

DoD 6010.15-M



Military Treatment Facility Uniform Business Office (UBO) Manual

**April 1997
Office of the Assistant Secretary of Defense
(Health Affairs)**



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

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FOREWORD

This Manual is issued under the authority of DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities (MTFs)," December 9, 1996. This Manual provides guidelines for the operations of the military treatment facility business office. It prescribes uniform procedures and accounting systems for the management and follow-up of accounts, including recovery, depositing, posting, and reconciliation. It also incorporates procedures for third party collection activities, such as identification of beneficiaries who have other health insurance, coordination of benefits, and recovery of claims.

This Manual applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Chairman of the Joint Chiefs of Staff, and the Unified Combatant Commands (hereafter referred to collectively as "the DoD Components"). The term "the Services," used in this Manual, refers to the Army, the Navy, the Air Force, and the Marine Corps.

This Manual does not apply to DoD Component facilities not involved in direct patient care, such as: medical research facilities; DoD Component facilities for field service; DoD Component facilities afloat, such as hospital ships and sick bays aboard ships; and DoD Component tactical casualty staging facilities, medical advance base staging facilities, and medical advance base components contained within mobile type units. This Manual is effective immediately; it is mandatory for use by all the DoD Components.

- Send recommended changes to this Manual through Service channels to:

Office of the Assistant Secretary of Defense for Health Affairs
Health Services Operations and Readiness
The Pentagon, Room 3E343
Washington, DC 20301-1200

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A handwritten signature in cursive script that reads "Edward D. Martin".

Edward D. Martin, M.D.

Acting Assistant Secretary of Defense

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REFERENCES

- (a) Section 1095 of title 10, United States Code
- (b) DoD 7220.9-M, "Department of Defense Accounting Manual," October 1983, authorized by [DoD Instruction 7220.9](#), October 22, 1981
- (c) DoD 7000.14-R, "Department of Defense Financial Management Regulation," all current volumes, authorized by [DoD Instruction 7000.14](#), November 15, 1992
- (d) Public Law 93-579, "The Privacy Act of 1974," December 31, 1974
- (e) Health Care Finance Administration (HCFA) Instruction Book for Providers, current edition¹
- (f) Section 1007(c) of title 37, United States Code
- (g) Title 32, Code of Federal Regulations, Part 220, "Collection from Third Party Payers of Reasonable Hospital Costs," current edition
- (h) DoD Instruction 6010.12, "Military-Civilian Health Services Partnership Program," October 22, 1987
- (i) Section 1074 of title 10, United States Code
- (j) Section 1076(a) and (b) of title 10, United States Code
- (k) Sections 2651-2653 of title 42, United States Code
- (l) Title 28, Code of Federal Regulations, Part 43, "Recovery of Costs of Hospital and Medical Care and Treatment Furnished by the United States," current edition
- (m) Sections 3711-3720A of title 31, United States Code
- (n) Title 4, Code of Federal Regulations, Parts 101-105, "Federal Claims Collection," current edition
- (o) Section 1072 of title 10, United States Code
- (p) Section 1078 of title 10, United States Code
- (q) DoD 6010.13-M, "Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment Facilities," October 1995, authorized by [DoD Directive 6000.12](#), April 29, 1996
- (r) Joint Federal Travel Regulation, Volume 1, "Uniformed Service Members," current edition
- (s) Sections 402 and 404 of title 37, United States Code
- (t) Executive Order 11157, "Regulations Relating to Incentive Pay, Special Pay, and Allowances," June 22, 1964
- (u) Title 32, Code of Federal Regulations, Part 199.2, "Definitions, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," current edition
- (v) Section 248c(a) of title 42, United States Code
- (w) Section 4351 of Public Law 101-508, "Omnibus Budget Reconciliation Act of 1990," November 5, 1990

- (x) DoD 1338.10-M, "Manual for the Department of Defense Food Service Program,"
November 1978, authorized by [DoD Instruction 1338.10](#), June 5, 1991

¹ Available from HCFA, Distribution Management Team, Room SLL-12-06, 7500 Security Blvd., Baltimore, MD
21244-1850, telephone (410) 786-3000, fax (410) 786-4786

C1. CHAPTER 1

GENERAL INFORMATION

C1.1. PURPOSE

The purpose of the Military Treatment Facility Uniform Business Office Manual (hereby referred to as the "UBO Manual") is to provide a uniform management system for Military Treatment Facility (MTF) business office functions. Specifically, this Manual outlines business practices for Medical Services Account (MSA), Third Party Collection (TPC), and Medical Affirmative Claims (MAC) (formerly Third Party Liability (TPL)) activities. MSA activities involve the billing of individuals and other Government Agencies for services rendered in MTFs. TPC activities involve the billing of health insurance, medical service, or health plan agreements on behalf of beneficiaries for treatment provided in MTFs. MAC activities involve the billing of all forms of liability insurance: automobile, products, premises and/or general casualty, homeowner's, renter's, medical malpractice (by civilian providers), or workers' compensation (other than Federal employees). Establishing and following uniform guidelines meet DoD Health Affairs and Comptroller requirements for a consistent and equitable structure.

C1.2. RESPONSIBILITIES

C1.2.1. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, shall:

C1.2.1.1. Issue policy guidance and provide oversight to ensure that MTF business office operations are cost-effective and result in maximum collections.

C1.2.1.2. Facilitate MTF effectiveness by providing management information systems and other automated systems that support the effective management of the MTF business office.

C1.2.1.3. Establish a systematic process by which recommendations, program changes, and management information system changes can be jointly evaluated and implemented, thereby reducing duplicity and inconsistencies.

C1.2.2. The Secretaries of the Military Departments shall:

C1.2.2.1. Ensure that MTF business office policies and directions are fully implemented and executed.

C1.2.2.2. Develop a training program that addresses all aspects of the MTF business office. Training should include interviewing patients, identification and verification of insurance candidates, accounts receivable management, accounts reconciliation (including validation of payments for various types of insurance plans), utilization management, and automated systems usage.

C1.2.2.3. Develop a marketing program to achieve maximum market penetration.

C1.2.2.4. Compromise, settle, or waive claims, as appropriate, and as determined by existing statute and Code of Federal Regulations.

C1.2.2.5. Provide consolidated and MTF-level reports to the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), as needed.

C1.2.2.6. Participate in Joint Services and Health Affairs work groups to facilitate the systematic evaluation of policy recommendations, program changes, and management information system changes.

C1.2.3. Each Major Medical Command shall:

C1.2.3.1. Implement the policies and procedures outlined in this Manual.

C1.2.3.2. Aggressively implement MSA, TPC, and MAC activities and provide adequate resources, leadership, training, and support.

C1.2.3.3. Consolidate MSA, TPC, and MAC procedures, as appropriate. Maintain separation of billing and collections duties.

C1.2.3.4. Follow all procedures prescribed by the Military Departments.

C1.2.3.5. Ensure that all revenues collected are used to enhance healthcare services and to enhance TPCP collection operations in compliance with 10 U.S.C. 1095 (reference (a)).

C1.2.3.6. Submit periodic reports to Service Headquarters as required.

C1.2.3.7. Use the Joint Services and Health Affairs work groups to request policy determination on recommendations and program or system changes.

C2. CHAPTER 2

THE MTF BUSINESS OFFICE

C2.1. FUNCTIONS

The business office shall consist of the MSA, TPC, and hospital support of the MAC Programs. These programs provide accounts receivable management and the accounts payable function through the Supplemental or Cooperative Care and the Centrally Managed Allotment (CMA) Programs, where applicable. For specific questions about Defense Finance and Accounting Service (DFAS) procedures, refer to DoD 7220.9-M, reference (b).

C2.2. ESTABLISHMENT

C2.2.1. The MTF commander shall establish and maintain the business office and where practical, functionally consolidate TPC, MSA, and hospital support of the MAC Programs, and all functions that pertain to the Uniform Business Office (UBO). If resources permit, the MTF commander should establish a business office manager position for the MSA and TPC Programs. This position may be military or a civilian equivalent, funded from existing Operations and Maintenance (O&M) funds.

C2.2.1. The MTF commander shall appoint in writing a primary and alternate Medical Service Corps (MSC) officer, qualified noncommissioned officer (NCO), or civilian equivalent, as the MSA officer. The TPC officer need not be appointed in writing.

C2.2.3. The MTF commander shall also appoint a disinterested officer, NCO in the grade of E-7 or above, or a civilian of comparable grade, to audit and evaluate the MTF business office each fiscal quarter.

C2.2.4. The MTF commander may delegate appointment authority.

C2.3. AUDIT AND EVALUATION

C2.3.1. The appointed audit officer shall evaluate the MTF business office on a quarterly basis and/or when a change occurs in the business office staff to verify the

following: security of funds; accuracy and completeness of records; and overall compliance with Service-specific guidance and/or regulations.

C2.3.2. The audit and evaluation checklist shall contain at a minimum:

C2.3.2.1. Storage of funds requirements are met.

C2.3.2.2. Separation of functions is maintained. The individual who posts accounts should not be the same person who collects and deposits funds.

C2.3.2.3. Individual change funds and local lock boxes are used.

C2.3.2.4. Outstanding accounts are followed up appropriately and are transferred promptly.

C2.3.2.5. All deposits have Financial Services Officer (FSO) or Defense Accounting Officer (DAO) or Disbursing Officer (DO) validation by cash control machine and/or voucher number and signature.

C2.3.2.6. Deposits agree with automated system and/or Cash and Sales Journal.

C2.3.2.7. Cash on hand agrees with automated system and/or Cash and Sales Journal.

C2.3.2.8. MSA officers are appointed in writing.

C2.3.2.9. All accountable forms are kept in a locked safe.

C2.3.2.10. Claims transferred to the designated legal office are followed up in accordance with Service-specific guidance and/or regulations and appropriately accounted for.

C2.3.2.11. MSA and TPC accounts, records, and reports are reconciled with the automated system at least on a quarterly basis.

C2.4. LOCATION

The MSA and TPC offices shall be located to provide appropriate access for patients.

C3. CHAPTER 3

MEDICAL SERVICES ACCOUNT

C3.1. GENERAL

The MSA function involves billing and collecting funds from DoD beneficiaries, others authorized treatment in MTFs, and civilian emergency patients for subsistence or medical services. MSA provides a complete and reliable financial record of financial transactions including collections control, accounts receivable, and deposits. At MTFs where the volume of cash transactions does not support an MSA office, the parent MTF or local or supporting FSO or DAO or DO shall make collections and deposits. MSA functions are automated in either the Composite Health Care System (CHCS), or as an interim measure, the Automated Quality of Care Evaluation and Support System (AQCESS). Program guidance for the respective systems should be followed. Certain provisions in this chapter, notably subsections C3.12.7. through C3.12.10., are not applicable to the Army's centralized billing structure. In these instances, Army personnel should follow Service-specific guidance and/or regulations.

C3.2. APPOINTMENT OF THE MSA OFFICER

Each fixed MTF commander shall appoint an MSA officer in writing (the Army requires orders). The MSA officer may be a commissioned officer, NCO, warrant officer, or civilian employee not otherwise accountable for appropriated funds for Government property.

C3.3. RESPONSIBILITIES OF THE MSA OFFICER

C3.3.1. The MSA officer shall:

C3.3.1.1. Ensure that all patients are aware of expected inpatient hospitalization or outpatient visit charges through the initial interview, admissions process, clinic check-in, discharge interview, and marketing materials such as inpatient and outpatient handbooks.

C3.3.1.2. Bill and collect for subsistence and medical services as prescribed in Chapter 6 of this Manual.

C3.3.1.3. Make every effort to collect accounts receivable before they become delinquent.

C3.3.1.4. Safeguard funds and controlled forms from loss or theft.

C3.3.1.5. Obtain and administer a change fund. The MSA officer shall not use or permit the use of undeposited collections or personal money as a change fund.

C3.3.1.6. Maintain an accounting record of all local subsistence and medical service charges and collections.

C3.3.1.7. Deposit collections as reimbursements to the proper appropriation in accordance with Service-specific guidance through the local or supporting FSO or DAO or DO using DD Form 1131, Cash Collection Voucher (see Appendix 14), or directly to the bank using SF215, Deposit Slip, (Appendix 14), as prescribed in this Manual. These deposits should be made in accordance with the servicing Accounting and Finance Office.

C3.3.1.8. Prepare and submit financial reports.

C3.3.1.9. Establish internal controls to ensure security of funds and segregation of duties in accordance with DoD 7000.14-R (reference (c)) and Service-specific resource protection requirements; storage of safeguarded forms; and accuracy of records when MSA duties are delegated to other individuals.

C3.3.1.10. Deposit all collections received for administrative services (such as copy charges and lost pagers) to the O&M appropriation in accordance with Service-specific guidance.

C3.3.1.11. Ensure voucher account number of Invoice and Receipts (I&Rs) or automated account numbers are recorded on the SF 600, Health Record-Chronological Record of Medical Care; SF 558, Medical Record-Emergency Care and Treatment; or other Service or facility-specific evaluation forms for all outpatient visits involving patients who are responsible for reimbursement.

C3.4. TRANSFERRING MSA OFFICER RESPONSIBILITIES

To transfer responsibilities from one MSA officer to another, the incumbent shall accomplish the following:

C3.4.1. Post all transactions occurring up to the end of the day before transfer in the accounting records and document in the files.

C3.4.2. Deposit all cash collections on hand with the local or supporting FSO or DAO or DO.

C3.4.3. Return all cash change funds to the FSO or DAO or DO, or effect transfer in accordance with disbursing officer requirements.

C3.4.4. Close the books as of the day before the transfer.

C3.4.5. Prepare and verify four copies of a statement listing all outstanding accounts receivable.

C3.4.6. Prepare four copies of a transfer certificate (see Appendix 2 for sample) showing the inclusive numbers of all unused numbered or controlled forms. The incumbent shall distribute the completed certificates as follows: original to the MSA files; second copy to the officer being relieved; third copy to the relieving officer; and fourth copy to the MTF commander.

C3.5. TEMPORARY ABSENCE OF THE MSA OFFICER

When the regularly appointed MSA officer is temporarily absent from duty (less than 30 calendar days), the MTF commander shall decide if transfer of MSA responsibilities is warranted. If so, the duties of the MSA officer are assumed by the alternate MSA officer or delegated by the MTF commander to the responsible Resource Management (RM), Comptroller, or Patient Administration (PAD) officer, or to a designated representative. The appointed individual is fully responsible and assumes the same responsibilities as the MSA officer during the period of absence of the MSA officer. Duties delegated by the MTF commander include: depositing all cash collections on hand with the local or supporting FSO or DAO or DO; transferring the authorized change fund to the relieving officer; completing a certificate of transfer (see Appendix 3 for sample); informing the FSO or DAO or DO of the acting MSA officer appointment and furnishing the required signature cards; briefing the relieving officer on MSA officer duties and responsibilities.

C3.6. CHANGE FUNDS

The MSA officer requests authority from the responsible FSO or DAO or DO (or from

the RM or Comptroller or PAD officer) to maintain a change fund. The MSA officer is responsible for the change fund and issues required amounts to cashiers by hand receipt or Receipt for Transfer of Cash and Vouchers. The minimum amount of funds required to provide a separate internal MSA change fund is maintained for each assigned alternate or relief cashier. The MSA officer ensures that change funds and other funds are not used to cash personal checks, postal money orders, or other negotiable instruments for the convenience of individuals. Personal checks are only accepted for the amount due. Change funds are not recorded in the Cash and Sales Journal.

C3.7. MINIMUM INTERNAL CONTROLS

The MSA officer shall establish the following minimum internal control procedures: (The RM or Comptroller or PAD officer responsible for business office functions may establish additional controls as deemed necessary.)

C3.7.1. The cashier shall record all receivables accurately and promptly.

C3.7.2. The MSA officer shall reconcile subsidiary records (e.g., I&Rs and DD Forms 1131) to the Monthly Medical Service Activity Report (MMSAR) of the MTF. The MMSAR is then forwarded to the servicing Accounting and Finance Office.

C3.7.3. Number all unused forms that require storage safeguard or are controlled by serial number at the time of receipt. Be sure to account for all numbers. Handle, receipt, and safeguard these forms as if they were cash.

C3.7.4. Ensure that the MSA officer is not the primary cashier. A separation of duties is necessary to ensure the integrity of the accounts.

C3.7.5. When feasible, one person should perform cashier duties so that responsibility for change funds and cash receipts can be clearly identified. If more than one person must have access to the safe where funds are kept, each responsible person should have an individual lock box for storage inside the safe. Cashiers and alternates must be assigned in writing and approved by the responsible RM or Comptroller or PAD officer.

C3.7.6. The MSA officer shall assign separate change funds and lock boxes to alternate or relief cashiers. All cashiers shall ensure that change funds are secured in a drawer where unauthorized persons cannot access. Each cashier shall retain and

safeguard I&Rs and other voucher forms generated for those collections transactions he or she processes.

C3.7.7. Use separate I&Rs for foreign currency and military payment certificates.

C3.7.8. The cashier settles the account with the MSA officer by turning over the cash collections and receipt vouchers at the end of the day or when relieved during the day. The MSA officer verifies that the change fund remaining in the cashier's cash box agrees with the receipt for the fund. Use a Receipt for Transfer of Cash and Vouchers to document cash received by the cashier and to account for vouchers returned to the MSA officer. Use a new receipt whenever a change of cashier takes place during the day. Identify numbered vouchers (I&Rs) transferred to the cashier by serial numbers.

C3.7.9. When the MSA officer advances a change fund to the cashier, ensure that appropriate documentation is signed by the cashier and retained by the MSA officer as evidence of accountability for the cash. The documentation is surrendered to the cashier when the change fund is returned to the MSA officer.

C3.7.10. The MSA officer may receipt permanent change funds to the permanent cashiers. Handle collections and settlements as outlined in subsections C3.7.1. through C3.7.9., above, except daily verification of change funds is not required. At least once a month, the MSA officer shall perform an unannounced audit of all funds entrusted to permanent cashiers.

C3.8. RESPONSIBILITY FOR LOSS OF FUNDS AND ACTION TO BE TAKEN

The MSA officer shall not procure surety bonds with appropriated funds. MSA officers shall not be required to provide bond at their personal expense. However, the absence of bond coverage does not relieve the custodian of responsibility for funds, patient valuables, or financial liability in case of loss. Any person who discovers a loss or deficiency of Government funds, vouchers, or papers shall immediately advise the MTF commander in writing. The MTF commander should submit a request for an investigation from the base and/or post. After completing the investigation, the investigator sends a copy of the investigation report to his or her headquarters. If a loss occurs, the appropriate action to be taken shall be consistent with the procedures outlined in subsections 060302 and 060403 of Chapter 6, Volume 5, of the DoD 7000.14-R (reference (c)).

C3.9. COMMINGLING OF FUNDS

Do not mix funds and records of the MSA with other funds and records. This includes TPC and MSA funds, as well as charity drive funds, lost and found currency, imprest funds, etc.

C3.10. APPROPRIATION REIMBURSEMENTS AND RATES

Appropriations on the O&M account of the MTF must be reimbursed for costs of providing medical services and subsistence to beneficiaries. Refer to the Patient Billing Category Standardization Table (hereafter referred to as the PATCAT table) in CHCS for entitlements, appropriate rates, and mode and site of collection. For example, depending on the patient, a full or interagency rate may be charged, a DD Form 7 or SF 1080 may be used, and the bill may be paid locally by the MSA officer or centrally by Service Headquarters. See Chapter 6 for a complete discussion of reimbursement rates.

NOTE: The PATCAT table is undergoing a reduction in the number of patient categories contained in the table. When completed, these reductions will be incorporated into the PATCAT table as a System Change Request (5CR) to CHCS and forwarded to the Services under separate cover.

C3.11. ACCOUNTS RECEIVABLE

The MSA office shall establish an account receivable for any health-related service or procedure that requires a payment. The same individual shall not be responsible for both establishing the accounts receivable and collecting and disposing of cash funds. Payments to the MTF shall be received only via acceptable forms of payment as described in section C3.14., below.

