TRICARE® Claims Tips

December 2015
Welcome

Upon completion of today’s presentation, you should:

1) Become familiar with PGBA, LLC (PGBA) and its website, www.myTRICARE.com.
2) Understand the TRICARE claims submittal process.
3) Become familiar with recent TRICARE policy changes and common billing errors.
PGBA, LLC

PGBA is the Health Net Federal Services, LLC (Health Net) partner for claims processing in the TRICARE North Region.
The Health Net and PGBA websites – www.hnfs.com and www.myTRICARE.com – offer many online claims customer service features including: eligibility, claim status, electronic claims submission, and the ability to print reports (pended, paid and denied).

Note: Certain features require registration on www.hnfs.com.
Submitting Claims

How to properly submit an electronic or paper claim, what to include and filing deadlines
Electronic Claims Submission

TRICARE network providers must file all TRICARE claims electronically (non-network providers are also encouraged to file electronically).

- Electronic claims are faster than paper claims, so you get paid faster.
- Electronic filing saves you time and money!

Keep in mind, electronic claims must be filed using the appropriate HIPAA-compliant and standard electronic claims format.

**XPressClaim**® – An online electronic claims system for providers with Internet access who submit fewer than 150 TRICARE claims per month. This option is *free* and does not require additional hardware or software. Corrected claims also can be submitted through XPressClaim.

**Claims clearinghouses** – Providers can contract with any commercial clearinghouse service to transmit TRICARE claims electronically to Health Net for processing. Some providers choose this option because it also allows them to submit claims to health care payers other than TRICARE.

To get started, visit www.hnfs.com or www.myTRICARE.com.
Submitting Paper Claims

We encourage non-network providers to look at the benefits of electronic filing options; however, they do have the option to submit paper claims.

- If a non-network provider must submit paper claims, TRICARE requires use of either a 1500 (professional charges) or a UB-04 (institutional charges) claim form.
- If the patient has other health insurance (OHI) you must include the OHI Explanation of Benefits (EOB). Please ensure the EOB matches the total charges billed.
- Detailed claims instructions can be found in the TRICARE North Region Provider Handbook, found at www.hnfs.com.

Mail your claim to:
Health Net Federal Services, LLC
c/o PGBA, LLC/TRICARE
PO Box 870140
Surfside Beach, SC 29587-9740
What to Include on a Claim

- Provider’s federal Tax Identification Number (TIN)
- Provider’s/facility’s physical address (including ZIP code) and pay-to address
- All applicable National Provider Identifiers (NPIs) including rendering provider’s NPI
- Provider’s signature or signature stamp
  - The signature stamp must be on file with Health Net/PGBA.
  - “Signature on File” is an acceptable signature on electronic claims only.
- Sponsor’s Social Security number or the 11-digit DoD Benefits Number
- Date(s) of service
- Basic data related to diagnosis
- Admitting diagnosis (inpatient claims)
- Place of service codes
- TRICARE beneficiary’s signature
  - You may indicate “patient not present” if the beneficiary’s signature is on file.
  - For laboratory and X-ray services you may indicate “patient not present for services.”

CPT is a registered trademark of the American Medical Association.
Timely Filing

- TRICARE network providers must file all claims within 90 days of the date of service.

- Where TRICARE is the secondary payer, the 90 days will begin once the primary payer has made payment or denied the claim.

- Non-network providers may file claims up to one year after the date of service.
ICD-10 Transition

Please review the following information as you and your staff move forward with ICD-10 compliance. Health Net wants to help you avoid any delays in claims processing or prior authorization and referral reviews.

- Your practice must submit all claims for services provided on or after October 1, 2015, with ICD-10 coding for payment consideration. Claims not coded following ICD-10 guidelines will be returned.

- Visit www.hnfs.com > I’m a Provider > Claims > ICD-10 Implementation for the latest information on the transition, including conversion tips and answers to frequently asked questions.
ICD-10 Frequently Asked Questions

Will you have a dual-use period?
No. A dual-use period was not included in the mandate published in the TRICARE manuals by the Defense Health Agency (DHA). ICD-10 codes must be submitted on professional and outpatient facility claims for dates of service on or after the mandated date (October 1, 2015).

