness: If the student incurs a disabling illness or injury while enrolled as a full-time student, and this prevents him or her 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 the 23rd birthday—whichever occurs first. Medical documentation is required to support that the illness or injury is of a disabling nature and that it prevents the student from attending school. Such documentation is also required to support the expected date the student will be able to return full time.

Change in student status: If the student fails 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 for repaying in full the government and/or the health care provider for their services.

Requirements for Helpless Child Status

A **child** who, prior to reaching age 18, becomes permanently incapable of self-support may qualify as a **helpless child**. This determination is made by a **Veterans Affairs Regional Office** (**VARO**). 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.

Impact of Marriage

If a child marries, regardless of whether he or she is under age 18, a full-time student or has **helpless child** status, that child will lose CHAMPVA eligibility as of midnight on the date of the marriage.

CUSTOMER SERVICE

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, the following sources may be of use to you.

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.The prompts will instruct you to leave a voice mail 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**
  Monday through Friday
  (excluding holidays)
- Hours of operation: 8:05 a.m. to 7:30 p.m. Eastern Time
- We have recently implemented a Virtual Hold system to allow us to call you back when our estimated wait time exceeds three minutes.

Web: www.mychampva.com

At this Web site you can retrieve information about your claim status, current period of eligibility and other health insurance (**OHI**) information the **HAC** has on file.

To register for the automated Web service, access **www.mychampva.com**. After completing the **HAC** online registration screen, please print the required **VA Form 10-5345**, *Request for Authorization to Release Medical Records or Health Information*,

Words that are in bold green print are defined on pages 60–64.

which is also available on this Web page. Print the form by clicking the link entitled *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 receive e-mail notification when you register for the automated Web service online. Shortly after that happens, you will receive an e-mail that will contain your log-in identification. After we receive your **mailed** *Request for Authorization to Release Medical Records or Health Information*, you will receive a second e-mail saying your account has been activated. You will not be able to access the site for 48 hours after activation. For your protection, keep your password in a safe place.

www.va.gov/hac

The following information is available on the Web site 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

Chat Line

Your CHAMPVA questions can be answered live, online by a **Chat Line** customer service representative, 10:00 a.m. to 6:00 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!”

E-mail

Please go to this Web link and follow the directions for submitting e-mail via IRIS: **www.va.gov/hac/contact**

Typically, you will receive a response to your question within one working day. To protect your privacy, we recommend that you do not 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 e-mail. If you are requesting that type of information, we will call you or send the information through regular mail.

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

Mail

When you write to us, please include your name and phone number.
Send your inquiry to:

VA Health Administration Center
CHAMPVA
PO Box 469063
Denver CO 80246-9063

WHERE TO GET FORMS AND PUBLICATIONS

Forms and publications are available to you through the customer service options identified on pages 11–12. When you use any of these options, make sure you provide your name and address.

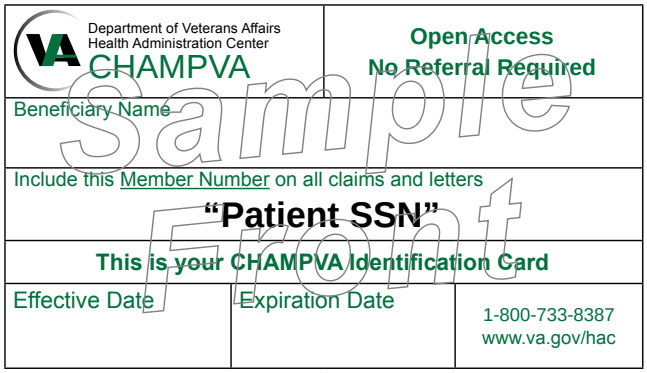
WHERE TO SEND COMPLETED FORMS

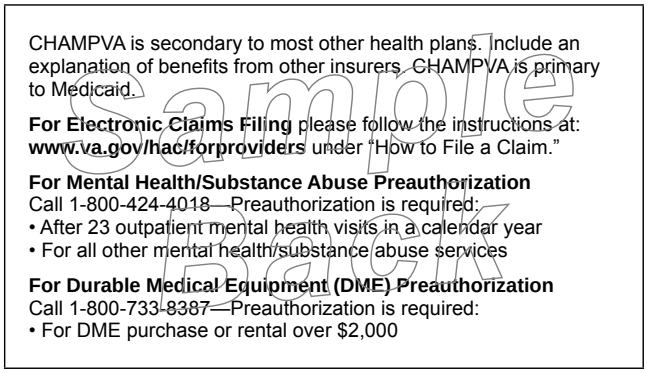
CHAMPVA Applications/ School Certifications	**VA Health Administration Center** **CHAMPVA Eligibility** **PO Box 469028** **Denver CO 80246-9028**
Other Health Insurance (**OHI**) Certification Forms	**VA Health Administration Center** **CHAMPVA** **PO Box 469063** **Denver CO 80246-9063**

Note: You can also provide **OHI** information by calling a customer service representative, at **1-800-733-8387**.

Completed Claims for Medical Services and Supplies	**VA Health Administration Center** **CHAMPVA** **PO Box 469064** **Denver CO 80246-9064**

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





When you visit your doctor, make sure you take your CHAMPVA Identification Card with you. Since your cost share (copayment) for care will be a percentage of the CHAMPVA **allowable amount** rather than a specific, predetermined dollar amount, talk to your doctor about how and when to pay your part of the bills. If you are receiving outpatient care (including 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 to show you have met one or both of these requirements for the year.

CHAMPVA covers most **medically necessary** health care services, including 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 they are determined to be **medically necessary** and are received from an authorized provider. When providers are performing services within the scope of their license or certification, we consider them to be authorized. The most common providers are: anesthetist, audiologist, certified clinical social worker, certified nurse midwife, certified nurse practitioner (NP or CNP), certified registered nurse anesthetist (CRNA), certified physician assistant (PA), certified psychiatric nurse specialist, clinical psychologist (Ph.D.), doctor of osteopathy (DO), licensed clinical speech therapist (LCSP), licensed practical nurse (LPN), licensed vocational nurse (LVN), marriage and family counselor/therapist, medical doctor (MD), occupational therapist (OT), pastoral counselor, physical therapist (PT), physiologist, podiatrist (DPM), psychiatrist and registered nurse (RN).

Words that are in bold green print are defined on pages 60–64.

