Today’s Action Plan

TRICARE Basic Training
PCM Validation
Referrals & Authorizations
Urgent Care Pilot
Inpatient Notification
Right of First Refusal
Consult Reporting
Claim Reminders
Provider Resources
Questions and Answers
Words of Appreciation

“When you provide care to TRICARE beneficiaries, you support the health and well-being of military service members, veterans and their families. In caring for them you also directly support the readiness of our military to do its mission. None of this could be accomplished without your experience, compassion and willingness to provide care to this population. My deepest thanks and appreciation for your service to those who serve our country.”

John Mateczun, M.D., M.P.H, J.D.
President, UnitedHealthcare Military & Veterans

Dr. Mateczun is the former:
• Deputy Surgeon General of the Navy.
• Commander of the Naval Medical Center in San Diego, California
• Chief of Staff for the Bureau of Medicine and Surgery
• Medical Advisor to the Chairman of the Joint Chiefs of Staff
• Assistant Chief for Healthcare Operations for the Navy Bureau of Medicine and Surgery
• Commander of the Naval Hospital in Charleston, South Carolina
TRICARE West Region: Basic Training
What is TRICARE?

TRICARE is the uniformed services health care program for:

• Active duty service members and their families
• Retired service members and their families
• Members of the National Guard & Reserve and their families
• Survivors and certain former spouses

TRICARE brings uniformed services and network civilian health care resources together to provide access to high-quality health services while maintaining the capability to support military operations.
TRICARE West Region

TRICARE is available worldwide and managed regionally

**TRICARE Regions**

**West Region**
UnitedHealthcare Military & Veterans
Provider Services Line:
877-988-9378
UHCMilitaryWest.com

**North Region**
Health Net Federal Services, LLC
Customer Service Line:
877-TRICARE/877-874-2273
hnfs.com

**South Region**
Humana Military Healthcare Services, Inc.
Customer Service Line: 800-444-5445
humana-military.com
UnitedHealthcare
Military & Veterans

A division of UnitedHealth Group - a national, diversified health and well-being company

An administrator/managed care support contractor for the Department of Defense (DoD)

Provides behavioral health and specialty networks through our vendor OptumHealth
- Behavioral health clinicians and facilities
- Free-standing Physical Therapy, Occupational Therapy and Speech Therapy clinics
Program Option - Prime

TRICARE Prime

- A managed care option (HMO)
- Offered in Prime Service Areas (PSAs)
- Requires enrollment (check eligibility/benefits before providing care)
- Offers lowest out-of-pocket costs (copays)
- Assigned to a primary care manager (PCM) who provides and coordinates primary care.
- PCM submits referral requests for specialty care.

PSAs, created by the government, are designated ZIP codes generally within a 40-mile radius of a military treatment facility (MTF).

Active duty service members (ADSMs) are always TRICARE Prime or TRICARE Prime Remote.
Program Option – Prime Remote

TRICARE Prime Remote

• A managed care option similar to TRICARE Prime.
• For ADSMs who live/work more than 50 miles or a one hour drive from an MTF.
• Also available for the eligible TPR Active Duty Family Members (TPRADFM) residing with the sponsor.
• Requires enrollment (check eligibility/benefits before providing care)
• Beneficiary receives care from a network provider (or an authorized non-network care provider if network care providers are unavailable)
• Referrals and/or prior authorizations are almost always required for specialty care (see Provider Handbook)
  • UHCMilitaryWest.com > Providers > Provider Handbook
Program Options – Standard/Extra

Standard and Extra

• Available to all TRICARE-eligible beneficiaries
  • Except ADSMs who are always Prime or Prime Remote
• No enrollment – check eligibility/benefits before providing care
• Beneficiary has annual deductible and cost-shares
• A referral is not required
• Some services require prior authorization

Standard - a fee-for-service option

• Care from any TRICARE-authorized non-network provider

Extra - a preferred provider option (PPO)

• Care from a network provider
• Reduced out-of-pocket costs
Program Options – Others

Premium-based TRICARE health care plans

• TRICARE Young Adult (TYA)
  • For eligible adult-age dependents who age out of “regular” TRICARE coverage at age 21 (or 23 if enrolled in college)
  • Options: Standard and Extra in addition to Prime

• TRICARE Reserve Select (TRS)
  • For eligible National Guard and Reserve members and their family members
  • Options: Standard and Extra

• TRICARE Retired Reserve (TRR)
  • For eligible retired reservists (until age 60) and their family members
  • Options: Standard and Extra
Office and Appointment Access

Contract requirements for network care providers

• A beneficiary’s office wait times for non-emergencies should not exceed 30 minutes.

