An Introduction to TRICARE®

September 2019

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Learning Objectives

Upon Completion of today’s presentation, you should:

• Understand the basics about TRICARE and the TRICARE West Region

• Be familiar with www.tricare-west.com and the tools available to you

• Know how to verify TRICARE eligibility

• Know how to submit and check status of prior authorizations and referrals

• Understand where and how to submit claims, and how to check status
What is TRICARE?

• The Department of Defense’s integrated health care delivery system through military hospitals and clinics, as well as a network of civilian health care providers

• Provides health benefits and services to active duty, reservist and retired members of the uniformed services, their families and survivors

• Available to Army, Navy, Air Force, Marine Corps, Coast Guard, the U.S. Public Health Service (USPHS) and the National Oceanic and Atmospheric Administration (NOAA)
Managed Care Support Contractors

**West:**
Health Net Federal Services, LLC (HNFS)

**East:**
Humana Military
The TRICARE West Region geographical area includes the following states:

- Alaska
- Arizona
- California
- Colorado
- Hawaii
- Idaho
- Iowa (except Rock Island Arsenal area)
- Kansas
- Minnesota
- Missouri (except St. Louis area)
- Montana
- Nebraska
- Nevada
- New Mexico
- North Dakota
- Oregon
- South Dakota
- Texas (areas of western Texas only)
- Utah
- Washington
- Wyoming
www.tricare-west.com

Secure Portal
Providers are encouraged to register at HNFS’ website at www.tricare-west.com.

What we offer
Our secure portal hosts interactive tools to assist you with TRICARE transactions, including:

- authorization and referral submission and status
- Case Management/Disease Management nomination forms
- claims status
- demographic updates
- eligibility verification
- inpatient hospital notification
- Prescription Monitoring Program look-up
- primary care manager (PCM) panel “PCM Enrollee Roster” Information
- secure electronic mail through Ask Us
- XpressClaim™ to electronically submit claims, view electronic remittance advice statements and sign up for electronic funds transfer
- and more!

Encourage your TRICARE patients to visit our beneficiary secure portal to access their Explanation of Benefits, authorization and referral letters, Ask Us feature, and more.
Public Portal

Our public portal hosts additional tools and resources, all of which do not require a user ID/password to access:

- appeal submission
- authorization and referral requirements look-up
- authorization and referral submission and status *(no log in option)*
- Benefits A–Z guide
- copayment/cost-share guide
- credentialing status
- eligibility verification *(no log in option)*
- forms

- fraud and abuse electronic reporting
- frequently asked questions
- general TRICARE program overview
- links to the TRICARE CHAMPUS Maximum Allowable Charge (CMAC) rates, and other TRICARE and health care related websites
- TRICARE Network Provider Directory and Non-Network Provider Listing
- TRICARE Provider Handbook and other education materials
Website Registration

If you have not done so already, register at www.tricare-west.com. Registration provides you access to all the self-service tools on our website.

We offer instant registration using claims or authorization data – a fast, easy way for you to register and immediately gain access to a suite of self-service tools.

Click on Log In/Register at the top of any page at www.tricare-west.com to get started.

Please only register once, as we are unable to support multiple accounts created by the same person. You can easily conduct transactions for multiple Tax Identification Numbers under one user name.
Provider Network & Credentialing
The HNFS West Region Network

What we offer

✓ HNFS completes processing of clean claims in less than five days.

✓ At www.tricare-west.com, you have access to web-based tools to check beneficiary eligibility, validate whether a service requires prior authorization, submit referral/prior authorization requests and check status, submit claims electronically and check status, check credentialing status, update demographics, and more.

✓ As an industry leader in developing comprehensive managed care programs for military families, HNFS has partnered for more than 30 years with the Department of Defense to provide health care for military members and their families.
Network Providers

Contracted providers and groups agree to:

• Submit TRICARE claims electronically. *(Note: Providers in Alaska are not required to submit electronically.)*
• Provide consultation reports, operative reports and/or discharge summaries to referring providers within seven (7) business days of delivering care.
• Comply with prior authorization and referral requirements.
• Supply HNFS with a Health Insurance Portability and Accountability Act (HIPAA)-compliant fax number for authorizations and referrals, and an email address to ensure secure communications.
• Accept contractual agreement rates.
• Maintain credentialing requirements for all providers within the group.
• Respond to notices about key prevention or chronic care measures (for example, screenings, immunizations, blood tests)

We list network providers in our online network provider directory.