C3.12. BILLING PROCEDURES

C3.12.1. General. The MSA officer shall generate a bill for each eligible patient. Before discharge or treatment, the MSA billing office shall clear all pay patients. Inpatients must settle their account before discharge. Collections from pay patients must occur before non-emergency outpatient care. The PATCAT table indicates applicable rates, patient billing categories, and appropriate billing forms for

all categories of patients. The MSA officer shall establish procedures to ensure that patients who are discharged after normal duty hours are provided the opportunity to either pay their bill or elect other payment arrangements.

C3.12.2. The procedures listed below contain both automated and manual procedures. Manual procedures are designated with "(Manual)" next to the heading. Manual procedures are listed to provide instruction when the automated systems cannot or are not available to perform these procedures and manual completion is required.

C3.12.3. Invoice and Receipt (I&R). The I&R is the primary form used for billing patients.

C3.12.3.1. When properly completed, the I&R serves as a receipt for patients. The I&R shows the charges for subsistence and health services and payments on account. The I&R serves as a record of cash receipts, an account receivable record for local collections, and the basic instrument for posting the Cash and Sales Journal. For the hospital dining facility or nutritional medicine service officer, the I&R serves as a receipt for cash collected and turned in to the MTF business office. It may also serve as a receipt for completed Cash Meal Logs and dining hall signature records returned to the MSA officer.

C3.12.3.2. Unless unusual circumstances dictate otherwise, complete the I&R before providing outpatient services and immunizations. For inpatients, complete the patient identification data not later than the next business day after the patient is admitted.

C3.12.3.3. The MSA officer shall ensure that an I&R is on file or established in the automated system for each inpatient who has charges for medical services or subsistence charges (in-house or base and/or post services).

C3.12.3.4. Compare I&Rs on file or in the automated system with the Admissions and Disposition (A&D) reports. Maintain an I&R regardless of whether charges are paid locally by a Governmental or non-Governmental Agency.

C3.12.3.5. When the I&R is prepared for individuals whose charges are paid locally by other Government Agencies, keep the I&R with the SF 1080 until the paid copy is received. The disbursing officer (DO) enters the DO voucher number on the I&R, a copy is stapled to the paid copy of the SF 1080, and a copy is placed in both the alphabetical file and the inactive accounts receivable file. The DO voucher number provides a ready cross-reference to the SF 1080.

C3.12.3.6. (Manual) Immediately upon receipt of I&Rs, the responsible RM or Comptroller or PAD officer (or designated representative other than cashiers or bookkeepers) shall number them consecutively on a fiscal year basis. The numbered forms will then be issued to the MSA officer and kept in a locked safe. Only the MSA officer and the alternate as designated in writing may use and control the forms. Under no circumstances shall the MSA officer be provided unnumbered forms. The unused numbered forms shall be inventoried quarterly concurrent with the MSA audit. See Appendix 4 for instructions on completing the I&R.

C3.12.3.7. (Manual) Use the third copy of the I&R as the master accounts receivable record when hospitalization extends beyond the month of admission or an unpaid balance exists. Record dates of billings or payments on the master accounts receivable record. Staple additional copies to the back of the master copy.

C3.12.3.8. (Manual) Use the original I&R to post the accounts receivable or cash collection to the Cash and Sales Journal. Then place it in the active or inactive numerical accounts receivable file. The I&R preparer shall initial, as appropriate, and the individual receiving payment (usually cashier) shall sign the form. Give the first copy of the I&R to the patient or sponsor as a receipt for payment made on the patient's account. The second copy of the I&R is filed in a separate alphabetical file to make auditing of the account easier.

C3.12.3.9. (Manual) After recording the initial entries, place the I&R alphabetically in the active hospital inpatient accounts receivable file until the patient is discharged. In addition to this basic file, file the I&R alphabetically within the following categories: inpatients discharged from the hospital, outpatients from whom payment in full has not yet been received, and accounts reported as delinquent.

C3.12.3.10. (Manual) For each patient discharged throughout the month or hospitalized at the end of the month, the MSA office shall prepare a statement of charges on an I&R. Do not prepare a new I&R if the patient remains at the end of month; however, interim billing is required. Do not prepare interim billings for those patients billed under a Diagnosis Related Group (DRG) methodology. Patients hospitalized for 30 days or more shall be advised monthly in writing of charges due.

C3.12.3.11. (Manual) To determine the number of days each patient is charged for hospitalization and subsistence, count the day of admission as a day of hospitalization and exclude the day of discharge. Make a one-day charge if the patient is admitted and discharged on the same day. Coordinate with the PAD office to distinguish between a valid same-day admission and discharge and a canceled

admission. Use the changes in patient status on the A&D list to determine proper charges. Do not give credit for charges for meals eaten away from the hospital unless the patient is in a "subsisting out" status for more than one day. Give credit for charges for days the patient is officially Absent Without Leave (AWOL) from the medical facility.

C3.12.4. DD Form 139, Pay Adjustment Authorization. A sample DD Form 139 is included at Appendix 5. Always attempt to collect payment from the patient at time of discharge.

C3.12.4.1. If the member requests payroll deduction, prepare a DD Form 139 with the statement, "The charges are for the hospitalization of (name of member) for the period (admission and discharge dates and times)." Forward the DD Form 139 and a signed consent statement to the member's servicing FSO or DAO or DO no later than the next duty day. A sample consent statement for deduction from pay is included at Appendix 6. If the member is scheduled to separate from the Service within 30 days, notify the FSO or DAO or DO of the projected separation date.

C3.12.4.2. For basic trainees and Officer Training School (OTS) and Officer Candidate School (OCS) candidates, prepare a DD Form 139 with the statement, "The above (basic training or OTS or OCS member) was hospitalized in this MTF (admission and discharge dates and times)." Forward the DD Form 139 to the member's servicing FSO or DAO or DO no later than the next duty day.

C3.12.4.3. If a member from another branch of Service requests payroll deduction, prepare a DD Form 139. The member must also sign a consent statement (Appendix 6). Forward the paperwork to the appropriate address.

C3.12.4.4. A check (possibly a composite check for several deductions) can be received from the payroll office, and the amounts credited and deposited as amounts collected in the usual manner. Otherwise, the credited fund cite can be provided on the DD Form 139, and the amount credited through the payroll voucher, and only a deduction listing sent to the MTF.

C3.12.4.5. In the case of a credit, zero out all collections in the automated system and post the account. Zero out the account again, print a Cash Collection Voucher and attach a copy of the credit documentation.

C3.12.5. SF 1080, Voucher for Transfer Between Appropriations and/or Funds and SF 1081, Voucher and Schedule of Withdrawals and Credits

C3.12.5.1. Use SF 1081 to process billings for collection from Reserve Forces (Army, Navy and Air Force), National Guard, and SF 1080 for billings to other Government Agencies. Use SF 1081 to charge for meal days served to an enlisted member of the Reserve Forces who is authorized subsistence at Government expense and is attached or assigned for duty to base medical services, while on active duty for training, or on inactive duty for training in a pay status. Obtain the appropriation to bill for such assigned personnel. Enter the bill number, name and address of the billed office, name and address of the billing office, billed appropriation citation when billing another DoD Component, and a description of services and charges. Attach any supporting documents to the SF 1081 or SF 1080.

C3.12.5.2. The RM or Comptroller or PAD officer and/or the MSA officer shall indicate the appropriate fund cite on the SF 1080 or SF 1081, and the billed appropriation citation when billing another DoD Component using the SF 1081. SF 1080s are submitted or sent directly to the billed office of the Agency as soon as the billed amount is determined or at the end of the month. SF 1081s are forwarded to the servicing FSO or DAO or DO for billing and collection processing at the end of the month.

C3.12.5.3. Do not submit bills for less than \$100 in a month. However, bill the accumulated balance at the end of the fiscal quarter even if less than \$100.

C3.12.6. Billing Patients Who Do Not Present Authorized Proof of Eligibility for Care. Patients should present an identification card or other documentation as specified in the PATCAT table before receiving treatment unless it is an emergency. For emergency treatment, the patient has 30 calendar days after the visit to present documentation of eligibility. Otherwise, the MSA officer shall bill the patient as a non-DoD beneficiary using an I&R. If the patient or sponsor provides proof of eligibility to the PAD office and/or MSA office after the bill is generated, void the I&R.

C3.12.7. Billing Non-DoD Beneficiary Patients Who Are Covered by Health Insurance Plans

C3.12.7.1. These patients are listed in the PATCAT table. They include State Department employees and their family members, contractors and Federal employees overseas, civilian employees paid from non-appropriated funds and their family members, and other non-DoD beneficiaries who have health insurance, such as civilian emergency patients. These patients are treated at their own expense and do not fall within the TPC Program since they are not DoD beneficiaries.

C3.12.7.2. Completion of Claims Forms

C3.12.7.2.1. Before treatment, these categories of patients shall present their identification card indicating eligibility for health benefits and sign an authorization for assignment of benefits to the MTF. The MTF will comply with any precertification and/or certification requirements set by the insurance carrier.

C3.12.7.2.2. The patient shall sign and date the claim form in the proper places. At the same time, the MSA officer shall advise the insured that they are personally liable for any amounts that are not paid by the insurance carrier within 6 months from the date the claim is filed. The MSA officer shall obtain a signed statement from the insured acknowledging their indebtedness to the MTF and shall ask the patient to notify the MSA office of any change of address while the claim is pending. The MSA officer shall retain the signed statement acknowledging indebtedness with the I&R in the active accounts receivable file until the account has been paid in full.

C3.12.7.2.3. The MSA officer shall submit completed claim forms to the appropriate insurance carriers. Upon receipt of payment or denial from insurance carriers, the MSA officer shall notify the insured of the account status and take appropriate action to collect the balance due, if any.

C3.12.7.3. Itemized Statements for Insurance Claims. The MSA officer shall prepare a Uniform Bill-Revised 1992 (UB-92), itemizing the billing unit (DRG, per diem, Ambulatory Procedure Visit rate, etc.) according to the patient category. Instructions for the UB-92 are at Appendix 7. For further instructions on completing the UB-92, there are commercial manuals available to the general public. Separate non-DRG rates into hospital, professional, and ancillary charges. Separate DRG rates into hospital and professional charges only. Do not release information covered under the Privacy Act (Pub. L. 93-579 (1974) (reference (d)) to unauthorized individuals without complying with the requirements of the Privacy Act.

C3.12.8. Billing Civilian Emergency Charges on Behalf of Medicare Patients. MTFs may bill Medicare on behalf of civilian emergency patients. The MSA billing office shall prepare a UB-92 (see Appendix 7) and submit it to the appropriate Medicare Fiscal Intermediary (FI) depending on the location of the MTF. The MTF shall follow Service-specific guidance and/or regulations for submission of the UB-92. The MTF shall complete an election form annually (see Appendix 7). For further guidance on billing Medicare FIs, the Health Care Finance Administration (HCFA) Instruction Book for Providers (reference (e)) is available to the general

public. The MSA office shall bill Medicare at the interagency rate. The MTF accepts assignment of benefits, therefore, the FI should pay the MTF directly.

C3.12.9. Billing Workers' Compensation (Employment-Related Injuries or Illnesses) Cases

C3.12.9.1. Civilian Emergency Patients or Contractor Employees. For civilians (non-DoD beneficiaries) or contractors, the MSA billing office shall bill the patient or patient's employer if the injury or illness is work-related. The preferred method is to bill the employer who will forward the bill to the appropriate insurance company. The employee is responsible for filing a workers' compensation claim through their employer. Refer to Service-specific guidance and/or regulations for billing of workers' compensation claims.

C3.12.9.2. DoD Federal Employees. The form CA-16, Authorization for Examination and/or Treatment (Appendix 14), shall be completed according to Service-specific guidance and/or regulations and forwarded to the civilian personnel office. However, the MTF shall not bill the Department of Labor for DoD Federal employees. The underlying rationale is that Congress appropriates DoD funds to provide care for DoD Federal employees under occupational injury and/or illness situations. If the Department of Defense billed the Department of Labor, the Department of Defense would have to pay the cost of medical care plus a surcharge for administrative costs to the Department of Labor.

C3.12.9.3. Other Federal Employees. For non-DoD Federal employees, the MSA office shall bill the appropriate Department, usually through the appropriate civilian personnel office of the employee. For all Federal employees, a CA-16 or other report of injury or illness shall be submitted to the appropriate civilian personnel office. For non-DoD interagency billings, use the SF 1080 in accordance with subsection C3.12.5., above.

C3.12.9.4. The officer with oversight of MSA, TPC and MAC will ensure the timely completion of forms required by the healthcare provider on a workers' compensation claim, as required by the insurer and/or payer and/or workers' compensation board.

C3.12.10. Billings to Other Government Agencies, Department of Veterans Affairs, Department of State, Medicaid and Other Special Categories. The PATCAT table lists by patient category the appropriate billing rate and form to use. Collect from other Government Agencies by the mode specified in the table. The MSA officer shall transmit bills as soon as possible after the services are provided and at

least monthly in accordance with Service-specific guidance and/or regulations. This subsection does not apply to Federal employees treated for work-related injury or illness. For non-DoD interagency billings, use the SF 1080 in accordance with subsection C3.12..5.

C3.12.11. Billing Processes. If a patient does not pay their bill upon discharge, the MSA officer shall advise the patient of his or her obligation to pay the bill within 30 days. The patient must sign a letter acknowledging the debt and a copy of the letter must be filed in the MSA office accounts receivable file. All letters shall state that payment is due within 30 days. If the patient is an active duty member, the MSA officer shall advise him or her that charges owed will be deducted from their pay if payment is not received within 30 days.

C3.13. COLLECTION AND DISPOSITION OF SUBSISTENCE CHARGES

The MSA office shall collect subsistence charges from all persons including inpatients and transient patients not entitled to food service at Government expense. See Appendix 10, Persons Authorized to Eat in MTF Dining Facilities. Subsistence charges will not be billed separately for DoD beneficiaries with other health insurance (OHI). Funds shall be collected and deposited locally. Do not charge for subsistence provided to transient patients while they are traveling in the aeromedical evacuation system, assigned to an aeromedical staging facility, or otherwise in a transient status awaiting aeromedical evacuation. For Academy or West Point cadets, bill and collect from the appropriate FSO or DAO or DO at the end of each month. Collect moneys from trustees or sponsors for mentally incompetent patients. If medical activities are supported by the base food service function, deposit surcharge collections to the appropriate fund indicated by the base and/or post food service officer and FSO or DAO or DO.

C3.14. FORMS OF ACCEPTABLE PAYMENT

The MSA officer shall accept payment of amounts due to the MTF in the following authorized forms:

C3.14.1. Cash. U.S. currency and coin.

C3.14.2. Negotiable Instruments. Authorized negotiable instruments may not be accepted in amounts larger than the amount due. Negotiable instruments made payable or endorsed to the servicing FSO or DAO or DO, as prescribed locally, are acceptable as follows:

C3.14.2.1. U. S. Treasury checks.

C3.14.2.2. Certified checks, cashier's checks, and bank drafts.

C3.14.2.3. Personal checks. Personal checks for more than the amount due shall not be accepted. Personal checks for partial payments are not accepted if they carry any conditional endorsements such as "payment in full."

C3.14.2.4. Traveler's checks.

C3.14.2.5. U.S. Postal money orders or money orders issued by banks or other financial establishments.

C3.14.2.6. VISA and Mastercard, where applicable.

C3.14.2.7. Military Payment Certificates. Military payment certificates may be accepted outside the continental United States (CONUS) where such certificates are required for use as currency.

C3.14.2.8. Foreign currency.

NOTE: Transactions affected by both military payment certificates and foreign currency are governed by directives of the overseas command concerned. Use separate I&Rs for foreign currency and military payment certificates.

C3.15. CASH AND SALES JOURNAL

C3.15.1. The procedures listed below contain both automated and manual procedures. Manual procedures are listed to provide instruction when the automated systems cannot perform these procedures and manual completion is required.

C3.15.2. The MSA officer shall use the Cash and Sales Journal to record and consolidate all MSA accounting transactions related to appropriation reimbursements by the MSA officer; identify locally collected reimbursements included in budget estimates; and provide accounting control for Government funds collected locally.

C3.15.3. Maintain the Cash and Sales Journal on a fiscal year basis. At the close of each month, carry the balance of accounts receivable (columns K and L) and the cash accounts (columns M, N, and O) forward to the next month. Following the close of the fiscal year, prepare separate Cash and Sales Journals for current and prior fiscal years until all outstanding accounts receivable from the prior year have been liquidated. Use the Cash and Sales Journal to prepare the Monthly Medical Service Activity Report (see section C3.23., below).

C3.15.4. The MSA officer may use Cash Meal Logs, I&Rs, DD Forms 1131, and/or SFs 1080 to support the Cash and Sales Journal.

C3.16. DD FORM 1131, CASH COLLECTION VOUCHER

C3.16.1. The MSA officer uses the DD Form 1131 to transfer moneys received to the local or supporting FSO or DAO or DO. The MSA officer shall assign a voucher number series of consecutive numbers by fiscal year to the DD Forms 1131. The MSA officer shall transfer all proceeds from sales to the local or supporting FSO or DAO or DO or make deposit to the Federal Reserve Bank or designated depository by SF215 deposit slip in accordance with requirements of their servicing Accounting and Finance Office. Confirmed copies of the SF 215 will be sent to the local or supporting FSO or DAO or DO. If funds are stored overnight, the MSA officer shall ensure that storage meets the requirements of Service-specific resource protection regulations and obtain approval for fund containers from the military police.

C3.16.2. Prepare a separate DD Form 1131 for each fiscal year. Credit each collection to the fiscal year in which services were rendered. The accounting classification block shows the full major accounting classification. Sales codes should be appropriately reported as part of the fund cite and different sales codes should be reported as necessary. Use a separate line for each accounting classification, if appropriate.

C3.16.3. The appropriate FSO or DAO or DO agent shall sign each DD Form 1131 collection voucher. Do not sign if offices are using a cash control machine to validate collection vouchers. The MSA officer retains a copy of the DD Form 1131 that contains the disbursing office voucher number.

C3.16.4. Use a separate DD Form 1131 to transfer foreign currency to the FSO or DAO or DO. Indicate the units and quantities of foreign currency and the equivalent value in U.S. currency. Based on the actual rate on date of receipt or transfer, indicate

the units and quantities of foreign currency based on the equivalent value in U.S. currency.

C3.16.5. DFAS does not require MTFs to attach receipts to the DD Form 1131. Add the following statement to each DD Form 1131: "Supporting documentation for this voucher is retained for three years."

C3.16.6. In the future, only two options will exist for Accounting and Finance office support for the MTF; either the MTF will be served by a DFAS Operating Location (OPLOC) or DAO located in the same vicinity or by a non-located (distant) DFAS OPLOC. It is anticipated that servicing by a distant DFAS OPLOC will be the dominant condition upon completion of the DFAS consolidation effort.

C3.17. UNCOLLECTIBLE OR DISHONORED CHECKS

The MSA officer shall handle uncollectible and dishonored checks in accordance with local or supporting FSO or DAO or DO guidance. When a recorded cash collection is made null and void by a dishonored check, the MSA officer shall do the following:

C3.17.1. Manual Procedures. Pull the original I&R copies from the files and adjust them by striking the collection entry column J and inserting the amount due in column K. Initial the adjustment and explain the adjustment in a footnote. Then file the forms in the unpaid section of the accounts receivable file. Immediately follow up on these accounts. Do not charge an administrative fee for dishonored checks.

C3.17.2. Automated Procedures. Zero out collections in the automated system by printing a Cash Collection Voucher. Post the negative amount corresponding to the original payment and print a negative final Cash Collection Voucher. Immediately follow up on these accounts. Do not charge an administrative fee for dishonored checks.

C3.18. METHODS OF SETTLING OUTSTANDING ACCOUNTS RECEIVABLE

The MSA office shall make every effort to collect accounts before they become delinquent. Accounts receivable are delinquent if not paid within 30 days of discharge or treatment.

C3.18.1. For definition purposes, the date of original billing is the date of discharge. The MSA officer shall attempt to collect all accounts receivable at the time of discharge.

C3.18.2. If the charges are not paid within 15 days, follow up on the account either by a delinquent letter (see Appendix 9), or by documented contact with the patient or sponsor (to include certified mail). You can generate delinquent letters through CHCS.

