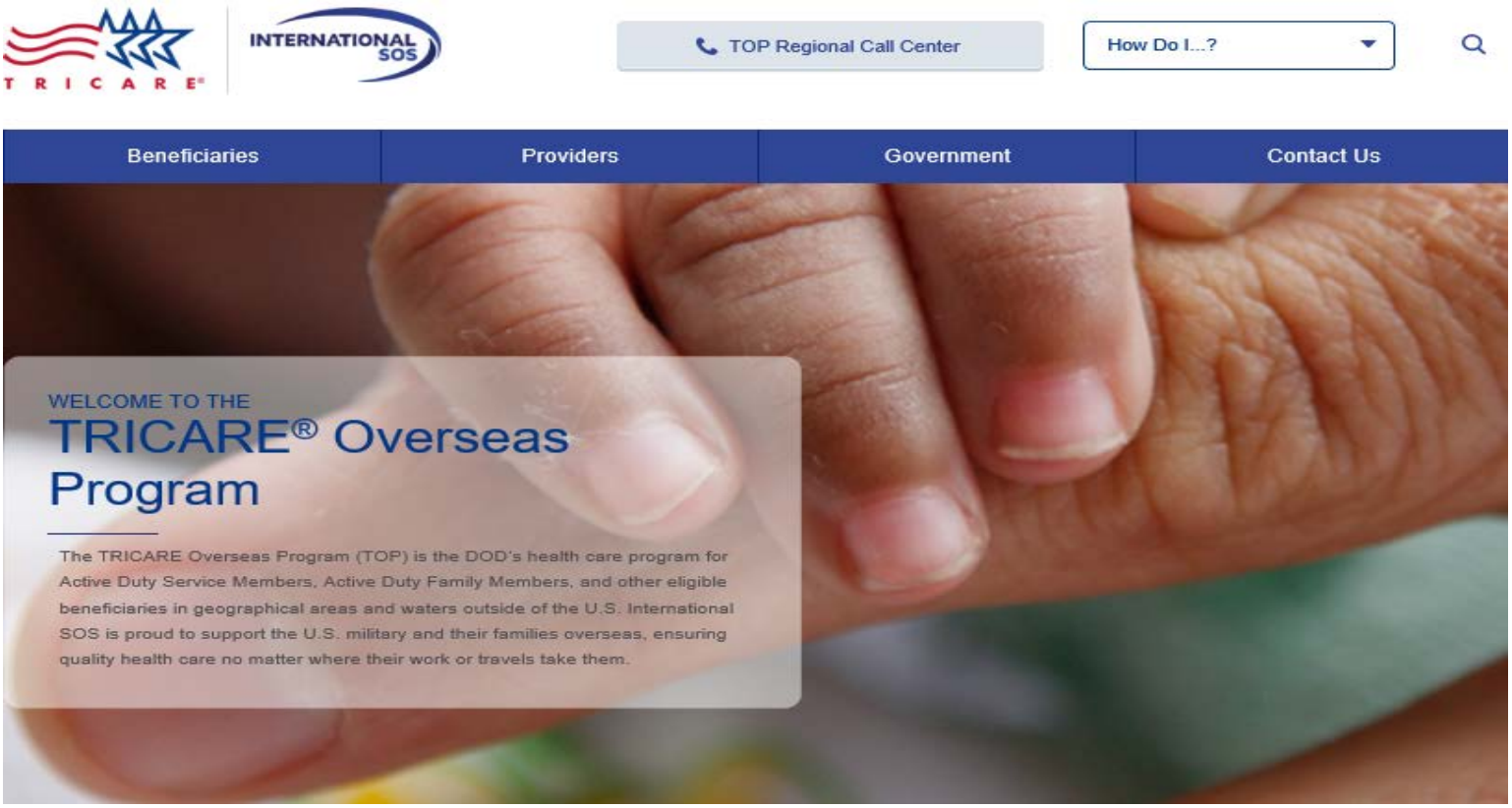
How to File Tricare Overseas Beneficiary Claims Online



Provider Search

Search for a Medical Professional in your area.

Beneficiary Secure Claims Portal

Log in to the Beneficiary Secure Claims Portal to submit, track and view your TOP Claims status, check eligibility, review your Explanation of Benefits, and more.

TRICARE Plans & Programs

With multiple plans and program options available to TOP Beneficiaries and their families, find out which one is right for you.

