# TRICARE® Appeals

The process for filing TRICARE medical appeals

Beneficiaries who disagree with certain decisions related to their benefits made by TRICARE Management Activity (TMA) or by a TRICARE contractor have the right to appeal those decisions. The appeals process varies depending on whether the denial of benefits involves a medical necessity determination, factual determination, provider authorization, provider sanction, and/or a dual-eligible determination. Beneficiaries will be notified of the appeals process they should follow at the same time they receive a written decision. All initial determination and appeal denials explain how, where, and by when to file the next level of appeal.

## WHO IS ABLE TO APPEAL?

- Any TRICARE beneficiary or a parent/guardian of a beneficiary who is under age 18.
- The guardian of a beneficiary who is not competent to act on his or her own behalf.
- A health care provider who has been denied approval, or who has been suspended, excluded, or terminated as a TRICARE-authorized provider.
- A non-network participating provider. **Note:** Network providers are not appropriate appealing parties, but may be appointed a representative, in writing, by you. Providers who do not participate in TRICARE cannot file appeals.
- A representative appointed in writing by a beneficiary or provider. Certain individuals may not serve as representatives due to a conflict of interest. An officer or employee of the U.S. government, such as an employee or member of a uniformed services legal office or a Beneficiary Counseling and Assistance Coordinator (BCAC), may not serve as a representative unless that person is representing an immediate family member.

## WHAT CAN BE APPEALED?

- A decision denying TRICARE payment for services or supplies received.
- A decision denying prior authorization for requested services or supplies.
- A decision terminating TRICARE payment for continuation of services or supplies that were previously authorized.
- A decision denying a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE.

## WHAT CANNOT BE APPEALED?

- The amount that the TRICARE contractor determines to be the allowable charge for a particular medical service; beneficiaries may ask the TRICARE contractor for an allowable charge review—not an appeal.
- The decision by TRICARE or its contractors to ask for more information before action is taken on the beneficiary's claim or appeal request.
- Beneficiaries cannot appeal decisions relating to the status of TRICARE providers. Although a TRICARE beneficiary may want to receive care, or have already received care, from a particular provider, the beneficiary cannot appeal a decision that denies the provider authorization to be a TRICARE provider, or a decision that suspends, excludes, or terminates the provider. The provider in question may appeal on his or her own behalf.
- Decisions relating to eligibility as a TRICARE beneficiary cannot be appealed. Eligibility is determined by registration in the Defense Enrollment Eligibility Reporting System (DEERS). Beneficiaries must address decisions regarding eligibility through their service branch.

## FILING A MEDICAL NECESSITY APPEAL

**Medical necessity determinations** are based solely on medical necessity—whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the condition. It may be necessary to show medical necessity for inpatient, outpatient, and specialty care. Information included in the denial decision will explain how to file an appeal. To appeal a medical necessity decision, beneficiaries should follow one of two processes: expedited or non-expedited.

*This fact sheet is **not** all-inclusive. For additional information, please visit www.tricare.mil.*

### Expedited Appeal

There are requirements for filing an expedited appeal (*typically for requests to reconsider inpatient stays or prior authorization of services*). You or an appointed representative must file an expedited review of a prior authorization denial within three calendar days after receipt of the initial denial. Contact your regional contractor for more information.

### Non-Expedited Appeal

A non-expedited review of a denial must be filed no later than 90 days after receipt of the initial denial. The following is the process for filing a non-expedited appeal:

1. First, send a letter to the TRICARE contractor at the address specified in the notice of the right to appeal. The address is included in the explanation of benefits (EOB) or other decision. The appeal letter must either be postmarked or received within 90 days of the date on the EOB or other decision. Include a copy of the EOB or other decision together with all documents that support the position that the service should not be denied. If all of the supporting documents are not available, state in the letter your intent to submit additional information. You should keep copies of all paperwork.
2. Next, the TRICARE contractor will review the case and issue a reconsideration decision. If you disagree with the reconsideration decision, the next level of appeal is the TRICARE Quality Monitoring Contractor (TQMC).
3. Send a letter to the TQMC at the address specified in the reconsideration decision. Make sure the letter is either postmarked or received within 90 days of the date on the reconsideration decision. Send a copy of the reconsideration decision and any supporting documents not previously submitted. If all of the supporting documents are not available, state in the letter your intent to submit additional information. You should keep copies of all paperwork.
4. Finally, the TQMC will review the case and issue a second reconsideration decision. If the amount in dispute is less than $300, the reconsideration decision by the TQMC is final. If you disagree and if the disputed services are $300 or more, you may request that TMA schedule an independent hearing.

## FILING A FACTUAL DETERMINATION APPEAL

**Factual determinations** involve issues other than medical necessity. Some examples of factual determinations include coverage issues (*i.e., determining whether the service is covered under TRICARE*), overseas claims, and denial of a provider's request for approval as a TRICARE-authorized provider. The following is the appeal process for factual determinations:

1. First, send a letter to the TRICARE contractor at the address specified in the notice of the right to appeal, included in the EOB or other decision. The letter must either be postmarked or received within 90 days of the date on the EOB. Include a copy of the EOB or other decision, and any supporting documents not previously submitted. If all of the supporting documents are not available, state in the letter the intent to submit additional information. You should keep copies of all paperwork.
2. If the amount in dispute is less than $50, the reconsideration decision from the TRICARE contractor is final. If you disagree, and if $50 or more is in dispute, you can request a formal review from TMA. If you disagree with a reconsideration decision, and the letter identifies TMA as the next level of appeal, you may ask TMA to review the case again and issue a formal review decision.
3. To request a formal review, send a letter to TMA, making sure the letter is either postmarked or received within 60 days of the date on the initial determination or reconsideration decision. Include copies of the determination or reconsideration decision, as well as any supporting documents not previously submitted. If all of the supporting documents are not available, state in the letter your intent to submit additional information. You should keep copies of all paperwork.

4 TMA will review the case and issue a formal review decision. If the amount in dispute is less than $300, the formal review decision by TMA is final. If you still disagree, and the disputed services are $300 or more, you may request that TMA schedule an independent hearing.

5. A request for an independent hearing should be sent to TMA, and the request must either be postmarked or received within 60 days of the date of the decision being appealed. Include a copy of the formal review decision being appealed and any supporting documents not previously submitted. If all of the supporting documents are not available, state in the letter your intent to submit additional information. You should keep copies of all paperwork. An independent hearing officer will conduct the hearing at a location convenient to both the requesting party and the government. The hearing officer will issue a recommended decision and the TMA director (*or designee*) or the Assistant Secretary of Defense for Health Affairs will issue the final decision.

**Provider sanction determinations** occur when providers are expelled from TRICARE. Providers may be sanctioned by TRICARE because of failure to maintain credentials, provider fraud, abuse, conflict of interest, or other reasons. Only the provider or his or her representative can appeal. If the sanction is appealed, an independent hearing officer will conduct a hearing administered by the TMA Appeals, Hearings and Claims Collection Division.

**Dual-eligible beneficiary determinations** apply to beneficiaries who are eligible for Medicare and TRICARE benefits because of age, disability, or end-stage renal disease. If the denial is appealed to Medicare, the Medicare appeal decision is final. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies considered for coverage by TRICARE, if denied, are subject to the factual appeal process. Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment can be appealed through the Medicare appeals process. For more information about the Medicare appeals process, visit the Centers for Medicare and Medicaid Services Web site at www.medicare.gov.

## FILING AN APPEAL OVERSEAS

Appeals must be postmarked within 90 days after the date that appears on the EOB or denial notification letter. If you are not satisfied with a decision rendered on an appeal, there may be further levels of appeal available to you. For specific information about filing an appeal in your region, contact your TRICARE Overseas Program Regional Call Center.