• A beneficiary’s wait times when scheduling:
  • appointments for acute illnesses may not exceed 24 hours
  • routine appointments may not exceed seven days
  • appointments for wellness and other specialty visits may not exceed 28 days

• PCMs are available by telephone or appointment 24 hours a day, seven days a week

• Facilities and offices must be accessible to persons with disabilities, in accordance with federal and state regulations
Primary Care Managers

A PCM must...

...be a network provider, contracted and credentialed by UnitedHealthcare Military & Veterans
...have a practice location within a PSA.

Eligible PCM specialty types:

- Internal medicine physicians
- Family practitioners
- Pediatricians
- General practitioners
- Obstetricians
- Gynecologists
- Physician assistants
- Nurse practitioners
Primary Care Manager’s Role

The primary care manager:

- Provides primary care services and manages all Prime beneficiary care (i.e. acute illness, minor accidents, follow-up care)
- Supports access to services such as specialty care
- Follows TRICARE procedures/requirements for specialty referrals and prior authorizations
- Is available 24/7 to include after hours and urgent care services, or arranges for on-call coverage
- Submits referral requests if unable to provide urgent care
  - “Primary Urgent Care” Episode of Care used on referral.

Refer to Provider Handbook for more information.
- UHCMilitaryWest.com > Providers > Provider Handbook
PCM Listings on UHCMilitaryWest.com > Find a Provider

1. Select “Find a Provider”

2. Use the Name/Location search option

3. Input information
   (Check the box to only search only for PCMs)

4. Click “Search” Click name link to review PCM status

Need to update your entry? Contact your Network Manager.
Accurate Provider Information

PROVIDING CORRECT PROVIDER DEMOGRAPHICS IS VITAL

Accurate provider demographics:

- Allow the beneficiary to reach you when appointments and care are needed.
- Enable referrals, correct claims processing, and payment.
- Reduce physician staff workload.

Changes that require an update:

- Phone/fax number
- Suite or address
- Staff termination
- Specialty

- Opening or closing panel
- Practitioner last name
- Age ranges of patients (younger than 18 or older than 65 only)

Report updated information through: MultiPlan
Email: govtcoordinator@multiplan.com  Fax: 630-799-3587
Care Coordination
Care Request Overview

Care coordination helps drive positive patient outcomes, and promote cost-effective use of health care resources.

The primary care manager (PCM) helps to coordinate care by referring TRICARE Prime beneficiaries for specialty care.

UnitedHealthcare Military & Veterans helps to coordinate care by managing the PCM referral request process for the TRICARE beneficiary’s specialty care.
Validating a PCM Referral

For any new care request from a network specialist, is there a current referral on file from the TRICARE Prime beneficiary’s enrolled PCM for the requesting specialty?

Care received without a validated PCM referral may not be considered TRICARE-approved, resulting in avoidable out-of-pocket (point-of-service) charges for the beneficiary.
Point of Service Option

- Point of Service (POS) option gives TRICARE Prime beneficiaries the freedom to visit any TRICARE-authorized provider without a referral or authorization from the assigned Primary Care Manager.
  - (Medical attention: routine care, urgent care, specialty care, preventative care)
- Non-Active Duty Prime may incur POS charges.

<table>
<thead>
<tr>
<th>Outpatient Deductible</th>
<th>Cost Shares</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiaries must pay this amount before cost sharing begins for outpatient services:</td>
<td>Outpatient Services: 50% of TRICARE allowable charge</td>
</tr>
<tr>
<td>Individual: $300</td>
<td>Hospitalization: 50% of TRICARE allowable charge</td>
</tr>
<tr>
<td>Family: $600</td>
<td></td>
</tr>
</tbody>
</table>

- Not available for active duty service members (ADSMs), newborn or adopted children (first 60 days) until enrolled in TRICARE Prime, and beneficiaries with other health insurance (OHI).
Other Care Requests

The following are examples of care request types that do not require a current referral from the beneficiary’s PCM:

- All care requests from military treatment facility (MTF)-based providers
- Durable medical equipment and behavioral health care requests (these care requests have a separate validation process)
- Requests for beneficiaries (for example, TRICARE Standard beneficiaries) who do not normally have an enrolled or assigned PCM
When a new care request cannot be reconciled with an original PCM referral for the requested specialty, UnitedHealthcare Military & Veterans would notify the requesting provider and the beneficiary that the requested services would be considered at the point-of-service (POS) benefit level.