TOP Select in the Philippines

TOP Select beneficiaries who reside in the Philippines and seek care within designated Philippine locations are encouraged to see a TRICARE Preferred Provider. The current Philippine Demonstration Approved Providers will be converted to TRICARE Preferred Providers beginning January 1, 2018.

Provider Resources

Access educational resources, such as as the TOP Provider Manual, Medical Briefs, secure claims portal Quick Start Guides, forms, and other important reminders about TRICARE processes and procedures.

Provider Secure Claims Portal

Log into the secure Provider Claims Portal to submit, track and view your TOP claims status, check eligibility, review your Explanation of Benefits, and more.

Claims

Find the proper ways to submit all necessary forms so that your TOP Claims are processed in an accurate and timely manner.

1.Go to www.tricare-overseas.com

2. Click the "Beneficiary Secure Claims Portal"

How Do I...?

SECURE LOGIN

Please read our Privacy Policy to be assured we keep your data secure and confidential.

Registered beneficiaries have two options to securely login and access their TRICARE-Overseas.com account:

DoD Self-Service Logon (DS Logon)*(Recommended)*

Login with your DS logon user name and password that give you access to multiple Department of Defense (DoD) websites and affiliated TRICARE websites, including TRICARE-Overseas.com.

Click here to login using your existing DS logon user name and password. You will automatically login after your DS logon user name and password are authenticated. A DS Logon (Level 2) account is required.

Click here to download useful DS Logon FAQs and learn more about how to obtain a DMDC Logon.

TRICARE-Overseas.com Login

Login with your existing TRICARE-Overseas.com user name and password.

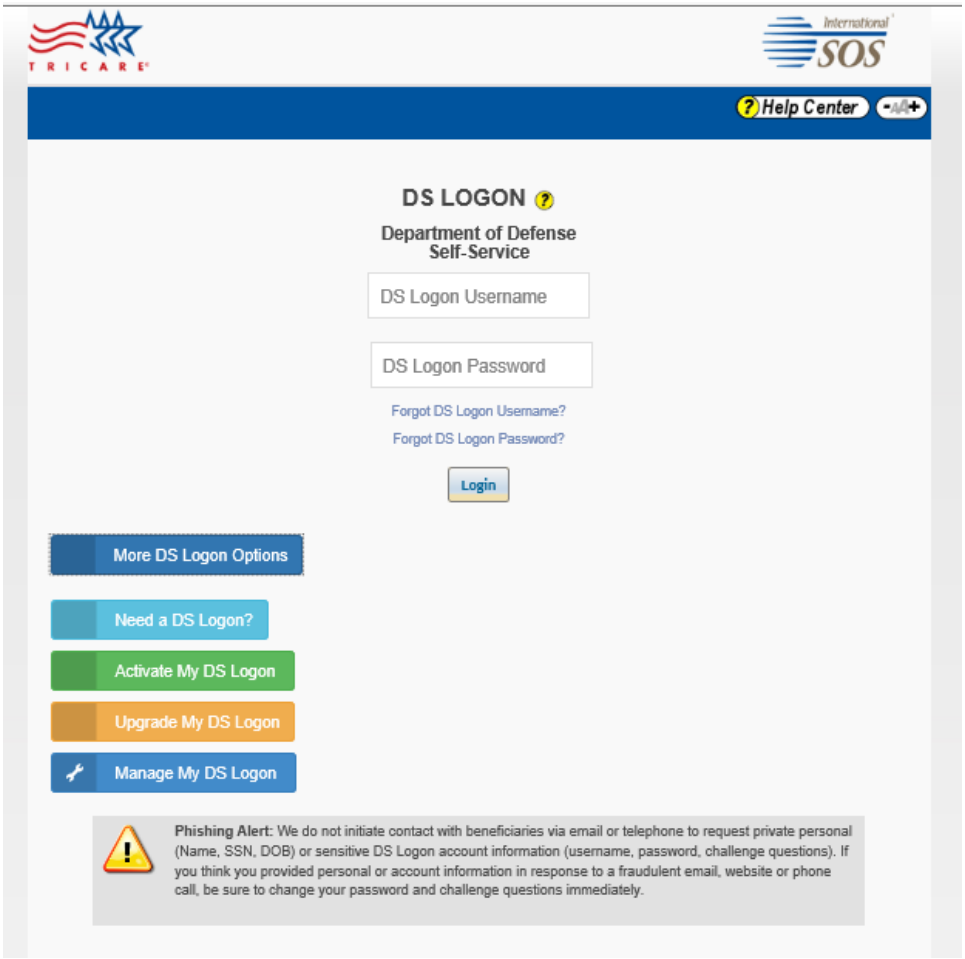
Login with a TRICARE-Overseas.com user name and password