You have many choices when 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") 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, **DME** and mental health services. 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. More than 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.

To find out if your local VAMC participates in this program

- Go to our Web site 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, e-mail or write us (see pages 11 and 12 for contact information).

When you contact your VAMC, they will be able to tell you which 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 **OHI** information. If you have Medicare or a **health maintenance organization** (**HMO**) or **preferred provider organization** (**PPO**) plan as your **OHI**, you will not be able to participate in the CITI program. Some VAMCs accept patients through the CITI program who have 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 whether 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 with the VA medical facility when you contact them about CITI participation.

NON-VA MEDICAL PROVIDERS

CHAMPVA does not have a network of medical providers. However, most TRICARE providers will also accept CHAMPVA patients. Go to the TRICARE Web site, at **www.tricare.osd.mil/standardprovider**, to locate a provider in your area, then contact them to ask if they also accept CHAMPVA patients.

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

Please call, e-mail or write us (contact information on pages 11 and 12) if you are having difficulty locating a provider, and we will help you find one.

Providers that accept "assignment" for CHAMPVA patients

When you locate a medical provider, find out if they will accept CHAMPVA. Providers most often refer to this 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 doing so at the allowable amount and cannot collect additional amounts from you beyond your copay.

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 your provider does not accept **assignment**, you can still see that provider, but be aware 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 in cases where CHAMPVA is your only insurance, you will have to submit the itemized bill from the provider along with a CHAMPVA claim form. When the claim is processed, we will send you our share of the **allowable amount**.

What all of this means to you is that when the medical provider does not accept **assignment**, your cost will include not only your share of our determined **allowable amount**, but also any charges over our **allowable amount**.

When CHAMPVA Is Secondary Insurance

To obtain reimbursement in cases where CHAMPVA is your secondary insurance, you can ask the provider to file the claim and **Explanation of Benefits (EOB)** from the primary insurer electronically with CHAMPVA as the secondary insurer. If the provider is not able or willing to do that, you will need to submit the itemized bill, CHAMPVA claim form and the EOB from the primary insurer to the Health Administration Center.

PHARMACY PROVIDERS

Meds by Mail (MbM)

This is by far the most cost effective way for you to receive your nonurgent, maintenance medications if you **do not have** another health insurance plan with pharmacy coverage (including Medicare Part D). There are **no copayments, 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 servicing centers, and you are assigned to a servicing center based on the area in which you live. Your servicing center will help you with the status of your prescription order, questions about drug availability and patient profile updates.

If you live in these states, districts or territories:	Your Meds by Mail Pharmacy Servicing Center is:
Alabama, Connecticut, Delaware, District of Columbia, Florida, Georgia, Guam, Kentucky, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Virgin Islands, West Virginia	**Meds by Mail** Servicing Center Dublin, GA Monday–Friday 8:00 a.m. to 5:30 p.m. (Eastern Time) 1-866-229-7389 E-mail: **medsbymaileast@va.gov**
Alaska, American Samoa, 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 8:00 a.m. to 5:30 p.m. (Mountain Time) 1-888-385-0235 E-mail: **meds.mail@va.gov**

Important facts to keep in mind when using MbM

- To begin using **MbM**, fill out the **MbM** Prescription Order Form **VA Form 10-0426**, available by visiting our Web site, at **www.va.gov/hac/forms/forms.asp** or by calling **1-800-733-8387** and selecting the self-service option to request the form 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 your local pharmacy and a longer-term supply to be filled through **MbM**.
- Original prescriptions must be sent to the servicing 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 or chronic pain medication) are available through **MbM**.
- 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 through **MbM** 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 **MbM**. 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 **MbM**.
- 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 **MbM**.
- If in the future you obtain other health insurance that includes a pharmacy benefit (including Medicare Part D, Drug Plan), you will no longer be eligible to use **MbM**.

If you need help with general information about **MbM** eligibility or applications for **MbM**, contact us at:

Phone:	**1-800-733-8387**
E-mail:	Please go to this Web URL and follow the directions for submitting e-mail: **http://www.va.gov/hac/contact**
Web site:	**www.va.gov/hac** (select "*For Beneficiaries, Meds by Mail*")

SXC RETAIL NETWORK PHARMACY

If you do not have another health insurance plan that includes pharmacy coverage, you can use our network of pharmacies. Our network consists of more than 55,000 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**. Typically, the use of a network pharmacy will result in a lower cost share to you. To obtain an SXC pharmacy identification card and information on local pharmacies in your area that are a part of the SXC network, call the following beneficiary number or go to our Web site and follow the instructions listed below.

Phone: **1-888-546-5502**
Bin#: 610593
Group#: HAC
PCN#: VA

Web site: **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 the **vahac.rxportal.sxc.com** URL.
- The SXC Health Solutions page will appear.
- Click on "Preferred Pharmacy Finder" on the left-hand side of the page.
- 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 participating pharmacies in or near your ZIP code.

Nonnetwork Retail Pharmacy

You can choose any pharmacy. The CHAMPVA Identification Card is your proof of coverage for a nonnetwork pharmacy. A pharmacy that is not part of the network 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. Your pharmacist can provide you with a printed document that contains all required information that CHAMPVA needs to reimburse you for pharmacy claims. The information required is the 11-digit **National Drug Code** (**NDC**), date the drug was dispensed, name and quantity of the drug, the drug's retail value and the amount of your copay. We cannot process the claim without this information.

CHAMPVA will cover only care that is **medically necessary** and appropriate. 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.

Any type of care that goes on for a long time (over a period of weeks, months, etc.), including physical therapy, medication, mental health services and 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 limitations apply whether you reside in the U.S. or in another country. For example, if you reside or travel overseas, we will only cover medications that are **FDA** approved for use in the U.S.

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 do not require authorization for most medical care, your physician may seek to obtain authorization for services. In that case, ask the physician to call us regarding the service requested, and we will provide information about what will be needed to determine if a specific service is covered. You may also want to consider showing your provider this section of the handbook, as it describes the criteria for coverage of many services.

Services that require authorization:

- **DME** with a purchase price or total rental price of $2,000 or more (see page 27)
- Hospice Care
- 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 mental health care (see page 30)
  - Outpatient mental health visits in excess of 23 per year
- Dental care coverage (Dental coverage is very limited and under most circumstances is not covered.)
- Organ transplants

Words that are in bold green print are defined on pages 60–64.