Communications advise the beneficiary to contact their PCM for a new specialty care referral to avoid out-of-pocket POS charges.

You can view your care request information through your secure UHCMilitaryWest.com provider account.
Scenarios

In these scenarios, care requests are submitted to UnitedHealthcare:

“Approved” means that the new care request has an associated valid referral request from the beneficiary’s PCM.

“Not Approved” means that the new care request does not have an associated valid referral request from the beneficiary’s PCM.

- To avoid POS charges, the beneficiary should obtain a new care request from their enrolled PCM.
Scenarios (continued)

Referral Request Example #1:

A network PCM submits a care request for a cardiologist. The beneficiary is enrolled to the PCM.

Action: Approved. This is an original care request from the enrolled PCM.
Scenarios (continued)

Referral Request Example #2:

An MTF-based provider submits a care request for a specialist. The beneficiary is not enrolled to this PCM or provider.

Action: Approved. Any MTF provider can submit a PCM care request.
Scenarios (continued)

Referral Request Example #3:

A network PCM sends in a care request for a cardiologist. However, the beneficiary is not enrolled to this PCM.

Action: Not Approved. The beneficiary would need to get a referral from their enrolled PCM or the beneficiary will be responsible for out-of-pocket POS charges.
Scenarios (continued)

Referral Request Example #4:

Network PCM submits a care request for a cardiologist. The beneficiary is not enrolled to this PCM, but the requesting PCM is part of the same group practice (same Taxpayer ID Number) as the enrolled PCM.

Action: Approved. PCMs, Nurse Practitioners and Physician’s Assistants in the same practice as the enrolled PCM may submit referral requests.
Scenarios (continued)

Referral Request Example #5:

The beneficiary’s PCM refers the beneficiary to an orthopedic surgeon. The orthopedic surgeon submits a new care request for physical therapy as part of the treatment plan after surgery.

Action: Approved. The PCM does not need to submit a new referral request for the physical therapy if the requested physical therapy is within the same date range and course of treatment as the PCM’s original referral to the orthopedic surgeon.
TRICARE
Referrals and Authorizations
Referral/Authorization Fax

A batch fax:
- Contains referrals/authorizations for two or more patients.
- Is accepted at Military & Veterans.
- Requires a bar coded separator sheet inserted between each individual care request.

Location of forms:
[www.uhcmilitarywest.com](http://www.uhcmilitarywest.com) > Provider > Find a Form > Medical-Surgical Referrals & Authorizations
- Batch Fax Barcode Separator Sheet
- Current Referral/Authorization Request Form
Referral/Authorization Reminders

The Referral/Authorization Request Form is marked “URGENT” only when medical care is needed with 72 hours.

Submit clinical information with Request Form when appropriate.

Check the status on a previous submission before potentially duplicating a request.

Specialists- ensure a valid PCM referral is on file before requesting services or referring a patient to another specialist.

IMPORTANT! If needing assistance contact:
- The MTF for clinical questions.
- Military & Veterans (1-877-988-9378) for all other questions.

An active duty service member is either TRICARE Prime or TRICARE Prime Remote and always requires a referral/authorization for all inpatient and outpatient services from the civilian network or non-network provider.
Referrals

Referral Request: sending a TRICARE Prime beneficiary to another professional care provider for a consult or treatment when the requested service is outside the scope of referring care provider.

A referral is required for: family)
TRICARE Young Adult Prime (family)
• TRICARE Prime (active duty and family, retiree and family)
• TRICARE Prime Remote (active duty and family)

Online Self-Service

www.uhcmilitarywest.com secure portal
Submit referrals and authorizations online
Check status of referrals and authorizations
Preventive Services and Referrals

Preventive care:
• Includes medical procedures that are not directly related to a specific illness, injury, or definitive set of symptoms or obstetrical care
• Medical procedures performed as periodic health screenings, health assessments, or health maintenance visits
• Is not diagnostic
• Is allowed without a PCM referral

If you determine the beneficiary needs medical follow-up during a preventive care visit, a PCM referral is required before any additional care is given.
• Without a current PCM referral, the beneficiary may have to pay out-of-pocket for the service using the TRICARE point-of-service (self-referral) option.
Prior Authorizations

Prior Authorization: a request for services, procedures, or admission to a hospital/facility that must be approved by UnitedHealthcare before any service is provided.

