



CHAMPVA Caregiver Program Handbook

Health Care Benefits for the Primary Caregiver



NAME	TELEPHONE NUMBER
Your Doctor (Primary Care)	
Your Doctor	
Your Doctor	
Your Hospital	
Your Pharmacy	
YOUR MEDICATIONS	
CHAMPVA	1-800-733-8387
Magellan Mental Health	1-800-424-4018
Meds by Mail (MbM) (see page 11 for the number of the servicing center for your state)	East: 1-866-229-7389 West: 1-888-385-0235
SXC Retail Pharmacy Network	1-888-546-5502

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KEEP THIS HANDBOOK

This handbook provides important information about the CHAMPVA program for the Primary Family Caregiver. This handbook is also available on our website at <http://www.va.gov/hac>.

The handbook is not reprinted yearly. Occasionally, there will be a change that could impact your benefits. When that happens, we will send you a notification of the change and ask you to add it to your handbook. Please remember this handbook is only a guide. The law, regulations and policy manual are the authoritative guidance for the program.



FINDING INFORMATION IN THIS HANDBOOK

The Table of Contents lists the topic areas by section, with corresponding page numbers.

The Index that begins on page 55 is an alphabetical listing of the topics addressed in this handbook, with corresponding page numbers. All page listings in the Table of Contents and Index of our on-line handbook are interactive: clicking on a page number in either list takes you to that page.

Words and acronyms that are in bold green text in this handbook are defined on pages 52–54.

CHAMPVA
 PO Box 469063
 Denver CO 80246-9063

Phone: 1-877-733-7927
 E-mail: Please go to this website and follow the directions for submitting e-mail via IRIS:
<http://www.va.gov/hac/contact>

CHANGE OF ADDRESS

It is very important that you notify us if your address or phone number changes by contacting us at:

Mail: **CHAMPVA**
PO Box 460637
Denver CO 80246-0637

Phone: **1-877-733-7927**

SPECIAL NEEDS

Hearing impaired callers please use the Federal Relay Operator at **1-800-877-8339**.

When English is not your first language, we can arrange for a third-party translator. When you call us, we will ask our translation service to participate in the phone call.

We can also provide you, on request, a copy of the **CHAMPVA** Handbook in any language or Braille. It will take about six weeks to provide you the translated handbook from the time we receive your request.

HELPING YOU TAKE AN ACTIVE ROLE IN YOUR HEALTH CARE

Our number one priority is keeping you healthy. Numerous studies have shown that patients who are well informed about their care and effectively communicate with their health providers report better overall health. That is why we encourage you to take control of your health and become an active partner every step of the way.

Effective communication with your provider begins even before your first appointment. The time you take to prepare for your appointment will help you and your physician better manage your care. Make a list of any prescription or **over-the-counter medications** you take on a regular basis, as well as the dosages. It may also be helpful to make a note of symptoms you may be having, including duration, intensity and what, if anything, relieves the symptoms. Finally, be sure to make a list of any specific questions you may have and prioritize them so you are sure to get answers to your most urgent concerns.

During your appointment, be sure to ask your physician to fully explain any terminology or procedure you do not understand, and write down the answers, if necessary. If you are prescribed any medications, make sure that you know how much you are supposed to take and when you are supposed to take them.

Words that are in bold green print are defined on pages 52–54.



Here is a list of questions that may also help you to gain understanding of your condition:

- Why do I have this problem?
- How will this problem affect me in the future?
- What treatment is needed?
- Will the treatment require any changes to my diet or lifestyle?
- What will happen if I don't treat this condition right away?
- Do I need any tests?
- Why do I need this medicine, and how long will I need to take it?
- Are there any foods or drinks I should avoid while taking this medicine?
- What are the side effects of this medication?
- When should I schedule a follow-up appointment?

The Civilian Health and Medical Program of the Department of Veterans Affairs, which is commonly referred to as **CHAMPVA**, is a health care benefits program in which the Department of Veterans Affairs (**VA**) shares the cost of certain health care services and supplies with certain eligible beneficiaries. CHAMPVA is managed by Purchased Care at the Health Administration Center (PC@HAC), located in Denver, Colo. PC@HAC processes all claims submitted for the reimbursement of medical services and supplies rendered by authorized providers in the community.

The Primary Family Caregiver qualifies for CHAMPVA when he/she is not entitled to care or services under a health plan contract such as a commercial health insurance plan, Medicare, Medicaid, Indian Health Service, Consolidated Omnibus Budget Reconciliation Act (COBRA), or a workers' compensation law or plan. In addition, Primary Family Caregivers who are eligible for TRICARE benefits are not eligible for CHAMPVA.

VA discourages the Primary Family Caregiver from discontinuing their coverage under a health plan contract without first considering, at a minimum, the following:

- Medicaid recipients may have less financial burden than they would under CHAMPVA. Many state Medicaid plans do not require the participant to pay co-payments, cost shares or deductibles. CHAMPVA has an outpatient deductible of \$50 per calendar year and a cost share of a minimum of 25 percent of the CHAMPVA allowable charge, up to the catastrophic cap, which is \$3,000 per calendar year.
- Some health plan contracts may have a comprehensive medical benefit services package that might not be covered by CHAMPVA. For example, CHAMPVA does not cover routine dental care, chiropractic services or routine eye exams and corrective lenses.
- CHAMPVA benefits are discontinued for the Primary Family Caregiver when the Veteran is no longer in need of personal care services or someone else is designated as the Primary Family Caregiver.
- CHAMPVA benefits do not extend to the family members of the Primary Family Caregiver.

You must notify CHAMPVA immediately at 1-877-733-7927 if there is a change in your health insurance status, a change in your address or phone number or if there is a change in your Primary Caregiver status. Failure to contact us immediately will result in **recoupment** action issued by our Debt Collection Unit for payments made during your period of ineligibility.

Words that are in bold green print are defined on pages 52–54.

CUSTOMER SERVICE



We are always working to improve our service to you. We are committed to getting you accurate and timely information about your benefits and giving you a variety of ways to obtain the needed information.

If this handbook does not provide you with the answers to your questions or the information you need, the following sources may be of use to you.

Interactive voice response system

Phone Toll Free: **1-800-733-8387,**
24 hours a day, 7 days a week

You can obtain information and request forms through our interactive voice response system, without waiting to speak to a customer service representative.

Services available through this system:

- Ordering **CHAMPVA** forms and applications. The prompts will instruct you to leave a voice mail request by leaving your CHAMPVA Member Number (Social Security number), full name and address.
- You can check on your eligibility, claims status, annual deductible and annual catastrophic cap.
- Your providers can check on your enrollment or the status of a payment.

Talk to a customer service representative

Phone Toll Free: **1-877-733-7927**
Monday through Friday (excluding holidays)
8:05 a.m. to 7:30 p.m. Eastern Time

We have recently implemented a Virtual Hold system to allow us to call you back when our estimated wait time exceeds three minutes.