Exceptions to the authorization requirement:

- Mental health services and durable medical equipment provided through the VA CITI program do not require authorization.
- When Medicare, as the primary payer, authorizes 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 for 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)

To obtain authorization for other services:

Mail: **VA Health Administration Center**
CHAMPVA
ATTN: Preauthorization
PO Box 469063
Denver CO 80246-9063

Phone: **1-800-733-8387**

COVERED BENEFITS (NOT ALL INCLUSIVE)

The following is an alphabetical list of the services we cover that will help you stay healthy and identify health problems early. 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 developing osteoporosis.
Cancer screening	Including colorectal, oral cavity, prostate, skin, testicular, breast and thyroid.
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.
Cholesterol screening	As recommended by your physician, based on your age, health and risk factors.
Colonoscopy	Once every 10 years after age 50, or more frequently if your physician determines you have an increased risk of colon cancer.
Diabetes screening	We cover this screening when you have these risk factors: • high blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride 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; immediate family history of diabetes (parents, brothers, sisters); 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. For more information, talk to your doctor.
Genetic testing	When there is a family history of breast cancer, certain high risk pregnancies or sickle cell anemia.
HIV testing	When there has been HIV exposure or symptoms of possible infection, or if there is a pregnancy.

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 (CDC) recommendations and other specific factors. We also cover postexposure rabies vaccines and Rh immune globulin, following the birth of an Rh-positive child to an Rh-negative woman.
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 • Annually, if your doctor determines you are at high risk Age 40+: • Annually
Pap test and pelvic exam	These exams check for cervical and vaginal cancers. We cover pap screenings for patients age 18 and older or those younger than 18 when recommended by a clinician.
School-required physical exams	School-required physical exams for beneficiaries through age 17 provided on or after October 1, 2001.
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 is an alphabetical list of services that are covered, when **medically necessary**, like the preventive services listed previously. This list is NOT all inclusive. For additional information, please refer to the CHAMPVA Policy Manual, Chapter 2, available on our Web site, at **www.va.gov/hac** For limitations, please refer to the conditions of coverage that follow and to the noncovered services identified on pages 37 through 39.

OTHER COVERED SERVICES

Covered Service	Conditions of Coverage
ADD, or ADHD	Attention deficit hyperactivity disorder (ADHD) is considered a mental health condition. Refer to “Mental health outpatient care” for benefit coverage.
Alcohol abuse (treatment for)	Preauthorization is required. Refer to “Substance abuse” for specific benefit coverage.

Covered Service	Conditions of Coverage
Allergy testing and treatment	Allergy testing and treatment are covered based on medical necessity. All claims for allergy testing must indicate the type and number of tests performed. We cover RAST (radioallergosorbent test), FAST (fluoro-allergosorbent test) and IPA (immunoperoxidase assay) for inhalant or food allergies and PRIST (paper radioimmunosorbent test), RIST (radioimmunosorbent test) and bronchial challenge testing.
Ambulance service	Life-sustaining equipment is necessary for a medically covered condition or other means of transportation are contraindicated. 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. Justification for the use of a service other than a land vehicle will be required before payment can be made.
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. Coverage should be verified prior to surgery. 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)	Surgery for tongue tie is covered in cases where total or complete ankyloglossia is documented.
Autologous blood collection (blood transfusion)	This is collection of the patient's own blood. Transfusion services are covered when there is a scheduled surgical procedure.

Covered Service	Conditions of Coverage
Barrier-free lift	Claim should be accompanied by a **Certificate of Medical Necessity** (**CMN**) or a doctor's order with diagnosis. Documentation should show a history of an inability to get out of bed and that there is no caregiver to get the patient in or out of bed. We will need the specifications for the lift. Home modifications are not covered.
Biofeedback	Certain types of therapy (electrothermal, electromyography and electrodermal) are covered when there is medical documentation that there has been no response to other conventional forms of therapy.
Birth control	Family planning benefits are provided for intrauterine devices (IUDs), diaphragms, birth control pills, Norplant system long-term reversible contraceptive implants and sterilization (vasectomy or tubal ligation).
Blepharoplasty	Surgery to improve the abnormal function of the eyelid is covered when a significant impairment of vision is medically documented. Medical documentation should include two visual field studies (one with and one without lid elevation) and photographs.
Bone growth stimulator	Claim should be accompanied by a **CMN**, or for electrical stimulation of bone, doctor's order with diagnosis or documentation of a history of fracture with nonhealing for three months or more.
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 documentation of a medical history of persistent symptoms, such as back pain, neck and shoulder pain, poor posture, ulnar paresthesia, shoulder grooving, rash and restriction of physical activities.

Covered Service	Conditions of Coverage
Cardiac rehabilitation programs	Limited to 36 sessions and normally completed within 12 months following a qualifying cardiac event.
Cleft palate (correction of)	Claim must include a medical statement from the physician that includes the following information: brief medical history, condition, symptoms, length of time symptoms have been present, other forms of treatment attempted, an operative report and photographs, if available.
CT scans	Computerized tomography when **medically necessary**.
Dental (adjunctive)	Dental care can be considered for coverage only when it is **adjunctive**. That means the dental treatment MUST be completed as part of the appropriate treatment of some other (nondental) 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).
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 conditions for which they are administered, prescribed by an authorized provider and dispensed in accordance with state law and licensing requirements.

Covered Service	Conditions of Coverage
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 CHAMPVA 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; determination of **medical necessity**; and the anticipated duration that the item will be 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 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.
Eyeglasses, contact lenses (limited coverage as noted)	When required after intraocular surgery, ocular injury or congenital absence of a human lens.

Covered Service	Conditions of Coverage
Family planning and maternity	We cover most treatment related to prenatal, delivery and postnatal care, including 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 (to determine risk of preterm delivery)	Services provided to the mother and those provided to the **child** must be billed separately.
Foot care services (very limited coverage)	Covered when they are a **medically necessary** treatment for a specific diagnosis like 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	Home health care is intermittent skilled care in a home setting for a homebound patient. It includes skilled nursing and rehabilitative care, as part of a physician's treatment plan, and is provided by a licensed or registered caregiver.
Hospice	CHAMPVA covers 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. Your hospice caregiver will be asked to provide the following information for authorization: hospice tax identification number; Medicare hospice provider number; address of

Covered Service	Conditions of Coverage
Hospice (cont.)	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 allowance.
Implants (surgical)	Must be approved by the **FDA**. There are limitations, so check with us before having 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 the 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.