Help keep our provider directory current by updating your demographic information online at www.tricare-west.com.
HNFS is required to conduct a credentials review on each network provider to determine if the provider meets the minimum requirements of the Defense Health Agency, HNFS and URAC. As part of the provider agreement process, medical, surgical and/or mental health care providers must complete this HNFS credentialing process.

Exception: Behavior technicians (BTs) are certified and not credentialed. However, BTs must be verified (“approved”) by HNFS’ credentialing committee as certified prior to seeing TRICARE patients.

Credentialing status

  - Enter the individual (Type 1) or facility/ancillary (Type 2) National Provider Identifier (NPI).
- Credentialing may take 60–90 days.
- Credentialing status is different than network status. Please refer to your Provider Participation Agreement for network status and effective date. (If your group has a delegated credentialing agreement, contact your group’s credentialing department for your contract execution date.)

If your practitioner(s)/health care delivery organization was previously credentialed by UnitedHealthcare, they are still required to be credentialed by HNFS.
A non-network provider is authorized to provide care to TRICARE beneficiaries by meeting TRICARE licensing and certification requirements, but has not signed a network agreement with HNFS.

Non-network providers can be participating or non-participating:

- **Participating:** Agree to file claims for TRICARE beneficiaries, accept payment directly from TRICARE and accept the TRICARE-allowable charge as payment in full for their services.
- **Non-participating:** Do not agree to accept assignment and are not required to file claims for beneficiaries. A non-participating provider may balance bill up to 115 percent of the TRICARE allowable charge.

Access non-network applications at [www.tricare-west.com > Become a TRICARE Provider > Become a Non-Network Provider.](#)
Military Hospitals and Clinics

Often referred to as Military Treatment Facilities or MTFs, military hospitals and clinics are operated by the military and are the health facilities of choice for all TRICARE beneficiaries.

Here is a list of the priorities for access to care:

<table>
<thead>
<tr>
<th></th>
<th>Active duty service members, including National Guard and Reserve members on active duty status</th>
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<tbody>
<tr>
<td>2</td>
<td>Active duty family members enrolled in a TRICARE Prime option</td>
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<tr>
<td>3</td>
<td>Retired service members, their dependents, and all others enrolled in a TRICARE Prime option</td>
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<td>4</td>
<td>Beneficiaries enrolled into the TRICARE Plus program</td>
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<td>5</td>
<td>Active duty family members <strong>not enrolled</strong> in a TRICARE Prime option</td>
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<tr>
<td>6</td>
<td>Retired service members and their dependents <strong>not enrolled</strong> in a TRICARE Prime option</td>
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<tr>
<td>7</td>
<td>All other eligible beneficiaries <strong>not enrolled</strong> in a TRICARE Prime option</td>
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Plan Types
TRICARE Plan Options

When a patient needs care, it is important to determine upfront which TRICARE plan will be used for treatment and how that care will be reimbursed. The plan type also affects which services may be covered.

<table>
<thead>
<tr>
<th>Current TRICARE Plans</th>
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<tr>
<td>TRICARE Prime</td>
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<tr>
<td>TRICARE Prime Remote</td>
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<tr>
<td>TRICARE Select (replaced TRICARE Standard</td>
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<td>and TRICARE Extra)</td>
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<td>TRICARE Reserve Select</td>
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<td>TRICARE Retired Reserve</td>
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<td>TRICARE For Life</td>
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TRICARE Prime

TRICARE Prime is a managed care option (HMO-like).

• Active duty service members must be enrolled in TRICARE Prime or TRICARE Prime Remote.*

• Other eligible TRICARE beneficiaries can choose to enroll.