Words that are in bold green print are defined on pages 52–54.

VA Caregiver Support website

The new Caregiver Support website at <http://www.caregiver.va.gov> provides information on more than two dozen services specific to Caregivers of Veterans of all eras that are currently being offered by VA. You can find contact numbers to your local Caregiver Support Coordinator for information on these and other Caregiver resources and services.

VA PC@HAC website

The following information is available at <http://www.va.gov/hac>, 24 hours a day, 7 days a week:

- *CHAMPVA Handbook for Primary Caregivers* and the **CHAMPVA** Policy Manual
- Frequently asked questions
- Fact sheets on all aspects of the CHAMPVA program

E-mail

Please go to this website and follow the directions for submitting e-mail via IRIS: <http://www.va.gov/hac/contact>.

Typically, you will receive a response to your question within one working day. To protect your privacy, we recommend that you do not include sensitive or personal information in the message. We do ask that you include your full name in the body of the message. We will not return information containing personal identifiers or medical information on e-mail. If you are requesting that type of information, we will call you or send the information through regular mail.

Mail

When you write to us, please include your name and phone number. Send your inquiry to:

CHAMPVA
PO Box 460637
Denver CO 80246-0637

Words that are in bold green print are defined on pages 52–54.

WHERE TO GET FORMS AND PUBLICATIONS

Forms and publications are available to you through the customer service options identified on pages 5–6. When you use any of these options, make sure you provide your name and address.

Where to Send Completed Forms

Send completed claims for medical services and supplies to:

CHAMPVA
PO Box 469064
Denver CO 80246-9064

Words that are in bold green print are defined on pages 52–54.

Each **CHAMPVA** Primary Family Caregiver receives an identification card. We changed our practice of displaying your Social Security number (SSN) as the member number on the identification card due to the potential risk of identity theft. The sample below shows that cards are issued with the phrase “*Patient SSN*” in the Member Number space rather than the actual number being displayed.

		Open Access No Referral Required
Beneficiary Name		
Include this Member Number on all claims and letters		
“Patient SSN”		
This is your CHAMPVA Identification Card		
Effective Date	Expiration Date	1-877-733-7927 www.va.gov/hac

FRONT

<p>For Electronic Claims Filing please follow the instructions at www.va.gov/hac/forproviders under “How to File a Claim.”</p> <p>For Mental Health/Substance Abuse Preauthorization Call 1-800-424-4018—Preauthorization is required:</p> <ul style="list-style-type: none"> • After 23 outpatient mental health visits in a calendar year • For all other mental health/substance abuse services <p>For Durable Medical Equipment (DME) Preauthorization Call 1-800-733-8387—Preauthorization is required:</p> <ul style="list-style-type: none"> • For DME purchase or rental over \$2,000

BACK

When you visit your doctor, make sure you take your CHAMPVA Identification Card with you. Since your cost share (co-payment) for care will be a percentage of the CHAMPVA **allowable amount** rather than a specific, predetermined dollar amount, talk to your doctor about how and when to pay your part of the bills. If you are receiving outpatient care (including prescriptions) and you have already paid your deductible or reached your catastrophic cap for the year, bring your most recent CHAMPVA **Explanation of Benefits (EOB)** with you to show you have met one or both of these requirements for the year.

CHAMPVA covers most **medically necessary** health care services, including ambulance, ambulatory surgery, **durable medical equipment (DME)**, family planning and maternity, hospice, inpatient services, mental health services, outpatient services, pharmacy, skilled nursing care and transplants.

We pay for covered services and supplies, when they are determined to be medically necessary and are received from an authorized provider. When providers are performing services within the scope of their license or certification, we consider them to be authorized. The most common providers are: anesthetist, audiologist, certified clinical social worker, certified nurse midwife, certified nurse practitioner (NP or CNP), certified registered nurse anesthetist (CRNA), certified physician assistant (PA), certified psychiatric nurse specialist, clinical psychologist (Ph.D.), doctor of osteopathy (DO), licensed clinical speech therapist (LCSP), licensed practical nurse (LPN), licensed vocational nurse (LVN), marriage and family



Words that are in bold green print are defined on pages 52–54.

counselor/therapist, medical doctor (MD), occupational therapist (OT), pastoral counselor, physical therapist (PT), physiologist, podiatrist (DPM), psychiatrist and registered nurse (RN).

You have many choices when selecting a provider. Medical services may be available to you at your local **VA** Medical Center through the CHAMPVA Inhouse Treatment Initiative (**CITI**) program, described in the following paragraph. You may also obtain medical services from non-VA providers.

VA MEDICAL PROVIDERS

Depending on whether your local VA Medical Center (VAMC) participates in the **CITI** – pronounced “city” – program and the type of services a VAMC has available, you may be able to receive all or a portion of your medical care at a VAMC through the CITI program. The care may include inpatient, outpatient, pharmacy, **DME** and mental health services. The care you receive through this program is at **no cost to you!** There is no cost share and no deductible for the care you receive through CITI. More than half of all VA medical facilities participate in the CITI program, so there is a good chance that a VAMC near you is a participant.

To find out if your local VAMC participates in this program

- Go to our website at <http://www.va.gov/hac>
- Select “Beneficiaries” from the side tab, then select “CHAMPVA.”
- Scroll down to the “CITI” link. You will find a list of participating facilities and their phone numbers on this page.
- Or you can call, e-mail or write us (see pages 5–6 for contact information).



When you contact your VAMC, they will be able to tell you which services are available. If the services you need are available, and you choose to receive your care through the CITI program, the VAMC will ask you to process through the patient administration section. They will review your CHAMPVA eligibility.

Words that are in bold green print are defined on pages 52–54.

NON-VA MEDICAL PROVIDERS

CHAMPVA does not have a network of medical providers. However, most TRICARE providers will also accept CHAMPVA patients. Go to the TRICARE website, <http://www.tricare.osd.mil/standardprovider>, to locate a provider in your area, then contact them to ask if they also accept CHAMPVA patients.

Most Medicare providers will also accept CHAMPVA patients. Medicare providers can be located through their website at <http://www.medicare.gov>. Use the “*Search Tools*” at the bottom of that page to locate a Medicare provider.

Please call, e-mail or write us (see pages 5–6 for contact information) if you are having difficulty locating a provider, and we will help you find one.

Providers that accept “assignment” for CHAMPVA patients

When you locate a medical provider, find out if they will accept CHAMPVA. Providers most often refer to this as accepting **assignment**. What that means is the provider will bill us directly for covered services, items and supplies. Doctors or providers who agree to accept assignment are doing so at the **allowable amount** and cannot collect additional amounts from you beyond your co-pay.

IMPORTANT NOTE: All hospitals that participate in Medicare, and hospital-based health care professionals who are employed by, or contracted to, such hospitals are required by law to accept CHAMPVA for inpatient hospital services.