Covered Service	Conditions of Coverage
Loss of jaw substance	Covered when due to direct trauma or treatment of neoplasm. Requires documentation 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.
Magnetic resonance angiography (MRA), magnetic resonance imaging (MRI) and magnetic resonance spectroscopy (MRS)	Claims for both an MRI and computerized tomography (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. Authorization is required from the mental health contractor. Benefit: 30 days for **beneficiaries** ages 19 and older, per year, or during a single episode of care; 45 days 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). 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 therapy. More than 23 visits per year or more than two visits per week can be allowed when authorized 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 authorized by the CHAMPVA mental health contractor are covered. Multiple sessions on the same day for crisis

Covered Service	Conditions of Coverage
Mental health outpatient care (cont.)	intervention and which are authorized by the CHAMPVA Mental Health contractor are covered.
Mercury hypersensitivity	The removal of dental amalgam mercury source is covered under the following conditions: • Independent diagnosis by a physician allergist based on generally accepted test(s) for mercury hypersensitivity. • Documentation that reasonably rules out sources of mercury exposure other than the dental amalgam.
Morbid obesity	Surgical correction of morbid obesity may be covered when one of the following conditions is met: • Patient's body mass index (BMI) is over 40, or • Patient's BMI is over 35 with serious medical conditions exacerbated or caused by obesity or • Second surgery (takedown) due to complications of previous surgical correction. Surgical procedures are limited to gastric bypass, 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 BMI, current height, weight, history of other medical conditions and history of other treatments tried and failed.
Myofascial pain dysfunction syndrome	Treatment of this syndrome may be considered a **medical necessity** only when it involves immediate relief of pain. Treatment beyond four visits or any repeat episodes of care within a six month period must be documented by the provider of services and medically reviewed by CHAMPVA.
Newborn care	The newborn's care is paid for as part of the mother's maternity care for the first three days following delivery. After three days, the newborn's care is subject to separate cost sharing.
Occupational therapy	Covered when training and assessment do not relate primarily to employment.

Covered Service	Conditions of Coverage
Orthopedic braces and other appliances	For the neck, arm, back and leg to assist you in movement or to provide support to a limb.
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)	Requires a **CMN** 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	Claims should be accompanied by a medical history that documents the complications experienced as a result of the enlarged pannus such as skin rashes/infection, conservative treatments that were tried and 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. **Professionally administered physical therapy** to help the patient attain greater self-sufficiency, mobility and productivity is covered when the exercises and other modalities improve muscle strength, joint motion, coordination and endurance.
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

Covered Service	Conditions of Coverage
Plastic surgery (cont.)	severe disfiguration or extensive scarring from cancer surgery or breast reconstructive surgery following a mastectomy that is covered by CHAMPVA.
Positron emission tomography (PET)	A covered benefit when used to identify complex partial seizure disorders, evaluate ischemic heart disease or identify 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 Web site **www.va.gov/hac/forbeneficiaries/champva/policymanual**
Prosthetic devices	Artificial limbs, eyes, voice and other prostheses, as well as **FDA**-approved surgical implants are covered.
Psychiatric partial hospitalization program (PHP)	Benefit: 60 days per year. To qualify as a PHP, the program must last at least three hours per day and be 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 postoperative 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. Authorization is required by the CHAMPVA mental health contractor at least three days before admission.

Covered Service	Conditions of Coverage
Residential treatment center (cont.)	Care must be provided in a TRICARE authorized facility. Care in an RTC is for adolescents ages 18 or 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 authorized by the mental health contractor.
Single photon emission computed tomography (SPECT)	A covered benefit when used to evaluate myocardial perfusion, evaluate seizure disorders or monitor 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 Web site **www.va.gov/hac/forbeneficiaries/policymanual**
Skilled nursing care	Skilled care may be provided by a variety of licensed professional caregivers, including 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 home, or a rehabilitation facility, depending on the amount and frequency of care needed and the severity of the illness.
Skilled nursing facility (SNF) care	An SNF provides skilled nursing or rehabilitative care to patients who require 24 hour care under the supervision of a registered nurse or physician. A service is considered skilled care when it **cannot** be performed by a nonmedical person.

Covered Service	Conditions of Coverage
Skilled nursing facility (SNF) care (cont.)	Skilled care can be provided either in a hospital or in a separate facility. Skilled nursing care does not require preauthorization, but all claims for such services are subject to medical review. Claims should be accompanied by medical documentation that justifies this level of care.
Speech therapy	For physical impairments including: • brain injury (e.g., traumatic brain injury, stroke/cerebrovascular accident, etc.) • congenital anomalies (e.g., 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 up to age 21. If services are not available through the state, documentation from the state is required.
Substance abuse (treatment of)	A beneficiary is allowed up to three substance-use disorder treatment benefit periods in a lifetime. A benefit period begins on the first day of covered treatment and ends 365 days later, regardless of the number of services that were actually used during that year. • **Outpatient rehabilitation** Sixty group therapy sessions are allowed for outpatient rehabilitation, when **medically necessary**, per benefit period (individual therapy for substance-use disorder rehabilitation is not covered). Fifteen outpatient sessions per benefit period are allowed for family therapy. Authorization is required for any additional group or family therapy sessions provided during a benefit year. • **Detoxification** Detoxification is an inpatient service, for which authorization by the CHAMPVA mental health contractor is required. The service is limited to

Covered Service	Conditions of Coverage
Substance abuse (treatment of) (cont.)	seven days per admission, which count toward the 30/45-day inpatient mental health limit. Detoxification will be approved only if it is performed under general medical supervision. • **Inpatient and partial hospitalization rehabilitation** Authorization 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 a Medicare certified facility.
Surgical sterilization	Tubal ligation and vasectomy are both covered.
Temporomandibular joint (TMJ)	Initial radiographs, up to four office visits, physical therapy for acute phase treatment only and construction of occlusal splint are covered.
TENS, neurostimulator	Claim should be accompanied by a **CMN** or doctor's order containing the diagnosis.
Transplants	A summary from the transplant team indicating the **medical necessity** for the procedure must be provided. The following 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

Covered Service	Conditions of Coverage
Transplants (cont.)	Small intestine-liver transplantation Umbilical cord blood stem transplantation
Ultrasound	Ultrasounds for diagnosis, guidance and postoperative 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 containing the diagnosis. Seating evaluation must be performed with proof that vehicle can be used inside the home.
Wig or hairpiece	When needed after treatment for cancer (one per lifetime).
Wound vac	Claim should be accompanied by a **CMN** or doctor's order. Provide the wound measurements (length/width/depth) and the starting date and length of time the vac will be required.