International SOS and the TRICARE Overseas Program (TOP) Claims Processor are excited to announce the improved secure beneficiary claims portal is now live! With feedback from beneficiaries like you, the improved secure claims portal website will make it easier and faster to access the TOP claims information you want and need.

Important Note Regarding Your Password:

If you are entering a temporary password, please do not copy and paste it from the system-generated email message. The temporary password must be manually entered upon log-in.

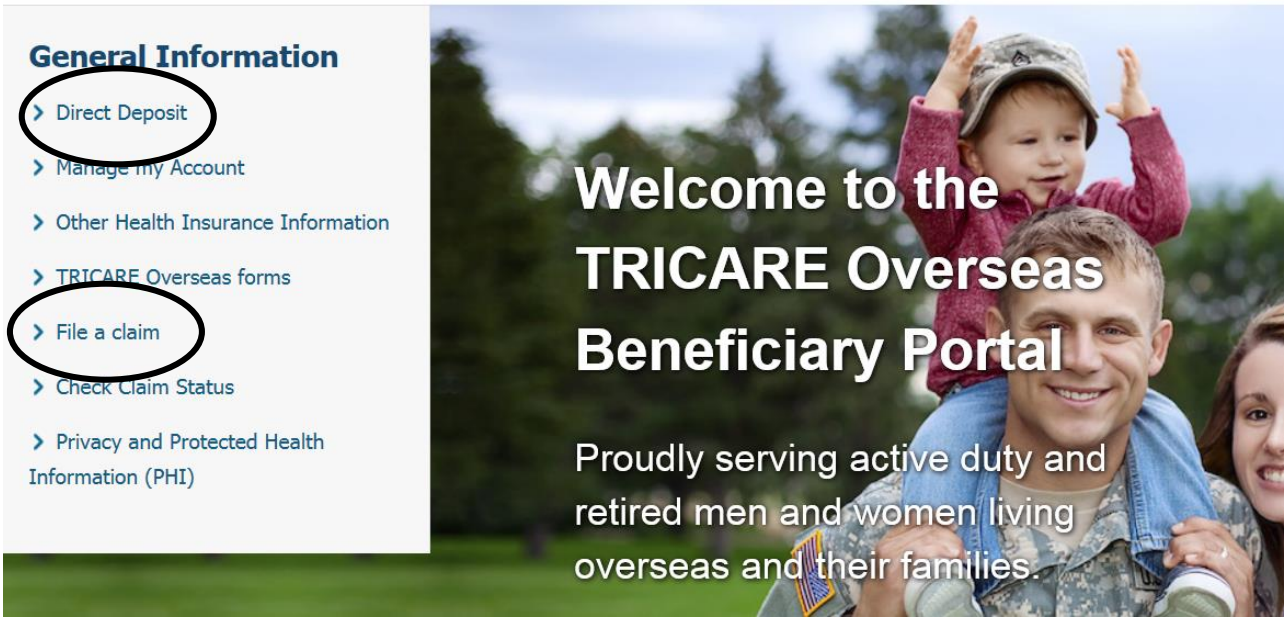
3."Click here" under DoD Self-Service Logon



4. Enter DS Logon information or click "Need a DS Logon" to set up an account.

5. Click on Direct Deposit to set up electronic reimbursement.

6. To submit claims, click on File a Claim and follow the instructions.



Set up Direct Deposit

Direct deposit for John Smith. Please note it will take up to 4 business days for the change to be complete.

Note: Only accounts from banks in the United States can be used to enroll.

Name of Account Holder

Social Security Number Account Holder

Type of Account

Checking Account Savings Account

Routing Number

Account Number

(Your account number should be between 6 and 17 digits.)

I agree to receive EOBs electronically. (Required for Direct Deposit)

I would like to set an expiration date for this account

Note: When enrolling minor children, EFT automatically expires on 18th birthday.