• Active duty service members and their families do not pay any enrollment fees or copayments. All other Prime enrollees pay an annual enrollment fee and may have a copayment for services.

• Care is managed by a primary care manager (PCM). Most specialty services require a referral from the PCM.

*TRICARE Prime Remote is a TRICARE Prime option available in remote areas for active duty service members and their family members who live and work usually more than 50 miles from a military hospital or clinic.
TRICARE Select

• TRICARE Select is a self-managed, preferred provider network option (PPO-like) for eligible, non-active duty beneficiaries not enrolled in TRICARE Prime.

• Enrollment *is* required.

• Group B beneficiaries will have an enrollment fee.

• Beneficiaries are not required to have a primary care manager and can choose to see any TRICARE-authorized provider for services covered by TRICARE without a referral.

• Beneficiaries pay cost-shares/copayments.
Premium-based plans are available for purchase by certain individuals who, by law, are no longer eligible for TRICARE Prime or Select due to age or inactive military status, or no longer eligible for military health care.

- **TRICARE Retired Reserve (TRR)**
  Available to qualified members of the retired Reserve (National Guard/Reserve) and their eligible family members. TRR offers TRICARE Select benefits.

- **TRICARE Reserve Select (TRS)**
  Available to qualified Selected Reserve members and their eligible family members. TRS offers TRICARE Select benefits.

- **TRICARE Young Adult (TYA)**
  Extends TRICARE to certain former dependent children under the age of 26 who lose TRICARE eligibility due to age (21–23). TRICARE Prime and TRICARE Select options available.
Additional Plans

• **TRICARE Overseas**
  Beneficiaries residing overseas and seeking care stateside or beneficiaries residing stateside and seeking care overseas must coordinate all claims, referrals and authorizations through International SOS. Visit [www.tricare-overseas.com](http://www.tricare-overseas.com) for country-specific contact information.

• **TRICARE For LIFE**
  A Medicare-wraparound program available to all Medicare-eligible beneficiaries with Medicare Part A and B. This program is administered by Wisconsin Physicians Service (WPS) in the U.S. and U.S. territories. Visit [www.TRICARE4u.com](http://www.TRICARE4u.com).

• **US Family Health Plan (USFHP)**
  An additional TRICARE Prime option. Contact [www.usfhp.com](http://www.usfhp.com) or 1-800-74-USFHP (1-800-748-7347) for more information.

• **Continued Health Care Benefit Program (CHCBP)**
  CHCBP acts as a bridge between military health benefits and a new civilian health plan. It is a premium-based program for former military beneficiaries. Visit [www.HumanaMilitary.com](http://www.HumanaMilitary.com) for more information.
TRICARE Pharmacy Program

- The TRICARE Pharmacy Program is available to all TRICARE-eligible beneficiaries registered in the Defense Enrollment Eligibility Reporting System (DEERS), except those enrolled in the US Family Health Plan.

- Beneficiaries can fill prescriptions at: military pharmacies, retail network and non-network pharmacies, and through TRICARE Pharmacy Home Delivery.

- The TRICARE pharmacy benefit is administered by Express Scripts, Inc.

- Visit [www.express-scripts.com](http://www.express-scripts.com)/TRICARE for complete TRICARE pharmacy program information.
TRICARE Dental/Vision Programs

TRICARE dental options are based on beneficiary eligibility.

- **Military dental clinics**: Active duty service members (ADSM) receive active duty dental care through military dental clinics.

- **TRICARE Active Duty Dental Program (ADDP)**: The ADDP provides civilian dental care to ADSMs who are unable to receive care from military dental clinics. The ADDP is administered by United Concordia Companies, Inc.

- **TRICARE Dental Program (TDP)**: The TDP is a voluntary, premium-based program for active duty family members of the National Guard and Reserve and/or their families. The TDP is administered by United Concordia.