➤ The ICD-10 version for inpatient claims will be determined by the discharge date.

➤ ICD-9 codes will be accepted for dates of service/discharge prior to October 1, 2015, until DHA mandates we discontinue their use.

Will you accept both ICD-9 and ICD-10 codes on a single claim?
No. A claim with both versions cannot be processed. A separate claim must be submitted for services provided on or before the mandated date, and be coded in accordance with the ICD-9-CM, as appropriate. Claims for services provided on or after the mandated date must be submitted separately and coded with the ICD-10-CM as appropriate.

For more information please visit, www.hnfs.com > I’m a Provider > Claims > ICD-10 Implementation > ICD-10 FAQs.
DoD Benefits Number

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

The ID card contains the following identifiers:

- **DoD ID Number** – a 10-digit number that is not used for TRICARE claims, eligibility, or authorization and referral purposes.
- **DoD Benefits Number (DBN)** – an 11-digit number that relates to TRICARE benefit eligibility. This number is located on the back of the new card.

When submitting claims, prior authorizations and referrals for TRICARE beneficiaries, please use the sponsor's SSN or the 11-digit DBN. Providers should continue to use the sponsor’s SSN when verifying eligibility through the Interactive Voice Response system at 1-877-TRICARE (1-877-874-2273), or choose to transfer to a call center agent if you only have the DBN.
Authorizations

Authorization requirements, penalties and additional services
Authorizations

Certain services require a prior authorization from Health Net.

Requirements – Use the Prior Authorization, Referral and Benefit Tool at www.hnfs.com > I’m a Provider > Authorizations > Prior Authorization, Referral and Benefit Tool to determine prior authorization requirements.

Penalty – Network and non-network provider claims submitted for services rendered without a required prior authorization are subject to a 10 percent penalty of the allowed amount.

Additional prior authorization – If you would like to render services beyond what has been covered by the initial prior authorization, you must submit a request to Health Net to extend the authorization or request additional services to ensure correct claims payment.

We also offer a Clarifying the Referral and Authorization Process webinar. Check www.hnfs.com for our webinar schedule.
Active Duty Approvals

Benefit Coverage Review
Active duty service members (ADSMs) receive benefit coverage review by Health Net for Supplemental Health Care Plan (SHCP) referrals. Previously, this review was conducted by the military hospitals or clinics.

- Requests for services NOT specifically excluded by TRICARE will be reviewed by Health Net against TRICARE coverage guidelines and will be approved or denied depending upon the results of the review.
- Requests for services not covered (including those listed on the government no-pay list) will continue to be denied if no DHA waiver approval is present.
- If the beneficiary does not sign a Request for Non-Covered Services form or equivalent, the provider is financially responsible for the cost of non-covered services he or she delivers. Network providers should keep copies of the Request for Non-Covered Services form or equivalent in their offices.

DHA Waivers
ADSMs receiving a denial will be notified via a response letter. The letter will indicate a DHA waiver is required.

- An authorized official of the uniform service may request a waiver for a denied service. Waivers are reviewed by the Director of DHA. Note: ADSMs (excluding TPR ADSMs) cannot request waivers.
- If the waiver is approved by DHA, it will be returned to either the military hospital or clinic, or the civilian provider (for TPR ADSMs not managed by a military hospital or clinic).
Active Duty Approvals

**Additional Information**
In some cases, Health Net must request additional information in order to determine if the requested services meet TRICARE benefit coverage criteria. This additional information must be submitted to Health Net by the date indicated in the *Additional Information Request Letter* or the authorization request will be cancelled.

- It is extremely important providers respond to these information requests in a timely manner, especially for services requested on an urgent basis.

- If a request is cancelled due to non-receipt of requested information, the DHA waiver process does not apply as TRICARE benefit coverage could not be determined. Instead, a new authorization request must be submitted to Health Net, along with the requested information, to allow the benefit determination review.
Other Health Insurance

How to submit claims when the beneficiary has other health insurance
Other Health Insurance

- TRICARE network providers must file TRICARE claims with Health Net/PGBA, even when a patient has other health insurance (OHI).
- Providers are encouraged to ask the beneficiary about OHI so benefits can be coordinated.
- Any OHI must be used before TRICARE.*
- Point of Service cost-sharing and deductible amounts do not apply to TRICARE Prime beneficiaries whose OHI is primary.