Providers that do not accept “assignment” for CHAMPVA patients

If your provider does not accept assignment, you can still see that provider, but be aware that you will likely have to pay the entire charge at the time of service. Additionally, you may be charged more than the CHAMPVA allowable amount. To obtain reimbursement if your provider does not accept CHAMPVA, you will have to submit the itemized bill from the provider along with a CHAMPVA claim form (VA Form 10-7959a). When the claim is processed, we will reimburse you for our share of the allowable amount.

What all of this means to you is that when the medical provider does not accept assignment, your cost will include not only your share of our determined allowable amount, but also any charges over our allowable amount.

Words that are in bold green print are defined on pages 52–54.

PHARMACY PROVIDERS

Meds by Mail (MbM) is by far the most cost effective way for you to receive your nonurgent, maintenance medications. There are **no co-payments, no deductible requirements and no claims to file!** Your maintenance medication is mailed to your home. This program is a great benefit, and we highly encourage you to use it.



There are two pharmacy servicing centers, and you are assigned to a servicing center based on the area in which you live. Your servicing center will help you with the status of your prescription order, questions about drug availability and patient profile updates.

If you live in these states, districts or territories:	Your Meds by Mail Pharmacy Servicing Center is:
Alabama, Connecticut, Delaware, District of Columbia, Florida, Georgia, Guam, Kentucky, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Virgin Islands, West Virginia	Dublin, GA Monday–Friday 8:00 a.m. to 5:30 p.m. (Eastern Time) 1-866-229-7389
Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming	Cheyenne, WY Monday–Friday 8:00 a.m. to 5:30 p.m. (Mountain Time) 1-888-385-0235

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Important facts to keep in mind when using MbM

- To begin using **MbM**, fill out the MbM Prescription Order Form, **VA Form 10-0426**, available on our website at <http://www.va.gov/hac/forms/forms.asp> or by calling **1-800-733-8387** and selecting the self-service option to request the form be mailed to you.
- Tell your physician you are using a mail order prescription service. Request that the physician prescribe up to a 90-day supply with up to three (3) refills, if possible. Certain medications may have a limit of 30 days for the supply amount. If you need to begin taking the medication right away, ask your provider to write two prescriptions—a one month supply that you can fill immediately at your local pharmacy and a longer-term supply to be filled through MbM.
- Original prescriptions must be sent to the servicing center (copied or faxed prescriptions cannot be filled).
- Maintenance medications (those taken for a longer period of time, such as blood pressure, heart, arthritis or chronic pain medication) are available through MbM.
- Certain controlled medications are also available through this program. For example, Tylenol No. 3, Valium, Klonopin and Vicodin are available. These are medications in Schedules 3, 4 and 5 for controlled drugs (your physician can tell you if the medication prescribed to you is on one of these schedules). Medications such as Percocet, Percodan, Ritalin and Oxycontin are **NOT** available through MbM and must be filled at your local pharmacy.
- Most prescriptions are filled with the generic equivalent. When the prescription does not have a generic equivalent and the brand-name drug prescribed is not on the VA's **formulary**, a pharmacist will contact your physician to obtain authorization to substitute the VA's formulary brand for the one prescribed.
- **Over-the-counter medications** are not covered and cannot be obtained through MbM. The **ONLY** exception is for insulin and insulin-related supplies.
- You can still use your local pharmacy for urgent care medications or any that are not available through MbM.

If you need help with general information about MbM eligibility or applications for MbM, contact via:

Phone: **1-877-733-7927**

E-mail: Please go to this website and follow the directions for submitting e-mail via IRIS: <http://www.va.gov/hac/contact>

Website: <http://www.va.gov/hac> (select “Beneficiaries, Meds by Mail”)

Words that are in bold green print are defined on pages 52–54.

SXC RETAIL NETWORK PHARMACY

Our network consists of more than 55,000 pharmacies. The advantage to you is that you need only pay your cost share for the medication (after your outpatient deductible has been met), and there are **no claims for you to file**. Typically, the use of a network pharmacy will result in a lower cost share to you. To obtain an SXC pharmacy identification card and information on local pharmacies in your area that are a part of the SXC network, call the following **beneficiary** number or go to our website and follow the instructions listed below.

Phone: **1-888-546-5502**
Bin#: 610593
Group#: HAC
PCN#: VA

Website: <http://www.va.gov/hac>

- Click on “Beneficiaries” and select the “Pharmacy Benefits” link under the **CHAMPVA** program.
- A paragraph will appear, entitled “Pharmacies That Accept CHAMPVA.” Go to the end of the paragraph and click on the <https://vahac.rxportal.sxc.com> link.
- The SXC Health Solutions page will appear. Click on “Preferred Pharmacy Finder” on the left side of the page.
- A page will appear with several boxes requesting information necessary to locate a network pharmacy near you. Follow the instructions on the page to get a list of participating pharmacies in or near your ZIP code.

NON-NETWORK RETAIL PHARMACY

You can choose any pharmacy. The CHAMPVA Identification Card is your proof of coverage for a nonnetwork pharmacy. A pharmacy that is not part of the network will most likely ask you to pay the full amount of the prescription. In that case, you will need to request reimbursement from us by submitting a CHAMPVA Claim Form (**VA Form 10-7959a**) and the itemized pharmacy statement. Your pharmacist can provide you with a printed document that contains all required information that CHAMPVA needs to reimburse you for pharmacy claims. We cannot process the claim without this required information:

- 11-digit **National Drug Code (NDC)**
- retail value of the drug
- date the drug was dispensed
- amount of your co-pay
- name and quantity of the drug

Words that are in bold green print are defined on pages 52–54.

CHAMPVA for the primary family caregiver will cover only care that is **medically necessary** and appropriate. The fact that your physician tells you that you need certain care does not mean that the care is covered under CHAMPVA. There may be limits on certain care, and some care is not covered at all.

Any type of care that goes on for a long time (over a period of weeks, months, etc.), including physical therapy, medication, mental health services and skilled nursing services, may be medically reviewed periodically, and medical documents will be requested during the course of treatment. We will notify you when additional documentation or a treatment plan is needed from your medical provider.

The same limitations apply whether you reside in the U.S. or in another country. For example, if you reside or travel overseas, we will only cover medications that are approved by the Food and Drug Administration (**FDA**) for use in the U.S.

AUTHORIZATION FOR CARE

You do not need advance approval for care from us, unless the care relates to one of the medical services listed below. Although we do not require authorization for most medical care, your physician may seek to obtain authorization for services. In that case, ask the physician to call us regarding the service requested, and we will provide information about what will be needed to determine if a specific service is covered. You may also want to consider showing your provider this section of the handbook, as it describes the criteria for coverage of many services.

Services that require authorization

- **DME** with a purchase price or total rental price of \$2,000 or more (see page 22)
- Hospice care
- Mental health care (approval needed from our mental health contractor)
 - Inpatient mental health care
 - Care at residential treatment facilities
 - Alcohol/substance abuse
 - Care in Partial Hospital Programs (PHP)
 - Requests for extensions to our yearly limits on inpatient mental health care (see page 25) or outpatient mental health visits in excess of 23 per year
- Dental care coverage (Dental coverage is *very* limited and under most circumstances is *not* covered.)
- Organ transplants

Words that are in bold green print are defined on pages 52–54.