NONCOVERED SERVICES (NOT ALL INCLUSIVE)

Following is an alphabetical listing of services that are not covered. For additional information, review the CHAMPVA Policy Manual, Chapter 2, available at our Web site **www.champva.gov** Claims submitted for these services will be denied.

- Abortion counseling
- Abortions, except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term
- Acupuncture
- Artificial insemination
- Biofeedback treatment of ordinary muscle tension, psychosomatic conditions, hypertension or migraine headaches
- Chiropractic services
- Chronic fatigue syndrome
- Cosmetic drugs (e.g., Retin A, Botox) or cosmetic surgery
- **Custodial care** (such as bathing, feeding), assisted living care, retirement or rest homes, halfway houses and domiciles (house or permanent residence)
- Dental care
- Dentures or partial dentures (adding or modifying)

Noncovered Services (Not All Inclusive)

Diagnostic tests to determine the sex or paternity of a child

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 by Medicare as not **medically necessary**

Embryo transfer

Exercise equipment

Exercise programs (general)

Experimental/investigational services and supplies

Eye examinations (routine)

Eyeglasses, contact lenses or other optical devices, except as noted under Covered Benefits

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)

Health club membership

Hearing aids

Hearing examinations, unless in connection with a covered illness/injury

Hot tubs

Housekeeping, homemaker and attendant services

Hypnosis

Immunizations for travel

In vitro fertilization

Laser eye surgery

Learning disorders, such as reading disorders or dyslexia, mathematics disorders, disorders of written expression/and or learning disorders not otherwise specified

Luxury or deluxe equipment

Maintenance agreements/contracts

Marriage counseling

Modifications to home or vehicle

Naturopathic services

Orthodontia care (braces)

Orthotic shoe devices, such as heel lifts, arch supports, shoe inserts, etc., unless associated with diabetes

Noncovered Services (Not All Inclusive)

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)

Postpartum inpatient stay of a mother for purposes of staying with the newborn (when the newborn requires continued treatment, but the mother does not)

Postpartum inpatient stay of a newborn for purposes of staying with the mother (when the mother requires continued treatment, but the newborn does not)

Private hospital rooms

Services by providers who have been 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 Web site, at **www.va.gov/hac** or access this information directly from the Department of Health and Human Services Office of Inspector General Web site at **http://org.hhs.gov/fraud/exclusions.html** Services provided by a member of your immediate family or person living in your household

Sex changes, therapy or sexual behavior modification

Smoking cessation medication and products

Spas

Stress management

Tattoo removal

Transportation services that do not require life sustaining equipment

Vehicle lifts that are nondetachable 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)

Weight control medication or weight reduction programs

Whirlpools

Workers' Compensation injuries

There are two parts to your costs: the annual deductible and a cost share (copayment).

If your provider does **not** accept **assignment**, you are responsible for paying your annual deductible, your cost share (both described below) and any provider-billed amount that exceeds our total **allowable amount**.

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

By accepting **assignment**, your provider agrees to accept our **allowable amount** as payment in full. A provider cannot **balance bill** you, which is to say they cannot bill you for the difference between their normally billable amount and the CHAMPVA **allowable 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 CHAMPVA 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, **MbM**).

COST SHARE

A cost share (copayment) 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 has been met. For your inpatient service cost share, please refer to the chart in this section entitled *Cost Summary*, starting on page 42.

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 **MbM** program.

CATASTROPHIC CAP

To provide financial protection against the impact of a long-term illness or serious injury, we have established an annual catastrophic cap of $3,000 per calendar year. This is the maximum out-of-pocket expense you and your family can incur for

Remember: words that are in bold green print are defined on pages 60–64.

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 December 31st. If you reach the $3,000 limit, you or your family's cost share for covered services is waived for the remainder of the calendar year, and we pay 100% of the CHAMPVA **allowable amount**.

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 **EOB** you receive after services are paid for. If you find an error, let us know promptly.

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 other health insurance (**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 (excluding the countries of Iraq, North Korea and Cuba), we provide the same benefits we would if you were in the U.S. Reimbursement for health care claims in foreign countries is based on reasonable and customary billed amounts. Your deductible and cost share will be the same as if you were in the U.S. Claims written in English (billing and medical documentation) will be processed faster because we will not need to arrange for translation.

If the billing and medical documentation is written in a foreign language, translation will be arranged at no cost to you. Our payments are made in U.S. dollars.

COST SUMMARY—WHEN YOU HAVE NO OTHER HEALTH INSURANCE (OHI)

BENEFITS	DEDUCTIBLE?	YOU PAY
Ambulatory Surgery	**NO**	25% of CHAMPVA **allowable amount**
Durable Medical Equipment (DME)	**YES**	25% of CHAMPVA **allowable amount**
Emergency Room Charges	**DEPENDS—whether the emergency 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 Mental Health: High Volume and Residential Treatment Centers	**NO**	25% of CHAMPVA **allowable amount**
Inpatient Mental Health: Low Volume	**NO**	Lesser of: 1) per-day amount times the number of inpatient days; or 2) 25% of billed amount
Inpatient Services: Diagnosis Related Groups (DRG) Based	**NO**	Lesser of: 1) per-day amount times the number of inpatient days; 2) 25% of billed amount; or 3) **DRG** rate
Inpatient Services: Non-DRG Based	**NO**	25% of CHAMPVA **allowable amount**
Outpatient Services (e.g., doctor visits, lab/ radiology, home health, mental health services, skilled nursing visits, ambulance)	**YES**	25% of CHAMPVA **allowable amount** after deductible
Pharmacy Services (retail)	**YES**	25% of CHAMPVA **allowable amount** after deductible
Professional Services	**YES**	25% of CHAMPVA **allowable amount** after deductible

COST SUMMARY—WHEN CARE IS PROVIDED BY A VA SOURCE: CITI PROGRAM—VAMC OR MEDS BY MAIL

BENEFITS	DEDUCTIBLE?	YOU PAY
Ambulatory Surgery	**NO**	$0
Durable Medical Equipment (DME)	**NO**	$0
Inpatient Services	**NO**	$0
Outpatient Services (e.g., doctor visits, lab/ radiology)	**NO**	$0
Pharmacy Services (Meds by Mail or CITI)	**NO**	$0
Professional Services	**NO**	$0

WHEN CHAMPVA PAYS INCORRECTLY

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 are not 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 whomever 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.