C3.18.3. If charges are not paid within 30 days, prepare a DD Form 139 with the following statement in the remarks section, "The member named above was notified in writing on (date) concerning these unpaid charges. The charges are for hospitalization of (name of member) for the period (admission and discharge dates and times). The member has not paid as of this date." Additionally, include a statement on the DD Form 139 certifying that the patient was provided due process in accordance with subsection 70704, Volume 7, Part A, of DoD 7000.14-R (reference (c)) and include the statutory authority for the debt: 37 U.S.C. 1007(c) (reference (f)). Forward the DD Form 139 to the member's servicing FSO or DAO or DO. Do not close out the account receivable at this time. The MSA officer shall follow up with the FSO or DAO or DO in writing after 60 and 90 days. If the FSO or DAO or DO has not forwarded payment in 180 days, the MSA officer shall transfer the account to the FSO or DAO or DO and close out the account receivable.

C3.18.4. For pay patients whose health insurance plan has been billed, send a follow-up letter after 60 and 90 days. If payment has not been received from the insurance carrier within 180 days from the date the claim was submitted, collect the payment from the patient or sponsor. A DD Form 139 may be processed with the local or supporting FSO or DAO or DO 30 days after notification of balance due to the patient. Ensure the patient is aware of balance due and has had time to settle the account before processing a DD Form 139. Transfer the account to the local or supporting FSO or DAO or DO for collection 30 days after the patient is notified of non-payment by the insurance carrier. If payment is received from the insurance carrier after transfer, forward the payment to the FSO or DAO or DO.

C3.18.5. Process unpaid accounts of Service members who have been found mentally incompetent according to applicable guidance from the FSO or DAO or DO.

C3.18.6. Transfer delinquent accounts with other U.S. Government Agencies, those that have not been settled within 180 days of the first billing, to the FSO or DAO or DO for collection in accordance with Service-specific guidance and/or regulations.

C3.18.7. For deceased active duty members, retirees and Federal Government employees, do not contact next of kin. Forward the account to the appropriate DFAS office.

C3.19. PROCEDURES FOR TRANSFERRING DELINQUENT ACCOUNTS

When an account receivable becomes delinquent, the MSA office shall transfer it to the FSO or DAO or DO for further collection action or write-off. Use the following procedures to transfer delinquent accounts receivable to the FSO or DAO or DO:

C3.19.1. Review the account to make sure that patient identification data is complete, charges are accurate, and past collection efforts are fully documented. Include copies of follow-up letters, records of phone calls or personal contacts made to effect collection, and any other information that may assist the FSO or DAO or DO in further collection efforts. Send two copies of all related documents and correspondence to the FSO or DAO or DO.

C3.19.2. A transmittal letter must include the status of the account; the patient's name, grade, social security account number, organization, address, sponsor, and any other identifying data; dates services and/or subsistence were provided; the amount of collections, if any, applied against the charge; the outstanding balance; a complete fund citation of the specific project and appropriation to which collections shall be deposited as reimbursements; and a record of follow-up actions and any other pertinent information. Send the delinquent account to the FSO or DAO or DO.

C3.19.3. Attach the original and reproduced copies, as needed, of I&R top copy to the transmittal letter. Staple one copy of the transmittal letter to the back of the second copy of the I&R; write "Reported Delinquent on (date)" across the face of the form. Place the form in the delinquent account section of the accounts receivable file. Note the "Reported Delinquent on (date)" on the I&R retained in the numerical file.

C3.19.4. After performing these actions and transferring the account to the FSO or DAO or DO, the MSA officer is released of further responsibility for collecting on the account. The MSA officer shall not accept payment for any account transferred for collection. The MSA officer shall provide patients who attempt to pay transferred accounts with a certified statement of the delinquent account and refer the patient to the FSO or DAO or DO for further action.

C3.20. CORRECTIONS IN ACCOUNTING RECORDS

C3.20.1. The procedures listed below contain both automated and manual

procedures. Manual procedures are listed to provide instruction when the automated systems cannot perform these procedures and manual completion is required.

C3.20.2. Bookkeeping Errors. If an error is discovered on the MSA records during the same month, line out the incorrect item and make the correct entry. If the error is discovered after the end of the accounting period, leave the original entry and make a reference to the correct journal entry in the transactions of the current month. **Do not erase errors.** The MSA officer shall initial all entries lined out or corrected.

C3.20.3. Processing Overcharges. Submit a claim for reimbursement of overcharges to the FSO or DAO or DO on a SF 1049, Public Voucher for Refunds. The SF 1049 must show the appropriation number and the DD Form 1131 under which the funds were deposited with the FSO or DAO or DO. Staple a copy of the SF 1049 to the back of the patient's I&R after entries are made on the front of the card adjusting the account. Cash refunds or refunds with purchased money orders are not authorized.

C3.20.4. Processing Undercharges. When a patient has been undercharged, the MSA officer contacts the patient or sponsor to collect the balance due the U.S. Government. The MSA officer makes the necessary adjusting entries on the I&R and other appropriate MSA records.

NOTE: Charges less than \$1.00 are written-off.

C3.21. PROCEDURES FOR HANDLING FEES COLLECTED FOR MEDICAL RECORDS COPYING, ETC.

C3.21.1. The PAD office processes requests for clinical information received from non-Government Agencies. They should use a locally developed transmittal letter or a copy of the transmittal letter from the insurance company to release this information.

C3.21.2. When payment is received, the PAD office sends the payment to the MSA office with a copy of the locally developed transmittal letter or transmittal letter from the insurance company. The MSA officer shall indicate receipt of funds by entering, "Received (\$ dollar amount received) on (date)." Retain a copy of the locally developed transmittal letter or transmittal letter from the insurance company as a source document attached to the DD Form 1131. The MSA officer shall deposit the funds with FSO or DAO or DO. The DD Form 1131 used for funds deposited under this section should be filed separately.

C3.21.3. When the PAD office releases information before proper payment for the service is received, the MSA officer shall maintain a 30 day suspense file using the PAD letter of transmittal and a copy of the locally developed transmittal letter or a transmittal letter from the insurance company as the notification of initial billing. If payment is not received in 20 days, send a second letter or make personal contact with the requesting Agency stating that payment has not been received and is overdue. If payment is not received within 30 days of the first billing, transfer to the FSO or DAO or DO for collection. If payment is received before the account is declared delinquent, remove the locally developed transmittal letter or the transmittal letter from the insurance company from the suspense file and enter "Received (\$ dollar amount received) on (date)" and enter initial in item 9. The MSA officer shall then deposit the funds with the FSO or DAO or DO and attach all related papers to the receipt copy of the DD Form 1131 for filing.

C3.22. SAFEGUARDING PATIENT VALUABLES

C3.22.1. The MSA office shall store and safeguard personal valuables (such as cash, jewelry, and similar articles). MTFs shall advise patients of the availability of storage facilities for valuables via the CA-16. Patients acknowledge this advice when they sign the admission authorization. In those cases when the patient is unable to sign the authorization form, the immediate next of kin, if present, is authorized to sign for the patient. If the immediate next of kin is not present, the command duty officer or PAD officer shall make an entry in the form relating that the patient was unable to sign and shall secure the patient's signature as soon as reasonably possible.

C3.22.2. The MSA office shall not accept personal firearms, knives with blades above the length permitted by law and/or regulation, or any other item or object that could be considered a menace to safety or health.

C3.22.3. The MSA office shall provide adequate facilities (such as a safe or locked cabinet) for the storage of patient valuables.

C3.22.4. The MSA office shall not permit the use of patient valuables as security for check cashing, loans, or other similar purposes.

C3.22.5. The MTF commander shall designate in writing an individual to serve as the custodian for patient valuables. The custodian maintains the necessary records and protects the security of the valuables accepted for safeguarding. Individuals authorized to perform the duties in the absence of the custodian shall also be

designated in writing. The current custodian shall properly transfer patient valuables and related records when a new custodian is designated.

C3.22.6. To verify adequacy of controls, the MTF commander or his designee shall appoint in writing a disinterested officer, NCO in the grade of E-5 or above, or a civilian of comparable grade, to conduct a monthly inspection of secured patient valuables, related records, and forms.

C3.22.7. Patient Valuables Envelope and DD Form 599, Patient's Effects Storage Tag

C3.22.7.1. The designated custodian shall use a valuables envelope for storing and safeguarding personal valuables. When storing large items, DD Form 599 (Appendix 14) may be used and cross referenced to the valuables envelope. The MSA officer shall consecutively number the forms immediately upon receipt and record them in a log.

C3.22.7.2. The MSA officer shall furnish to the designated custodian only the quantity of forms needed to meet expected requirements for a reasonable period. The MSA officer shall maintain all excess forms in a locked safe or cabinet inaccessible to the custodian and other individuals.

C3.22.7.3. The custodian shall enter a description of all items for storage on the valuables envelope. Be specific in listing cash and money orders by amounts, check numbers, and articles of jewelry. Jewelry should be referred to as "gold in color" instead of "gold ring," and include any identifying marks or inscriptions.

C3.22.7.4. The custodian provides the patient with the detachable receipt from DD Form 599 for items received into custody. The patient or the patient's designated representative shall surrender the receipt to the custodian at the time valuables are returned. The patient or the patient's designated representative shall also acknowledge receipt of the returned valuables by signing opposite the depositor's original signature and envelope number.

C3.22.8. Any individual who discovers a loss of patient valuables shall report the loss immediately to the MTF commander for administrative action. The report shall state how the loss was discovered and any other facts concerning the loss.

C3.22.9. Patients whose valuables are lost, mistakenly released, or stolen while in the custodian's possession may file claims for compensation from the Staff Judge Advocate (SJA) or Judge Advocate General (JAG).

C3.23. MEDICAL SERVICES ACCOUNT REPORTS

The MSA office shall prepare the following reports:

C3.23.1. Initial and Final Reports. The MSA officer shall type the word "Initial" or "Final" in the top margin of all reports covering the first or last month's operation or portion thereof resulting from activation, redesignation, opening operations at a new station, or completion of operations at a station before moving to a new station.

C3.23.2. Corrected Reports. For automated systems, corrections made to a previous month's report are reflected in the current report. For manual systems, the MSA officer shall produce all corrected reports in complete form for submission instead of the initial incorrect report. The corrected report automatically and entirely cancels any previous report for the same period of time, subject, and data. Place an asterisk ("*") by each corrected entry on the corrected report. Type "Corrected - (date of corrected copy)" in the top margin. Enter the actual month and year of the initial report in the block provided for the date on the report. Corrected DD Form 7 and 7A reports (see subsections C3.23.4. and C3.23.5., below) will indicate only the differences from what was originally submitted.

C3.23.3. Medical Food Cost Report. This report is prepared by the Air Force only. It provides quarterly and cumulative fiscal year summary data on fiscal operations and output measures relative to food purchased and used in nutritional medicine service activities. It shows the financial status of nutritional medicine service activities operating under the subsistence credit allowance management system. It also provides programming data for central budgeting for medical subsistence in the military personnel appropriation. The designated nutrition care or medical food service personnel shall prepare the Medical Food Cost Report within 5 work days of the close of each fiscal quarter and send copies, as required, to the nutritional medicine service officer and major commands.

C3.23.4. DD Form 7 Report of Treatment Furnished Pay Patients - Hospitalization Furnished (Part A). At the end of each calendar month, the MSA officer shall prepare a report of inpatient care on DD Form 7 (instructions are at Appendix 10) for the categories of pay patients in the PATCAT table. A person who received inpatient care and for whom a bed is maintained in the facility, is reported as a pay patient on DD Form 7. Prepare a separate report for each major category of patient. Reports are due out of the base medical service no later than calendar day 7

of the following month. Send an original plus two copies to Service headquarters, as required.

C3.23.5. DD Form 7A, Report of Treatment Furnished Pay Patient - Outpatient Treatment Furnished (Part B). At the end of each calendar month, the MSA officer shall prepare a DD Form 7A (instructions are at Appendix 10) for certain categories of pay patients in the PATCAT table. Prepare a separate DD Form 7A for each major category of outpatients. Reports are due out of the base medical facility no later than calendar day 7 of the following month. Send an original plus two copies to Service headquarters, as required.

C3.23.6. Monthly MSA Report

C3.23.6.1. At the end of each month, the MSA officer shall provide the FSO or DAO or DO a summary of MSA activity showing billing and collections for reimbursable services and subsistence. Appendix 11 provides instructions for the Monthly MSA Report. The MSA officer shall send all copies of the Monthly MSA report to the RM or Comptroller or PAD officer of base medical services or authorized representative for information and approval. The original approved report is furnished to the local or supporting FSO or DAO or DO.

C3.23.6.2. Submit a separate report for the current and prior fiscal years until all prior years outstanding accounts receivable have been collected.

C3.23.6.3. The MSA officer shall report the following separate sections by sales code: Subsistence, Medical Services, and Surcharge Collections.

C3.23.6.4. Classify the accrued bills for patients still hospitalized as of the last day of the month as current month sales on the Monthly MSA report, column D.

C3.24. DISPOSITION OF RECORDS

The MSA office shall retain for 3 years all accounting forms and records used in operating the MSA office. The MSA officer shall dispose of records in accordance with Service-specific guidelines and/or requirements for handling sensitive material.

C4. CHAPTER 4

THIRD PARTY COLLECTION PROGRAM

C4.1. GENERAL

C4.1.1. It is DoD policy to collect from third party payers the cost of medical services provided to DoD beneficiaries to the fullest extent allowed under 10 U.S.C. 1095 (reference (a)). Each MTF shall designate an office responsible for TPC Program implementation to include program awareness, identification and collection of insurance information, filing claims with third party payers, collecting and depositing funds, and reporting TPC Program status.

C4.1.2. Implementing an effective TPC Program requires a review of all aspects of accounts receivable management. It necessitates the participation of many functions within the MTF, including physician and nursing staffs, admissions, medical records, the legal office, utilization and quality assurance review, ancillary departments, information management, as well as the MTF finance offices, wherever they are located.

C4.1.3. MTFs shall follow procedures outlined for third party payers under 32 CFR 220 (reference (g)) and Service-specific guidance and/or regulations. The MTF shall establish a TPC Program that, at a minimum, performs the following functions:

C4.1.3.1. Identifies those Uniformed Services beneficiaries with third party payer plan coverage.

C4.1.3.2. Complies with third party payer requirements.

C4.1.3.3. Submits claims to third party payers.

C4.1.3.4. Follows up to ensure collections are made.

C4.1.3.5. Documents and reports collection activities.

C4.1.4. For inpatient hospital care, authority to collect applies to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after April 7, 1986. For Medicare supplemental plans, automobile liability and no-fault insurance plans, and outpatient care, authority to collect also applies to an insurance, medical service, or health plan agreement entered into, amended, or

renewed on or after November 5, 1990. An amendment may include, but is not limited to, premium rate changes, benefit changes, carrier changes, or conversions from insured plans to self-insured plans or the reverse.

C4.2. HEALTHCARE PLANS NOT SUBJECT TO THE TPC PROGRAM

The only plans not subject to the TPC Program are Medicare, Medicaid, CHAMPUS, CHAMPUS supplemental plans, and income (or wage) supplemental plans. Typically, Health Maintenance Organization (HMO) plans that require hospitalization in an HMO hospital do not reimburse MTFs except for emergent care, urgent care, opt-out or point-of-service, and out-of-service area care (subject to policy coverage).

C4.3. MEDICAL SERVICES BILLED

The MTF shall file claims to third party payers for each visit including multiple visits on the same day to different clinics. Multiple visits to the same clinic on the same day shall result in one charge. The MTF may bill insurance companies for the following healthcare services:

C4.3.1. Inpatient Hospital Care

C4.3.2. Ambulatory Procedure Visits

C4.3.3. Outpatient Visits

C4.3.4. Cooperative and/or Supplemental Care

C4.3.5. High Cost Ancillary Services and Procedures, (as specified by OASD(HA)) when Requested or Ordered by External Provider

C4.3.6. Hyperbaric Medicine

C4.3.7. Immunizations

C4.3.8. Dental Care

C4.3.9. Ground and Air Ambulance Services

C4.4. MEDICAL SERVICES NOT BILLED

The only medical services not billed are those for which rates have not yet been established by OASD(HA). MTFs are not authorized to establish rates in the absence of DoD-provided rates.

C4.5. IDENTIFICATION OF BENEFICIARIES WHO HAVE OTHER HEALTH INSURANCE

C4.5.1. General Requirements. Timely and accurate identification of beneficiaries who have other health insurance (OHI) is crucial to a successful TPC Program. The pre-admission, admission, outpatient, or TPC staff shall obtain written certification from beneficiaries at the time of each inpatient admission or outpatient visit, if written certification is not in the patient medical record or has not been updated within the past 12 months. To achieve 100 percent contact rate, TPC staff shall establish a process whereby all patients who have not already certified their OHI status, are queried about OHI upon discharge. DD Form 2569, Third Party Collection Program - Insurance Information, is currently being revised and will be distributed upon final approval. TPC staff shall discuss with patients the legislative requirements and benefits of the TPC Program, the types of insurance plans subject to collection, and the patient's responsibility. In addition, TPC staff shall ascertain Medicare Parts A and B enrollment status for patients aged 65 and older.

C4.5.2. Documentation. All patients, including active duty, must be asked if the treatment is accident or work-related. At a minimum, how, when and where the injury occurred must be obtained and entered on the insurance declaration form. The patient's employer information must always be obtained, even in instances when the patient states he or she has no health insurance. For beneficiaries indicating insurance coverage, obtain and verify the insurance company and/or payer name, group and/or plan identification information, and related employer information--including employer or former employer's name, address, phone number, group number, and member identification number. The patient's insurance card must be copied when available.

C4.5.3. Interviewing Techniques

C4.5.3.1. During the interview process, MTF personnel shall maintain a friendly and professional demeanor. Initially the interviewer shall ask the patient if they or their spouse are employed or retired. Usually, employers subsidize health insurance premiums for employees and this may be extended to an employee during retirement. The next question the interviewer should ask the patient is, "What is your health insurance company or HMO plan?," followed by, "May I see your insurance

card?" The goal of the interview is to obtain the insurance information without asking, "Do you have health insurance?" In addition, the interviewer should ask the patient if their admission and/or visit is due to an injury sustained in an accident and, if so, obtain relevant accident insurance information.

C4.5.3.2. Specific health insurance questions may include, but are not limited to: policyholder's name and policy number; effective date(s) of coverage, and if the policy is listed as expired, the end date of coverage; whether the policy is a group policy, the name of the group and group number; whether the policy includes family members, and if so, which ones; whether precertification is required for an inpatient stay and the phone number to call for precertification; covered benefits under the plan, amount of deductible, percentage of costs covered under the policy, if the policy covers pharmaceuticals, etc.; and the health insurance company's mailing address.

C4.5.3.3. If the insurance information is already in CHCS, verify that the information is correct, make any required changes, and in the Precertification and/or UR free text fields, enter the date the information was verified. Verify insurance information for billable policies and enter it into the Third Party Outpatient Collection System (TPOCS) or any other outpatient billing system at the same time it is entered into CHCS. Do not enter CHAMPUS supplements, income (or wage) supplemental policies, or any other non-billable policies into TPOCS or other outpatient billing system.

C4.5.3.4. For all newly identified billable policies, check CHCS for prior admissions and verify that insurance claims were filed and payment received for all treatment provided during the policy effective dates. Note any register numbers for admissions less than two years old but within the effective dates of the insurance policy. Check all family members listed on the policy for prior admissions and verify that payment has been received if prior admissions exist.

C4.6. MANDATORY COMPLIANCE BY HEALTH INSURANCE CARRIERS

C4.6.1. Insurance companies and OHI plans shall abide by the provisions of 10 U.S.C. 1095 (reference (a)) and 32 CFR 220 (reference (g)). According to law, insurance plans cannot deny claims based on the fact that care was rendered in a Government facility.

C4.6.2. MTFs may reach understandings with third party payers on claims procedures and other administrative matters, if such understandings are not

preconditions to complying with State and local statutory and regulatory requirements. However, MTFs shall not enter into participation agreements with payers. Participation agreements are predicated on State and local laws, whereas, MTFs are governed by Federal statutes and/or regulations. Payment is not contingent upon the military facility entering into a participating hospital agreement with the insurance entity.

C4.6.3. Insurance companies shall not deny full reimbursement of claims based on the premise that it will reimburse only the amount the patient would have been liable for had the insurance policy not existed. Denial of claims for this reason or any other invalid reason shall be referred to the appropriate supporting or designated legal office in accordance with Service-specific guidance and/or regulations.