*Exceptions are: Medicaid, State Victims of Crime Compensation Programs, the Indian Health Service and plans specifically designated as TRICARE Supplements

Note: Active duty service members (including activated National Guard and Reserve members) can't use other health insurance as their primary insurance.
Other Health Insurance

- Dual-eligible Medicare and TRICARE for Life beneficiaries must submit Medicare claims first. Claims will automatically be transmitted from Medicare to TRICARE for secondary claims processing, and Wisconsin Physicians Service (WPS) will process the TRICARE portion of the claim.

- Active duty service members who have OHI require an approval from Health Net for all services. All other beneficiaries with OHI only require a prior authorization for inpatient behavioral health services.

- When working with OHI, all TRICARE providers should keep in mind TRICARE will not pay more as a secondary payer than it would have as a primary payer.
Prior Authorization and Billing Tips

Helpful information to ensure prompt claims payment for TRICARE providers
Physician Assistants/Nurse Practitioners

When providing care to TRICARE beneficiaries, physician assistants (PAs) and nurse practitioners (NPs) must be identified as the rendering provider on all claims.

- The procedure or service performed by the PA is billed by the supervising or employing physician, billing it as a separately identified line item (for example, PA office visit) and accompanied by the PA’s NPI.
- The employing physician must be an authorized TRICARE provider.

For NPs, covered services should also be billed by the employing physician, group or clinic listing the NP as the rendering provider.

- NPs can bill on their own behalf for certain services in accordance with TRICARE policy and federal and state laws.

When billing for a PA or any other rendering provider, you must include the provider’s name, SSN or NPI on the claim form.
Prior authorization for home infusion/injectables is required for all beneficiaries except those with other health insurance. The prior authorization must be received before the initiation of the therapy in order to ensure medications are received from the correct TRICARE source and any required nursing visits are pre-approved.

The type of medication and length of administration will determine whether the home infusion/injection medication will be paid under the medical benefit or through the TRICARE pharmacy benefit.

The request must be submitted to Health Net for home infusion/injection services. When requesting authorization, be sure to include the dose, frequency and route of administration for the medication.

Health Net will generate authorizations as appropriate if the drug is a covered benefit.
Home Infusion/Injectables

Submitting claims:

- If covered under the medical benefit, the provider should submit the claim to PGBA.
- If covered under the TRICARE pharmacy benefit, Health Net will send the authorization information to Express Scripts, Inc. **Please note:** While this process may take up to 3–5 business days after Health Net approves the request, Express Scripts will honor the dates and services approved by Health Net so patient care is not delayed.

Please include the following on your claim:

- an 11-digit National Drug Code (NDC) number (if the claim does not include an NDC, the claim will be rejected for “NDC required”)
- the corresponding CPT or HCPCS code
- the quantity (package vs. unit) for each NDC number and how the immunizations/drugs were provided (P for package or U for unit)
Durable Medical Equipment

All TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime beneficiaries require an approval from Health Net for all* durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) purchases, repairs and rentals. Remember to include the authorization number when submitting claims.

Any DMEPOS with a purchase price of $150 or greater and all rental items regardless of the price require a certificate of medical necessity (CMN) be submitted with the claim (unless prior authorized). No specific CMN form is required and this information should be faxed to 1-888-377-4191. The CMN should include:

- type of DMEPOS equipment,
- diagnosis/reason DMEPOS is needed,
- length of time the equipment is needed,
- start date/prescribing date, and
- physician name or signature (must be an M.D. or D.O.; it may not be a nurse practitioner, physician’s assistant or podiatrist).

Note: Podiatrists can order prosthetic and orthotic devices and supplies within the scope of their license.