## REMEMBER, YOU MUST:

- Meet all the required deadlines.
- Send appeals in writing with signatures.
- Include copies of all supporting documents in the appeal. If the paperwork is not available, you may send the letter by the deadline, and note that more information will be sent.
- Keep copies of all paperwork.

## FOR INFORMATION AND ASSISTANCE

| | | |
|---|---|---|
| **TRICARE North Region**<br>Health Net Federal Services, LLC<br>1-877-TRICARE (1-877-874-2273)<br>www.hnfs.com<br>**Claims Appeals**<br>Health Net Federal Services, LLC<br>TRICARE Claim Appeals<br>P.O. Box 105266<br>Atlanta, GA 30348-5266<br>**Authorization Appeals**<br>Health Net Federal Services, LLC<br>TRICARE Authorization Appeals<br>P.O. Box 105087<br>Atlanta, GA 30348-5087 | **TRICARE South Region**<br>Humana Military Healthcare Services, Inc.<br>1-800-444-5445<br>www.humana-military.com<br>**Claims Appeals**<br>TRICARE South Region Appeals<br>P.O. Box 202002<br>Florence, SC 29502-2002<br>**Authorization Appeals**<br>Humana Military Healthcare Services, Inc.<br>Attn: Clinical Appeals<br>P.O. Box 740044<br>Louisville, KY 40201-9973 | **TRICARE West Region**<br>TriWest Healthcare Alliance<br>1-888-TRIWEST (1-888-874-9378)<br>www.triwest.com<br>**Claims Appeals**<br>TriWest Healthcare Alliance<br>Claims Appeals<br>P.O. Box 86508<br>Phoenix, AZ 85080<br>**Authorization Appeals**<br>TriWest Healthcare Alliance<br>Reconsideration Appeals<br>P.O. Box 86036<br>Phoenix, AZ 85080 |
| **TRICARE Overseas Program (TOP) Regional Call Center—Eurasia-Africa**[1]<br>+44-20-8762-8384 (*overseas*)<br>1-877-678-1207 (*stateside*)<br>tricarelon@internationalsos.com<br>**Claims Appeals**<br>TRICARE Overseas Program<br>Claims Appeals<br>P.O. Box 7992<br>Madison, WI 53707-7992<br>USA | **TOP Regional Call Center—Latin America and Canada**[1]<br>+1-215-942-8393 (*overseas*)<br>1-877-451-8659 (*stateside*)<br>tricarephl@internationalsos.com<br>**Claims Appeals**<br>TRICARE Overseas Program<br>Claims Appeals<br>P.O. Box 7992<br>Madison, WI 53707-7992<br>USA | **TOP Regional Call Centers—Pacific**[1]<br>Singapore: +65-6339-2676 (*overseas*)<br>1-877-678-1208 (*stateside*)<br>sin.tricare@internationalsos.com<br>Sydney: +61-2-9273-2710 (*overseas*)<br>1-877-678-1209 (*stateside*)<br>sydtricare@internationalsos.com<br>**Claims Appeals**<br>TRICARE Overseas Program<br>Claims Appeals<br>P.O. Box 7992<br>Madison, WI 53707-7992<br>USA |
| **Authorization Appeals**<br>TRICARE Management Activity<br>Appeals, Hearings, and Claims<br>Collection Division<br>16401 E. Centretech Parkway<br>Aurora, CO 80011-9066<br>**TRICARE Appeals**<br>www.tricare.mil/appeals | **Beneficiary Counseling and Assistance Coordinator (BCAC)**<br>www.tricare.mil/bcac | **Defense Enrollment Eligibility Reporting System (DEERS)**<br>www.tricare.mil/deers |

*1. For a list of toll-free contact information, visit www.tricare-overseas.com.*

***An Important Note about TRICARE Program Information***

*At the time of printing, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended.* ***Military treatment facility guidelines and policies may be different than those outlined in this product.*** *For the most recent information, contact your TRICARE regional contractor, TRICARE Service Center, or local military treatment facility.*



FS11011BET03122W