If you were overpaid, you will receive a letter requesting repayment and explaining your rights under the law. You should respond to the request within 30 days. 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 might be reduced or waived. If you do not respond to our notification, action to collect the amount owed to the VA will begin.

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 submitting it to us at the address below:

OHI Certification Forms: **VA Health Administration Center**
CHAMPVA
PO Box 469063
Denver CO 80246-9063

Or, you can call our toll free number and provide the information to a customer service representative at **1-800-733-8387**.

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**), include a copy of the plan's copayment information and schedule of benefits.

CHAMPVA AS PRIMARY PAYER

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

Medicaid

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.

Indian Health Services (IHS)

We always pay first if you are eligible under Indian Health Services.

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 copayments, often are payable by the **supplemental insurance** policy. If you have a policy that was specifically obtained for the purpose

Words that are in bold green print are defined on pages 60–64.

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 Web site **www.va.gov/hac**. Further information about supplemental health plans can also be obtained from Federal Publishing **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 pay up to our allowable amount.

You or the provider must file the claim with the other insurance plan before submitting it to us for payment. Upon receiving the **EOB** 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 copayments under the HMO/PPO) for CHAMPVA covered services up to our **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. Additionally, if you have Medicare and choose to obtain care from a provider who does not accept Medicare patients, we will not pay for the care. You must follow your primary insurer's guidelines, to include obtaining care from their network or participating providers.

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 copayment
Medical services NOT covered by your OHI, but covered by CHAMPVA (NOTE: We do NOT pay for services that were determined noncovered by your OHI because you failed to follow the OHI plan requirements.)	**$0**	The CHAMPVA **allowable amount** (see table on pages 42 and 43)	Your cost share for the type of service (see table on pages 42 and 43)

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 copayment is published yearly in your Medicare handbook. If Medicare denies a claim because you did not go to a Medicare participating provider, we will not pay the claim either.

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 Medicare denies a claim because 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 nonpayment, 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 Section 1: Eligibility Requirements).

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 copayment	Your Medicare copayment	$0
Hospital Stay 61–90 days	All but the Medicare copayment	What you owe up to the CHAMPVA **allowable amount**	In most cases, $0
Hospital Stay 90–150 days	All but the Medicare copayment	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 at least 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 copayment	What you owe up to the CHAMPVA **allowable amount**	In most cases, $0
>100 days	$0	75% of the CHAMPVA **allowable amount** (based on Medicare Resource Utilization Guidelines [RUG])	25% of the CHAMPVA **allowable amount**

SERVICE	MEDICARE PAYS	CHAMPVA PAYS	YOU PAY
PART B – Outpatient			
	(after Medicare deductible met)	(after CHAMPVA 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** **MbM**: 100%	25% of CHAMPVA **allowable amount** $0
Pharmacy (with Medicare Part D)	Varies	What you owe up to the CHAMPVA **allowable amount**	Varies

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 **EOB** 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 necessary** 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).

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 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 will need to send in three items:

1. CHAMPVA Claim Form, **VA Form 10-7959a** (available by phone or on the Web)
2. An itemized billing statement on a **CMS 1500** or **UB-04** with the same information listed in the Provider Submitted Claims section.
3. When you have other health insurance (**OHI**), an explanation of benefits (**EOB**) from the other health insurer.

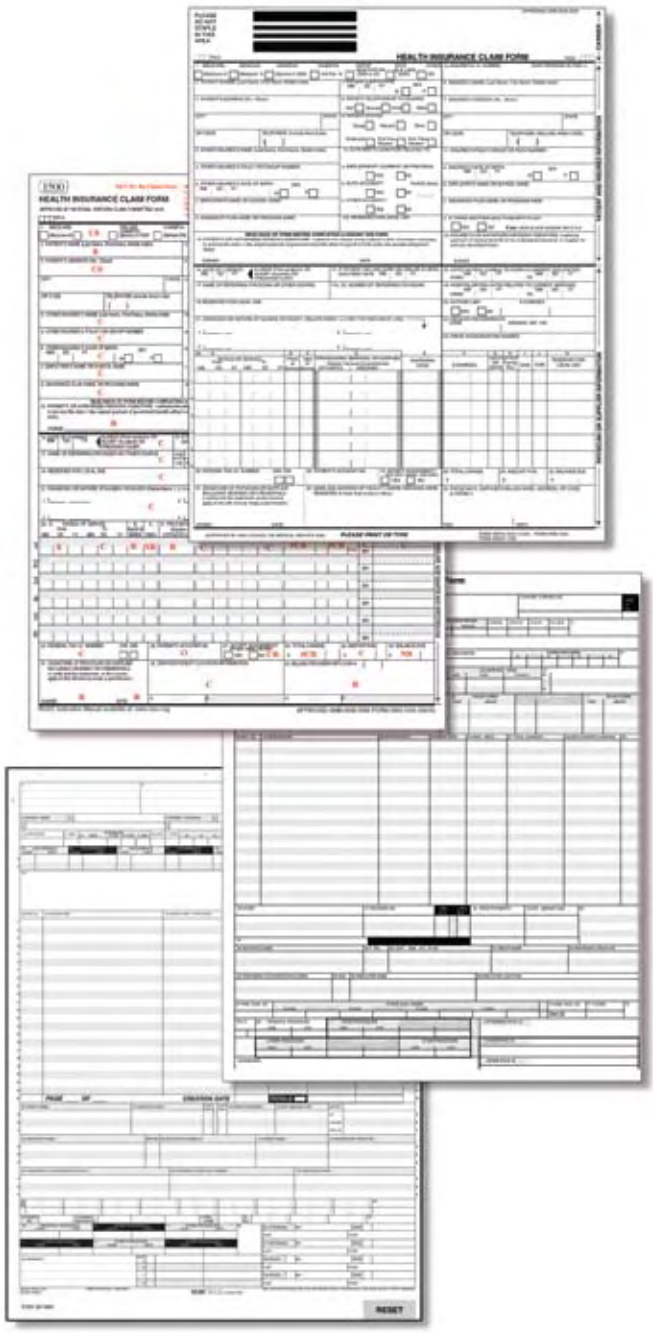
Tips for when you file claims

- Your name must be listed on the claim form exactly as it is on the CHAMPVA Identification Card.
- Your CHAMPVA Member Number (**your** Social Security number) must be on the claim.
- Keep copies of all receipts, invoices and other documents.
- Separate claim forms are required for each CHAMPVA **beneficiary** in your household.
- If you do ***NOT*** use CHAMPVA Claim Form, **VA 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.