- **Federal Employees Dental and Vision Insurance Program (FEDVIP)**: FEDVIP replaced the TRICARE Retiree Dental Program (TRDP) on Jan. 1, 2019. The FEDVIP is a voluntary dental and vision insurance program offered by the U.S. Office of Personnel Management (OPM). FEDVIP offers comprehensive, cost effective dental and vision coverage for uniformed services retirees and their eligible family members, retired National Guard and Reserve members and their eligible family members, certain surviving family members of deceased active duty sponsors, and Medal of Honor recipients and their immediate family members and survivors.
Direct Care Only

REMINDER ...

With the introduction of TRICARE Select in 2018, eligible beneficiaries who are not enrolled in a TRICARE plan are not covered under TRICARE for civilian care (care rendered outside a military hospital or clinic).

Eligible beneficiaries not enrolled in a TRICARE plan can receive covered services through a military hospital or clinic, but only on a space-available basis.
Eligibility
TRICARE Eligibility

Who is eligible?

All TRICARE eligibility is based on the Defense Enrollment Eligibility Reporting System (DEERS).

- active duty service members
- active duty family members
- retired service members and their family members
- National Guard and Reserve members and their family members
- survivors and transitional survivors
- Medicare-entitled age 65 and over
- Medal of Honor recipients and their immediate family members
- other eligible beneficiaries *(Note: Dependent parents and parents-in-law may not use TRICARE civilian health care services.)*
Verifying Eligibility

Providers must verify TRICARE eligibility at the time of service. You may verify eligibility one of three ways:

- Log in to the HNFS website at www.tricare-west.com. Be sure to retain a printout of the eligibility verification screen for your files.

- Call HNFS’ interactive voice response (IVR) system at 1-844-866-WEST (1-844-866-9378).

- Submit an electronic data interchange (EDI) transaction.
TRICARE Identification Cards

There are several ID and enrollment cards for TRICARE

- Most active duty service members and National Guard and Reserve members carry the Common Access Card (CAC), which replaced the uniformed services ID card.

- Although CACs are valid uniformed services ID cards, they do not, on their own, prove TRICARE eligibility.
DoD Benefits Number

Social Security numbers (SSNs) are no longer printed on Department of Defense (DoD) identification (ID) cards. This change was made by the DoD to protect the personal identity information of our beneficiaries.

Current ID cards contain the following identifiers:

- **DoD ID Number** – a 10-digit number *not* used for TRICARE claims, eligibility, or authorization and referral purposes.

- **DoD Benefits Number (DBN)** – an 11-digit number *that relates to TRICARE benefit eligibility*. This number is located on the back of the new card.

When submitting claims, prior authorizations and referrals for TRICARE beneficiaries, please use the sponsor's SSN or the 11-digit DBN.
Enrollment cards are provided for enrollment-based TRICARE plans. These include:

- TRICARE Prime
- TRICARE Prime Remote
- TRICARE Overseas Prime
- TRICARE Select
- TRICARE Reserve Select
- TRICARE Retired Reserve
- TRICARE Young Adult

Enrollment cards are not required to obtain care, but contain important information for beneficiaries.

**Note:** The TRICARE enrollment cards have program enrollment start dates. However, these are **not** the same as eligibility dates and do not guarantee coverage.
Copying Cards

It is legal to copy ID cards for authorized purposes. Per DoD instruction, it is both allowable and advisable for providers to copy CACs or ID cards for authorized purposes, which may include:* 

- facilitating medical care eligibility determination and documentation 
- cashing checks 
- administering other military-related benefits 
- verifying TRICARE eligibility 

The DoD recommends providers retain photocopies of both sides of CACs and ID cards for future reference.

*Title 18, United States Code, Section 701 prohibits photographing or possessing uniformed services ID cards in an unauthorized manner. Unauthorized use exists only if the bearer uses the card in a manner that would enable him or her to obtain benefits, privileges, or access to which he or she is not entitled.
Out-of-Pocket Costs

A TRICARE beneficiary's out-of-pocket costs are based on not only plan type and military status, but on the date the sponsor entered active duty.

- **Group A:** Sponsor's enlistment or appointment date occurred prior to Jan. 1, 2018.
- **Group B:** Sponsor's enlistment or appointment date occurred on or after Jan. 1, 2018.