C4.7. AUTHORIZATION TO RELEASE MEDICAL INFORMATION IN SUPPORT OF TPC

Upon request by representatives of third party payers, MTFs shall make available applicable healthcare records of the patients for whom insurance payment is sought. This applies only to those records necessary to verify the services provided and that permissible terms and conditions of the plan were met. The MTF shall not bill the insurance carrier for copying these records. MTF personnel shall inform patients when insurance information is collected that medical information relevant to an episode of care being billed will be provided to third party payers if requested. Additional authorization for release of applicable medical records is not required except in the case of alcohol and/or drug abuse, AIDS, and sickle cell cases.

C4.8. BILLING ACTIVITIES

C4.8.1. The MTF shall bill allowable charges for DoD beneficiary patients to insurance carriers or Government Agencies or programs in accordance with section C3.12. of Chapter 3, above.

C4.8.2. Facilities that are part of a larger system and rely on a parent MTF for support are considered subordinate facilities. Subordinate medical facilities that issue third party billings shall establish and maintain memorandum accounting records as required by the parent MTF and in accordance with Service-specific guidance and/or regulations. The memorandum accounting records shall include the following data:

C4.8.2.1. Action taken on each claim.

C4.8.2.2. Amount billed.

C4.8.2.3. Amount collected.

C4.8.2.4. Amount in dispute.

C4.8.2.5. Delinquent amount.

C4.8.2.6. Final account disposition.

C4.8.3. MTFs shall accurately prepare and submit claims to third party payers using the UB-92 or the HCFA 1500, Health Insurance Claim Form. To the extent practical, MTFs shall comply with the data elements and code specifications of the National Uniform Billing Committee (NUBC) and the Uniform Claim Forms Task Force for submitting claims to third party payers. The MTF shall prepare and send inpatient claims to the third party payer within 10 business days following completion of the medical record. Outpatient claims shall be prepared and sent within 7 business days after the outpatient encounter information for billing is obtained. The TPC officer shall check the report of discharged OHI patients for a status of the coding of their medical record. The TPC officer shall also coordinate with the PAD officer to ensure that records are completed and/or coded within 30 days following the patient's discharge from the MTF. In situations involving long term hospitalization of beneficiaries, prepare interim claims on a periodic basis, not to exceed 90 day intervals. Do not prepare interim claims for those patients billed under a DRG methodology.

C4.8.4. The Under Secretary of Defense (Comptroller) (USD(C)), in coordination with OASD(HA), establishes the rates and the methodology used for billing third party payers. USD(C) reviews, revises, and publishes the rates each fiscal year in a DoD memorandum and in the Federal Register. MTFs are not authorized to establish rates.

C4.8.5. Two quick reference tables to assist with claims and reporting are included at Appendix 12. The Type of Services Billed by Beneficiary Category (Table AP12.T1.) indicates what services to bill by beneficiary category. The Type of Services Billed by Insurance Policy (Table AP12.T2.) shows what services to bill for each type of insurance plan.

C4.8.6. For inpatient hospital care, rates are based on DRGs.

C4.8.7. For outpatient medical care, the MTF must use the appropriate clinic or

procedure rate established and published annually by USD(C). For ambulatory surgery cases, use the separately established Ambulatory Procedure Visit (APV) rate.

C4.8.8. If an MTF provides certain high cost ancillary services (HCAS), prescription drugs, or other procedures requested from a source other than a Uniformed Services facility and not incident to an outpatient visit or inpatient service at the MTF, the TPC office shall file third party health insurance claims using the appropriate established rates. The threshold dollar amount for billing HCAS and prescription drugs is published in the annual rate package (see subsection C4.8.4., above). For example, effective March 15, 1996, the Fiscal Year 1996 threshold is \$25.00.

C4.8.9. When a civilian physician provides healthcare services in an MTF under the Partnership Program (DoD Instruction 6010.12 (reference (h))), for insured family members and retirees, the MTF shall bill the third party payer for the total charge minus the professional component. Thus, the MTF shall bill the net charge of hospital and ancillary services components only. The civilian physician bears the responsibility for billing the third party payer on a primary basis and CHAMPUS on a secondary basis for the professional portion of the bill.

C4.8.10. Under the new TRICARE contracts, the MTF and managed care contractor can negotiate a resources sharing arrangement, in which the contractor hires an individual or individuals to work in the MTF. Under such an arrangement, the MTF shall file third party claims using the appropriate established rates for patients treated by a resources sharing provider.

C4.8.11. For patients scheduled for air evacuation through the Global Patient Movement Requirements Center (GPMRC), the MTF shall enter all insurance information in the Defense Medical Regulating Information System (DMRIS). GPMRC will perform the billing and collection activities for these patients.

C4.8.12. For insured family members and retirees, the TPC office shall not charge the patient for medical services or subsistence charges. These amounts are considered covered and payable by the plan. If no payment is received or expected from the third party payer, the TPC office shall bill the patient for the subsistence amount.

C4.8.13. The MTF shall not require DoD beneficiaries to pay the MTF any deductible or copayment amounts imposed by the third party payer. A beneficiary is any person eligible for benefits and authorized treatment in a Uniformed Services facility as covered by 10 U.S.C. 1074 (reference (i)) and 10 U.S.C. 1076(a) and (b)

(reference j)). Beneficiaries may be retirees, family members of retirees, or family members of active duty personnel. For the purposes of automobile insurance, authority to collect extends to active duty members of the Uniformed Services (10 U.S.C. 1095(i) (reference (a))). Civilian emergency patients are not beneficiaries.

C4.8.14. The TPC office shall bill HMO plans to the extent that the MTF can reasonably expect to be paid. Typically, HMOs only pay for emergent care, urgent care, OPT-OUT (or point-of-service), and out-of-service area care. MTFs shall:

C4.8.14.1. Identify patients with HMO coverage.

C4.8.14.2. Certify admissions, file, and pursue all claims with HMOs (inpatient and outpatient) with OPT-OUT provisions.

C4.8.14.3. Certify all admissions for emergent, urgent and out-of-service area admissions.

C4.8.14.4. Identify all outpatient treatment for emergent, urgent and out-of-service area care.

C4.8.14.5. File and pursue resultant claims with gatekeeper HMOs.

C4.8.15. The TPC office shall prepare separate claims for the mother and the baby in an inpatient delivery case.

C4.8.16. The TPC office shall bill a separate charge for multiple outpatient visits on the same day to different clinics. Multiple visits on the same day to the same clinic will result in only one charge.

C4.8.17. Title 32 CFR 220.2d (reference (g)) states that executed, written assignment of benefits is not necessary. MTFs have statutory assignment of benefits, and third party payers must pay MTFs directly. The MTF has no responsibility and shall not attempt to collect from the patient any amounts erroneously paid to the patient by a third party payer. To ensure proper payment is made, it is necessary to annotate "Y" for YES in field 53 of the UB-92. This will indicate the assignment of benefits to the MTF as opposed to the patient.

C4.8.18. Medicare supplemental insurers are required by law to accept TPC claims as involving Medicare-covered services. They cannot deny a TPC claim on the grounds that no claim had been submitted previously by the provider or beneficiary for payment under Medicare. The obligation of a Medicare supplemental plan to pay

shall be determined as if the MTF were a Medicare-eligible provider and the provided services as if they were Medicare-covered services. In general, Medicare supplemental plans are responsible for paying amounts comparable to beneficiary out-of-pocket costs under normal operation of the Medicare program. Currently, efforts to collect from Medicare supplemental policies for covered services, with the exception of inpatient Medicare Part A deductible amounts, are deferred. The obligation to pay the Medicare inpatient deductible amount only applies to Medicare supplemental policies that cover the inpatient deductible. The Medicare supplemental insurer shall not be obliged to pay the MTF if the benefit is required to satisfy a patient's inpatient deductible in a civilian hospital arising from an admission within the same Medicare benefit period. If the benefit has already been paid to a facility of the Uniformed Services, it shall be refunded to permit the benefit to be paid to the civilian hospital. This will ensure that duplicate payment from the insurer will not occur and that beneficiaries will not be left without insurance coverage for an out-of-pocket expense in connection with the inpatient deductible. However, in all cases when the Medicare supplemental payment is refunded, the patient is to be billed the appropriate subsistence amount.

C4.8.19. DoD collection authority under 10 U.S.C. 1095 (reference (a)) was expanded to include automobile liability and no-fault insurance policies. For these types of cases, this authority extends to active duty members as well. See Chapter 5, Medical Affirmative Claims, for more information.

C4.9. COLLECTION ACTIVITIES

C4.9.1. Follow-up Claims Inquiries. If reimbursement is not received within 30 days of the initial claim, conduct either a written or telephone follow-up. Conduct at least one additional follow-up 60 days after the initial claim submission.

C4.9.2. Referral of Outstanding Claims. The RM or Comptroller or PAD officer shall refer TPC accounts receivable to the appropriate supporting or designated legal office for legal action within 180 days of initial billing, but not more than 270 days from the date of discharge or outpatient visit, unless there is clear evidence the claim will be paid. All collections made by the SJA or JAG office shall be deposited into the MTF O&M account. Review all outstanding TPC accounts to ensure they are valid claims before referring them to SJA or JAG. The MTF shall close outstanding TPC claims that fall into one of the following categories for valid denial: amount of coverage; care not covered; CHAMPUS and/or income supplemental plans; Medicare supplemental plans; HMO; no utilization review; patient copays and deductibles; and

other. The records of these accounts must be clearly documented and state the reason for closure without collection or collection for less than 100 percent of the claimed amount.

C4.9.3. Deposits. Deposit third party collections in the local O&M appropriation of the MTF providing the medical services. Deposit collections in the year received, not in the year in which medical care was rendered or billed.

C4.9.4. Validating Accuracy of Payments. The TPC office is responsible for ensuring the accuracy of third party payer payments and shall validate (check) the payer's Explanation of Benefits (EOB). Ensure that the insurance carrier has processed the claim properly. At a minimum, the TPC office shall verify the following:

C4.9.4.1. All charges on the insurance claim are listed on the EOB.

C4.9.4.2. All deductibles, copayments and any other pertinent factors affecting insurance payments have been considered.

C4.9.4.3. A valid explanation is given for unpaid or unprocessed charges.

C4.9.4.4. Codes listed on the EOB match the codes on the insurance claim.

C4.9.4.5. Payment meets expectations and any precertification penalty is appropriate.

C4.9.4.6. Reductions in payment by the third party payer are valid. To reduce the MTF's charges, the carrier must be able to prove that the average reimbursement in their provider network for the same service is lower than that charged by the MTF, and the MTF (or an authorized Government representative) must agree to the lower amount (see 32 CFR 220.8 (reference (g))). Since DoD charges are based on costs only, assume that any reductions made by the carrier are invalid and must be investigated.

C4.9.5 Disposition of Claims Files. TPC claims files shall be maintained according to Service-specific guidance and/or regulations until paid in full or appropriately closed and examined in the post-settlement review process.

C4.10. MINIMUM INTERNAL CONTROLS

C4.10.1. The MTF commander shall ensure that appropriate separation of duties

is maintained to minimize the risk of misappropriation of funds. The individual responsible for billing shall not receive, post, and deposit funds. Separate accounting records should be maintained for both the TPC Program and treasurer offices to provide adequate audit trails.

C4.10.2. The officer responsible for TPC, MSA, and MAC oversight shall ensure the appropriate separation of duties with a minimum of three individuals (where possible). Separate individuals shall:

C4.10.2.1. Prepare and mail claims.

C4.10.2.2. Receive, post (receipt), and deposit checks and validate payments.

C4.10.2.3. Reconcile TPC Program accounting and reporting records.

C4.10.3. The MSA officer shall:

C4.10.3.1. Receive and open mail including checks or payments.

C4.10.3.2. Ensure checks are posted (recorded) and deposited according to Service-specific protection guidance and/or regulations.

C4.10.4. The TPC officer shall:

C4.10.4.1. Forward TPC Program checks or payments received in the mail to the MSA officer.

C4.10.4.2. Ensure collections are recorded accurately and when earned.

C4.10.4.3. Reconcile insurance documents indicating amounts paid with total charges to validate payment of the full amount, less deductibles and copayments.

C4.10.4.4. Ensure insurance payments are validated and that Service-specific guidance and/or regulations regarding claim closure and disputed claims are followed.

C4.10.4.5. Ensure documents indicating amounts paid and/or collected equals amounts resource deposited.

C4.10.4.6. Ensure TPC records are reconciled with MSA and TPC deposits, and TPC reports are reconciled monthly with Accounting and Finance office records.

C4.11. TPC PROGRAM ANNUAL REPORT TO CONGRESS

Annually, each MTF shall submit a narrative report to their respective Service Headquarters and/or Surgeon General in the format prescribed by Service-specific guidance and/or regulations. Each Service shall report to OASD(HA) the amount collected by facility from third party payers during the preceding fiscal year and the amounts requested by facility for O&M for the previous fiscal year, the fiscal year for which the report is submitted, and the next fiscal year. The TPC Program Annual Report to Congress is due at OASD(HA) by January 15, each year. See Appendix 13 for a sample annual report.

C5. CHAPTER 5

MEDICAL AFFIRMATIVE CLAIMS (FORMERLY THIRD PARTY LIABILITY CLAIMS)

C5.1. MEDICAL AFFIRMATIVE CLAIMS

C5.1.1. The Medical Affirmative Claims (MAC) Program (42 U.S.C. 2651-2653 (reference (k)) and 28 CFR 43 (reference (l))), the Federal Claims Collection Act (31 U.S.C. 371 1-3720A (reference (m)) and 4 CFR 101-105 (reference (n))), and the Third Party Collection Program, (10 U.S.C. 1095 (reference (a)) and 32 CFR 220 (reference (g))), apply to these claims. This Chapter may not reflect each Service's methodology for handling MAC claims. Each Service should follow Service-specific guidance and/or regulations when discrepancies occur with this Chapter.

C5.1.2. The MAC Program provides the statutory and regulatory authority to recover the reasonable value of medical care rendered for injuries or illnesses provided at Government expense to active duty members, dependents (as defined at 10 U.S.C. 1072 (reference (o))), and retirees (as defined at 10 U.S.C. 1074(b) (reference (i))), under circumstances creating third party tort liability.

C5.1.2.1. MAC includes all forms of liability or tort based insurance such as:

C5.1.2.1.1 Automobile (including uninsured and/or underinsured)

C5.1.2.1.2. Boat and Airplane

C5.1.2.1.3. Product and/or Manufacturers' (i.e., defective products)

C5.1.2.1.4. Premises

C5.1.2.1.5. General Casualty (e.g., "slip and fall") or Umbrella (covering a variety of real or personal properties--business, home, farm, boat, car, airplane, etc.)

C5.1.2.1.6. Homeowners' and/or Renters'

C5.1.2.1.7. Medical Malpractice (other than Federal providers)

C5.1.2.2. It also includes all types of contract-based medical indemnity insurance or coverage such as:

C5.1.2.2.1. Workers' Compensation (other than Federal employees)

C5.1.2.2.2. No-Fault and/or Personal Injury Protection (PIP)

Automobile Accidents

C5.1.2.2.3. Medical Payments (automobile accidents and defective products--some policies)

C5.1.2.2.4. Commercial and/or Public Premises

C5.1.2.2.5. Boat and Airplane (most policies)

C5.1.2.2.6. Homeowners' and/or Renters'

C5.1.2.3. The Third Party Collection Program provides a statutory and regulatory basis for recovery from automobile insurance for the costs of healthcare services rendered for illnesses or injuries provided to authorized beneficiaries (active duty, dependents and retirees), including automobile liability, no-fault and/or PIP, and uninsured and/or underinsured coverage. Section 1095 of 10 U.S.C. (reference (a)) also authorizes the deposit of collections "...under any other provision of law from any other payer..." to the responsible MTF's O&M account. This includes reimbursements from both TPC and MAC Programs.

C5.2. RECOVERY JUDGE ADVOCATE RESPONSIBILITIES

C5.2.1. The designated Recovery Judge Advocate (RJA) is responsible for the assertion and compromise, waiver, or settlement of claims arising from an injury or illness as a result of a recoverable accident. The RJA is responsible for determining if a patient's treatment represents a potential recoverable claim.

C5.2.2. MTFs shall cooperate and collaborate with their supporting RJA and execute a Memorandum of Understanding (MOU), as appropriate. MTFs shall ensure that MOUs are consistent with applicable Service regulations and/or directives. Each MTF must establish and implement procedures in accordance with applicable Service regulations to facilitate the exchange of information necessary to support recovery activities. MTFs and RJAs shall coordinate to ensure that inpatient and outpatient records (including emergency room, physical therapy, and outpatient records), and requests for information from third parties are screened to identify potentially recoverable treatment.

C5.2.3. MTFs shall use existing TPC Program procedures and documents to the greatest extent possible to ensure accident information (how, when, and where) is obtained at point of entry. The procedures and documents used to obtain and document accident information include, but are not limited to: pre-admission and admission interviews, inpatient insurance declaration forms, outpatient encounter forms, emergency room logs, admitting and discharge summaries, and other pertinent medical treatment documents.

C5.2.4. The RJA shall provide the treating MTF with copies of deposit vouchers for collections deposited to the MTF's account or a monthly report containing pertinent information regarding the patient(s) and the amount(s) deposited to the MTF's account. RJAs shall provide the referring MTF a monthly list of claims that were closed without recovery and claims that were transferred to another claims jurisdiction.

C5.3. MTF RESPONSIBILITIES

C5.3.1. MTFs shall establish internal controls for cases sent to the RJA for recovery. These controls shall cover dispositions of claims, deposits of funds to the MTF's account, timely reporting of information about potential or ongoing affirmative claims, provision of accurate cost computations for care provided through the MTF, and copies of supporting medical records. MTFs must provide an updated fund cite for depositing funds at the start of each fiscal year.

C5.3.2. MTFs shall:

C5.3.2.1. Screen admitting, emergency room, physical therapy, and outpatient clinic records; outpatient clinic encounter and insurance disclosure forms; supplemental care payments; and patient, insurance, attorney, and work release requests for potential MAC cases.

C5.3.2.2. Interview patients at point of entry regarding accident information (how, when, where). This includes outpatient care, pre-admission, and admissions interviews.

C5.3.2.3. Promptly notify the RJA regarding treatment.

C5.3.2.4. Provide claim forms with accurate cost computation.

C5.3.2.5. Provide copies of supporting medical records, as requested by the RJA.

C5.3.2.6. Provide copies of paid vouchers for patients treated in civilian facilities (supplemental care, etc.), as requested by the RJA.

C5.4. MULTIPLE SOURCES OF RECOVERY

Often the patient is covered by both a health insurance policy or plan (TPC claim) and one or more recoverable MAC (e.g., automobile liability and a no-fault and/or PIP claim). Both the TPC and MAC cases must be pursued simultaneously according to State insurance regulations regarding coordination of insurance benefits. The Government cannot collect more than the cost of medical care from any one source or combination of sources. MTFs must establish procedures to ensure coordination with and timely notification to the supporting legal office on any TPC health insurance claim and subsequent collection or denial in cases where the legal office has a concurrent MAC. The MTF cannot wait until payment is received from the health insurer to notify the supporting legal office about a potential MAC because the legal office must assert the MAC in a timely manner to preserve the MTF's rights. For non-Federal employees, the MTF shall not file a TPC claim to the patient's health insurer when covered by workers' compensation. The legal office shall file the non-Federal employee's workers' compensation claim as a MAC.

C6. CHAPTER 6

CHARGES FOR CARE AND SUBSISTENCE

C6.1. POLICY REGARDING CHARGES FOR CARE

C6.1.1. Section 1078 of 10 U.S.C. (reference (p)) prescribes the establishment of fair charges for medical and dental care given to dependents under 10 U.S.C. 1076 (reference (j)). These charges are to be applied equally to all classes of dependents. Inpatient charges are per diem or DRG-based rates depending on the patient category. Outpatient charges are per visit rates according to the type of services or procedures provided.

C6.1.2. The USD(C) establishes rates annually. The Services shall publish the rate changes in the annual medical reimbursement rate memorandum and in the Federal Register.