- Include supporting clinical information when requested.
- Authorization is not required for emergencies and certain services. See the TRICARE Provider Handbook for partial list.

An authorization is required for: All TRICARE beneficiaries:

- TRICARE Prime & Family
- TRICARE Standard
- TRICARE Extra
- TRICARE Young Adult
- TRICARE Prime Remote & Family
- TRICARE Reserve Select
- TRICARE Retired Reserve
- All care provided under Extended Care Health Option (ECHO)
Prior Authorization List

Important references to determine if authorization is required:

Narrative Prior Authorization List

Questionable Services List

UHCMilitaryWest.com > Providers > Referrals and Prior Authorizations
  • Scroll to end of page for Information links

No Government Pay List - codes excluded from TRICARE coverage and not payable
  • http://tricare.mil/nogovernmentpay/

Referral/Authorization approval is required before providing services.
OHI and Prior Authorization

**Other Health Insurance (OHI)** - TRICARE is last payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other plans identified by Defense Health Agency (DHA).

For TRICARE claim consideration, beneficiaries must meet all primary insurance (OHI) requirements and claim filing rules.

TRICARE beneficiaries with OHI are required to obtain TRICARE referrals or prior authorizations for these covered services:

- TRICARE Extended Care Health Option (ECHO) services
- Applied Behavior Analysis (ABA) services
- Inpatient behavioral health
- Transplants
Episode of Care (EOC)

An Episode of Care consists of medical services addressing a specific condition or procedural event within a defined time frame. An EOC:

• Is based on best business practices.
• Contains codes, units, and time duration.

www.uhcmilitarywest.com > Provider > Referrals and Prior Authorizations
• EOC Reference Table
• Online Referral & Authorization Guide
• TRICARE Provider Handbook
Locating a Copy of Orders

A beneficiary’s MTF orders are attached as the last page of a referral or prior authorization approval letter.

Call Customer Service at 877-988-9378 to ask them to fax a copy of the orders to your location.
TRICARE
Urgent Care Pilot Program
Urgent Care Defined

Medically necessary services (i.e. a sprain, sore throat, or rising temperature) that are required for illness or injury that would not result in further disability or death if not treated immediately is referred to as Urgent Care.

Urgent Care includes any illnesses or injuries that require professional attention and have the potential to develop into a health threat if treatment is delayed longer than 24 hours.
TRICARE Urgent Care Pilot

Beginning May 23, 2016, most TRICARE Prime beneficiaries can receive two urgent care visits per fiscal year (Oct. 1 to Sept. 30) without a referral and authorization.

Eligible beneficiaries:
- TRICARE Prime beneficiaries (except active duty service members)
- TRICARE Prime Remote beneficiaries (including active duty service members)
- TRICARE Young Adult – Prime beneficiaries
- TRICARE Overseas Program – (active duty service members only when traveling stateside)

Beneficiaries can see any of the following TRICARE-authorized provider types for urgent care services:
- Family practice
- Pediatrician
- OB/GYN

- Internal medicine
- Urgent care center
- Certified nurse midwife

- General practice
- Convenience clinic
- Physician assistant
TRICARE Urgent Care Pilot

• The Defense Health Agency is scheduled to run the TRICARE Urgent Care Pilot for three years.

• After the two visits allowed under the Pilot, beneficiaries will be responsible for their TRICARE point-of-service deductible and cost-share if they do not have a referral for urgent care from their primary care manager (PCM) before receiving additional urgent care services.

• TRICARE authorization requirements have not changed for follow-up care, specialty care or inpatient care. You can find more information at UHCMilitaryWest.com > Providers > Provider Handbook.

• Find more information about urgent care and the pilot program at TRICARE.mil > Plans > Special Programs > Urgent Care Pilot Program.
TRICARE
Inpatient Admission and Notification
Inpatient Admission & Notification

A pre-service request for all inpatient covered services is:

- Made by primary care manager (PCM) or specialist to a network or military treatment facility (MTF) provider
- Reviewed and authorized by UnitedHealthcare Military & Veterans
- A pre-service request is not required for emergency services

Admitting facilities are required to send notification of inpatient admission to UnitedHealthcare Military & Veterans by fax or phone.