Exceptions to the authorization requirement

Mental health services and **durable medical equipment** provided through the **VA CITI** program do not require authorization.

To obtain authorization for mental health and substance abuse services:

Mail: **Magellan Behavioral Health
CHAMPVA / Primary Family Caregiver
PO Box 3567
Englewood CO 80155**

Phone: **1-800-424-4018 (domestic)
1-720-529-7400 (international)**

To obtain authorization for other services:

Mail: **CHAMPVA
ATTN: Preauthorization
PO Box 469063
Denver CO 80246-9063**

Phone: **1-800-733-8387**

COVERED BENEFITS (NOT ALL INCLUSIVE)

The following is an alphabetical list of the services we cover that will help you stay healthy and identify health problems early. In all cases, your physician will determine when it is **medically necessary** and appropriate for the medical service.

Preventive services

Bone mass measurements	These measurements help determine if you are at risk for developing osteoporosis.
Cancer screening	Including colorectal, oral cavity, prostate, skin, testicular, breast and thyroid.
Cardiovascular screenings	Ask your doctor to test your cholesterol, lipid and triglyceride levels so he/she can help you prevent a heart attack or stroke.
Cholesterol screening	As recommended by your physician, based on your age, health and risk factors.

Words that are in bold green print are defined on pages 52–54.

Preventive services

Colonoscopy	Once every 10 years after age 50, or more frequently if your physician determines you have an increased risk of colon cancer.
Diabetes screening	<p>We cover this screening when you have these risk factors:</p> <ul style="list-style-type: none"> high blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity or a history of high blood sugar. <p>Or if you have two or more of the following characteristics:</p> <ul style="list-style-type: none"> age 65 or older; overweight; immediate family history of diabetes (parents, brothers, sisters); a history of gestational diabetes (diabetes during pregnancy) or delivery of a baby weighing more than nine pounds. Based on the results of these tests, you may be eligible for up to two diabetes screenings every year. For more information, talk to your doctor.
Genetic testing	When there is a family history of breast cancer, certain high risk pregnancies or sickle cell anemia.
HIV testing	When there has been HIV exposure or symptoms of possible infection, or if there is a pregnancy
Immunizations and vaccines	Your physician will advise you when it is appropriate for you to have routine immunizations, based on the Centers for Disease Control (CDC) recommendations and other specific factors. We also cover postexposure rabies vaccines and Rh immune globulin, following the birth of an Rh-positive child to an Rh-negative woman.

Words that are in bold green print are defined on pages 52–54.

Preventive services

Mammograms	<p>These tests check for breast cancer before you or your doctor are otherwise aware of a problem.</p> <p>Age 35–40:</p> <ul style="list-style-type: none"> one baseline mammogram or annually, if your doctor determines you are at high risk <p>Age 40+:</p> <ul style="list-style-type: none"> annually
Pap test and pelvic exam	These exams check for cervical and vaginal cancers.

OTHER COVERED SERVICES

On the following pages is an alphabetical list of services that are covered, when **medically necessary**, like the preventive services listed previously. This list is NOT all inclusive. For additional information, please refer to the **CHAMPVA** Policy Manual, Chapter 2, available on our website at <http://www.va.gov/hac/forbeneficiaries/champva/policymanual>. For limitations, please refer to the conditions of coverage that follow and to the noncovered services identified on pages 33 through 36.

Covered Services	Conditions of Coverage
Attention Deficit Disorder (ADD), or Attention Deficit Hyperactivity Disorder (ADHD)	ADD and ADHD are considered a mental health condition. Refer to Mental health outpatient care for benefit coverage.
Alcohol abuse (treatment for)	Preauthorization is required. Refer to Substance abuse for specific benefit coverage

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Allergy testing and treatment	Allergy testing and treatment are covered based on medical necessity . All claims for allergy testing must indicate the type and number of tests performed. We cover RAST (radioallergo-sorbent test), FAST (fluoro-allergosorbent test) and IPA (immunoperoxidase assay) for inhalant or food allergies and PRIST (paper radioimmuno-sorbent test), RIST (radioimmunosorbent test) and bronchial challenge testing.
Ambulance service	Life-sustaining equipment is necessary for a medically covered condition or other means of transportation are contraindicated. Ambulance service, other than land vehicles (such as boat or airplane), may be considered only when the pickup point is inaccessible by a land vehicle or when great distances or other obstacles are involved. Justification for the use of a service other than a land vehicle will be required before payment can be made.
Ambulatory surgery	<p>Performed on an outpatient, walk-in or same-day basis in an appropriately equipped and staffed facility. Surgery is usually conducted under general anesthesia with no overnight stay required. Our coverage of ambulatory surgical procedures is dependent on where the surgery takes place.</p> <p>Coverage should be verified prior to surgery. Most ambulatory surgical procedures performed in a hospital are covered when medically necessary. Certain procedures are also covered when performed in a Medicare- approved, free-standing ambulatory surgical center.</p>

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Ankyloglossia (total or complete tongue tie—surgery for)	Surgery for tongue tie is covered in cases where total or complete ankyloglossia is documented.
Autologous blood collection (blood transfusion)	This is collection of the patient's own blood. Transfusion services are covered when there is a scheduled surgical procedure.
Biofeedback	Certain types of therapy (electrothermal, electromyography and electrodermal) are covered when there is medical documentation that there has been no response to other conventional forms of therapy.
Birth control	Family planning benefits are provided for intrauterine devices (IUDs), diaphragms, birth control pills, Norplant system long-term reversible contraceptive implants and sterilization (vasectomy or tubal ligation).
Blepharoplasty	Surgery to improve the abnormal function of the eyelid is covered when a significant impairment of vision is medically documented. Medical documentation should include two visual field studies (one with and one without lid elevation) and photographs.
Bone growth stimulator	Claim should be accompanied by a Certificate of Medical Necessity (CMN) , or for electrical stimulation of bone, doctor's order with diagnosis or documentation of a history of fracture with nonhealing for three months or more.
Breast reconstruction	Covered, following a medically necessary mastectomy.

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Breast reduction (reduction mammoplasty)	This is covered when there are signs and symptoms of macromastia or intractable pain not amenable to other forms of treatment. Symptoms must be present for at least one year. Claims must include documentation of a medical history of persistent symptoms, such as back pain, neck and shoulder pain, poor posture, ulnar paresthesia, shoulder grooving, rash and restriction of physical activities.
Cardiac rehabilitation programs	Limited to 36 sessions and normally completed within 12 months following a qualifying cardiac event.
Cleft palate (correction of)	Claim must include a medical statement from the physician that includes the following information: brief medical history, condition, symptoms, length of time symptoms have been present, other forms of treatment attempted, an operative report and photographs, if available.
CT scans	Computerized tomography when medically necessary .
Dental (adjunctive)	Dental care can be considered for coverage only when it is adjunctive . That means the dental treatment MUST be completed as part of the appropriate treatment of some other (nondental) covered medical condition. For example, an oral surgeon has to remove broken teeth to repair an injured jaw. Dental care requires preauthorization.
Dermatological procedures	For the treatment of covered conditions such as acne and for hypertrophic scarring and keloids resulting from burns, surgical procedures or traumatic events.

