TRICARE West Region
PO Box 202106
Florence SC 29502-2106
Fax: 844-730-1373

Request for Reimbursement of TRICARE Hospice Cap Amount

Period Ended – October 31, 2024

Hospice Provider Name: _____

Tax Identification Number: _____

_____ Number of TRICARE beneficiaries electing hospice care during the period 9/28/23 – 9/27/24.

_____ Dollar amount of total payments received and receivable for services furnished to TRICARE beneficiaries during the cap period from 11/01/23 through 10/31/24, including employed physician's services not of an administrative and/or general supervisory nature.

_____ Total reimbursement received and receivable for general and respite inpatient care furnished to TRICARE beneficiaries for the period from 11/01/23 through 10/31/24.

_____ Aggregate number of TRICARE inpatient days for both general and respite inpatient care for the period from 11/01/23 through 10/31/24.

> _____ Aggregate number of TRICARE routine days for the period from 11/01/23 through 10/31/24.
>
> _____ Aggregate number of TRICARE continuous home care hours for the period 11/01/23 through 10/31/24.

_____ Aggregate total number of days of hospice care provided to all TRICARE beneficiaries for the period from 11/01/23 through 10/31/24.

_____ _____
Signature Date

_____
Title