*DMEPOS items considered inexpensive according to Centers for Medicare and Medicaid Services (CMS) guidelines, such as gauze, tape and crutches, do not require a referral from Health Net (check the CMS DMEPOS Fee Schedule for details).
Durable Medical Equipment

**Upgrades**
Per TRICARE policy, if a beneficiary prefers to upgrade a prescribed DMEPOS item, which otherwise meets TRICARE requirements, the beneficiary is responsible for the costs that exceed the standard equipment’s allowed amount.

- The claim must be submitted with a GA modifier for the line item covered by the beneficiary and a GK modifier for the line item covered by TRICARE, in addition to any other appropriate modifiers.

- For providers who supply capped rental DMEPOS, only include the GA modifier for the upgraded item on the initial claim (first month's rental). For subsequent months, bill for the basic DMEPOS item with no upgrade modifier.

TRICARE network providers may collect payment for the non-covered upgrade or item from the beneficiary only when a request for non-covered services form is completed and submitted with the claim. **Without this form, network providers may not bill the beneficiary, per TRICARE’s hold harmless policy.**
Durable Medical Equipment

Ordering guidelines
• TRICARE recently clarified that physicians, dentists or any TRICARE-authorized allied health care professional may order or prescribe durable medical equipment (DME). Previously, TRICARE required DME to be ordered/prescribed by a physician (M.D. or D.O.).
• All orders/prescriptions are considered valid for one year. A beneficiary should return to his or her PCM annually for assessment of his or her condition and ongoing treatment/needs.

Supplies provided within military hospitals and clinics
Companies that provide DMEPOS within military hospitals and clinics may not bill TRICARE for the items provided. This includes, but is not limited to, crutches, wheelchairs, Continuous Positive Airway Pressure (CPAP) equipment, knee braces, splints, and foot orthotics. Payment should come directly from the military hospital or clinic.
Breastfeeding Benefit

Effective July 1, 2015, TRICARE covers breast pumps, breast pump supplies and additional lactation counseling services at no cost for new mothers, including mothers who adopt an infant and plan to breastfeed.

- Prior authorization is not required; however, for breast pumps, the beneficiary must have a prescription from a TRICARE-authorized physician, physician assistant, nurse practitioner, or nurse midwife. The prescription must, at a minimum, indicate the type of breast pump prescribed (manual, standard electric or hospital-grade). Please include supporting medical documentation when prescribing hospital-grade breast pumps.

- For active duty service members (ADSMs), a referral is required for the hospital grade breast pump (E0604) as of October 1, 2015, along with a doctor's prescription. All other breast pumps for ADSMs only require the prescription.

- As a TRICARE provider, you may see an increase in new breast pump prescription requests from beneficiaries. Beneficiaries also may ask for prescriptions for breast pumps previously purchased, as TRICARE is offering reimbursement for lactation supplies retroactive to December 19, 2014.

- Refer TRICARE beneficiaries to www.tricare.mil for current benefit information and instructions on how to request reimbursement for previously purchased breast pumps and supplies.

Providers can visit www.hnfs.com > I’m a Provider > Benefits A–Z > Breast Pumps for complete benefit details.
Partial Hospitalization Program

TRICARE covers limited behavioral health services rendered in a TRICARE-authorized partial hospitalization program (PHP). The following tips should be used to ensure accurate and timely reimbursement for services provided.

**Be sure you are a TRICARE-authorized PHP provider**

**Hospital-based PHPs:** When a hospital is a TRICARE-authorized (certified) provider (Joint Commission Accreditation required for Network), the hospital’s PHP shall also be considered a TRICARE-authorized provider.

**Freestanding PHPs:** The facilities must be certified and enter into a participation agreement with TRICARE and obtain the required preauthorization prior to admitting patients. Applications for freestanding PHP certification may be obtained from KePRO.
Partial Hospitalization Program

Obtain authorization before providing services
Prior authorization is required for PHP services for all TRICARE beneficiaries. Providers should submit a new request for services before rendering services that differ or extend beyond the original Health Net Federal Services, LLC approval.

For example:
- A full day was approved, but only a half day was billed – the claim will be processed as submitted.
- A half day was approved, but a full day was billed – the claim will undergo review for extra services and a penalty will be applied.