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Diabetes self-management training program (outpatient)	Prescribed by a physician for education about self-monitoring of blood glucose, diet and exercise (limitations apply, and medical documentation from the provider must accompany the billing).
Drug abuse (treatment for)	Preauthorization is required. Refer to Substance abuse for specific benefit coverage.
Drugs and medications	Drugs and medications must be approved by the Department of Health and Human Services' Food and Drug Administration for the treatment of the conditions for which they are administered, prescribed by an authorized provider and dispensed in accordance with state law and licensing requirements.
Durable medical equipment	DME is equipment that can withstand repeated use, is primarily used to serve a medical purpose, is generally not useful in the absence of an illness or injury and is appropriate for use in the home. DME must be ordered by a physician and be preauthorized by CHAMPVA if the total cost (for rental or purchase) exceeds \$2,000. Requests for preauthorization must include the CMN or doctor's DME order. This information can be submitted in the form of a letter or by using a CMN form. In either case, the following information must be included: the name, address and tax identification number of the provider; the required equipment (the make and model number, cost and specifications for any customization); diagnosis; determination of medical necessity ; and the anticipated duration that the item will be needed.

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Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Durable medical equipment (continued from previous page)	Coverage may be authorized for customization, accessories or supplies that are essential to provide a therapeutic benefit and to ensure proper functioning of the equipment; maintenance by a manufacturer's authorized technician; repair and adjustment; replacement needed as a result of normal wear or a change in the medical condition; temporary rental when the purchased DME is being repaired and/or a vehicle wheelchair lift (detachable).
Eating disorders	Covered when preauthorized by the CHAMPVA mental health contractor.
Eyeglasses, contact lenses (limited coverage as noted)	When required after intraocular surgery, ocular injury or congenital absence of a human lens.
Family planning and maternity	We cover most treatment related to prenatal and delivery care, including complications associated with pregnancy, such as miscarriage, premature labor and hemorrhage. Services provided to the mother and those provided to the child must be billed separately as newborns are not covered.
Foot care services (very limited coverage)	Covered when they are a medically necessary treatment for a specific diagnosis like diabetes.
Genetic testing during pregnancy	We cover this for any of the following: <ul style="list-style-type: none"> women 35 or older one parent has had a previous child with a congenital abnormality one parent has a history (personal or familial) of congenital abnormality mother contracted rubella during first trimester history of cystic fibrosis or recessive genetic disorder

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Gingival hyperplasia	When caused by prolonged medication therapy for conditions such as epilepsy or seizure disorders.
Home health care	Home health care is intermittent skilled care in a home setting for a homebound patient. It includes skilled nursing and rehabilitative care, as part of a physician's treatment plan, and is provided by a licensed or registered caregiver.
Hospice	<p>CHAMPVA covers hospice care for terminally ill patients who have a life expectancy of six months or less. The CHAMPVA benefit closely resembles Medicare's hospice benefit. The program is designed to provide care and comfort to our beneficiaries and emphasizes supportive services such as pain control, home care and patient comfort.</p> <p>Your hospice caregiver will be asked to provide the following information for authorization:</p> <ul style="list-style-type: none"> hospice tax identification number Medicare hospice provider number address of hospice county in which hospice is located remit- to address (where the payment is to be mailed) name of attending physician name of hospice physician diagnosis whether request is for inpatient, home care or respite care physician certification of terminal illness

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Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Hospice (continued from previous page)	<ul style="list-style-type: none"> patient's election of hospice (signed by patient or patient's representative based on a health care power of attorney) Medicare hospice per diem (daily) reimbursement rate itemized list of medications or any other services not included under the hospice per diem allowance
Implants (surgical)	Must be approved by the FDA . There are limitations, so check with us before having the surgery. For example, breast implants are covered for reconstructive surgery following removal of the breast, but not for breast augmentation.
Infertility testing and treatment	Services include diagnostic testing, surgical intervention, hormone therapy and other covered procedures to correct the cause of infertility.
Insulin and diabetic related supplies	Covered even though a prescription may not be required by state law. Insulin pumps are covered when the claim is accompanied by a CMN or doctor's order with diagnosis of diabetes mellitus.
Laser surgery	Covered when the surgical procedure is medically necessary , considered acceptable medical practice for the condition, the laser is FDA approved and the laser is merely used as a substitute for the scalpel.
Loss of jaw substance	Covered when due to direct trauma or treatment of neoplasm. Requires documentation that provides the diagnosis, history of the trauma or treatment of a neoplasm and the patient's age. Include a detailed description of the prosthetic treatment plan when applicable.

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Magnetic resonance angiography (MRA), magnetic resonance imaging (MRI) and magnetic resonance spectroscopy (MRS)	Claims for both an MRI and computerized tomography (CT) scan of the same body area for the same episode of care will require documentation of need and will be reviewed for medical appropriateness.
Mastectomy bras and prostheses	Up to seven bras every 12 months; replacement of breast prostheses every 24 months.
Mental health inpatient care	<p>Acute care to include room, board and other hospital services. Authorization is required from the mental health contractor.</p> <p>Benefit: 30 days for beneficiaries ages 19 and older, per year, or during a single episode of care; 45 days for beneficiaries ages 18 or younger; one psychotherapy session per day not to exceed seven sessions per week (more than seven sessions per week requires authorization from the mental health contractor). The CHAMPVA mental health contractor may consider a waiver of the 30- to 45-day limit.</p>
Mental health outpatient care	<p>Benefit: 23 outpatient psychotherapy sessions per year when medically necessary, not to exceed two psychotherapy sessions per week in any combination of individual, family, collateral or group therapy. More than 23 visits per year or two visits per week can be allowed when authorized by the CHAMPVA mental health contractor.</p> <p>Individual psychotherapy (limited to 60 minutes, unless for crisis intervention) and individual psychotherapy sessions in excess of 50 minutes that have been authorized by the CHAMPVA mental health contractor are covered. Multiple sessions on the same day for crisis intervention and which are authorized by the CHAMPVA Mental Health contractor are covered.</p>