**What this means?**

Your TRICARE patients may have different cost-shares/copayments for the same service rendered. Additionally, under TRICARE Select, using a network vs. a non-network provider will affect Group B beneficiaries’ deductible and cost-share/copayment amounts.

We encourage you to always verify current copayments and cost-shares at [www.tricare-west.com](http://www.tricare-west.com).
Authorizations and Referrals
What is a Referral?

Referrals are for services that are not considered primary care. An example of a referral is when a primary care manager (PCM) sends a patient to see a cardiologist to evaluate a possible heart problem.

The referral may be:

- **Evaluate only** – HNFS will approve two office visits with the specialist to evaluate the beneficiary, and perform diagnostic services, but not treat. This type of referral includes diagnostic/ancillary services that do not require HNFS approval.

- **Evaluate and treat** – HNFS will approve one evaluation visit with the specialist and five follow-up visits. This type of referral includes subsequent care (diagnostic and ancillary services, related procedures) that does not require HNFS approval.

- **Procedure only** – HNFS will approve the test/procedure only.

- **Second opinion** – HNFS will approve one evaluation visit with the specialist and one follow-up visit.
Who Needs a Referral?

Who Needs a Referral

- TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime beneficiaries must have a referral from their PCM before seeking most (not all) specialty care from other professional or individual paramedical providers.

- Without an approved referral (when required), beneficiaries in TRICARE Prime plans are subject to Point of Service charges.

Who Does Not Need a Referral

- In general, TRICARE Select, TRICARE Reserve Select, TRICARE Retired Reserve and TRICARE Young Adult Select beneficiaries do not require a referral for specialty care. The exception being applied behavior analysis services require a referral.

- TRICARE dual-eligible beneficiaries do not require a referral for specialty care.

- Beneficiaries with other health insurance (OHI) only require approval for applied behavior analysis services. (Active duty service members cannot use OHI.)
Active Duty Service Members

Active duty service members require a referral for all care, except:

- emergency inpatient admissions
- chemical dependency detoxification

**Note:** Active duty service members enrolled in TRICARE Prime Remote *do not require a referral* for urgent care due to their remote location.
Non-Active Duty Prime Enrollees

Non-active duty TRICARE Prime/TRICARE Prime Remote beneficiaries require a referral for most, but not all, specialty care.

A referral is NOT required for:

• urgent care
• ancillary services (such as laboratory, radiology and pulmonary function tests); Based upon location, some radiology services require authorization
• outpatient behavioral health services (some services require authorization)
• preventive care services from network providers
• emergency services
The Point of Service (POS) option allows most TRICARE Prime beneficiaries to self-refer to any TRICARE network or non-network provider for medical/surgical or mental health services without referrals from their PCMs or HNFS.

- Beneficiaries who use the POS option will pay a deductible and have higher cost-shares for services.
- The POS option does not apply to active duty service members, so they may be responsible for the entire cost of self-referred care.
- The POS option *does not apply* for services that *do not* require a referral.
Urgent Care

TRICARE allows most beneficiaries to seek urgent care without a referral and without visit limits.

**TRICARE Prime plans**
Except for active duty service members, TRICARE Prime beneficiaries do not need a referral for urgent care. Point of Service will not apply when seeking urgent care from the following:

- any network or non-network urgent care center (must be TRICARE-authorized)
- any network primary care type provider (family practice, general practice, internal medicine, pediatrics, OB/GYN, physician assistant, nurse practitioner, or certified nurse midwife)

Active duty service members enrolled in TRICARE Prime still require a referral for urgent care; however, active duty service members enrolled in TRICARE Prime Remote do not require a referral due to their remote location.

**All other plans**

- **There is no referral requirement for urgent care,** and care may be rendered by any TRICARE-authorized (network or non-network) provider.
- **TRICARE Overseas Program** enrollees who are traveling and seeking stateside urgent care do not require a referral.
Prior Authorization

Certain services and/or procedures require HNFS review and approval, prior to being provided. Services and/or procedures that require this approval, or prior authorization, can include:

- certain mental health care
- hospitalization
- surgeries
- therapeutic procedures

Another way to think of it ...

