HEALTHCARE SERVICES or SUPPLIES
TRICARE ITEMIZED/OHI CLAIM CHECKLIST

PROVIDER Name: _____
PROVIDER Address: _____
PROVIDER TRICARE Number:_____

Patient Name: _____ Sponsor SSN: _____
Date of Service: _____

Diagnosis or description of symptoms. (List all pertinent diagnosis)

1	
2	
3	
4	
5	
6	
7	

List each item or service or supply

Item of Service or Supply	Date of Service	Number & Frequency of Service	Charges*****
Total Amount of Charges*****			
Total Amount of Discount (if applicable)			
Total Amount Paid by Other Health Insurance (OHI) (Please enter "N/A" if patient does not have OHI)			
Total Due from Patient			

(*Charges are assumed to be in Pesos unless otherwise indicated.)

If no amount was paid by the other health insurance, please explain why:
_____
_____
_____

Provider's Signature: _____ Date Signed: _____

NOTE: A completed and signed DD-2642 claim form as well as a copy of all itemized receipts showing payment for these services are required documentation when filing a claim with TRICARE. This checklist is only supplemental information that, when applicable, must be attached to the above required claims documentation.

NOTE: If the provider marked N/A above, and you do not have OHI, there is no need for you to complete page 2.

Other Health Insurance Information Requested

Please complete the Beneficiary Attestation portion below <u>if you currently have Other Health Insurance.</u>

Beneficiary Attestation

I understand that TRICARE cost-sharing is available only as a secondary payer if I have other health care coverage. I _____ (beneficiary name) certify that if other health care coverage exists, that regardless of any provisions in my primary coverage plan, I am required to file my claim with my primary payer and obtain a payment determination from my primary payer. The payment determination, if not provided by my primary coverage plan, may include the completion of this form with all required payment information, signed and dated by the appropriate individual(s). The submittal of this form certifies that the services provided are not a covered benefit or were not fully reimbursable under that plan and that I may now request reimbursement from TRICARE based on my status as an eligible TRICARE beneficiary.

_____ Beneficary Signature _____ Date

Please complete the following information <u>if you no longer have Other Health Insurance</u>

I understand that when the TRICARE Management Activity (TMA) contractor performs the required eligibility/enrollment verification and my DEERS record shows that I have other health insurance (OHI), this signed statement is my confirmation that I no longer have OHI and that TRICARE is my primary payer. I agree to contact the contractor to update my OHI status.

_____ Beneficiary Name
_____ Beneficiary Signature _____Date