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Mercury hypersensitivity	<p>The removal of dental amalgam mercury source is covered under the following conditions:</p> <ul style="list-style-type: none"> independent diagnosis by a physician allergist based on generally accepted test(s) for mercury hypersensitivity documentation that reasonably rules out sources of mercury exposure other than the dental amalgam
Morbid obesity	<p>Surgical correction of morbid obesity may be covered when one of the following conditions is met:</p> <ul style="list-style-type: none"> patient's body mass index (BMI) is over 40 patient's BMI is over 35 with serious medical conditions exacerbated or caused by obesity second surgery (takedown) due to complications of previous surgical correction <p>Surgical procedures are limited to gastric bypass, gastroplasty (including vertical banding gastroplasty), Roux-en-Y gastrojejunostomy, adjustable silicone gastric banding (LAP-BAND) and medically necessary revisions. Claims must be accompanied by the BMI, current height, weight, history of other medical conditions and history of other treatments tried and failed.</p>
Myofascial pain dysfunction syndrome	<p>Treatment of this syndrome may be considered a medical necessity only when it involves immediate relief of pain. Treatment beyond four visits or any repeat episodes of care within a six month period must be documented by the provider of services and medically reviewed by CHAMPVA.</p>

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Occupational therapy	Covered when training and assessment do not relate primarily to employment.
Orthopedic braces and other appliances	For the neck, arm, back and leg to assist you other appliances in movement or to provide support to a limb.
Orthotic shoes for diabetics	<p>One pair of custom molded shoes (including inserts) per calendar year.</p> <p>One pair of extra-depth shoes (not including inserts provided with such shoes) per calendar year.</p> <p>Three pairs of multi-density inserts per calendar year.</p>
Oxygen and related equipment (to include oxygen concentrators)	Requires a CMN that includes the oxygen flow rate with frequency and duration of use, estimated length of time oxygen will be required and the method of delivery, or the physician can provide this information on his/her letterhead. If the initial CMN shows an indefinite or lifetime need, a new prescription is not required with each billing, as long as the diagnosis supports a continued need.
Panniculectomy	Claims should be accompanied by a medical history that documents the complications experienced as a result of the enlarged pannus such as skin rashes/infection, conservative treatments that were tried and failed and/or low back pain.
Penile implant/testicular prosthesis	For organic impotence, correction of a congenital anomaly or correction of ambiguous genitalia.

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Physical therapy	Physical therapy services must be prescribed by a physician. Professionally administered physical therapy to help the patient attain greater self-sufficiency, mobility and productivity is covered when the exercises and other modalities improve muscle strength, joint motion, coordination and endurance.
Plastic surgery	This benefit is limited. It can be covered to correct a serious birth defect, such as a cleft lip/palate, to restore body form or function after an accidental injury, to improve appearance after severe disfigurement or extensive scarring from cancer surgery or breast reconstructive surgery following a mastectomy that is covered by CHAMPVA .
Positron emission tomography (PET)	A covered benefit when used to identify complex partial seizure disorders, evaluate ischemic heart disease or identify unknown primary tumors. The PET scan is considered experimental or investigational for the diagnosis of a number of other conditions. For additional information, access the CHAMPVA Policy Manual, Chapter 2 Benefits, Section 26.9, available on our website at http://www.va.gov/hac/forbeneficiaries/champva/policymanual .
Prosthetic devices	Artificial limbs, eyes, voice and other prostheses, as well as FDA -approved surgical implants are covered.

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Psychiatric partial hospitalization program (PHP)	Benefit: 60 days per year. To qualify as a PHP, the program must last at least three hours per day and be available five days per week (day, evening or weekend program). The facility must be a TRICARE approved provider or a Medicare certified facility. Preauthorization is required from the CHAMPVA mental health contractor.
Pulmonary rehabilitation programs	Limited to pre- and postoperative lung or heart lung transplants and cardiopulmonary disease.
Radiation therapy	Brachytherapy, fast neutron, hyperfractionated and radioactive chromic phosphate synviortheses are covered.
Single photon emission computed tomography (SPECT)	A covered benefit when used to evaluate seizure disorders, evaluate myocardial perfusion or monitor metastatic prostate cancer after surgery. The SPECT scan is considered experimental or investigational for the diagnosis of a number of other conditions. For additional information, access the CHAMPVA Policy Manual, Chapter 2 Benefits, Section 26.11, available on our website at http://www.va.gov/hac/forbeneficiaries/champva/policymanual .
Skilled nursing care	Skilled care may be provided by a variety of licensed professional caregivers, including a registered nurse (RN), licensed practical/vocational nurse (LPN/LVN), physical therapist, occupational therapist, respiratory therapist or social worker. Skilled care can be provided in different settings, such as a patient's home, or a rehabilitation facility, depending on the amount and frequency of care needed and the severity of the illness.

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Skilled nursing facility (SNF) care	<p>An SNF provides skilled nursing or rehabilitative care to patients who require 24 hour care under the supervision of a registered nurse or physician. A service is considered skilled care when it cannot be performed by a nonmedical person.</p> <p>Skilled care can be provided either in a hospital or in a separate facility.</p> <p>Skilled nursing care does not require preauthorization, but all claims for such services are subject to medical review.</p> <p>Claims should be accompanied by medical documentation that justifies this level of care.</p>
Speech therapy	<p>For physical impairments including:</p> <ul style="list-style-type: none"> • brain injury (e.g., traumatic brain injury, stroke/cerebrovascular accident, etc.) • congenital anomalies (e.g., cleft lip and cleft palate) • neuromuscular disorders, such as cerebral palsy • congenital sensory disorders
Substance abuse, treatment of	<p>A beneficiary is allowed up to three substance-use disorder treatment benefit periods in a lifetime. A benefit period begins on the first day of covered treatment and ends 365 days later, regardless of the number of services that were actually used during that year.</p>

continued on next page

Words that are in bold green print are defined on pages 52–54.

Covered Services	Conditions of Coverage
Substance abuse, treatment of (continued from previous page)	<p>Detoxification</p> <p>Detoxification is an inpatient service, for which authorization by the CHAMPVA mental health contractor is required. The service is limited to seven days per admission, which count toward the 30- to 45-day inpatient mental health limit. Detoxification will be approved only if it is performed under general medical supervision.</p> <p>Inpatient and partial hospitalization rehabilitation</p> <ul style="list-style-type: none"> • Authorization is required. • Limited to no more than one inpatient stay during a single benefit period of 21 days. • Limited to three benefit periods or rehabilitation stays per lifetime. <p>The facility must be a TRICARE approved provider or a Medicare certified facility</p> <p>Outpatient rehabilitation</p> <p>When medically necessary, 60 group therapy sessions are allowed for outpatient rehabilitation per benefit period (individual therapy for substance-use disorder rehabilitation is not covered). Fifteen outpatient sessions per benefit period are allowed for family therapy. Authorization is required for any additional group or family therapy sessions provided during a benefit year.</p>
Surgical sterilization	Tubal ligation and vasectomy are both covered.
Temporomandibular joint (TMJ)	Initial radiographs, up to four office visits, physical therapy for acute phase treatment only and construction of occlusal splint are covered.

Words that are in bold green print are defined on pages 52–54.

Transcutaneous Electrical Nerve Stimulator (TENS)

Claim should be accompanied by a **CMN** or doctor's order containing the diagnosis.