Words that are in bold green print are defined on pages 60–64.

PROVIDER SUBMITTED CLAIMS

If your provider submits the claim, they will either send it electronically or on a standardized paper form (**CMS-1500** 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 and are not doing so, have your provider contact us.
- An itemized billing statement on a **CMS-1500** 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 **OHI** 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 **EOB** (please include a copy of that as well). If you have two **OHIs** (such as Medicare and a Medicare Supplemental), we will need both **EOBs** to process your claim.
- Medical records or notes must be submitted with the bill in some cases. The handbook notes many of those services, like skilled nursing, home health care and some surgical procedures that require medical documentation.

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
  - 11-digit National Drug Code (**NDC**) for each drug
  - Charge for each drug
  - Date prescription was filled

  Note: Ask your pharmacist to provide you with a printout showing all of the necessary information.
- If you send us a claim, use CHAMPVA Claim Form (**VA Form 10-7959a**).
- If you send us a claim and you have other health insurance, your copayment amount must be included on your receipt.

WHERE TO MAIL CLAIMS

VA Health Administration Center
CHAMPVA
PO Box 469064
Denver CO 80246-9064

CLAIM-FILING DEADLINES

You have one year after the date of service 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.

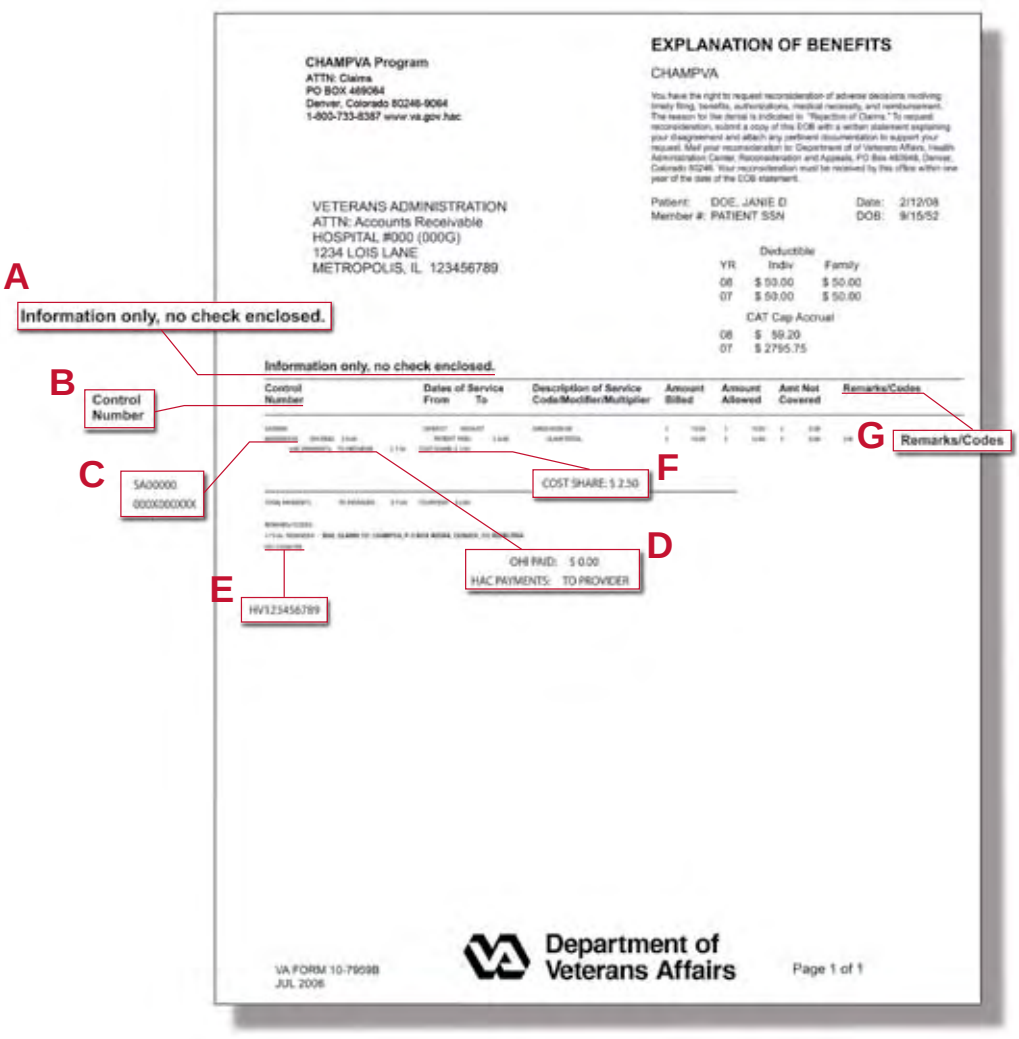
When you have been denied either a claim for CHAMPVA eligibility or a claim for benefits, and that denial was overturned because you submitted additional information in support of the claim, a retroactive authorization will be made. You have 180 days after notification of an approved retroactive authorization of eligibility to file a claim.

EXPLANATION OF BENEFITS (EOB)

After a claim has been 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 paid for the service and submitted a claim for reimbursement, the **EOB** will tell you how we calculated your cost share. The **EOB** contains the following information:

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



A – Information only, no check enclosed: Indicates that a U.S. Treasury check is not enclosed. When there is a payment, this will read "Check Enclosed."

B–Control Number(s): CHAMPVA claim specific identifier (always starts with two alpha characters)

C–Patient Control Number: Provider claim specific identifier (not always present)

D–OHI Paid: Amount paid by other health insurance, including adjustments applied as a result of agreements between the provider and the OHI

E–FMS Doc ID Number: Sometimes starting with HV, this 11-digit number further assists in identifying payments.