- Medical/Surgical and Maternity Admissions
  - Notify within 24 hours of admission, unless otherwise specified in provider contract
- ER Psychiatric / Mental Health Admissions
  - Facility must notify within 24 hours or the next business day after admission, but no later than 72 hours post admission.
Claims Without Required Authorization

Claims for services rendered without a required authorization

- Claims for a covered benefit that are medically necessary are paid per CHAMPUS Maximum Allowable Charge (CMAC) rates.
- Penalty for no authorization may be assessed to the claim and may not be billed to the beneficiary.
- Contractual discounts are handled alongside any assessed penalty.

Post-service, pre-payment claim review

- Review is permitted if beneficiary did not advise provider of TRICARE coverage before services were rendered.
- Network provider may submit documentation for review:
  TRICARE West Region
  Correspondence Department
  P.O. Box 7065
  Camden, SC 29021-7065

Claims without required authorizations from non-network providers are denied.
Important Contact Numbers

Medical/surgical admission and maternity notification
- Face sheet by fax 877-578-2738
- Inpatient notification by phone 877-988-9378
- Outpatient observation - notification not required
- Referral or authorization request for all medical/surgical services
  - Medically urgent request fax 877-890-8203
  - Routine request fax 877-890-9309
- Emergency psychiatric admissions
  - Complete Inpatient Emergency Admission—Mental Health form UHCMilitaryWest.com > Provider Forms > Behavioral Health
  - Routine request fax 877-581-1590
  - Urgent request fax 877-579-8589
TRICARE West Region

Right of First Refusal
Right of First Refusal

The Right of First Refusal (ROFR) process supports beneficiary care at the MTF.

As a result of the ROFR, a Prime beneficiary within a PSA may be directed to receive care at the MTF instead of from a civilian provider.

This might happen with:

- Inpatient admission referrals
- Specialty appointments
- Procedures requiring prior authorization
ROFR Process

How is a ROFR review request determined for a Prime beneficiary?

- Does the MTF have the capability?
- Is a specialty appointment available within TRICARE access standards?
- If the MTF accepts the care, the Prime patient must obtain the services at the MTF.
- If the MTF does not accept the care, the patient is referred to a civilian network provider.

ROFR does not apply to TRICARE Prime Remote and TRICARE Prime Remote Family Members seeking care at MTFs.

Find more information on ROFR in the Provider Handbook: UHCMilitaryWest.com > Providers > Provider Handbook
Consult Reporting
Consult Reporting helps:

- Promote effective communication and coordination of care between MTFs and the civilian provider network
- Complete the medical record to determine combat readiness and fitness for duty

**Reporting Timeframe**

- Within 24 hours of encounter – preliminary reports for urgent/emergent services
- Within 10 working days of encounter – reports regarding additional procedures or skilled therapies conducted during follow-up visits as well as final reports
- Within 30 working days of encounter – facilities and specialists submit items such as reports (e.g., consults, operative, therapy, imaging study, additional procedures or skilled therapies, final) and discharge summaries to the referring provider or MTF

**Return 1 fax containing 1 report about 1 patient**
TRICARE West Region
Claims Reminders
Balance Billing

Balance billing is when a provider bills a beneficiary for the difference between billed charges and the TRICARE allowable charge after TRICARE (and other health insurance) has paid everything it is going to pay. Balance billing is prohibited.

Network providers:  
May bill beneficiaries for applicable deductible, copayment or cost-sharing amounts.  
May not bill for charges that exceed contractually agreed upon payment rates.

Non-network providers accepting assignment may only collect the TRICARE-allowable charge. If the billed charge is less than the allowable charge, the billed charge becomes the allowed amount.