File A Claim

Are you uncertain about whether you are responsible for filing a claim? If so,reasons to file will help answer your questions. Also see our filing tips for some suggestions from us on what to pay attention to when filing a claim.

To file a claim:

1. Download and print a ready-to-use claim form. Follow the instructions for filing a claim on page one of the form to guide you through the steps required to help ensure your claim is submitted correctly.
2. Upload your completed claim form(s), with original itemized bill(s) attached.
3. Allow approximately 30 days from the time you submit your claim form to the time you receive your Explanation of Benefits.

From*

suzanne.welby@gmail.com

Subject

Contract 00001 - File a claim

First Name of Patient*

Last Name of Patient

Begining Date of Service*

mm/dd/yyyy

Ending Date of Service*

mm/dd/yyyy

Was this care provided in the US?

Yes • No

Country*

Bahrain

Billed Amount *

Currency of the claim (i.e. US Dollars = USD, Euros = EUR, Mexican Peso = MXN, etc.)*

BHD

Amount*

0 . 0

Attachments

Upload documents, scans, pictures or screenshots of your DD2642 claim form, receipts, invoices, itemized bills, proof of payment, medical records or any other documentation needed to support your inquiry. Remember to only attach your documents in black and white format and to attach all documents into one file. Please make sure the information is clear and legible. For further details, please click here.

Accepted File Types 15 MB Max

Browse... Clear File

Add a new file

Message to Send*

Please tell us as much detail about the problem as possible

Cancel Send

1. PATIENT'S NAME *(Last, First, Middle Initial)*

2. PATIENT'S TELEPHONE NUMBER *(Include Area Code)*

DAYTIME ( )

EVENING ( )

3. PATIENT'S ADDRESS *(Street, Apt. No., City, State, and ZIP Code)*

4. PATIENT'S RELATIONSHIP TO SPONSOR *(X one)*

☐ SELF ☐ STEPCHILD

☐ SPOUSE ☐ FORMER SPOUSE

☐ NATURAL OR ADOPTED CHILD ☐ OTHER *(Specify)*

5. PATIENT'S DATE OF BIRTH *(YYYYMMDD)*

6. PATIENT'S SEX *(X one)*

☐ MALE ☐ FEMALE

7. IS PATIENT'S CONDITION *(X both if applicable)*

ACCIDENT RELATED? ☐ YES ☐ NO

WORK RELATED? ☐ YES ☐ NO

8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.

8b. WAS PATIENT'S CARE *(X one)*

☐ INPATIENT? ☐ PHARMACY?

☐ OUTPATIENT?

☐ DAY SURGERY?

9. SPONSOR'S OR FORMER SPOUSE'S NAME *(Last, First, Middle Initial)*

10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER

11. OTHER HEALTH INSURANCE COVERAGE

a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements. ☐ YES ☐ NO

b. TYPE OF COVERAGE *(Check all that apply)*

☐ (1) EMPLOYMENT *(Group)* ☐ (3) MEDICARE ☐ (5) MEDICARE SUPPLEMENTAL INSURANCE ☐ (7) OTHER *(Specify)*

☐ (2) PRIVATE *(Non-Group)* ☐ (4) STUDENT PLAN ☐ (6) PRESCRIPTION DISCOUNT PLAN

	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE *(Street, City, State, and ZIP Code)*	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE *(YYYYMMDD)*	f. DRUG COVERAGE?
INSURANCE 1				☐ YES ☐ NO
INSURANCE 2				☐ YES ☐ NO

REMINDER: Attach your other health insurances's Explanation of Benefits or pharmacy receipt that indicates the actual drug cost, amount the OHI paid, and the amount that you paid.

12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?

☐ YES ☐ NO

HOW TO FILL OUT THE TRICARE/CHAMPUS FORM

You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's daytime telephone number and evening telephone number to include the area code.
3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.
5. Enter patient's date of birth (YYYYMMDD).
6. Check the box for either male or female (patient).
7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity." The form may be obtained from the claims processor, BCAC, or TRICARE Management Activity.

8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident.

8b. Check the box to indicate where the care was given.

9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."
10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN).
11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICARE/CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.

NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. *The claims processor cannot process claims until you provide the other health insurance information.*

12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a. and sign the claim.

Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.

13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment available only in some local currencies.