_An authorization is a non-office visit._
Don’t Guess. Go Online.

We realize TRICARE referral and authorization guidelines can be complicated, so we offer the following online resources to help simplify the process:

• The Prior Authorization, Referral and Benefit tool
• A searchable list of ancillary services that do not require separate HNFS approval

*It’s important to verify requirements online before you submit!*

Go to **www.tricare-west.com > Provider > Is Approval Needed** to verify referral and authorization requirements before submitting a request to HNFS.
Submitting Online

As of April 16, 2018, HNFS requires providers to submit prior authorization and referral requests online. HNFS offers two online submission options.

**When you submit, be sure to:****
- Complete all required fields.
- Be clear and concise when providing clinical information.
- Include the complete name and address when requesting a specific provider. *Do not abbreviate.*
- Use the attachment feature (in CareAffiliate®) to include supporting documentation.

We offer a video tutorial, step-by-step user guides and referral/authorization-specific webinar presentations at [www.tricare-west.com > Provider > Education](http://www.tricare-west.com).
Authorization Submission

We offer two online submission tools at www.tricare-west.com > Provider.

If not already logged in, click on Submit a Request from the drop-down menu.

You will see two options.
- CareAffiliate® (preferred, requires website registration)
- Web Authorization/Referral Form (WARF)

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<thead>
<tr>
<th>CareAffiliate (requires login)</th>
<th>Web Authorization/Referral Form (does not require login)</th>
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</thead>
<tbody>
<tr>
<td>Key features of this option include:</td>
<td>Key features of this option include:</td>
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<tr>
<td>• provides immediate responses</td>
<td>• does not require website registration</td>
</tr>
<tr>
<td>• can be used for outpatient and inpatient requests</td>
<td>• can be used for outpatient requests only</td>
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<tr>
<td>• use to check status of requests</td>
<td>• provides the option to print and save a PDF</td>
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<tr>
<td>• save frequently used providers, request profiles and diagnosis lists</td>
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<td>• allows for attachments</td>
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Tips:
- Use our step-by-step CareAffiliate Guide as a resource.
- Be sure to use the provider lookup feature when requesting a provider.
- Do not select “multi-specialty” as a specialty. This will delay processing of your request.
The Right of First Refusal

Your patients may be required to seek care at a military hospital or clinic

- Requests for specialty care, inpatient admissions or procedures requiring prior authorization will be directed to military hospitals or clinics first, followed by TRICARE network providers if the services are not available at the military hospital or clinic.

- In order to minimize beneficiary dissatisfaction, and to reduce any confusion as to who will render care, please refrain from advising your patients where their specialty care will be rendered.

- Instead, advise that a referral for specialty care has been submitted and he or she will be contacted by the military hospital or clinic, or HNFS, as to where care may be obtained.
Scenarios

Example 1: The PCM refers a retired service member with chest pain to a cardiologist, specifying “evaluate and treat.” In order to make a complete assessment, the cardiologist orders an echocardiogram, a holter monitor and a routine treadmill test as part of the evaluation. The cardiologist does not need a separate approval from HNFS to perform these services. Why?

1. The PCM specified “evaluate and treat” on the original referral.
2. Echocardiograms, holter monitors and routine treadmill tests do not require prior authorization for this beneficiary category.
3. The services are TRICARE covered benefits.
4. The cardiologist performed the services within the duration of the approved PCM referral.

Tip: For the same reasons, the cardiologist may also perform outpatient cardiac catheterization procedures to diagnose and/or treat the heart condition without requesting approval from HNFS.

Example 2: The cardiologist in Example 1 identifies the need for surgical intervention as a result of cardiac catheterization findings. The patient must now be referred to a cardiothoracic surgeon. In this case, the cardiologist must submit a new referral request to HNFS. What changed?