Include the correct primary diagnosis
If services provided are for psychiatric services, the primary diagnosis must be psychiatric. Likewise, if services provided are for chemical dependency, the primary diagnosis must be chemical dependency.

Visit www.hnfs.com > I’m a Provider > Claims > Partial Hospitalization Programs Claims Tips for more information.
Hospital Clinic Billing

When billing for provider outpatient services in a hospital setting, the following guidelines allow the claim to process in a timely manner and *keeps the beneficiary from being charged a double copayment*.

**Hospital:** Bill revenue code 510 on a UB-04 institutional claim form.

**Provider:** For service provided in a facility on an outpatient basis, the appropriate place of service is outpatient facility and not office visit.
Private Rooms

When billing for private rooms on institutional claims, be sure to use the appropriate indicator in box 39 of the UB-04 claim form.

For example:
- 01: semi-private room rate
- 02: no semi-private room
Billing for Multiple Procedures

When billing for multiple procedures on the same date of service, list the CPT code on one line, indicating multiple units, instead of billing the same CPT code on multiple lines.

For example, billing a pathology exam on three breast biopsy specimens on the same date of service:

**Correct:** One line with the CPT code and 3 units

**Wrong:** Three lines with the CPT code with 1 unit each

If the claim includes three lines with one unit for each line on the same date of service, the additional lines appear as duplicates causing the additional lines to deny.
TRICARE uses the Outpatient Prospective Payment System (OPPS) to pay claims filed for hospital-based outpatient services.

While the TRICARE OPPS closely mirrors Medicare’s OPPS method, there are some necessary differences to accommodate the uniqueness of the TRICARE program.

Visit www.tricare.mil/OPPS for quarterly and annual payment rate and status updates.
Processing and Payment

Claims processing times, summary of payment vouchers, electronic funds transfer, balance billing, and avoiding duplicate claims
Claims Processing Times

Most clean claims process within 30 days. Generally, clean claims aged more than 30 days will be paid interest in addition to the payable amount.

Clean claims:
- Comply with billing guidelines and requirements.
- Have no defects or improprieties.
- Include substantiating documentation, when applicable.
- Do not require special processing that would prevent timely payment.

Claim status can be viewed at www.hnfs.com once registered, at www.myTRICARE.com or through Health Net’s IVR at 1-877-TRICARE (1-877-874-2273).
Summary Payment Voucher

You will receive a copy of the TRICARE Summary of Payment Voucher/Remit with your payment from Health Net.

- The TRICARE Summary of Payment Voucher/Remit reflects the services provided that pertain to the payment.

- View online remits through www.hnfs.com and www.myTRICARE.com.
Electronic Funds Transfer

Sign up for electronic funds transfer
With electronic funds transfer (EFT), payments are deposited directly into your bank account within days of processing completion. Register at www.myTRICARE.com or call 1-877-EDI-CLAIM (1-877-334-2524) for assistance.

What about electronic remittance advice (ERA)?
An electronic remittance advice (ERA) can change the way your business tracks accounts receivables. Also known as an 835 transaction, ERA is the electronic equivalent of a paper remittance advice (or explanation of benefits) that provides claims processing details. It’s a secure and reliable alternative to manually posting claims information to an accounts receivable software program. Visit myTRICARE.com for more information.
Balance Billing

What is balance billing?
Balance billing occurs when a provider bills a TRICARE beneficiary for any amount in excess of the TRICARE-allowable charge after TRICARE has processed the claim. This practice is limited by law.

Network vs. non-network provider responsibilities
TRICARE network providers agree to be paid the lesser of the TRICARE maximum allowable charge or their contracted rate.

If you are a non-network TRICARE-authorized provider and have agreed to participate on a claim, this means you have agreed to accept the TRICARE-allowable charge as payment in full for this claim and you may not bill patients for any amount in excess of the TRICARE-allowable charge. Non-network providers who do not accept assignment are limited by federal balance billing laws on how much they can bill TRICARE beneficiaries.
Avoid Duplicate Claims

Duplicate claims add unnecessary processing costs that must be paid by the government, not to mention the additional administrative costs to your practice. Keeping unnecessary health care costs low is a responsibility of all members of the health care community.

