



TRICARE® Appeals

The process for filing TRICARE medical appeals

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

WHO IS ABLE TO APPEAL?

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

beneficiary counseling and assistance coordinator, may not serve as a representative unless that person is representing an immediate family member.

WHAT CAN BE APPEALED?

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

WHAT CANNOT BE APPEALED?

- The amount that the TRICARE contractor determines to be the allowable charge for a particular medical service; beneficiaries may ask the TRICARE contractor for an allowable charge review, not an appeal
- The decision by TRICARE or its contractors to ask for more information before action is taken on the beneficiary's claim or appeal request
- Decisions relating to the status of TRICARE providers. Although a TRICARE beneficiary may want to or has already received care from a particular provider, the beneficiary cannot appeal a decision that denies the provider authorization to be a TRICARE provider, or

a decision that suspends, excludes, or terminates the provider. **Note:** The provider in question may appeal on his or her own behalf.

- Decisions relating to eligibility as a TRICARE beneficiary cannot be appealed. Eligibility for TRICARE is determined by the services and information maintained in the Defense Enrollment Eligibility Reporting System. Beneficiaries must address decisions regarding eligibility with their service branch.

FILING A MEDICAL NECESSITY APPEAL

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

Expedited Appeal

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

Non-Expedited Appeal

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

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

FILING A FACTUAL DETERMINATION APPEAL

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

1. First, send a letter to the TRICARE contractor at the address specified in the notice of the right to appeal. The address is included in the EOB or other decision letter. The appeal letter must either be postmarked or received within 90 days of the date on the EOB or other decision letter. Include a copy of the EOB or other decision letter, and any supporting documents not previously submitted. If not all of the supporting documents are available, state in the letter your intent to submit additional information. You should keep copies of all paperwork.
2. If the amount in dispute is less than \$50, the reconsideration decision from the TRICARE contractor is final. If you disagree, and if \$50 or more is in dispute, you can

request a formal review from DHA. If you disagree with a reconsideration decision, and the letter identifies DHA as the next level of appeal, you may ask DHA to review the case again and issue a formal review decision.

3. To request a formal review, send a letter to DHA, making sure the letter is either postmarked or received within 60 days of the date on the initial determination or reconsideration decision. Include copies of the determination or reconsideration decision, as well as any supporting documents not previously submitted. If not all of the supporting documents are available, state in the letter your intent to submit additional information. You should keep copies of all paperwork.
4. DHA will review the case and issue a formal review decision. If the amount in dispute is less than \$300, the formal review decision by DHA is final. If you still disagree, and the disputed services are \$300 or more, you may request that DHA schedule an independent hearing.
5. A request for an independent hearing should be sent to DHA, and the request must either be postmarked or received within 60 days of the date of the decision being appealed. Include a copy of the formal review decision being appealed and any supporting documents not previously submitted. If not all of the supporting documents are available, state in the letter your intent to submit additional information. You should keep copies of all paperwork. An independent hearing officer will conduct the hearing at a location convenient to both the requesting party and the government. The hearing officer will issue a recommended decision and the DHA director (or designee) or the Assistant Secretary of Defense for Health Affairs will issue the final decision.

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

Dual-eligible beneficiary determinations apply to beneficiaries who are eligible for Medicare and TRICARE benefits because of age, disability, or end-stage renal disease. If the denial is appealed to Medicare, the Medicare appeal

decision is final. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies considered for coverage by TRICARE, if denied, are subject to the factual appeal process. Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment can be appealed through the Medicare appeals process. For more information about the Medicare appeals process, visit the Centers for Medicare & Medicaid Services website at www.medicare.gov.

FILING AN APPEAL OVERSEAS

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

REMEMBER, YOU MUST:

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

LOOKING FOR **More Information?**GO TO **www.tricare.mil/contactus**

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TRICARE North Region

Health Net Federal Services, LLC
1-877-TRICARE (1-877-874-2273)
www.hnfs.com

Claims Appeals

Health Net Federal Services, LLC
TRICARE North Claim Appeals
P.O. Box 2606
Virginia Beach, VA 23450-2606

Authorization Appeals

Health Net Federal Services, LLC
TRICARE North Authorization Appeals
P.O. Box 9530
Virginia Beach, VA 23450-9530

S

TRICARE South Region

Humana Military
1-800-444-5445
HumanaMilitary.com

Claims Appeals

TRICARE South Region Appeals
P.O. Box 202002
Florence, SC 29502-2002

Authorization Appeals

Humana Military
P.O. Box 740044
Louisville, KY 40201-7444

W

TRICARE West Region

UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

Claims Appeals

UnitedHealthcare Military & Veterans
Attn: Claim Appeals
P.O. Box 105493
Atlanta, GA 30348-5493

Authorization Appeals

UnitedHealthcare Military & Veterans
Attn: Authorization Appeals
P.O. Box 105493
Atlanta, GA 30348-5493

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TRICARE Overseas Program (TOP)

International SOS Government Services, Inc.
www.tricare-overseas.com

For toll-free contact information,
visit this website.

Claims Appeals

TRICARE Overseas Program Appeals
P.O. Box 7889
Madison, WI 53707-7889
USA

Authorization Appeals

International SOS Government Services, Inc.
Reconsideration/Grievances Department
P.O. Box 11570
Philadelphia, PA 19116
USA

TOP Regional Call Centers**Eurasia-Africa**

+44-20-8762-8384 (overseas)
1-877-678-1207 (stateside)
tricarelon@internationalsos.com

Latin America and Canada

+1-215-942-8393 (overseas)
1-877-451-8659 (stateside)
tricarephl@internationalsos.com

Pacific (Singapore)

+65-6339-2676 (overseas)
1-877-678-1208 (stateside)
sin.tricare@internationalsos.com

Pacific (Sydney)

+61-2-9273-2710 (overseas)
1-877-678-1209 (stateside)
sydricare@internationalsos.com

Defense Health Agency Appeals

Defense Health Agency
Appeals, Hearings, and Claims
Collection Division
16401 E. Centretech Parkway
Aurora, CO 80011-9066

TRICARE Appeals

www.tricare.mil/appeals

TRICARE For Life

Wisconsin Physicians Service (WPS)
1-866-773-0404
www.TRICARE4u.com

Claims Appeals

WPS/TRICARE For Life
Attn: Appeals
P.O. Box 7490
Madison, WI 53707-7490

Defense Enrollment Eligibility Reporting System (DEERS)

www.tricare.mil/deers

Beneficiary Counseling and Assistance Coordinator (BCAC)

www.tricare.mil/bcaccdao

An Important Note About TRICARE Program Information

At the time of publication, this information is current. It is important to remember that TRICARE policies and benefits are governed by public law and federal regulations. Changes to TRICARE programs are continually made as public law and/or federal regulations are amended. **Military hospital and clinic guidelines and policies may be different than those outlined in this publication.** For the most recent information, contact your TRICARE regional contractor or local military hospital or clinic. The TRICARE program meets the minimum essential coverage requirement under the Affordable Care Act.

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