Transplants

A summary from the transplant team indicating the **medical necessity** for the procedure must be provided. The following transplants are covered (as well as donor costs):

- allogeneic bone marrow transplantation
- autologous bone marrow transplantation
- corneal transplantation
- heart transplantation
- heart-kidney transplantation
- heart-lung transplantation
- kidney transplantation
- liver transplantation
- liver-kidney transplantation
- lung transplantation
- multivisceral transplantation
- pancreas transplantation
- pancreas after kidney transplantation
- pancreas-kidney simultaneous transplantation
- peripheral stem cell transplantation
- small intestine transplantation
- small intestine-liver transplantation
- umbilical cord blood stem transplantation

Words that are in bold green print are defined on pages 52–54.

Covered Services**Conditions of Coverage****Ultrasound**

Ultrasounds for diagnosis, guidance and postoperative evaluation of surgical procedures may be cost shared. Maternity related ultrasound is limited to the diagnosis and management of a high-risk pregnancy or when there is a reasonable probability of neonatal complications.

Wheelchair or scooter (motorized)

Claim should be accompanied by a **CMN** or doctor's order containing the diagnosis. Seating evaluation must be performed with proof that vehicle can be used inside the home.

Wig or hairpiece

When needed after treatment for cancer (one per lifetime).

Wound vac

Claim should be accompanied by a **CMN** or doctor's order. Provide the wound measurements (length/width/depth) and the starting date and length of time the vac will be required.

NONCOVERED SERVICES (NOT ALL INCLUSIVE)

Following is an alphabetical listing of services that are not covered. For additional information, review the **CHAMPVA** Policy Manual, Chapter 2, available on our website at <http://www.va.gov/hac/forbeneficiaries/champva/policymanual>. Claims submitted for these services will be denied.

Noncovered Services (Not All Inclusive)

- Abortion counseling
- Abortions, except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term
- Acupuncture
- Artificial insemination

Words that are in bold green print are defined on pages 52–54.

Noncovered Services (Not All Inclusive)

- Biofeedback treatment of ordinary muscle tension, psychosomatic conditions, hypertension or migraine headaches
- Chiropractic services
- Chronic fatigue syndrome
- Cosmetic drugs (e.g., Retin A, Botox) or cosmetic surgery
- Dental care
- Dentures or partial dentures (adding or modifying)
- Diagnostic tests to determine the sex or paternity of a child
- Drug maintenance programs where one addictive drug is substituted for another (such as methadone for heroin)
- Drugs that are not **FDA** approved
- Embryo transfer
- Exercise equipment
- Exercise programs (general)
- Experimental/investigational services and supplies
- Eye examinations (routine)
- Eyeglasses, contact lenses or other optical devices, except as noted under Covered Services
- Foot care services of a routine nature, such as removal of corns and calluses
- Group C drugs for terminally ill cancer patients (these medications are available free from the National Cancer Institute through its registered physicians)
- Health club membership
- Hearing aids
- Hearing examinations, unless in connection with a covered illness/injury
- Hot tubs
- Housekeeping, homemaker and attendant services
- Hypnosis

Words that are in bold green print are defined on pages 52–54.

Noncovered Services (Not All Inclusive)

- Immunizations for travel
- In vitro fertilization
- Laser eye surgery
- Learning disorders, such as reading disorders or dyslexia, mathematics disorders, disorders of written expression, and learning disorders not otherwise specified
- Luxury or deluxe equipment
- Maintenance agreements/contracts
- Marriage counseling
- Modifications to home or vehicle
- Naturopathic services
- Orthodontia care (braces)
- Orthotic shoe devices, such as heel lifts, arch supports, shoe inserts, etc., unless associated with diabetes
- **Over-the-counter medications** that do not require a prescription (except for insulin and diabetic-related supplies, which are covered even when a physician's prescription is not required under state law)
- Postpartum inpatient stay of a mother for purposes of staying with the newborn (when the newborn requires continued treatment, but the mother does not)
- Postpartum inpatient stay of a newborn for purposes of staying with the mother (when the mother requires continued treatment, but the newborn does not)
- Private hospital rooms
- Services by providers who have been suspended or sanctioned by any federal agency. To obtain a listing or search for an excluded provider, use the Medicare exclusions link at the Health Administration Center website, <http://www.va.gov/hac>, or access this information directly from the Department of Health and Human Services Office of Inspector General website at <http://oig.hhs.gov/exclusions/index.asp>.

Words that are in bold green print are defined on pages 52–54.

Noncovered Services (Not All Inclusive)

- Services provided by a member of your immediate family or person living in your household
 - Sex changes, therapy or sexual behavior modification
 - Smoking cessation medication and products
 - Spas
 - Stress management
-
- Tattoo removal
 - Transportation services that do not require life sustaining equipment
-
- Vehicle lifts that are nondetachable and cannot be removed from one vehicle and used on another
 - Vitamins, except for formulations of folic acid, niacin and vitamins D, K and B12 (injection)
-
- Weight control medication or weight reduction programs
 - Whirlpools
 - Workers' Compensation injuries



There are two parts to your costs: the annual deductible and a cost share (co-payment).

If your provider does **not** accept **assignment**, you are responsible for paying your annual deductible, your cost share (both described below) and any provider-billed amount that exceeds our total **allowable amount**.

For care that is **not** covered by **CHAMPVA**, you pay the full bill.

By accepting assignment, your provider agrees to accept our allowable amount as payment in full. A provider cannot **balance bill** you, which is to say they cannot bill you for the difference between their normally billable amount and the CHAMPVA allowable amount.

ANNUAL DEDUCTIBLE

The annual (calendar year) outpatient deductible is the amount that you must pay before we pay for a covered outpatient medical service or supply. The deductible is \$50 per year. The annual deductible must be paid prior to our paying 75% of the allowable amount. As claims are processed for covered services, charges are automatically credited to your deductible requirements for each calendar year. Do **not** send checks to CHAMPVA to satisfy your deductible requirement.

There is no deductible for inpatient services, ambulatory surgery facility services, partial psychiatric day programs, hospice services or services provided by **VA** medical facilities (**CITI**, **MbM**).

COST SHARE

A cost share (co-payment) is the portion of the CHAMPVA allowable amount that you are required to pay. With few exceptions, you will pay something toward the cost of your medical care. For covered outpatient services, we pay up to 75% of the CHAMPVA allowable amount after the deductible has been met. For your inpatient service cost share, please refer to the chart in this section entitled “*Cost Summary*,” starting on page 39.

There is **no cost share** for hospice or services received through VA medical facilities. This includes services received at VA facilities under the CITI program or medications obtained through the MbM program.

Words that are in bold green print are defined on pages 52–54.

Words that are in bold green print are defined on pages 52–54.

To provide financial protection against the impact of a long-term illness or serious injury, we have established an annual catastrophic cap of \$3,000 per calendar year. This is the maximum out-of-pocket expense you can incur for **CHAMPVA** covered services and supplies in a calendar year. Credits to the catastrophic cap are applied starting January 1st of each year and run through December 31st. If you reach the \$3,000 limit, your cost share for covered services is waived for the remainder of the calendar year, and we pay 100% of the CHAMPVA **allowable amount**.