Prior to resubmitting a claim, you can do the following at www.hnfs.com and/or www.myTRICARE.com:

- Check your TRICARE claims status online to verify completed, in process/pending, returned or transferred claims.
- Reconcile your accounts receivables by viewing your TRICARE remits online.
- Sign up for EFT to receive your TRICARE payments faster.
- Ensure your provider demographic information on file is up-to-date and accurate.
- When submitting a corrected claim, use the correct bill type and always include the original claim number to avoid it processing as a duplicate.

Note: Wait at least 30 days before claims resubmission or phone inquiry.
Appeals/Claim Review

Appeals, claims review and filing deadlines
Appeals and Claim Reviews

**Appeal** – Only charges denied because the service is not covered by TRICARE or not medically necessary may be appealed. Your TRICARE Explanation of Benefits (EOB) or provider remittance will indicate if a denied charge is appealable.

*Note: Claims processed with Point of Service charges can only be appealed if the services were for emergency care.*

**Claim review** – If the notes on your provider remittance do not include any appealable denied charges, you may request a claim review.
Claim Review

A claim review, also called an allowable charge review, is separate from the appeals process.

Common reasons for a claim review:

• allowed amount disputes
• charges denied as “included in a paid service"
• charges denied as “requested information not received"
• claim denied as provider not authorized"
• claim check denials
• coding issues
• cost-share and deductible issues
• eligibility denials
• other health insurance issues
• penalties for no authorization
• Point of Service disputes (exception: Point of Service for emergency services is appealable)
• third party liability issues
• timely filing limit denials
• wrong procedure code
Claim Appeal/Review Submittal

A claim appeal must be filed in writing within 90 days of the date on the EOB or provider remittance. You may submit your appeal online at www.hnfs.com, or fax or mail an appeal letter. There is no specific appeal form required.

Claim reviews must be submitted by mail within 90 calendar days of the date on the EOB or the provider remittance.

For complete details, visit www.hnfs.com > I’m A Provider > Claims > Claims Review.
Resources

Claims mailing addresses, out-of-region claims, online provider education, and customer service resources
**Claims Addresses**

Find all claims-related addresses at
www.hnfs.com > Contact Us > Mailing Addresses.

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**Mailing Addresses/Fax Numbers**

Please note: Many of the Health Net Federal Services, LLC mailing addresses have changed. Please use the addresses listed below when submitting correspondence to Health Net.

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<tr>
<th>Claims</th>
<th>Appeals and Grievances</th>
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<td>TRICARE North Authorization Appeals</td>
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<td>PO Box 870140</td>
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<tr>
<td>Surfside Beach, SC 29587-9740</td>
<td>Virginia Beach, VA 23450-9530</td>
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Please note some mailing addresses have changed.

Be sure to check www.hnfs.com for the most up-to-date claims mailing addresses!
Out-of-Region Claims

Submit claims to the TRICARE region where the beneficiary resides and/or is enrolled.

- **TRICARE North**: Health Net Federal Services, LLC
- **TRICARE West**: United Healthcare Military & Veterans
- **TRICARE South**: Humana Military
Online Provider Education


Online Tools Tutorial – A step-by-step guide to online tools currently available on our website.

Webinars – Live briefings offered every other week. Recorded briefings and downloadable presentations also available.
Customer Service

Visit www.hnfs.com and www.myTRICARE.com (PGBA) for 24 hours a day, seven days a week access to up-to-date information.

We encourage you to try the AskUs feature on www.myTRICARE.com. You can use AskUs to send confidential questions and receive quick responses in your myTRICARE secure mailbox.

**Customer service resources:**

- Interactive voice response (IVR) system is available 24 hours a day, seven days a week at 1-877-TRICARE (1-877-874-2273)
- For assistance with electronic claims, call 1-877-EDI-CLAIM (1-877-344-2524).
- For questions unrelated to general claim status, speak with a customer service agent by calling 1-877-TRICARE (1-877-874-2273), Monday–Friday, 7:00 a.m.–7:00 p.m. (ET).
Your Continued Partnership

Thank you for your continued partnership and caring for our military service members, retirees and their families.
Questions and Answers