C6.1.3. When a physician provides services for family members or retirees under the Partnership Program (DoD Instruction 6010.12 (reference (h))), the MTF shall bill the third-party payer for the hospital and ancillary charges only. The physician is responsible for billing the physician's fees.

C6.1.4. The MTF shall not bill eligible family members or retirees for any deductible, copayment, or other amount that insurance carriers deny. Beneficiaries shall not pay subsistence to the extent that payment received from the payer exceeds the medical services or subsistence charge.

C6.2. INPATIENT RATES

C6.2.1. Inpatient Charges. When reimbursement is required for hospitalization, the MTF bills the appropriate inpatient per diem or DRG-based rate for the day of admission and for each succeeding day. There is no charge for the day of discharge. If admission and discharge occur on the same day, the claim will be filed as a one-day admission with the appropriate DRG rate. If the patient is administratively admitted as an APV patient and treated and released in less than 24 hours, the claim should be filed as an ambulatory surgery claim with the APV rate.

C6.2.2. Inpatient Transfers. No charge is made if the patient is admitted to the MTF and transferred to another military facility on the same day, since the gaining

military facility charges for this day. For transfers to civilian facilities, a charge is made for the admission day if the patient is admitted to the MTF and transferred the same day. For lengths of stay exceeding one day, the originating MTF bills the patient for any days spent in the MTF, except for the transfer day, which is considered the discharge day. For patients transferred to other facilities (civilian or military) after the day of admission, the original treating facility is paid the appropriate weighted value of treatment. This is based on the full payment amount (ASA rate multiplied by DRG case weight) divided by the CHAMPUS DRG geometric length of stay (GLOS) and then multiplied by the actual length of stay (LOS) of the patient. The receiving facility (civilian or military) receives the full reimbursable amount, regardless of what the original treating facility is reimbursed. The billing calculation procedure is as follows:

EXAMPLE: DRG 1 Case Weight: 3.7759
 ASA Rate: \$5000
 Geometric LOS: 7.3 Days

Scenario: Patient is admitted to MTF A and is transferred to MTF B after 2 inpatient days.

Full Payment Amount: \$18,879 (3.779 x \$5000)

Per Diem Rate: \$2,586 (\$18,879 ÷ 7.3)

MTF A Reimbursement: \$5,172 (\$2586 x 2)

MTF B Reimbursement: \$18,879 (3.779 x \$5000)

C6.2.3. Newborn Charge. For MSA and TPC accounts, the newborn is charged the applicable rate according to his or her beneficiary category. The infant is billed separately from the mother from the time of birth. A separate charge is made for each newborn when there is a multiple birth involved.

C6.2.4. Transient Patients. The MTF or aeromedical staging facility that provides medical care to a transient patient does not charge for medical services. A transient patient is one who is in transit through aeromedical evacuation channels. This includes any delay or layover during evacuation, such as a rest overnight, unless the patient is removed from the aeromedical evacuation system by the medical authority and admitted to an MTF, either en route or at the final destination. A patient ceases to be a transient patient when admitted to an MTF.

C6.3. OUTPATIENT RATES

C6.3.1. Outpatient Charges. These rates pertain to medical care received by individuals who are required to pay for outpatient care in MTFs and to the TPC Program. Established annually, these rates are per visit or procedure. The MTF shall charge patients for follow-up visits that meet the criteria of a visit as defined by DoD 6010.13-M (reference (q)). Visits entail interaction between a patient and a healthcare provider, involve evaluation and management services, and include documentation in the medical record. Telephone consultations, if they meet the MEPRS guidelines (DoD 6010.13-M (reference (q))) for an outpatient visit, are chargeable. Referrals or consultations are considered visits. The MTF shall bill patients for each visit including multiple visits on the same day to different clinics. MSA office personnel should review emergency room logs daily to ensure all pay patients are identified and billed in a timely manner. Procedures should be established for the emergency room to provide the MSA office with all the information needed to bill, including insurance information.

C6.3.2. Collection. For pay patients, the MSA office normally collects the appropriate outpatient reimbursement rate from the patient or sponsor before the service is provided. Each MSA office shall establish procedures to ensure that collections are made or accounts receivable are established for these visits. If the non-active duty patient has OHI, the MTF may bill the insurance company directly but must establish an accounts receivable.

C6.3.3. Overseas Outpatient Charges. At overseas locations, certain categories of non-DoD beneficiaries are entitled to care at MTFs. These patients are required to pay for the services they receive. If a reimbursement rate has not been established for a particular service, the MSA office cannot bill the patient for that service. The MTF shall charge patients for follow-up visits that entail evaluation and management services and referral visits to other clinics. The following services are provided without charge:

C6.3.3.1. Check-in at "sick call" to make an appointment for a visit on a subsequent day.

C6.3.3.2. Prescription refills and/or renewals when consultation or evaluation by a healthcare provider is not required (obtaining refills to the extent authorized by the prescription).

C6.3.3.3. Weight checks.

C6.3.3.4. Blood pressure checks, when requested by the physician as follow-up treatment.

C6.3.3.5. Follow-up visits for the sole purpose of checking bandages, dressings, sutures, and casts.

C6.3.3.6. Removal of sutures or casts.

C6.3.3.7. Vision tests for military driver's licenses.

C6.3.3.8. Family member school children's visits to public health nurses who are employees of the medical facility and located at the school.

C6.3.3.9. Follow-up visits for contact lens adjustment. A new refraction or prescription would result in a chargeable visit.

C6.3.3.10. Follow-up visits for suture removal, bandage check, blood pressure check, etc., by civilian employees from CONUS on official temporary duty (TDY) orders at an area overseas.

C6.3.3.11. Physical examinations provided to prospective family members (pre-adoptive) of Uniformed Services beneficiaries.

C6.3.3.12. Pre-employment physicals provided to civilian employees if required for Federal positions. If an employee is hospitalized for further examination, prior notice must be submitted and approved. Medical care provided under the Occupational Health Services Program for U.S. civilian employees.

C6.3.3.13. Physical examinations required for enlistment or induction into the Service or application to one of the Service academies.

C6.3.3.14. When one family member is under care, associated visits made by family members for services that do not involve care or treatment, such as throat cultures and stool specimens, are not charged.

C6.3.3.15. Collection of specimens for blood and/or alcohol tests performed at the request of security police.

C6.3.3.16. Confidential medical care and advice provided at authorized teen clinics and youth health centers to adolescent family members of Federal civilian employees.

C6.3.3.17. Patient education, such as plaque control, family planning, or expectant parent classes. Organized group examinations or evaluations, such as school or sports physicals, conducted in schools, community centers, or medical facilities.

C6.3.3.18. Public health measures requested by the base or post military commander upon the recommendation of the principal medical staff officer in the interest of the health of the community. Such measures include immunizations, interviews, examinations, outpatient treatment, follow-up of cases dealing with communicable diseases, and biological tests associated with epidemiological surveys.

C6.3.4. Ambulatory Procedure Visits. The MTF shall bill the ambulatory procedure visit rate, even when the patient was administratively admitted and was assigned a DRO.

C6.4. SUBSISTENCE CHARGES

C6.4.1. Appropriated fund food service activities furnish meals to patients, staff, and others. The activity meal rate includes a food charge and related surcharge, if applicable. The food charge covers the basic cost of the food while the surcharge covers overhead, supplies, labor, and associated meal preparation costs. The USD(C) publishes these rates annually. Appendix 8 contains a table listing those persons who may eat in MTF dining facilities and the appropriate rate to charge. All active duty members, Academy and West Point cadets, and midshipmen in a TDY status pay the surcharge unless they are specifically exempted by orders. Individuals receiving physical examinations who are held over during a meal must pay the surcharge.

C6.4.2. New guidance regarding subsistence charges is anticipated to be issued in FY97, as part of Volume 12 of DoD 7000.14-R (reference (c)). It will supersede the guidance in this Manual.

C6.5. CHARGES IN A LA CARTE SYSTEM (ALACS) FACILITIES

C6.5.1. The food charge in ALACS facilities is the sum of prices of the individual food items selected by the patron. Item prices are established monthly at the local level using the Nutrition Management Information System (NMIS) to reimburse for the actual cost of subsistence. The item prices for locations using the Service Information Management System (SIMS) are contained in the SIMS monthly food service update.

Each facility will determine whether to round to the nearest nickel or charge exact prices. Menu prices will be prominently displayed on menu boards and item price signs.

C6.6. CHARGES FOR MEALS CONSUMED IN THE FIELD

C6.6.1. For the purposes of this subsection, use the definition for "field duty" contained in the Joint Federal Travel Regulation (reference (r)). When subsisting under field duty, military members do not normally receive the subsistence portion of per diem even though in a travel status. Personnel pay for their meals based on their status.

C6.6.2. To calculate actual charges for Meals Ready to Eat (MREs): Add the basic meal rate for breakfast, lunch, and dinner; divide the total by 3; and round the amount to the closest nickel. This is the basic MRE charge. If the surcharge applies, add the surcharge to the basic MRE meal cost to obtain the total charge.

C6.6.3. When participating in Joint Service exercises where food service support is provided by another Military Service, identification and reimbursement procedures are prescribed by the supporting Service.

C6.7. EXEMPTIONS FROM SURCHARGE

The MSA office will not collect a surcharge for meals served to the following:

C6.7.1. Inpatients in the MTF.

C6.7.2. Spouses and other dependents of enlisted personnel in grades E-1 through E-4.

C6.7.3. Members of organized nonprofit youth groups sponsored at either the National or local level under agreements in effect on June 30, 1986, and permitted to eat in the general dining facility by the commanding officer of the institution.

C6.7.4. Officers and Federal civilian employees who are not receiving the meal portion of per diem and who are:

C6.7.4.1. Performing duty on a U.S. Government vessel.

C6.7.4.2. On field duty.

C6.7.4.3. In a group travel status.

C6.7.4.4. Included in essential unit messing (EUM) as defined in the Joint Federal Travel Regulation (reference (r)).

NOTE: Enlisted members are not entitled to the meal portion of per diem nor a monetary allowance for subsistence when on field duty, sea duty, group travel or EUM. Meals should be furnished at no cost to those enlisted members. There is no reimbursable rate for enlisted members when on field duty, sea duty, group travel, or EUM (37 U.S.C. 402 and 404 (reference (s)) and E.O. 11157 (reference (t))).

C6.7.5. Officers, enlisted members, and Federal civilian employees who are not receiving the meal portion of per diem and who are on a U.S. Government aircraft on official duty either as a passenger or as a crew member engaged in flight operations.

C6.7.6. Officers, enlisted members, and Federal civilian employees on Joint Task Force operations other than training at temporary U.S. installations or using temporary dining facilities.

C6.7.7. Officers, enlisted members, and Federal civilian employees receiving the subsistence portion of per diem, all officers and enlisted members receiving an allowance for subsistence (other than those addressed above), and all other personnel authorized to eat in DoD appropriated fund dining facilities.

C6.7.8. Refer to the current Food Services Rates package for updates to this list.

AP1. APPENDIX 1

ABBREVIATIONS, ACRONYMS AND DEFINITIONS

AP1.1.1. ABBREVIATIONS, ACRONYMS

ABBREVIATION OR ACRONYM	DEFINITION
AP1.1.1.1. A&D	Admissions and Disposition
AP1.1.1.2. ALACS	A La Carte System
AP1.1.1.3. AOD	Administrative Officer of the Day
AP1.1.1.4. APV	Ambulatory Procedure Visit (formerly Same Day Surgery)
AP1.1.1.5. AQCESS	Automated Quality of Care Evaluation and Support System
AP1.1.1.6. ASA	Adjusted Standard Amount
AP1.1.1.7. ASD(HA)	Assistant Secretary of Defense (Health Affairs)
AP1.1.1.8. ASF	Aeromedical Staging Facility
AP1.1.1.9. AWOL	Absent Without Leave
AP1.1.1.10. BAS	Basic Allowance For Subsistence Uniformed Services
AP1.1.1.11. CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
AP1.1.1.12. CHCS	Composite Health Care System
AP1.1.1.13. CMA	Centrally Managed Allotment
AP1.1.1.14. CONUS	Continental United States
AP1.1.1.15. DAO	Defense Accounting Officer
AP1.1.1.16. DBMS	Data Base Management System
AP1.1.1.17. DFAS	Defense Finance and Accounting Service
AP1.1.1.18. DMRIS	Defense Medical Regulating Information System
AP1.1.1.19. DO	Disbursing Officer
AP1.1.1.20. DoD	Department of Defense
AP1.1.1.21. DRG	Diagnosis Related Group
AP1.1.1.22. EOB	Explanation of Benefits
AP1.1.1.23. FI	Fiscal Intermediary
AP1.1.1.24. FMS	Foreign Military Sales
AP1.1.1.25. FRR	Full Reimbursement Rate
AP1.1.1.26. FSO	Financial Services Officer
AP1.1.1.27. GLOS	Geometric Length of Stay
AP1.1.1.28. GPMRC	Global Patient Movement Requirements Center
AP1.1.1.29. HCAS	High Cost Ancillary Service
AP1.1.1.30. HCFA	Health Care Finance Administration

ABBREVIATION OR ACRONYM	DEFINITION
AP1.1.1.31. HMO	Health Maintenance Organization
AP1.1.1.32. I&R	Invoice and Receipt
AP1.1.1.33. IMET	International Military Education and Training
AP1.1.1.34. JAG	Judge Advocate General
AP1.1.1.35. LOS	Length of Stay
AP1.1.1.36. MAC	Medical Affirmative Claims (formerly Third Party Liability Claims)
AP1.1.1.37. MAJCOM	Major Command
AP1.1.1.38. MEPRS	Medical Expense and Performance Reporting System
AP1.1.1.39. MOD	Medical Officer of the Day
AP1.1.1.40. MOU	Memorandum of Understanding
AP1.1.1.41. MRE	Meal Ready to Eat
AP1.1.1.42. MSA	Medical Services Account
AP1.1.1.43. MSC	Medical Service Corps
AP1.1.1.44. MTF	Military Treatment Facility
AP1.1.1.45. NCO	Non-Commissioned Officer
AP1.1.1.46. NMA	Non-Medical Attendant
AP1.1.1.47. NMIS	Nutrition Management Information System
AP1.1.1.48. O&M	Operations and Maintenance (Health Affairs)
AP1.1.1.49. OASD(HA)	Office of the Assistant Secretary of Defense
AP1.1.1.50. OHI	Other Health Insurance
AP1.1.1.51. OPLOC	Operating Location
AP1.1.1.52. OTS	Officer Training School
AP1.1.1.53. PAD	Patient Administration
AP1.1.1.54. PATCAT	Patient Category
AP1.1.1.55. PATCAT Table	Patient Billing Category Standardization Table
AP1.1.1.56. RM	Resource Management
AP1.1.1.57. ROTC	Reserve Officer Training Corps
AP1.1.1.58. SIK	Subsistence In Kind
AP1.1.1.59. SIMS	Service Information Management System
AP1.1.1.60. SJA	Staff Judge Advocate
AP1.1.1.61. TDY	Temporary Duty
AP1.1.1.62. TPC	Third Party Collection (MAC))
AP1.1.1.63. TPL	Third Party Liability (now Medical Affirmative Claims (MAC))
AP1.1.1.64. TPOCS	Third Party Outpatient Collection System
AP1.1.1.65. UBO	Uniform Business Office
AP1.1.1.66. USD(C)	Under Secretary of Defense (Comptroller)
AP1.1.1.67. USO	United Service Organization

AP1.1.2. DEFINITIONS

AP1.1.2.1. Ambulatory Procedure Visit. Immediate (day of procedure) preprocedure and immediate post-procedure care in an ambulatory setting. Care is provided in the facility for less than 24 hours.

AP1.1.2.2. Automobile Liability Insurance. Insurance against legal liability for health and medical expenses resulting from personal injuries arising from the operation of a motor vehicle. Automobile liability insurance includes:

AP1.1.2.2.1. Circumstances in which liability benefits are paid to an injured party only when the insured party's tortuous acts are the cause of the injuries.

AP1.1.2.2.2. Uninsured and underinsured coverage when there is a third party individual (tortfeasor) who caused the injuries, but the medical expenses are covered by the patient's insurance because the tortfeasor is uninsured or underinsured.

AP1.1.2.3. Billable Visit. A billable visit must meet the MEPRS definition of a visit. See the definition for "Visit" in this Appendix.

AP1.1.2.4. CHAMPUS Supplemental Plan. An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under CHAMPUS. The term has the same meaning as in 32 CFR 199.2 (reference (u)). No insurance, medical service, or health plan provided by an employer or employer group may qualify as a CHAMPUS supplemental plan.

AP1.1.2.5. Contract Based Health Insurance. Indemnification of medical care expenses based on the contractual rights (i.e., terms of the policy, certificate or booklet) of the insured and/or policyholder, family member, dependent or other third party beneficiary. For example, health insurance policy or plan; automobile no-fault and/or personal injury protection (PIP); medical payments (automobile, boat, commercial and/or public premises and general casualty, airplane (limited); product and/or manufacturers' (limited); and homeowners' and/or renters' insurance); and workers' compensation coverage.

AP1.1.2.6. Facility of the Uniformed Services. Any MTF or dental treatment facility of the Uniformed Services (as "Uniformed Services" is defined in 10 U.S.C. 1072 (reference (o))). Contract facilities such as Navy NAVCARE clinics and Army and Air Force PRIMUS clinics that are funded by a facility of the Uniformed Services are considered to operate as an extension of the local MTF and are included

within the scope of this Manual. Facilities of the Uniformed Services also include several former Public Health Services facilities that are deemed to be facilities of the Uniformed Services under 42 U.S.C. 248c(a) (reference (v)) (often referred to as "Uniformed Services Treatment Facilities" or "USTFs").

AP1.1.2.7. Healthcare Services. Inpatient, outpatient, and designated high cost ancillary services.

AP1.1.2.8. Inpatient Hospital Care. Treatment provided to an individual other than a transient patient, who is admitted (i.e., placed under treatment or observation) to a bed in a facility of the Uniformed Services, which has authorized beds for inpatient medical or dental care. Infants born to active duty Service members who have personal health insurance coverage or who are covered by a spouse's plan fall within the TPC Program, and the third party payer should be billed when appropriate. (Inpatient hospital care provided in USTFs (see the definition for "Facility of the Uniformed Services") is not governed by this Manual. Although USTFs are covered by 10 U.S.C 1095 (reference (a)), procedures for USTFs are separately established.)

AP1.1.2.9. Insurance, Medical Service, or Health Plan. Any plan or program designed to provide compensation or coverage for expenses incurred by a beneficiary for health or medical services and supplies. It includes:

AP1.1.2.9.1. Plans or programs offered by insurers, corporations, organized healthcare groups or other entities.

AP1.1.2.9.2. Plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

AP1.1.2.9.3. Medicare supplemental insurance plans.

AP1.1.2.10. Medicare Supplemental Insurance Plan. An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" under Pub. L. 101-508 (1990), Section 4351 (reference (w)) and 32 CFR 220 (reference (g)).

AP1.1.2.11. No-Fault Insurance. An insurance contract providing compensation for health and medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who

may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

AP1.1.2.12. Outpatient Care. Visits to a separately organized clinic or specialty service made by patients who are not currently admitted to the reporting MTF. Patient receives healthcare services for an actual or potential disease, injury, or lifestyle-related problem.

AP1.1.2.13. Third Party Payer. An entity that provides an insurance, medical service, or health plan by contract or agreement. A third party payer includes:

AP1.1.2.13.1. State and local governments that provide such plans.

AP1.1.2.13.2. Insurance underwriters and private employers (or employer groups) offering self-insured or partially self-insured and/or partially underwritten health insurance plans.

AP1.1.2.13.3. Automobile liability insurance and no-fault insurance carriers. It also includes Medicare supplemental insurance policies.

AP1.1.2.14. Third Party Payer Plan. Any plan provided by a third party payer but not an income supplemental plan or workers' compensation plan.

AP1.1.2.15. Tort Based Insurance. Indemnification for physical injuries and property damage resulting from a person's negligence established through legal processes or adjudication. For example, automobile liability and uninsured and/or underinsured motorist coverage; commercial and/or public premises ("slip and fall") or general casualty and umbrella (covering a variety of real or personal properties such as business, home, farm, boat, car, airplane, etc.) insurance; product (manufacturer's) liability insurance; homeowners' and/or renters' insurance; medical malpractice coverage; and boat or airplane casualty insurance.