F–Cost Share: Patient's payment responsibility unless there is OHI.

G–Remarks/Codes: A code in this column relates to the narrative description below

YOU MAY APPEAL DENIALS OF

- Eligibility determinations
- Benefit coverage
- Authorization requests
- 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 21 of the handbook).

For an appeal to be considered, you must:

- Submit the request in writing within one year of the date of the **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 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 you 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 initial decision. 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 to you with no further action.

Words that are in bold green print are defined on pages 60–64.

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.
- The allowable amount based on a payment methodology.
- Medical providers sanctioned or excluded by the Department of Health and Human Services (DHHS) or the Office of Inspector General (OIG).
  - Providers may be sanctioned for failure to maintain proper medical credentials, fraud and abuse, default on public loans or various other reasons. Only the sanctioned provider or appointed representatives can appeal this decision, and that appeal must go to DHHS-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 has been 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 **EOB** from an **OHI**.
- Billing errors (e.g., incorrect date of service, incomplete or missing procedure codes and/or billed charges) where a corrected bill is submitted to modify the original claim.
- **Determinations of Veteran's service connected disability rating must be submitted to the local servicing VARO. The VARO determines the service connected rating, and a challenge regarding their determination must be submitted to them.**

SECTION 9: HELP FIGHT FRAUD

Combating fraud and abuse takes a cooperative effort. Please help us by reviewing your **EOB** to be sure that the services billed to us were reported properly. If you see a service or supply billed to us that you did not receive, please report it 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
- 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 (copayment).
- Providers billing for services that you did not receive.
- Providers billing for services or supplies that are different from what you received.

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

Mail: **VA Health Administration Center**
ATTN: Program Integrity
PO Box 469060
Denver CO 80246-9060

PREVENTION TIPS

- Always protect your CHAMPVA Identification 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 know how to bill for the item or service to get it paid.

Phone: **1-800-733-8387**

E-mail: Please go to this Web link and follow the directions for submitting e-mail: **http://www.va.gov/hac/contact**

Words that are in bold green print are defined on pages 60–64.

The VA Notice of Privacy Practice briefly describes:

- 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 Web site.

Your Health Information

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

Words that are in bold green print are defined on pages 60–64.

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 that 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.
- Receive our VA *Notice of Privacy Practices* upon request.

Changes

We reserve the right to change the *VA Notice of Privacy Practices*. In the event that happens, the revised privacy practices will apply to all of your health information we already have, as well as to the information we receive in the future. We will send a copy of the revised notice to your last address of record within 60 days of any change.

Complaints

If you are concerned that your privacy rights have been violated, you can 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** Complaints do not have to be in writing, although 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 request that a copy of your record or a copy of a document in your record to be sent 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. For example, this form is 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* and print the words "Recurring Disclosure Authorization" in the *Authorization* block, if you want us to discuss your claim and eligibility information with a person who regularly assists you in handling your medical care needs, such as your spouse, adult child or friend.


Department of Veterans Affairs

INDIVIDUALS' REQUEST FOR A COPY OF THEIR OWN HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION

VETERAN'S LAST NAME- FIRST NAME- MIDDLE INITIAL | SOCIAL SECURITY NO. | DATE OF BIRTH

DESCRIPTION OF INFORMATION REQUESTED

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

10-5345

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*, and print the words "HAC ON-LINE" in the signature block, to obtain access to selected information from your CHAMPVA record about yourself through an online secure Internet connection. Additional information about HAC On-Line is at our Web site under *For Beneficiaries, CHAMPVA*.

Where do I mail these requests?

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

Adjunctive	The treatment is a necessary part of approved care for a covered medical condition.
Allowable Amount	The amount we pay plus 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, it 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.
Centers for Disease Control (CDC)	The major United States government agency for disease prevention based in Atlanta, Georgia.
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.

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**).
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.
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 services 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 could 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 determine the reimbursement to the hospital.

Durable Medical Equipment (DME)	Medical equipment used in the course of treatment or home care, including such items as crutches, knee braces, wheelchairs, hospital beds, prostheses, etc. Health coverage levels for DME often differ from coverage levels for office visits and other medical services.
Explanation of Benefits (EOB)	A 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 drugs' effectiveness, safety and cost.
HAC	Health Administration Center. Administers the CHAMPVA program.
HCPCS	Healthcare Common Procedure Coding System
Health maintenance organization (HMO)	An organization that provides comprehensive health care to voluntarily enrolled individuals and families in a particular geographic area by member physicians with limited referral to outside specialists.
Helpless Child	A child who, before the age of 18, becomes permanently incapable of self-support and is rated as a helpless child by a Veterans Affairs Regional Office (VARO).
High Volume	Residential and treatment centers that have 25 or more mental health discharges annually are considered high-volume facilities.
Low Volume	Treatment centers that have fewer than 25 mental health discharges annually are considered low-volume facilities.
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 U.S.;

Medical Necessity (cont.)	• 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.
Meds by Mail (MbM)	A pharmacy mailing service that provides a safe, easy and cost-free way for eligible CHAMPVA beneficiaries to receive nonurgent maintenance medications delivered directly to their homes.
NDC	National Drug Code, used to identify pharmaceuticals.
Non-Peak Hour	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.
Preferred provider organization (PPO)	An organization providing health care that gives economic incentives to the individual purchaser of a health-care contract to patronize certain physicians, laboratories and hospitals that agree to supervision and reduced fees.
Primary Payer	A health insurance plan that will pay first on the bills for service. These are typically major medical health plans.
Qualifying Veteran Sponsor	A Veteran who is in receipt of a VARO award that establishes eligibility for CHAMPVA benefits for his/her dependents. These dependents cannot 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 Veteran 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 after a Medicare supplemental policy.
Survivors	Widow(er)s and dependent children
Tertiary Payer	A payer that provides coverage after the primary and secondary payers have made payment on a claim.
VA	Department of Veterans Affairs
VARO	Veterans Affairs Regional Office
Widow(er)	The surviving spouse of a qualifying Veteran sponsor.

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.

3000309

Department of Veterans Affairs
Health Administration Center
CHAMPVA
PO Box 469063
Denver CO 80246-9063