1. The original specialist (the cardiologist) does not perform the needed service and is enlisting evaluation from a new type of specialist (cardiothoracic surgeon). Therefore, a new referral is required.
2. This new referral must also go through the ROFR process and be reviewed for military hospital/clinic capability and capacity.
Clear and Legible Reports

Network providers treating beneficiaries who were referred by a military hospital or clinic must provide the referring military facility with medical documentation from that visit in a timely manner. This documentation is known as a clear and legible report (CLR), and can include consultation reports, operative reports and discharge summaries.

*Beyond meeting The Joint Commission accreditation requirements, these reports help ensure the patient’s military providers are informed of care received within the civilian network.*

**Non-mental health providers:**
- Submit within seven (7) business days of delivering care to a beneficiary.
- For urgent and emergency situations, submit a preliminary report of a specialty consultation within 24 hours.

**Mental health providers:**
- Submit brief initial assessments to the referring military hospital or clinic within seven (7) business days.

**Urgent care centers:**
- Submit within two (2) business days of delivering urgent care. The CLR must specify any referrals made during the urgent care visit.

For complete details on CLRs, and to access HNFS’ West Region CLR Fax Matrix, visit [www.tricare-west.com > Provider > Take Me To ... Clear and Legible Reports](http://www.tricare-west.com).
Claims
NPIs/EFT/ERA

National Provider Identifier

- **HNFS offers payments and remittances by National Provider Identifier (NPI) number.** The NPI billed on the claim will determine where payment and remittance will be sent. Medical facilities, groups, clinics, and sole practitioners and durable medical equipment suppliers should complete the HNFS West Region NPI Form, available at [www.tricare-west.com](http://www.tricare-west.com) as soon as possible.

Go Green

- **HNFS requires network providers to submit TRICARE claims electronically via electronic data interchange (EDI),** except providers in Alaska. We encourage non-network providers to take advantage of EDI as well.
- **We strongly recommend electronic funds transfer (EFT) and electronic remittance advice (ERA) for faster payment and remits.** Visit [www.tricare-west.com](http://www.tricare-west.com) for EFT and ERA enrollment.
The following are options for electronic claims submission:

- **XPressClaim®** – A secure, full service online electronic claims system recommended for providers with Internet access who submit fewer than 150 TRICARE claims per month. This service is free, requires no additional hardware or software, accepts 1500 claim forms and UB-04 claims, will adjudicate most TRICARE claims upon submission and provides a clear explanation of what TRICARE allows and what the patient owes. You can sign up for XPressClaim® at [www.tricare-west.com](http://www.tricare-west.com).

- **Claims clearinghouses** – You can establish clearinghouse services to transmit TRICARE claims electronically to HNFS/PGBA for processing. This option allows you to submit claims to other health care payers as well. Visit [www.tricare-west.com](http://www.tricare-west.com) for more information on which clearinghouses are accepted.

**Important:** PGBA's Payer ID is 99726 for the TRICARE West Region.
Other Health Insurance

- TRICARE is the secondary payer (except for Medicaid, MediCal, State Victims of Crime Compensation Programs, the Indian Health Service, and plans specifically designated as TRICARE supplements).

- Active duty service members with other health insurance (OHI) require an approval from HNFS for all services.

- All other beneficiaries with OHI only require a prior authorization for inpatient behavioral health services or applied behavior analysis (ABA) services.

- Providers are encouraged to ask the beneficiary about OHI so that benefits can be coordinated.
Claim Status and Remits

Log in at www.tricare-west.com to check claim status, view and print remits and more.
Resources
Reference Materials

In addition to the online tools on the secure and public portals, we offer printable reference materials, including the TRICARE Provider Handbook and quick reference charts. We also post our TRICARE Provider News newsletter and “In Case You Missed It” summary emails online.
• Interactive voice response (IVR) system is available 24 hours a day, seven days a week at 1-844-866-WEST (1-844-866-9378)

• 1-844-866-WEST (1-844-866-9378), Monday–Friday, 5:00 a.m.– 9:00 p.m. (Pacific time) to speak with a live representative

• For assistance with electronic claims, PGBA's EDI Provider Help Desk at 1-800-259-0264, Monday–Friday, 8:00 a.m.– 4:00 p.m. (Pacific time)