- Allowable charges at tricare.mil/cmac
TRICARE Beneficiary Liability Form - Waiver of Non-Covered Services

Waiver Form:
- Is used by network providers
- Informs the beneficiary in writing of non-covered services
- Is given in advance of a particular non-covered TRICARE service
- When signed, documents beneficiary financial responsibility

Find the form at UHCMilitaryWest.com > Provider Forms > General > TRICARE Beneficiary Liability Form – Waiver of Non-Covered Service

Form may not be used for TRICARE services that are not payable for other benefit reasons, such as:
- ClaimCheck® edits
- Administrative expenses
- Difference between allowed and paid amount
Patient Waiver and Excluded Services

- Date Of Service
- Specific non-covered procedure code
- Estimated billed amount
- Beneficiary signature
- Network rendering provider information
Exclusions and Resources

- The active duty service member (ADSM) **cannot** sign a patient waiver.
- A **general agreement** signed at time of services are rendered or general statement of financial liability **is not evidence** the beneficiary knew specific services were excluded or not covered.
- The provider accepts full financial liability if a signed waiver is not obtained before providing non-covered services and UnitedHealthcare Military & Veterans does not authorize care.

Resources

- TRICARE Provider Handbook (UHCMilitaryWest.com > Providers > Provider Handbook)
- Excluded services are found at tricare.mil/nogovernmentpay.
Timely Filing

TRICARE requires all claims be submitted to UnitedHealthcare Military & Veterans no later than:

• one year after the date of services were provided; or
• one year from the date of discharge for an inpatient admission for facility charges billed by the facility.

Professional services by the facility must be submitted within:

• one year from the date of service; or
• one year from the date of discharge for an inpatient admission.
PGBA Contact Information

www.myTRICARE.com

- Claims phone
- Correspondence address
- Authorization and Referral fax
- Medical Documentation fax
- OHI Documentation fax
- Routine correspondence fax
TRICARE West Region

Resource Readiness
Clinical Authorization Guidelines

Clinical Authorization Guidelines (CAGs):
• Enhance quality of care requests
• List required criteria
• Allow efficient and quick processing

Transcutaneous Electrical Nerve Stimulation (TENS) Unit
• First in the series
• Located at www.uhcmilitarywest.com > Provider > Find a Form > Medical – Surgical Referrals & Authorizations

What to Submit:
✓ Referral/Authorization Request Form
✓ Clinical Authorization Guidelines Form
✓ Other supporting medical documentation
TRICARE Program Manuals

The UnitedHealthcare Military & Veterans contract is governed by the February 2008 Edition.

TRICARE Manuals are found at manuals.tricare.osd.mil

Always select the latest version and change number

➢ TRICARE Operations Manual
➢ TRICARE Policy Manual
➢ TRICARE Reimbursement Manual
➢ TRICARE Systems Manual

TRICARE Program Manuals - 2008 Edition

These manuals serve for contracts awarded on or after 06/27/2008 for the North, South, and West Regions along with TQMC, CARS, TOP, and TPharm. The manuals will apply to the TDEFIC contract upon direction of the Contracting Officer.

The MCS Manuals for contracts prior to 06/26/2008 are now superseded and can be found in the "Superseded" portion (indicated by a red banner) of each manuals' web page. Select the desired manual below, then proceed to the "Superseded" manual(s) that exist below the "Current" manual. For the ADP Manual, select the TSM Manual.

TRICARE Policy Manual 6010.57-M, February 2008
View Program Manuals

Word Search Example: Use the latest Policy Manual

February 1, 2008 edition
This manual is valid for contracts awarded on or after June 27, 2008 for the North, South, and West Regions along with TQMC, CARS, TOP, and TPharm. The manuals will apply to the TDFIC contract upon direction of the Contracting Officer.

The February 1, 2008 edition of the TRICARE Policy Manual (TPM), 9010.57-M, is available online.

All future changes will be published to this edition.

Last Updated: June 5, 2015
Most Recent Change Number: Change 136

Navigation
Version: Change 136 (June 5, 2015) Select
Page Count: 1,084

Summary of Changes: This revision implements Section 706 of the Fiscal Year 2015 National Defense Authorization Act which mandates TRICARE coverage of breast pumps, breast pump supplies, and breastfeeding counseling.

