How to get a Medical Bill removed from a Credit Report by MMSO

Who This is For

Active duty, National Guard, and Reservist.

Background and purpose

To assist members with resolving debt collection issues, the Under Secretary of Defense established Debt Collection Assistance Officer (DCAO) Programs at every Lead Agent Office and Military Treatment Facility worldwide.

DCAOs provide priority assistance when presented documentation verifying that collection action has been started or that negative information is reflected on a member's credit report as a result of late or non-payment for authorized health or dental care received through TRICARE.

Note: While DCAOs cannot provide legal advice or act as beneficiary advocates, they will take all measures necessary to ensure each case is thoroughly researched and that beneficiaries are provided with written findings and assistance in the minimum time possible.

Eligibility

The following personnel may seek assistance via the Military Medical Support Office (MMSO) DCAO to resolve debt collection issues:

If…	Member, must…
Active Duty	be enrolled in TRICARE Prime Remote (TPR) at the time of the authorized care/debt incurred.
National Guard and Reservist	have been issued a Line of Duty Determination (LOD) at the time of care/debt incurred. Note: The LOD must be on file at MMSO prior to requesting assistance. See "How to Forward a Line of Duty Determination (LOD) to MMSO" topic sheet for complete instructions.

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How to Request Assistance

Follow these steps to receive assistance from the MMSO DCAO:

Step	Action
1	Member completes the following forms: • Authorization For Disclosure of Medical or Dental Information, DD Form 2870 • Notice of the Role of the DCAO form Note: MMSO must have these forms to legally contact the credit bureau and/or collection agencies involved.
2	Member FAXes or mails the following documentation to MMSO DCAO: • DD Form 2870 • Notice of the Role of the DCAO form • Copy of the final notice letter from the collection agency/credit bureau, stating this information has been noted on the member's credit report • LOD (if appropriate) Mail: Military Medical Support Office Attn: Debt Collection Action Officer P.O. Box 886999 Great Lakes, IL 60088-6999 FAX: 847-688-6460 Note: If the MMSO DCAO does not receive all the information listed above from the member, the DCAO will send the member a letter requesting information needed to pursue the case.

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Results and follow up

Once a complete package is received, the MMSO DCAO will contact the credit bureau/collection agency and requests a 60-day hold until TRICARE pays the claim. Once paid by TRICARE, a notice goes to the credit bureau/collection agency with information pertaining to the date of the check and check number. The letter also requests that the negative credit information be removed within 14 days.

If the care in question is not covered by TRICARE, or the member was ineligible, the MMSO DCAO will send a letter to the member stating the facts.

Website

Contact information for DCAOs can be found on the TRICARE web site at:

http://www.tricare.osd.mil/dcao/DCAO_Dir.doc

Enclosures

- Notice of the Role of the DCAO form
- Authorization For Disclosure of Medical or Dental Information, DD Form 2870

Point of Contact

If you have questions or need additional assistance beyond the information provided here, contact:

Position	Debt Collection Assistance Officer (DCAO)
Phone	888-647-6676, ext 6649
Fax	847-688-6460

NOTICE OF THE ROLE OF THE DEBT COLLECTION ASSISTANCE OFFICER

ACKNOWLEDGEMENT

I, _____, understand that the role of the Debt Collection Assistance Officer (DCAO) is one of researching TRICARE claims that are the basis for an underlying debt. The DCAO has my consent to contact all necessary agencies – including military personnel offices, military treatment facilities, TRICARE Lead Agent offices, the TRICARE Management Activity (TMA), managed care support contractors, creditors who have issued bills, even debt collection agencies if appropriate – in order to research the TRICARE claim involved. The DCAO will assist me in understanding the basis for the underlying debt. The DCAO will coordinate with TMA to provide an official determination as to the appropriate resolution of a TRICARE claim.

I acknowledge and understand that the DCAO is NOT acting as my advocate in assisting me regarding the pending debt collection action. In addition, I acknowledge that the DCAO is NOT acting as my legal representative in this matter. In the event the DCAO determines that the debt appears to be valid, I have the right to continue to challenge the correctness of the debt, including exercising my TRICARE appeal rights. I understand I have the right to seek legal assistance through my legal assistance officer or private attorney.

_____ DATE: _____

_____
PRINTED NAME AND SOCIAL SECURITY NUMBER

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	

DD FORM 2870, DEC 2003

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