AP1.1.2.16. Uniformed Services Beneficiary. Any person who is covered by 10 U.S.C. 1074 (reference (i)) or 10 U.S.C. 1076(a) and (b) (reference)). For purposes of Chapter 5 (but not for other sections), a Uniformed Services beneficiary can also be an active duty member of the Uniformed Services.

AP1.1.2.17. Visit. Healthcare characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen. See the definition of "Visit" in the MEPRS Manual (DoD 6010.13-M (reference (q))).

AP1.1.2.18. Workers' Compensation. Injury or illness due to a work-related accident or cumulative trauma. Workers' compensation law varies from State to State.

AP2. APPENDIX 2

SAMPLE PERMANENT MSA OFFICER TRANSFER CERTIFICATE

"I certify that, to the best of my knowledge and belief, the attached is an accurate and complete summary of all outstanding accounts receivable and an accurate listing of all forms on hand as of (time and date). All transactions within the MSA since the last audit report (date) are accurately reflected in the accounts and records of the MSA, documented by the retained and currently available copies of cash collection vouchers, accounts receivable records, Cash Meal Logs, or other authorized vouchers. All records of the MSA are hereby transferred to my successor."

Signature (full name and grade of outgoing MSA officer)

"I hereby certify that I have examined the records of the MSA and accept accountability as of (time and date)."

Signature (full name and grade of incoming MSA officer)

APPROVED: Signature and grade of MTF commander

AP3. APPENDIX 3

SAMPLE TEMPORARY MSA OFFICER TRANSFER CERTIFICATE

"I hereby certify that, to the best of my knowledge and belief, the records, balances, and supporting documents pertaining to the MSA are both true and correct. The records and accounts are hereby temporarily transferred to the acting MSA officer."

Signature (full name and grade of regular MSA officer)

"I hereby certify that I have examined the records of the MSA and accept accountability as of (time and date)."

Signature (name and grade of temporary MSA officer)

APPROVED: Signature (name and grade of MTF commander)

NOTE: When the MSA officer will be absent for 5 days or less, his or her direct supervisor assumes the MSA duties. Strict accountability of funds and controlled forms shall be maintained.

AP4. APPENDIX 4

INSTRUCTIONS FOR COMPLETING THE INVOICE AND RECEIPT (I&R)

Items 1-9A. Complete items 1 through 9A in ink or use plate imprinter card. Show patient status in item 6. For example: Dependent of AF Capt, Civilian Emergency, USAF Col Ret, Govt Employee, OSI Agent, etc.

Item 9B. Enter the date of patient's discharge. If the patient is still confined in the hospital at the end of the month, enter the last day of the month followed by the letters "REM."

Item 9C. Enter the billing or collection day and month, as appropriate.

Item 9D. Enter the subsistence rate per day in the column heading. Multiply the number of days by the rate and enter the total amount.

Item 9E. Enter the hospitalization rate per day in the column heading. Multiply the number of days by the rate and enter the total amount. Also, use this column for outpatient and immunization rates. Enter the appropriate rates. Enter the appropriate charge in the heading. Multiply the rate for immunizations by the number of immunizations received and enter the total amount.

Item 9F. Enter the amount of reimbursement to be credited to the O&M appropriation.

Item 9H. Enter the sum of columns D, E, and F.

Item 9I. No entry in this column is required for the initial payment on the account. For subsequent payments, however, enter the voucher numbers of the additional I&Rs issued to the payee in column H of the master accounts receivable record. If the charges are paid by other Governmental Agencies, enter the, voucher number of the paid SF 1080.

Item 9J. Enter the amount of payment in this column. When the account is paid in full, draw a double line under the entries in columns H and J. If a balance remains, record subsequent payments on the next vacant line.

Item 9K. If a patient's account is not paid in full, enter the balance due and file the second copy of the I&Rs in the active accounts receivable file.

SAMPLE INVOICE & RECEIPT (I&R)

BETHESDA NAVAL CENTER 31 Mar 1995@1450 Page: 1
 Personal Data - Privacy Act of 1974 (PL 93-579)

SAIC BETHESDA NAVAL CENTER
 123456789 ADMIRAL KIDD DRIVE
 SAN DIEGO, VA 92129

DEPARTMENT OF THE NAVY
 HOSPITAL INVOICE AND RECEIPT

SPONSOR NAME: WALKER, JOE
 DUTY ADDRESS: 13 MORRIS LN
 SAN DIEGO CA 92117

SERVICE: A
 GRADE: 06

BILLING NAME: WALKER, JOE
 BILL ADDRESS: 2431 ALEXANDRE EAST
 STEUBENVILLE OH 43952

FMP/SSN: 20/333-45-3345

PATIENT NAME: WALKER, PAM ACCOUNT NO: 198
 ADM: 29 May 1994@2200 DISCH: 29 May 1994@2400 TOTAL CHARGES: \$458.00

-----CHARGES-----

INPATIENT CHARGES:

BEG DATE	END DATE	CHG DAYS	NCHG DAYS	RATE	CHARGE
29 May 1994	29 May 1994	1	0	458.00	458.00

ONE TIME CHARGES:

DATE	DESCRIPTION	CHG CAT	QTY	CHARGE
29 May 1994	UTILITIES	UL	1	123.00

-----INVOICES & RECEIPTS-----

DATE	PAYMENT	TYPE PAY	CONTROL NUMBER	BALANCE
05 Jun 1994	0.00		94-10174	458.00
31 Jul 1994	0.00		N94-9	0.00

1. Payment of this bill is due upon receipt. You may inspect and copy government records related to this debt to the United States and question its validity or accuracy. If payment is not received for this debt within 30 days of hospital discharge or outpatient date of service, your account is subject to referral to higher authority for collection action, involuntary pay checkage (if you or your spouse is a federal employee), and referral to your employer.

2. Per the Debt Collection Act of 1982, interest and/or administrative charges will be assessed on accounts not paid within 30 days of the initial billing. If payment in full is not possible at this time, installment payment arrangements may be made by contacting the MSA Business Office at (619) 535-7118.

3. Please make checks payable to: Captain B. Griggs
 and mail to: BETHESDA NAVAL CENTER
 MSA BUSINESS OFFICE
 10260 CAMPUS POINT DR
 SAN DIEGO CA 92121
 ATTN: JOHN SMITH

Prepared by: _____ Received by: _____

AF FORM 1127/DA FORM 3154/NAVMED FORM 7270/1 (CG-CHCS/SAIC)

AP5. APPENDIX 5SAMPLE DD FORM 139

Personal Data - Privacy Act of 1974 (PL 93-579)				
PAY ADJUSTMENT AUTHORIZATION		NOTE: If member has been transferred, forward authorization to officer currently maintaining pay record		D91-10
Member	SSN	Grade/Rank/Rate	Br Svc	Date
WALKER, MARINA	070-12-1212	E7/CPO	N	22 May 1991
Pay Grade No.	Last Pay Record Examined (if applicable)	Amount \$	Appropriation Data	
		100.39	SEE BELOW	
From	DD 139 ACCT AGENCY OFFICE NAVY BASE SAN DIEGO, CA 92129	Name of Accounting D. O. MALVEY, KEVIN		
		Symbol No. 123	G.A.O. Exception Code	
TO	DD139 ADDRESSEE DD139 OFFICE ADDRESS DD139 CITY STATE ZIP	You are hereby authorized to <input checked="" type="checkbox"/> CHARGE CREDIT the military pay record of the member listed above.		
EXPLANATION AND/OR REASON FOR ADJUSTMENT				
The member named above was notified in writing on 29 May 1991 and 15 Apr 1991 concerning these unpaid charges. The charges are for subsistence during the hospitalization of the member named above for the period 12 Mar 1991@0949 to 12 Mar 1991@1712, register # 92. No payment has been received to date. Following DODPM, part 7, chapter 7; SDS PROMAN volume II, part 7, Chapter 4; and Navy Pay and Personnel Procedures Manual, chapter 7, Section G, the disbursing officer will check the above member's pay without the member's consent. Request remittance be made by Treasury check payable to:				
MSA NAVAL FINANCE OFFICE T				
Due process has been afforded per DOD manual.				
FY	Cust No.	Account Class	Amount	
1991	1711804.1889	30Z ##### 0 ##### 3C 000000 #####1175Z	-3.60	
1991	1711804.188#	006 ##### 0 ##### 3C 000000 #####1#####Z	4.00	
1991	1711804.188E	006 ##### 0 ##### 3C 000000 #####1#####Z	99.99	
From	DD139 ADDRESSEE DD139 OFFICE ADDRESS DD139 CITY STATE ZIP	Certifying Officer FOLLINGSTAD, MARIANNE Signature		
I certify that the adjustment indicated above has been entered on the above named member's military pay record. (If adjustment has not been entered, give explanation on reverse over D.O.'s signature and symbol number.)				
C E R T I F I C A T E			Typed Name and Grade D.O.	
	DD 139 ACCT AGENCY OFFICE NAVY BASE SAN DIEGO, CA 92129		D.O. Symbol No.	Date
			Signature	

DD FORM 139, 1 MAY 53 (CG-CHCS/SAIC)

AP6. APPENDIX 6

SAMPLE CONSENT STATEMENT FOR DEDUCTION FROM PAY

"I hereby certify that I am not able to make payment directly to the medical facility for charges of _____. I am requesting and consenting to immediate collection of these medical care charges from my pay and understand the collection shall be a one-time deduction."

Patient's Name _____

Date and Time of Admission _____

Date and Time of Discharge _____

AP7. APPENDIX 7

INSTRUCTIONS FOR THE UB-92

AP7.1. INTRODUCTION

AP7.1.1. The Uniform Bill-Revised 1992 (UB-92) is intended to be used by the major third-party payers, most hospitals (for inpatient and outpatient billing) and, at the option of the payer, hospital-based skilled nursing facilities and home health agencies. The data elements and design of the form were determined by the National Uniform Billing Committee (NUBC). The NUBC includes representatives from the Health Care Financing Administration (HCFA), Blue Cross/Blue Shield Association, Health Insurance Association of America, Office of CHAMPUS, Federation of American Hospitals, Healthcare Financial Management Association, American Hospital Association, and various State hospital associations.

AP7.1.2. While the UB-92 was principally designed to be used as a form to bill health services, it will also be used as a data collection tool. The data currently gathered on the uniform bill is used by National, State and local governments and other organizations to create health data bases and to develop health policy. In the future, the data abstracted from the uniform bill will also be used to measure quality, efficiency and effectiveness of providers.

AP7.2. DATA SET

The data set included on the form is negotiated by the payers and hospitals on the National and State committees. In determining the data to be included on the form, the NUBC attempted to balance the payers need to know certain information against the burden of providing that information. The data set included on the UB-92 accomplishes this by providing a basic data set of elements (i.e., patient name, date of admission, etc.) needed by most payers to adjudicate a large majority of their claims. Those data elements identified by the NUBC as necessary in most cases to process a bill for payment have been assigned a designated location on the form. Those elements needed occasionally by a limited number of payers for claims payment (i.e., employment information, value codes, condition codes, etc.) have been incorporated into general fields and assigned numeric codes. In addition, both unassigned codes and unassigned spaces were included on the form to meet unique provider or payer needs on a National or State level. The wide range of designated data elements, coded data fields, and unassigned codes and spaces are intended to provide the flexibility

necessary to promote the greatest use of the form. The goal is to expedite claims processing, or eliminate attachments.

AP7.3. CERTIFICATIONS

Statements indicating certifications or authorizations to release information are on file appear on the back of the UB-92 form. These certifications have been approved by the appropriate Agencies on a National basis. In addition, the following notice appears on the back of the UB-92: "Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal and/or State law."

AP7.4. FORM DESCRIPTION

The UB-92 is a multi-part form set printed in red ink. Form sets will be composed of two or three payer copies and one or more hospital copies. The form has a patient billing option that would allow hospitals to use the UB-92 for patient billing. The form is designed to be typed or computer-printed. It will be available as unit sets or in a pin-fed version. The number of copies in each form set will be determined by the hospital according to its planned use of the form. The UB-92 is automatically generated by CHCS for certain patient categories.

AP7.5. PROCEDURE

AP7.5.1. Often the State in which the MTF is located will provide a State procedural manual. The Medicare, CHAMPUS, and Commercial Insurance instructions shall be adopted as developed nationally. For other payers, State procedures reflecting the unique needs of the State have been developed.

AP7.5.2. Hospitals and other healthcare providers have agreed to many requests for additional data in an attempt to meet payer needs for claims adjudication information. In return for these agreements, insurers are requested to supply the patient control number to the hospital in its payment check, remittance advice or voucher. In recognition of the difficulty in verifying and editing this information for accuracy, payers are requested to attempt to return accurate information to the hospitals.

AP7.5.3. The following definitions of frequently used instructions in the procedural guidelines should be noted:

AP7.5.3.1. Required Information. Without this information, it is not possible for the payer to determine the benefits due on this bill.

AP7.5.3.2. Desirable Information. This information is necessary to process the bill but may be available from a source other than the hospital.

AP7.5.3.3. If Applicable. The data is required when the conditions described in the definition of the codes exist.

AP7.6. RECOMMENDED FORMAT (if more than one page)

AP7.6.1. If the number of revenue code lines plus the total charge line exceed 23, another page is required to complete the UB-92. All revenue code lines should be printed followed by a space and then the total charges line. The space between revenue codes and the total charges line should be eliminated if it would require printing another page.

AP7.6.2. On each page except for the last page, print at least the form locators 1, 3, 4, 5, 6, 12, 38, 51, and 60, and revenue information in form locators 42 through 49.

AP7.6.3. If going to other pages, print "(page XX of XX)" on the last line in the column for form locator 43. For example, the format including the parentheses is as follows: (page 1 of 3).

AP7.6.4. On the last page, print all the required form locators 1 through 86 except for revenue codes and changes to previous pages.

NOTE: Providers using electronic media to send claims to payers should consult with those individual payers to obtain the available options and the required formats to be used.

MEDICARE *Part A*

P.O. Box 660155
Dallas, Texas 75266-0155

Identification Number:

Dear _____:

Your election to bill the Medicare program for emergency services furnished to Medicare beneficiaries will expire on December 31. Payment for emergency services can be made to a nonparticipating hospital only if the hospital elects to receive payment from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year.

If you elect to bill the program, please return to us in the enclosed self-addressed envelope a statement signed by a authorized official of your hospital stating that you elect to claim payment under the Medicare program. An election to bill cannot be withdrawn during the year. If a statement is not received by December 31, we will assume that you do not wish to continue to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to (him/her).

Hospitals electing to bill the program for emergency services may obtain information on payment by contacting the intermediary serving nonparticipating hospitals in your State. If a hospital does not elect to bill, the beneficiary may apply for payment by submitting an itemized bill.

Please contact us if you need any further information. In addition, if at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely yours,

APPROVED OMB NO. 0938-0279

		2		3 PATIENT CONTROL NO.						
5 FED. TAX NO.		6 STATE IDENT. COVERG. PRG.		7 COV. D.	8 N-C D.	9 C-I D.	10 L-R D.	11		
12 PATIENT NAME				13 PATIENT ADDRESS						
14 BIRTHDATE	15 SEX	16 MS	21 D HR	22 STAT	23 MEDICAL RECORD NO.		25	27	29	31
33 CODE		OCCURRENCE DATE		33 CODE		OCCURRENCE DATE				
39		40 CODE		VALUE CODES		40 CODE		VALUE CODES AMOUNT		
		a		b		c		d		
42 REV. CD.	43 DESCRIPTION			44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1										
2										
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22										
23										
50 PAYER			51 PROVIDER NO.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56	
A			B		C		D		E	
57 DUE FROM PATIENT										
58 INSURED'S NAME			59 P.REL.		60 CERT. - SSN - HIC. - ID NO.		61 GROUP NAME		62 INSURANCE GROUP NO.	
A			B		C		D		E	
63 TREATMENT AUTHORIZATION CODES			64 ESC		65 EMPLOYER NAME		66 EMPLOYER LOCATION			
A			B		C		D			
67 PRIN. DIAG. CD.		68 CODE		71 CODE		73 CODE		75 CODE		78
79 P.C.		80 PRINCIPAL PROCEDURE CODE		81 DATE		82 OTHER PROCEDURE CODE		83 DATE		84 ATTENDING PHYS. ID
85		86		87		88		89		90
84 REMARKS		85		86		87		88		89
a		b		c		d		e		f

UB-02 HCFA-1480

OCR/ORIGINAL

C-5

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UNIFORM BILL: NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND OR STATE LAW.

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare purposes:
If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his medical expenses and he wants information about his claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and other information to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes:
This is to certify that the foregoing information is true, accurate, and complete.
I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

This is to certify that:

- (a) the information submitted as a part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;
- (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within the catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
- (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face of the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;
- (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;
- (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
- (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
- (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.
- (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

**UB-92 INPATIENT BILLING REQUIREMENTS
(111 TYPE OF BILL)**

FORM
LOCATOR:

#1	Provider Name, Address and Telephone
#3	Patient Control Number
#4	Type of Bill (111)
#6	Statement Covers Period
#7	Covered Days
#8	Non Covered Days (If applicable)
#9	Coinsurance Days (If applicable)
#10	Life Reserve Days (If applicable)
#12	Patient Name
#13	Patient Address
#14	Patient Birth Date (Not required, but preferred)
#15	Patient Sex
#17	Admission Date
#19	Type of Admission
#20	Source of Admission
#22	Patient Status
#23	Medical/Health Record Number
#24-30	Condition Codes (If applicable)
#32-35 (A-B)	Occurrence Codes and Dates (If applicable)
#36 (A-B)	Occurrence Span Codes and Dates (If applicable)
#37	Internal Control Number (ICN) Document Control Number (DCN) (Required on adjustment requests on previous processed claim)
#39-41 (A-D)	Value Codes (If applicable)
#42	Revenue Codes
#43	Description
#46	Units of Service
#47	Total Charges
#48	Non Covered Charges (If applicable)
#50 (A-C)	Payer Identification Provider Number
#51 (A-C)	Provider Number
#58 (A-C)	Insured's Name
#59 (A-C)	Patient's Relationship to Insured (When Medicare is not primary)
#60 (A-C)	Certificate/Social Security Number/Health Insurance Claim/Identification Number
#61 (A-C)	Insured Group Name (When Medicare is not primary)
#62 (A-C)	Insurance Group Number (When Medicare is not primary)
#64 (A-C)	Employment Status Code (When Medicare is not primary)
#65 (A-C)	Employer Name (When Medicare is not primary)

**UB-92 INPATIENT BILLING REQUIREMENTS
(111 TYPE OF BILL)--Continued**

FORM

LOCATOR:

- #66 (A-C) Employer Location (When Medicare is not primary)
- #67 Principal Diagnosis Code
- #68-75 Other Diagnosis Codes (If applicable)
- #76 Admitting Diagnosis
- #80 Principal Procedure Code and Date (If applicable)
- #81 (A-E) Other Procedure Codes and Dates (If applicable)
- #82 Attending Physician/Admitting Physician ID/Referring Physician Name and UPIN
NOTE: Use OTH000 as the UPIN number
- #83 (A&B) Other Physician ID (Indicate the physician who performed the principal procedure)

NOTE: If a second physician assisted with the procedure, an additional field has been added to report this information)
- #84 Remarks (If applicable)
- #85 Provider Representative Signature
- #86 Date Bill Submitted (Not required, but preferred)

**UB-92 ANCILLARY (PART B) BILLING REQUIREMENTS
(121 TYPE OF BILL)**

FORM
LOCATOR:

#1	Provider Name, Address and Telephone
#3	Patient Control Number
#4	Type of Bill (121/221)
#6	Statement Covers Period
#12	Patient Name
#13	Patient Address
#14	Patient Birth Date (Not required, but preferred)
#15	Patient Sex
#23	Medical/Health Record Number
#24-30	Condition Codes (If applicable)
#32-35 (A-B)	Occurrence Codes and Dates (If applicable)
#36 (A-B)	Occurrence Span Codes and Dates (If applicable)
#37	Internal Control Number (ICN)/Document Control Number (DCN) (Required on adjustment requests on previous processed claim)
#39-41 (A-D)	Value Codes (If applicable)
#42	Revenue Codes
#43	Description
#46	Units of Service
#47	Total Charges
#48	Non Covered Charges (If applicable)
#50 (A-C)	Payer Identification
#51 (A-C)	Provider Number
#58 (A-C)	Insured's Name
#59 (A-C)	Patient's Relationship to Insured (When Medicare is not primary)
#60 (A-C)	Certificate/Social Security Number/Health Insurance Claim/Identification Number
#61 (A-C)	Insured Group Name (When Medicare is not primary)
#62 (A-C)	Insurance Group Number (When Medicare is not primary)
#64 (A-C)	Employment Status Code (When Medicare is not primary)
#65 (A-C)	Employer Name (When Medicare is not primary)
#66 (A-C)	Employer Location (When Medicare is not primary)
#67	Principal Diagnosis Code
#68-75	Other Diagnosis Codes (If applicable)
#80	Principal Procedure Code and Date (If applicable)
#81 (A-E)	Other Procedure Codes and Dates (If applicable)

**UB-92 INPATIENT BILLING REQUIREMENTS
(121 TYPE OF BILL)--Continued**

FORM
LOCATOR:

- #82 Attending Physician/Admitting Physician ID/Referring Physician Name and UPIN
 NOTE: Use OTH000 as the UPIN number
- #83 (A&B) Other Physician ID (Indicate the physician who performed the principal procedure)
 NOTE: If a second physician assisted with the procedure, an additional field has been added
 to report this information
- #84 Remarks (If applicable)
- #85 Provider Representative Signature
- #86 Date Bill Submitted (Not required, but preferred)

**UB-92 OUTPATIENT BILLING REQUIREMENTS
(131 TYPE OF BILL)**

FORM
LOCATOR:

#1	Provider Name, Address and Telephone
#3	Patient Control Number
#4	Type of Bill (131)
#6	Statement Covers Period
#12	Patient Name
#13	Patient Address
#14	Patient Birth Date (Not required, but preferred)
#15	Patient Sex
#19	Type of Admission
#20	Source of Admission
#22	Patient Status
#23	Medical/Health Record Number
#24-30	Condition Codes (If applicable)
#32-35 (A-B)	Occurrence Codes and Dates (If applicable)
#36 (A-B)	Occurrence Span Codes and Dates (If applicable)
#37	Internal Control Number (ICN)/Document Control Number (DCN) (Required on adjustment requests on previous processed claim)
#39-41 (A-D)	Value Codes (If applicable)
#42	Revenue Codes
#43	Description
#46	Units of Service
#47	Total Charges
#48	Non Covered Charges (If applicable)
#50(A-C)	Payer Identification
#51 (A-C)	Provider Number
#58 (A-C)	Insured's Name
#59 (A-C)	Patient's Relationship to Insured (When Medicare is not primary)
#60 (A-C)	Certificate/Social Security Number/Health Insurance Claim/Identification Number
#61 (A-C)	Insured Group Name (When Medicare is not primary)
#62 (A-C)	Insurance Group Number (When Medicare is not primary)
#64 (A-C)	Employment Status Code (When Medicare is not primary)
#65 (A-C)	Employer Name (When Medicare is not primary)
#66 (A-C)	Employer Location (When Medicare is not primary)
#67	Principal Diagnosis Code
#68-75	Other Diagnosis Codes (If applicable)
#80	Principal Procedure Code and Date (If applicable)

**UB-92 INPATIENT BILLING REQUIREMENTS
(131 TYPE OF BILL)--Continued**

FORM

LOCATOR:

- #81 (A-E) Other Procedure Codes and Dates (If applicable)
- #82 Attending Physician/Admitting Physician ID/Referring Physician Name and UPIN
NOTE: Use OTH000 as the UPIN number
- #83 (A&B) Other Physician ID (Indicate the physician who performed the principal procedure)
NOTE: If a second physician assisted with the procedure, an additional field has been added to report this information
- #84 Remarks (If applicable)
- #85 Provider Representative Signature
- #86 Date Bill Submitted (Not required, but preferred)

**UB-92 QUICK REFERENCE FOR HOSPITAL SERVICES
Blue Cross and Blue Shield of Virginia - August 1993**

UB-92 Locator		Appropriate Codes and Comments
1	Provider Name, Address and Telephone Number	Enter the name of the provider submitting the bill and the complete mailing address.
4	Type of Bill	1st Digit 1 - Hospital Type of Facility 2 - Skilled Nursing 2nd Digit Hospital Bill 1 - Inpatient Classification 3 - Outpatient Special Facilities 3 - Ambulatory Surgery 9-Other (Use for Partial Day Intensive Outpatient Psychiatric) 3rd Digit 1 - Admission through Discharge Frequency 2-First Interim Bill 3-Second Interim Bill 4-Final Bill For Interim Claims
6	Statement Covers Period	If services occur over more than one billing cycle, the "From" date should be the first day of treatment of the current billing cycle. Enter both dates as month, day and year _____ (MMDDYY). Example: 081593
12	Patient Name	Enter last name, first name and middle initial.
14	Birthdate	Enter patient's date of birth. Enter as MMDDYYYY. Example: 10101992
15	Sex	Enter F (Female), M (male), or U (Unknown).
17	Admission Date	Enter admission date.
18	Admission Hour	Enter admission hour.
19	Type of Admission	Required for inpatient bills. 1 - Emergency 2 - Urgent 3 - Elective 4 - Newborn

UB-92 QUICK REFERENCE FOR HOSPITAL SERVICES
Blue Cross and Blue Shield of Virginia - August 1993--Continued

UB-92 Locator		Appropriate Codes and Comments
20	Source of Admission	<p>Required for inpatient bills.</p> <p>For Emergency, Urgent, and Elective admissions:</p> <ul style="list-style-type: none"> 1 - Physician referral 2 - Clinic referral 3 - HMO referral 4 - Transfer from a hospital 5 - Transfer from skilled nursing facility 6 - Transfer from another health care facility 7 - Emergency room 8 - Court/law enforcement <p>For Newborn care:</p> <ul style="list-style-type: none"> 1 - Normal delivery 2 - Premature delivery 3 - Sick baby 4 - Extramural birth
22	Patient Status	<p>Required only for inpatient bills.</p> <ul style="list-style-type: none"> 01 - Routine discharge 02 - Discharged/transferred to another short term general hospital 03 - Discharged/transferred to a skilled nursing facility 04 - Discharged/transferred to an intermediate care facility 05 - Discharged/transferred to another type of institution for inpatient care or referred for outpatient care to another type of institution 06 - Discharged/transferred to home under care of organized home health service organization 07 - Left against medical advice or discontinued care 08 - Discharged/transferred to home under care of home IV provider 20 - Expired 30 - Still patient or expected to return for outpatient services

UB-92 QUICK REFERENCE FOR HOSPITAL SERVICES
Blue Cross and Blue Shield of Virginia - August 1993--Continued

UB-92 Locator		Appropriate Codes and Comments
24-30	Condition Codes	Enter, if applicable: 01 - Military Service-related condition 02 - Employment-related condition 05 - Lien has been filed 31 - Patient is full-time day student 33 - Patient is full-time night student 39 - Private room medically necessary 41 - Partial hospitalization 71 - Full care in unit 74 - Renal dialysis in the home 83 - Special consideration: Multiple visits to same hospital on the same day A7 - Induced abortion danger to life A8 - Induced abortion victim/rape/incest
32-35	Occurrence Codes	Enter, if applicable: 01 - Auto accident 03 - Accident/tort liability 04 - Accident/employment-related 05 - Other accident 10 - Last menstrual period (Applies only when patient is being treated for maternity-related condition) 11 - Onset of symptoms/illness 41 - Date of first test for pre-admission testing (Applies only if admission date was scheduled prior to administration of test) 50 - Initial treatment for accident
38	Responsible Party Name and Address	Required for FEP, Interplan Bank, and Central Certification. Enter Name and address of party responsible for the bill.
39-41	Value Codes and Amounts	Enter, if applicable: 30 - Charges for pre-admission testing 37 - Pints of blood furnished 45 - Accident hour. Enter time code indicated in the UB-92 manual in the "Amount" field 82 - No other coverage available 83 - Billed and paid - Another carrier other than Medicare paid. Indicate the amount paid by other carrier in the "Amount" field 85 - Another carrier other than Medicare was billed, but payment has not been made

**UB-92 QUICK REFERENCE FOR HOSPITAL SERVICES
Blue Cross and Blue Shield of Virginia - August 1993--Continued**

UB-92 Locator		Appropriate Codes and Comments
42	Revenue Code	As required by BCBSVA
44	HCPCS/Rates	Outpatient: Enter HCPCS rate _____ Inpatient: Enter accommodation rate
46	Service Units	As required by BCBSVA
47	Total Charge	Enter charges pertaining to the related revenue code.
50	Payer	Enter plan code indicated on the insured's ID card.
51	Provider Number	Enter the BCBSVA provider number.
58	Insured's Name	Enter the name of the person in whose name the insurance is carried.
59	Patient's Relationship to Insured	Enter the appropriate code. 01 - Patient 02 - Spouse 03 - Natural child/insured financial responsibility 04 - Natural child/insured does not have financial responsibility 05 - Step child 06 - Foster child 07 - Ward of the Court 08 - Employee 09 - Unknown 10 - Handicapped dependent whose coverage extends beyond normal termination age limits 11 - Organ Donor 12 - Cadaver donor 13 - Grandchild 14 - Niece/nephew 15 - Injured plaintiff 16 - Sponsored dependent 17 - Minor dependent of a minor dependent 18 - Parent 19 - Grandparent
60	Certificate/Social Security Number/Health Insurance Claim/Identification Number	Enter the insured identification number. If the number includes prefix, include the prefix.
62	Insurance Group Number	Enter only for TPA or Central Certification policies.
63	Treatment Authorization Code	Enter the authorization number, if available. This number is not required on the claim, however including the number may help to avoid potential processing delays.

UB-92 QUICK REFERENCE FOR HOSPITAL SERVICES
Blue Cross and Blue Shield of Virginia - August 1993--Continued

UB-92 Locator		Appropriate Codes and Comments
65	Employer Name	Required only when BCBSVA is not primary.
67	Principal Diagnosis Code and Date	Enter the ICD-9-CM code for principal diagnosis. Use the complete code (all digits). Do not include decimal points..
68	Other Diagnosis Codes	ICD-9-CM(s) for additional condition(s) that co-exist and have an effect on treatment or length of stay. Do not include decimal points.
80	Principal Procedure Code and Date	Required if an operating room service (revenue codes 36X, 49X, or 76X) or cardiac catheterization (revenue code 481) is billed. Enter ICD-9-CM procedure code and the date. Do not include decimal points.
81	Other Procedure Codes and Dates	If applicable, enter ICD-9-CM procedure codes and the dates for significant procedures other than the principal procedure indicated in locator 80. Do not include decimal points.
82	Attending Physician ID	Enter physician name, license number, or BS provides number.
84	Remarks	Enter additional information, if applicable. Use the "recommended format" in the UB-92 manual.

AP8. APPENDIX 8

PERSONS AUTHORIZED TO EAT IN MTF DINING FACILITIES

AP8.1. AUTHORITY

DoD 1338.10-M (reference (x)).

AP8.2 CATEGORY DEFINITION

Charges for persons authorized to eat in a military MTF dining room vary, depending on the status of each person. The five major categories of personnel are: officers, enlisted personnel, military dependents, Federal civilian employees, and others.

AP8.3 GENERAL ENTITLEMENTS

See Table AP8.T1., Persons Who May Eat in MTF Dining Facilities, on the next page.

AP8.4 SPECIAL CONSIDERATIONS

AP8.4.1. Outpatients and visitors may eat in MTF dining rooms when authorized to do so by the MTF commander, but must pay either the discount or full meal rate, depending on their status.

AP8.4.2. Inpatients traveling in the aeromedical evacuation system are not charged for their meals.

AP8.4.3. Outpatients traveling in the aeromedical evacuation system pay the full rate for their meals in the dining room (exception: dependents of E1 - E4).

AP8.4.4. Non-medical attendants traveling in the aeromedical evacuation system pay the full meal rate (exception: dependents of E1 - E4).

AP8.4.5. Military members of foreign governments pay the same rates as their U.S. counterparts.

AP8.4.6. National Guard and Air National Guard, ROTC (all Services), and Army, Air Force, Navy, Marine, and Coast Guard Reserves, on active duty or inactive duty for training, pay the same rates as their active duty counterparts. They can pay for meals by cash or cross-Service billing.

AP8.4.7. The discount rate includes the cost of food only.

AP8.4.8. The full rate includes the cost of food and a proportional charge for operating expenses, formerly known as surcharge.

AP8.4.9. Charges for meals are based on annual published DoD rates. The Services provide the rates to medical resource management officers by message in October.

AP8.4.10. Surcharge waiver authority is at DoD level. Requests for waivers should be submitted to the appropriate Service-specific office.

TABLE AP8.T1. PERSONS WHO MAY EAT IN MTF DINING FACILITIES

These Customers	Pay This Amount		
	No Charge	Discount Rate	Full Rate
Enlisted members entitled to Subsistence-in-Kind (SIK).	X		
Ambulatory inpatients eating in the dining room, including aeromedical evacuation patients.	X		
Enlisted members drawing Basic Allowance for Subsistence (BAS).			X
Federal civilian employees on official duty as a result of an act of providence or civil disturbance when no other comparable food service facilities are available.			X
Commanders as designated in writing by the installation commander.			X
Officers eating a meal to determine the quality and quantity of food served (must have permission in writing from installation commander).			X
Officers on alert status requiring immediate availability that keeps them from leaving the unit area. Such status will be in writing and specify the times on alert.			X
Officers in hostile fire areas as designated by DoD 7000.14-R, Volume 7, Part A (reference (c)).			X
International Military Education Training (IMET) and Foreign Military Sales (FMS) students not receiving the meal portion of per diem and the meal operating charges are recovered through tuition charges.			X
Officer candidate, cadet, midshipman, or ROTC (all Services) students not receiving the meal portion of per diem.			X
Members and chaperones of the Boy Scouts, Girl Scouts, Boys Clubs of America, Big Brothers-Big Sisters of America, Little League Baseball, Inc., and Future Farmers of America, extended the privilege of visiting a base or who are living on base and the installation commander permits them to eat.		X	
Students in DoD Dependents Schools overseas not receiving the meal portion of per diem and alternative student meal facilities are not available.			X
Red Cross volunteers, uniformed and non-uniformed, CONUS and overseas, not receiving the meal portion of per diem.			X

TABLE AP8.T1. PERSONS WHO MAY EAT IN MTF DINING FACILITIES--Continued

These Customers	Pay This Amount		
	No Charge	Discount Rate	Full Rate
Dependents of E-1 through E-4.		X	
Officers and active duty military family members at Thanksgiving, Christmas, and the Service birthdays.			X
Outpatients who are active duty enlisted personnel receiving BAS or dependents of active duty E-1 through E-4.			X
Active duty aeromedical evacuation outpatients not receiving per diem.			X
Non-active duty aeromedical evacuation outpatients who are not receiving per diem.			X
Active or non-active duty non-medical attendant (NMA) to an aeromedical evacuation patient, not receiving per diem.			X
Federal civilian employee who is a patient in a military hospital due to a job-related accident or injury while on duty including aeromedical evacuation patients.			X
Active duty aeromedical evacuation patients or NMAs on orders and receiving per diem.			X
Dependents of E-5 through E-9.			X
Outpatients and visitors who are retirees, dependents of retirees, dependents of E-5 through E-9, officers, or dependents of officers.			X
Anyone receiving the subsistence portion of per diem.			X
Officers on duty in the MTF.			X
Federal civilian employees assigned to the MTF, on duty.			X
Dependents of officers, except on Thanksgiving, Christmas, and Service birthdays.			X
Full-time paid professional field and headquarters Red Cross staff workers.			X
Full-time paid secretarial and clerical Red Cross workers on duty in Red Cross offices.			X
MET and FMS students when the operating charge is not included in tuition.			X
United Service Organization (USO) personnel authorized by the installation commander.			X

AP9. APPENDIX 9

SAMPLE DELINQUENT LETTER

Department of the Navy
SAIC Bethesda Naval Center
2555 Presidents Street
San Diego, CA 92129

May 9, 1997

Prudential
1313 Westboro Boulevard
Rockville, MD 20850

Subject: Claim for Hospitalization Charges for John Doe (Req # 123)
Policy Number: 123456789
Hospitalization Date(s): 01 Feb 97 - 03 Feb 97

Dear Sir/Madam:

This is our second request for payment of hospitalization charges for John Doe. A copy of the original Uniform Bill (UB-92) is enclosed. To date, we have not received your payment or reply.

Title 10, United States Code, section 1095 is the basis for this claim. Under this title, Department of Defense (DoD) military treatment facilities are required to collect from third party payers for the reasonable inpatient hospital care costs incurred on behalf of DoD healthcare beneficiaries.

Please provide your payment or advise us of your processing status as soon as possible. Our collection staff is available at (619)123-4567, if you have any questions. Your attention and cooperation in this matter is appreciated.

Sincerely,

Jane Smith
Accounts Manager

Enclosure:
As stated

AP10. APPENDIX 10

INSTRUCTIONS FOR COMPLETING DD FORM 7 AND DD FORM 7A

AP10.1. DD FORM 7, REPORT OF INPATIENT TREATMENT FURNISHED TO PAY PATIENTS HOSPITALIZATION FURNISHED - PART A.

AP10.1.1. Enter the Report Control Symbol.

AP10.1.2. Section 1. Name of medical activity, base and/or post, and Major Command (MAJCOM), as applicable, providing medical care in CONUS. Enter name of medical activity, APO, and MAJCOM outside CONUS.

AP10.1.3. Section 2. Month and year of service covered by the report.

AP10.1.4. Section 3. Patient Category.

AP10.1.5. Section 4. Authority for treatment. If a written authorization is required before treatment, submit a copy of the authorization with DD Form 7. For beneficiaries of the Office of Workers' Compensation Programs, submit two copies of CA-16, Request for Examination and/or Treatment, with DD Form 7.

AP10.1.6. Section 5. Name in full and identification number of each patient. Include the social security claim number if applicable.

AP10.1.7. Section 6. Grade or status of individual (that is, civilian, eligible family member, title of seaman, etc.)

AP10.1.8. Section 7. Organization. As applicable, unless other information is required for the category of patient concerned.

AP10.1.9. Section 8. Diagnosis and DRG of each patient.

AP10.1.10. Section 9. Admission date. Day, month, and year of admission to hospital.

AP10.1.11. Section 10. Discharge date. Enter the day, month, and year each patient was discharged from the hospital or, if remaining in the hospital at the end of the month, enter the last day of the month followed by the notation "REM" (remaining). A patient on any authorized or unauthorized absence from the hospital

for more than 24 hours is reported as discharged from the hospital on the date of departure (the day of departure is not counted as a day of hospitalization).

AP10.1.12. Section 11. Total. Enter the total days each patient was hospitalized during the report period. Day of admission is included but not the day of discharge.

AP10.1.13. Section 12. Enter date of certification.

AP10.1.14. Section 13. Signature of the MTF commander or authorized representative (on the original only) including grade and organization.

AP10.1.15. Section 14. Show total days hospitalized and total amount. Item 11 shall equal the total reported in item 14.

AP10.1.16. Patients Attached for Meal Days Only. Transient patients, casuals, enlisted outpatients attached for meal days only and duty personnel (other than Air Force, Army, Navy and Marine Corps) who are entitled to subsistence at Government expense.

AP10.1.16.1. Submit DD Form 7 in two copies.

AP10.1.16.2. Complete items 1 through 4. Omit items 5 through 8. In item 9, "Admission Date," indicate the date meal days were provided. Omit item 10. In item 11, enter the total number of meal days served.

AP10.2. DD FORM 7A, REPORT OF TREATMENT FURNISHED PAY PATIENTS OUTPATIENT TREATMENT FURNISHED - PART B

AP10.2.1. Section 1. Name of medical facility, base and/or post, and MAJCOM, as applicable, providing the care in CONUS. Enter unit number, APO, and MAJCOM, if facility is outside CONUS.

AP10.2.2. Section 2. Month and year of service covered by the report.

AP10.2.3. Section 3. Patient Category.