View
Table of Contents at Change 136
Change History
Affected Pages
Change Transmittal
Published Paper Change
Color Legend (79 KB)

Download
Entire Manual at Change 136 (13 MB)
Sections Affected by Change 136 (983 KB)

Search
Preventive
Search Entire Manual at Change 136

View the entire manual or the Table of Contents
Download sections or the entire Manual
Use key words to search the entire Manual
Search the Program Manuals

Search results for “Preventive” in Policy Manual

<table>
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<tr>
<th>Search Summary</th>
<th>Search Criteria</th>
<th>Selected Manuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Showing 1-10 of 24 results</td>
<td>Preventive</td>
<td>TP08 (Change 136) (24)</td>
</tr>
</tbody>
</table>

**TP08 Chap 7 Sect 2.1 -- Clinical Preventive Services - TRICARE Standard (TRICARE Policy Manual)**

Policy Manual 6010.57-M, February 1, 2008 Medicine Chapter 7 Section 2.1 Clinical Preventive Services - TRICARE Standard.

Date: April 19, 1983 Authority: 32 CFR 199.4(a)(3)...

...and immunizations to family members under the age of six and establishes immunizations and comprehensive preventive care for family members age six and above to include health promotion and disease prevention...


C7S2_1.PDF - View (Highlight Search Words) | View (No Highlighting)

**TP08 Chap 7 Sect 2.2 -- Clinical Preventive Services - TRICARE Prime (TRICARE Policy Manual)**

Policy Manual 6010.57-M, February 1, 2008 Medicine Chapter 7 Section 2.2 Clinical Preventive Services - TRICARE Prime.

Date: May 15, 1996 Authority: 32 CFR 199.17 1.0 POLICY 1.1 TRICARE Prime enrollees may receive Prime Clinic Services from any network provider without referral or authorization. If a Prime Clinical Preventive Service...


C7S2_2.PDF - View (Highlight Search Words) | View (No Highlighting)

**TP08 Chap 7 TOC -- Medicine (TRICARE Policy Manual (TPM))**

Subject/Addendum Title 1.1 Sexual Dysfunctions, Paraphilias, And Gender Identity Disorders 2.1 Clinical Preventive Services - TRICARE Standard 2.2 Clinical Preventive Services - TRICARE Prime 2.3 Family Planning 2.4 Cervical Cancer Screening...


C7TOC.PDF - View (Highlight Search Words) | View (No Highlighting)

**TP08 Chap 7 Sect 2.7 -- Chelation Therapy (TRICARE Policy Manual (TPM))**

PROCEDURE CODE 90784 2.0 DESCRIPTION Chelation techniques for the therapeutic or preventive removal of unwanted metal ions from the body. 3.0 POLICY Chelation therapy is...


C7S2_7.PDF - View (Highlight Search Words) | View (No Highlighting)

**TP08 Chap 7 Sect 2.5 -- Well Child Care (TRICARE Policy Manual (TPM))**
Contact Information
UnitedHealthcare Military & Veterans (UHC M&V)
7:00 a.m. to 7:00 p.m. local time, Monday - Friday
Customer Service 1-877-988-9378

www.uhcmilitarywest.com
## Programs Not Managed by M&V

Complete contact chart at [www.uhcmilitarywest.com](http://www.uhcmilitarywest.com) > Provider > Provider Handbook

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
<th>Contact Information</th>
</tr>
</thead>
</table>
| Dental: Delta Dental | TRDP: For military retirees only | Phone: 888-838-8737  
Online: trdp.org or tricare.mil/dental |
| Dental: Metropolitan Life Insurance Company | TDP: ADFMs, National Guard and Reserve Members, and Individual Ready Reserve. | Phone: 855-638-8371  
Online: tricare.dentalprogram.com |
| Dental: United Concordia Companies | ADDP: For active duty family members who cannot be seen at an MTF. | Phone: 866-984-ADDP (2337)  
Online: adp-ucci.com or tricare.mil/dental |
| TRICARE For Life (TFL) | Contact the TFL administrator, Wisconsin Physicians Service (WPS)/TFL, for assistance with TFL benefits, claims, and requirements. | Phone: 866-773-0404  
TDD: 866-773-0405  
Online: TRICARE4u.com |
| TRICARE North Region | For claims inquiries regarding beneficiaries with a residential address in the North Region contact Health Net. | Phone: 877-874-2273  
Online: hnsf.com |
| TRICARE South Region | For claims inquiries regarding beneficiaries with a residential address in the South Region contact Humana-Military. | Phone: 800-444-5445  
Online: humana-military.com |

U.S. Department of Veterans Affairs (VA) [http://www.va.gov/](http://www.va.gov/)  
CHAMPVA  
Veterans Choice Program (VCP)  
Patient-Centered Community Care (PC3)
Local Contact Information

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Thank You For Attending

Questions?