How to File Tricare Overseas Beneficiary Claims Online





C TOP Regional Call Center

How Do I ...?

Q

Beneficiaries

Providers

Government

Contact Us

WELCOME TO THE TRICARE® Overseas Program

The TRICARE Overseas Program (TOP) is the DOD's health care program for Active Duty Service Members, Active Duty Family Members, and other eligible beneficiaries in geographical areas and waters outside of the U.S. International SOS is proud to support the U.S. military and their families overseas, ensuring quality health care no matter where their work or travels take them.



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...?

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

		International SOS
		?)Help Center
	DS LOGON ? Department of Defense Self-Service	
	DS Logon Username	
	DS Logon Password	
	Forgot DS Logon Username? Forgot DS Logon Password?	
	Login	
More DS Logon Options		
Need a DS Logon?		
Activate My DS Logon		
Upgrade My DS Logon		
A Manage My DS Logon		
Phishing Alert: We do not (Name, SSN, DOB) or sen you think you provided per call, be sure to change you	initiate contact with beneficiaries via email or telepho sitive DS Logon account information (username, pass sonal or account information in response to a fraudule r password and challenge questions immediately.	ne to request private personal word, challenge questions). If ant email, website or phone

- 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.

0

Name of Account Holder

Social Security Number Account Holder

Type of Account

a

○ 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	~
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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 <u>click</u> <u>here</u>.

Accepted File Types 15 MB Max

	Browse
	Dionso

Clear File

Add a new file.

Send



Please tell us as much detail about the problem as possible

Cancel

	NAME (Last, First, Mi	ddle Initial)		2. PATIENT'S TELEPHONE	NUMBER (Include Area Code)	
				DAYTIME ()			
				EVENING ()			
3. PATIENT'S	ADDRESS (Street, A	pt. No., City, State, and	ZIP Code)	4. PATIENT'S RELATIONSHI	P TO SPO	NSOR (X one)	
				SELF	Г	STEPCHILD	
				SPOUSE		FORMER SPO	USE
				NATURAL OR ADOPTED		OTHER (Speci	fv)
5. PATIENT'S	DATE OF BIRTH	6. PATIENT'S SEX		7. IS PATIENT'S CONDITION	(X both if a	pplicable)	
(YYYYMMDD)	1	(X one)		ACCIDENT RELATED?		YES	
				WORK RELATED?	H.	VES	
8a DESCRIBE	CONDITION FOR V	WHICH THE PATIEN	T RECEIVED T	REATMENT, SUPPLIES OR	8b. W	AS PATIENT'S CA	RE (X one)
MEDICATIO	N. IF AN INJURY,	NOTE HOW IT HAPP	PENED. REFE	R TO INSTRUCTIONS BELOW			
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	TUNCUDANOS	00/50405					
11. OTHER HEA	LIHINSURANCE	LOVERAGE	• • •	1			
a. Is patient co	vered by any other h	ealth insurance plan	or program to i	nclude health coverage available	e through a	other family membe	rs?
If yes, check	the "Yes" block and	COMPLETE DIOCKS 11	and 12 (see ins	structions below). If no, you mus	a report Me	e No block and edicare supplement	s NO
complete bio	CK 12. DO NOT PIOVI		00 supplement	tar mourance information, but u	o report me	school of supplement	J
b. TYPE OF CO	DVERAGE (Check all	that apply)					
(1) EMPLC	YMENT (Group)	(3) MEDICARE	(5) MEDICARE SUPPLEMENTAL	INSURAN		IER (Specify)
(2) PRIVAT	E (Non-Group)	(4) STUDENT P	LAN (6) PRESCRIPTION DISCOUNT F	PLAN		
	c. NAME AND ADDR	ESS OF OTHER HEAL	TH INSURANCE	d. INSURANCE IDENTIFICA	TION	e. INSURANCE EFFECTIVE DA	TE . DRUG
	(Street, City, State	, and ZIP Code)		NUMBER		(YYYYMMDD)	COVERAGE
INSURANCE							YES
INSURANCE							
1							NO NO
							YES
INSURANCE							
2							NO NO
REMI	NDER: Attach your	other health insuranc	es's Explanatio	on of Benefits or pharmacy recei	pt that indi	cates the actual dru	ig cost,
		amount	the OHI paid,	and the amount that you paid.		12 OVERSEAS	CLAIMS ONLY
12. SIGNATUR	E OF PATIENT OR	AUTHORIZED PERS	ON CERTIFIE	S CORRECTNESS OF CLAIM	AND	PAYMENT	N LOCAL
AUTHORIZI	AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE		INSURANCE	INFORMATION		CURRENCY?	
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