AP10.2.4. Section 4. Authority for treatment.

AP10.2.5. Section 5. Full name and identification number (if any) of each patient.

AP10.2.6. Section 6. Grade or status of individual, that is, civilian, eligible family member, title of seaman, etc.

AP10.2.7. Section 7. Organization or other similar information required for the category of patient concerned.

AP10.2.8. Section 8. Diagnosis for each patient. List the diagnosis, physical examination, immunization, and any vaccinations.

AP10.2.9. Section 9. Dates. List day, month, and year for each medical or dental outpatient visit furnished.

AP10.2.10. Section 10. Number of outpatient visits and corresponding dollar amount during the month for each patient.

AP10.2.11. Section 11. Date of certification of report. Enter date of certification.

AP10.2.11. Section 12. Signature of the MTF commander or authorized representative (on original only), showing grade and organization.

AP10.2.13. Section 13. Total visits and/or total dollar amount. Enter total outpatient visits and/or total dollar amounts for all patients listed. Double check this figure to make sure that the addition is correct. The sum of the outpatient visits reported in item 10 shall equal the grand total in item 13.

REPORT OF TREATMENT FURNISHED PAY PATIENTS HOSPITALIZATION FURNISHED (PART A)				REPORT CONTROL SYMBOL		
1. INSTALLATION PROVIDING HOSPITALIZATION (Name and address)				2. MONTH AND YEAR COVERED BY THIS REPORT		
3. CATEGORY OF PATIENTS			4. AUTHORITY FOR ADMISSION			
NAME (Last, first, middle initial) AND SSN 5	MILITARY GRADE 6	ORGANIZATION 7	DIAGNOSIS 8	DATES		
				ADMISSION 9	DISCHARGE 10	TOTAL 11
12. DATE	13. AUTHENTICATION (Signature, military grade, organization of Commanding Officer)			14. TOTAL DAYS HOSPITALIZED		

DD Form 7, JAN 76 (EG)

EDITION OF 1 APR 50 WILL BE USED UNTIL EXHAUSTED

Designed using Perform Pro, WHS/DIOR, Nov 94

AP11. APPENDIX 11

INSTRUCTIONS FOR THE MONTHLY MSA REPORT

AP11.1.1. Column A - Project Number. Enter budget project number to which the reimbursements are credited.

AP11.1.2. Column B - Sales Code. List by separate budget project number all applicable accounts receivable sales codes to identify the sources (customers) of reimbursements.

AP11.1.3. Column C - Balance of Accounts Receivable Prior Month. Enter amounts reported in column G of the prior months report. Column C shall always be reported as zero on October reports for the current fiscal year.

AP11.1.4. Column D - Current Month Sales. Enter amounts of sales made during the current month as indicated on I&Rs, SF 1080 forms, or other forms.

AP11.1.5. Column E - Accounts Transferred Out. Enter by sales code amounts in each category of all accounts transferred to the FSO or DAO or DO for final collection action.

AP11.1.6. Column F - Total Funds Collected. Enter total collections for medical services, subsistence, surcharges and other services by accounts receivable sales code and budget project. The combined amount reported in column F shall agree with total cash collections for the month shown in column M, Cash and Sales Journal.

AP11.1.7. Column G - Outstanding Balance - Accounts Receivable. For each line entry, subtract the sum of amounts shown in column E plus F from the sum of amounts shown in columns C plus D. Enter the difference in column G. The results shall agree with the combination of outstanding balances of accounts receivable in the active I&Rs file.

AP11.1.8. Column H - Funds Collected But Undeposited. Enter any amount received too late for inclusion in the MSA deposit for the last business day of the month. The combined amount in this column shall always agree with the entry in column O, Cash and Sales Journal at the end of the month.

AP11.1.9. Column I - Total Funds Deposited with the FSO or DAO or DO. For each line entry, subtract the amount in column H from the amount in column F. Add the difference to the amount reported in column H of the prior month's report. Enter the resulting figure in column I. (The grand total of column I shall agree with the total of all amounts shown on DD Form 1131 during the current month.)

AP12. APPENDIX 12

TABLE AP12.T1. TYPE OF SERVICES BILLED BY BENEFICIARY CATEGORY

Beneficiary Category	Inpatient Hospital Billing	Outpatient Visit Billing	Ancillary Services Billing	No-Fault Accident Billing
Active Duty	NO	NO	NO	YES
Retiree	YES	YES	YES	YES
Family Member	YES	YES	YES	YES

TABLE AP12.T2. TYPE OF SERVICES BILLED BY INSURANCE POLICY

Type of Insurance Policy to be Billed	Inpatient	Outpatient	Ancillary
Private Enrollment Plan	YES	YES	YES
Group Health Plan	YES	YES	YES
Employer Health Plan	YES	YES	YES
Association and/or Organization Health Plan	YES	YES	YES
No-Fault Automobile Insurance	YES	YES	YES
Third Party Automobile Liability (Tort Claim)	YES	YES	YES
Medicare Supplemental Plan	YES	NO	NO
Workers' Compensation Plan	YES	YES	YES
CHAMPUS Supplement	NO	NO	NO
Income Supplement	NO	NO	NO

AP13. APPENDIX 13

SAMPLE TPC PROGRAM ANNUAL REPORT
THIRD PARTY COLLECTION PROGRAM
SERVICE ANNUAL REPORT FOR FY95

Base/Facility	Inpatient Collections FY95	Outpatient Collections FY95	Total Collections FY95	FY95 O&M Budget Actual	FY95 O&M Budget Estimated	FY95 O&M Budget Requested
MTF1						
MTF2						
MTF3						
MTF4						
Total						



HEALTH AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

January 18, 1996

MEMORANDUM FOR DEPUTY ASSISTANT SECRETARY OF THE ARMY (MPM&EO),
OFFICE OF THE ASSISTANT SECRETARY OF THE ARMY
(M&RA)
DEPUTY ASSISTANT SECRETARY OF THE NAVY (MPWR),
OFFICE OF THE ASSISTANT SECRETARY OF THE NAVY
(M&RA)
DEPUTY ASSISTANT SECRETARY OF THE AIR FORCE (FM&P),
OFFICE OF THE ASSISTANT SECRETARY OF THE
AIR FORCE (MRAI&E)

SUBJECT: Congressional Third Party Collection Program (TPCP) Reporting Requirements--
FY94 Defense Authorization Act

This is to request that you provide information required by the Congress. The FY94 Defense Authorization Act changed Title 10 USC 1095, expanding the authority for the Department of Defense to collect from insurance companies, and other third party payers, health care costs for services provided in military hospitals. Additionally, the Act specified new TPCP reporting requirements to the Congress.

Section 718 of the Act (extract attached) requires that the Secretary of Defense submit a report to Congress specifying the following for each medical treatment facility (MTF) of the uniformed services:

- a. The amount collected during the preceding fiscal year from third party payers.
- b. The amount requested for operation and maintenance of the facility for the preceding fiscal year, the fiscal year in which the report is submitted, and the next fiscal year.

Please report the information listed above for each of your MTFs by February 8, 1995. The third party payer data is to include inpatient and outpatient collections for FY95. The amount requested for operation and maintenance is for fiscal years 1995, 1996, and 1997. In addition to a hard copy, please provide an electronic version of your report. If you cannot complete this report by February 1, provide us with your estimated completion date so we can request an extension.

My point of contact is LCDR Pat Kelly at (703) 681-8910.

A handwritten signature in black ink that reads "George K. Anderson". The signature is fluid and cursive, with a long horizontal stroke at the end.

George K. Anderson, MajGen, USAF, MC
Deputy Assistant Secretary of Defense
(Health Service Operations and Readiness)

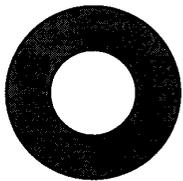
Attachment:
As stated

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Deputy Assistant Secretary of the Army (Budget)
Director, Navy Budgets and Reports
Deputy Assistant Secretary of the Air Force (Budget)

AP14. APPENDIX 14

OTHER FORMS NOT INCLUDED ELSEWHERE

SAMPLE DD FORM 599

	
DD FORM 599 OCT 51	
PATIENT'S EFFECTS STORAGE TAG	NO. 000001
NAME	
SERVICE NUMBER OR CATEGORY OF PERSONNEL	
DATE RECEIVED	RACK OR BIN
HOSPITAL	
SIGNATURE OF PATIENT <i>(upon withdrawal)</i>	

PATIENT'S STUB	NO. 000001
DATE RECEIVED	RACK OR BIN
HOSPITAL	
<i>This identification tag must be presented when access to your personal effects is desired.</i>	

CASH COLLECTION VOUCHER		DISBURSING OFFICE COLLECTION VOUCHER NUMBER		
		RECEIVING OFFICE COLLECTION VOUCHER NUMBER		
RECEIVING OFFICE	ACTIVITY (Name and location)			
	RECEIVED AND FORWARDED BY (Printed name, title and signature)			DATE
DISBURSING OFFICE	ACTIVITY (Name and location)			
	DISBURSING OFFICER (Printed name, title and signature)		DISBURSING STATION SYMBOL NUMBER	
PERIOD: From To				
DATE RECEIVED	NAME OF REMITTER DESCRIPTION OF REMITTANCE	DETAILED DESCRIPTION OF PURPOSE FOR WHICH COLLECTIONS WERE RECEIVED	AMOUNT	ACCOUNTING CLASSIFICATION
TOTAL				

DD FORM 1131, APR 57 (EF)

PREVIOUS EDITION MAY BE USED.

Form approved by Comptroller General, U.S.
24 January 1956

SAMPLE STANDARD FORM 215

STANDARD FORM 215 (REV. 5-78) PRESCRIBED BY DEPT. OF TREASURY IFORM 5-3000 215-102		DEPOSIT TICKET		DEPARTMENT OF THE TREASURY BUREAU OF GOVERNMENT FINANCIAL OPERATIONS	
DEPOSIT NUMBER	DATE PRESENTED OR MAILED TO BANK M M D D Y Y	8-DIGIT OR 4-DIGIT AGENCY LOCATION CODE (ALC)	AMOUNT		
(1) <input type="text"/>	(2) <input type="text"/>	(3) <input type="text"/>	(4) <input type="text"/>		<small>SINGLE SPACE ALL ENTRIES ON THIS LINE USE NORMAL PUNCTUATION—OMIT \$ SIGN</small>
(6) AGENCY USE					
(9) DEPOSITORS TITLE, DEPARTMENT OR AGENCY AND ADDRESS			(7) NAME AND ADDRESS OF DEPOSITARY		
			<small>(8) I CERTIFY THAT THE ABOVE AMOUNT HAS BEEN RECEIVED FOR CREDIT IN THE ACCOUNT OF THE U.S. TREASURY ON THE DATE SHOWN. SUBJECT TO ADJUSTMENT OF UNCOLLECTIBLE ITEMS INCLUDED THEREIN.</small>		
			_____ AUTHORIZED SIGNATURE	M M D D Y Y CONFIRMED DATE	
DEPOSITARY FORWARD THIS DOCUMENT WITH STATEMENT OR TRANSCRIPT OF THE U.S. TREASURY ACCOUNT OF THE SAME DATE.			ORIGINAL		

NSN 7540-01-075-3786

MEDICAL RECORD		EMERGENCY CARE AND TREATMENT (Patient)				LOG NUMBER	TREATMENT FACILITY
						RECORDS MAINTAINED AT	
PATIENT'S HOME ADDRESS OR DUTY STATION						ARRIVAL	
STREET ADDRESS						DATE (Day, Month, Year)	TIME
CITY				STATE	ZIP CODE	TRANSPORTATION TO FACILITY	
SEX	DUTY/LOCAL PHONE		MILITARY STATUS			THIRD PARTY INSURANCE	
	AREA CODE	NUMBER	PRP	ITEM	YES	NO	N/A
AGE	HOME PHONE		FLYING STATUS			ADDITIONAL INSURANCE	
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM			DD 2568 IN CHART	
CURRENT MEDICATIONS		INJURY OR OCCUPATIONAL ILLNESS			EMERGENCY ROOM VISIT		
		ITEM	YES	NO	WHEN (Date)	DATE LAST VISIT	24 HOUR RETURN
		IS THIS AN INJURY?		WHERE		<input type="checkbox"/> YES	<input type="checkbox"/> NO
ALLERGIES		INJURY/SAFETY FORMS			DATE LAST SHOT	COMPLETED INITIAL SERIES	
		HOW				<input type="checkbox"/> YES	<input type="checkbox"/> NO
CHIEF COMPLAINT							
CATEGORY OF TREATMENT				VITAL SIGNS			
<input type="checkbox"/> EMERGENT	TIME		TIME				
<input type="checkbox"/> URGENT	INITIALS		BP				
<input type="checkbox"/> NON-URGENT			PULSE				
			RESP				
			TEMP				
			WT				
LAB ORDERS	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT	X-RAY ORDERS	CXR PA & LAT/PORTABLE	C-SPINE
	URINE C&S	UA MSCC/CATH	CHEM:			ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X					SINUS	HEAD CT
						ANKLE R/L	
ORDERS							
<input type="checkbox"/> PULSE OX				<input type="checkbox"/> MONITOR			
	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE		
DISPOSITION		DISPOSITION QUARTERS /OFF DUTY		PATIENT/DISCHARGE INSTRUCTIONS			
<input type="checkbox"/> HOME	<input type="checkbox"/> FULL DUTY	<input type="checkbox"/> 24 HRS.	<input type="checkbox"/> 48 HRS.	<input type="checkbox"/> 78 HRS.			
MODIFIED DUTY UNTIL		RETURN TO DUTY					
CONDITION UPON RELEASE		ADMIT TO UNIT/SERVICE		REFERRED	TO	WHEN	
<input type="checkbox"/> IMPROVED	<input type="checkbox"/> UNCHANGED						
<input type="checkbox"/> DETERIORATED		TIME OF RELEASE		I have received and understand these instructions.			
PATIENT'S IDENTIFICATION				PATIENT'S SIGNATURE			

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

STANDARD FORM 1081
 A TREASURY FORM 2500
 FISCAL SERVICE
 BUREAU OF ACCOUNTS
 1081-107

**VOUCHER AND SCHEDULE
 OF WITHDRAWALS AND CREDITS**

Vou. No. _____
 (OFFICE BILLED)
 Vou. No. _____
 (BILLING OFFICE)

Disbursing Officer-Office Billed _____
 (D.O. symbol)

You are authorized to effect the withdrawals and credits indicated below.

Disbursing Officer-Billing Office _____
 (D.O. symbol)

PAID BY

 (Address)

WITHDRAW FROM			PAY TO		
DEPARTMENT			DEPARTMENT		
BUREAU			BUREAU		
AGENCY STATION SYMBOL			AGENCY STATION SYMBOL		
ADDRESS			ADDRESS		
BUREAU REFERENCE	SUMMARY APPROPRIATION OR FUND SYMBOL	AMOUNT	BUREAU REFERENCE	SUMMARY APPROPRIATION OR FUND SYMBOL	AMOUNT
TOTAL			TOTAL		

Details of charges or reference to attached supporting documents

For use of office billed: BILLING AGENCY CONTACT: Prepared By: Approved By: Telephone #:	For use of billing office:
--	----------------------------

CERTIFICATE OF OFFICE BILLED

I certify that the items listed herein are correct and proper for payment from the appropriation(s) designated.

 Date (Authorized administrative or certifying officer)

Paid by check No. _____ C/D No. _____ dated _____

U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Federal Employees' Compensation (OFEC)		REQUEST FOR EXAMINATION AND/OR TREATMENT	
PART A - AUTHORIZATION			
1. NAME AND ADDRESS OF THE MEDICAL FACILITY OR PHYSICIAN AUTHORIZED TO PROVIDE THE MEDICAL SERVICE			
2. EMPLOYEE'S NAME (Last, first, middle)		3. DATE OF INJURY (month, day, year)	4. OCCUPATION
5. DESCRIPTION OF INJURY OR DISEASE			
6. YOU ARE AUTHORIZED TO PROVIDE MEDICAL CARE FOR THE EMPLOYEE SUBJECT TO THE FOLLOWING CONDITIONS.			
<input type="checkbox"/> A - Furnish office and/or hospital treatment as necessary for the effects of this injury. Any surgery, other than emergency, must have prior OFEC approval.			
<input type="checkbox"/> B - There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty or is otherwise related to his employment. You are authorized to examine the employee, using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstance of the employment. Pending further advice, you may provide necessary conservative treatment if you believe the condition may be due to the injury or to the employment.			
7. IF A DISEASE OR ILLNESS IS INVOLVED, OFEC APPROVAL FOR ISSUING AUTHORIZATION UNDER ITEM 6B ABOVE, WAS * OBTAINED FROM _____ (Name of OFEC authorizer)			
8. SIGNATURE OF AUTHORIZING OFFICIAL (Sign all copies)		9. TITLE	
10. LOCAL OFFICE TELEPHONE NUMBER		11. DATE (month, day, year)	
12. SEND ONE COPY OF YOUR REPORT TO (Fill in address): U. S. DEPARTMENT OF LABOR Employment Standards Administration Office of Federal Employees' Compensation		13. NAME AND ADDRESS OF EMPLOYEE'S PLACE OF EMPLOYMENT. Dept. or Agency Bureau or Office Local Address (Including Zip Code)	

Form **CA-16**
(REV. SEPT 1972)

INSTRUCTIONS TO AUTHORIZING OFFICIAL
FOR COMPLETION OF PART A

- | | | |
|--|---|---|
| USE OF
UNITED STATES
MEDICAL
FACILITIES | ● | A Federal employee injured by accident while in the performance of duty should be referred for examination and treatment to a U.S. medical facility (Public Health Service, Military, VA) where available and use is practicable -- employee's disability and local travel conditions must be considered. Federal health service facilities (health units) established under the provisions of 5 U.S.C. 7901 are not U. S. medical facilities as used herein. |
| EMPLOYEE'S
RIGHT TO
SELECT
PHYSICIAN | ● | If U.S. medical facilities are not available or use is not practicable the employee shall be given the right to initial selection of his choice of a qualified physician within 25 miles of employment or residence. OFEC must approve a change of physician. |
| QUALIFIED
PHYSICIAN | ● | Includes only doctors of medicine (M.D.) and osteopathic physicians (D.O.) within the scope of their practice as defined by State law. |
| PRIOR
ARRANGEMENTS | ● | The physician or medical facility shall be contacted by the authorizing official to confirm availability before authorization is issued. |
| ILLNESS OR
& DISEASE | ● | Treatment for illness or disease shall not be authorized unless prior approval has been obtained from OFEC. |
| FORM
COMPLETION | ● | Part A shall be completed in full. In case of injury by accident, check Box A or B of item 6, whichever is appropriate. In case of disease or illness only Box B may be checked after obtaining approval from OFEC. Show the address of the proper OFEC district office in item 12. Send original and one copy of authorization to the medical officer or physician. If issued for disease or illness, send one copy to the OFEC. |
| ADDITIONAL
INFORMATION | ● | See 20 CFRI and/or Chapter 810, Federal Personnel Manual (FPM). |

INFORMATION FOR PHYSICIAN - SEE REVERSE SIDE

Form CA-16
Rev. Sept. 1972

INFORMATION FOR PHYSICIAN		
YOUR AUTHORIZATION	●	Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in item 5, subject to the conditions in item 6.
USE OF CONSULTANTS AND HOSPITALS	●	You may use consultants, laboratories and local hospitals, if needed. Use semi-private accommodations unless a private room is medically necessary. If hospitalized, necessary ancillary treatment may be provided.
REPORTS	●	After examination, complete items 14 through 38 (Part B) and promptly send your report to the address listed in item 12 of Part A. If additional space is needed or a narrative report is made, attach it to the form. Submit monthly narrative reports covering continued treatment and arrange for submission of reports from consultants. Delay in reporting may delay payment of compensation.
RELEASE OF RECORDS	●	Injury reports are the official records of OFEC. They shall not be released to anyone nor may any other use be made of them without the approval of OFEC.
FEES	●	OFEC does not have a specific fee schedule. Local usual and customary rates are acceptable. Submit itemized bill by completing item 39 of Part B, or on your billhead stationery. Bills for any further treatment may be submitted with your progress reports.
ADDITIONAL INFORMATION	●	Contact OFEC office shown in item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report