Each time we pay a bill, your deductible and cost share are calculated and credited to your catastrophic cap. The cumulative amount credited to your catastrophic cap is shown on the **EOB** you receive after services are paid for. If you find an error, let us know promptly.

The allowable amount is the most we will pay for a covered medical service or supply. We determine the allowable amount before we calculate your cost share, or deductible. The CHAMPVA allowable amount is generally the same as TRICARE's or Medicare's allowable amount.

COST SUMMARY

BENEFITS	DEDUCTIBLE?	YOU PAY
Ambulatory Surgery	NO	25% of CHAMPVA allowable amount
Durable Medical Equipment (DME)	YES	25% of CHAMPVA allowable amount
Emergency Room Charges	DEPENDS—whether the emergency care becomes part of inpatient charges or remains as an outpatient charge	The charges will be included in the inpatient charge if once you stabilize you are admitted to the hospital. Your payment will then be based on inpatient services. If you are not admitted, your payment is based on outpatient services.
Inpatient Mental Health: High Volume	NO	25% of CHAMPVA allowable amount
Inpatient Mental Health: Low Volume	NO	Lesser of: 1) per-day amount times the number of inpatient days; or 2) 25% of billed amount
Inpatient Services: Diagnosis Related Groups (DRG) Based	NO	Lesser of: 1) per-day amount times the number of inpatient days; 2) 25% of billed amount; or 3) DRG rate
Inpatient Services: Non-DRG Based	NO	25% of CHAMPVA allowable amount
Outpatient Services (e.g., doctor visits, lab/radiology, home health, mental health services, skilled nursing visits, ambulance)	YES	25% of CHAMPVA allowable amount after deductible
Pharmacy Services (retail)	YES	25% of CHAMPVA allowable amount after deductible
Professional Services	YES	25% of CHAMPVA allowable amount after deductible

Words that are in bold green print are defined on pages 52–54.

Words that are in bold green print are defined on pages 52–54.

COST SUMMARY WHEN CARE IS PROVIDED BY A VA SOURCE: CITI PROGRAM—VAMC OR MEDS BY MAIL

BENEFITS	DEDUCTIBLE?	YOU PAY
Ambulatory Surgery	NO	\$0
Durable Medical Equipment (DME)	NO	\$0
Inpatient Services	NO	\$0
Outpatient Services (e.g., doctor visits, lab/radiology)	NO	\$0
Pharmacy Services (Meds by Mail or CITI)	NO	\$0
Professional Services	NO	\$0

In the processing of millions of claims each year, there may be an inadvertent overpayment to you or your provider, depending on who submitted the claim. This might happen when we are not aware that you have other health insurance, when a provider bills us twice for the same service or if we mistakenly pay for services for you during a period of ineligibility. No matter whose fault the incorrect payment was, we are required to take action to get the money back from whomever received the erroneous payment. That is called **recoupment**, and it is done to help ensure that your tax dollars are spent properly, according to the law.

If you were overpaid, you will receive a letter requesting repayment and explaining your rights under the law. You should respond to the request within 30 days. If you cannot afford to pay the money all at once, you may be able to make monthly payments. You will be asked for financial information if you request a waiver of the overpayment. Depending on the outcome of the review of that information, the debt might be reduced or waived. If you do not respond to our notification, action to collect the amount owed to the VA will begin.

Words that are in bold green print are defined on pages 52–54.

The Primary Family Caregiver only qualifies for **CHAMPVA** when he/she is not entitled to care or services under a health plan contract such as a commercial health insurance plan, TRICARE, Medicare, Medicaid, Indian Health Service, Consolidated Omnibus Budget Reconciliation Act (COBRA), or a workers' compensation law or plan.

Words that are in bold green print are defined on pages 52–54.

It is important to fill out a claim form correctly. In most cases, the provider will complete and send in the claim form for you. There are times you will have paid for the medical service or supply and need to request reimbursement from us. An incomplete claim form can slow down your claim or result in an initial rejection of the claim. We cannot process the claim until we have all the information.

WHEN YOU SUBMIT THE CLAIM

You will need to send in these items:

- CHAMPVA Claim Form, **VA Form 10-7959a** (available by phone or on the Web)
- An itemized billing statement on a **CMS 1500** or **UB-04** with the same information listed in the Provider Submitted Claims section.

Tips for when you file claims

- Your name must be listed on the claim form exactly as it is on the **CHAMPVA** Identification Card.
- Your CHAMPVA Member Number (your Social Security number) must be on the claim.
- Keep copies of all receipts, invoices and other documents.
- If you do **NOT** use CHAMPVA Claim Form, **VA Form 10-7959a**, payment will be made directly to the health care provider instead of to you.



PROVIDER SUBMITTED CLAIMS

If your provider submits the claim, they will either send it electronically or on a standardized paper form (**CMS-1500** or **UB-04**).

Tips for when your provider files claims

- Claims submitted electronically are processed more quickly. If your providers can send the claims electronically and are not doing so, have your provider contact us.

Words that are in bold green print are defined on pages 52–54.

- An itemized billing statement on a **CMS-1500** or **UB-04** form is required with the following information:
 - Full name, address and tax identification number of the provider
 - Address where payment is to be sent
 - Address where services were provided
 - Provider professional status (doctor, nurse, physician assistant, etc.)
 - Specific date of each service provided. Date ranges are acceptable only when they match the number of services/units of services
 - Appropriate medical code (ICD-9, **CPT**, **HCPCS**) for each service
 - Itemized charges for each service
- Medical records or notes must be submitted with the bill in some cases. The handbook notes many of those services, like skilled nursing, home health care and some surgical procedures that require medical documentation.



PHARMACY CLAIMS

Most pharmacies submit claims to us electronically. The following information is required for pharmacy claims, regardless of whether submitted electronically or on paper and regardless of whether submitted by the pharmacy or by you:

- An invoice/billing statement that includes:
 - name, address and phone number of the pharmacy
 - name of prescribing physician
 - name, strength, quantity for each drug
 - 11-digit **National Drug Code (NDC)** for each drug
 - charge for each drug
 - date prescription was filled

NOTE: Ask your pharmacist to provide you with a printout showing all of the necessary information.
- If you send us a claim, use **CHAMPVA** Claim Form (**VA Form 10-7959a**).

Words that are in bold green print are defined on pages 52–54.

CHAMPVA
PO Box 469064
Denver CO 80246-9064

You have one year after the date of service to file any claims. In the case of inpatient care, the claim must be filed within one year of the discharge date. Claims submitted after the claim filing deadline will be denied.



After a claim has been filed for your health care service, you will receive an EOB from us in the mail. The EOB lists the details of the services you received and the amount you may be billed by your provider. If you paid for the service and submitted a claim for reimbursement, the EOB will tell you how we calculated your cost share. The EOB contains the following information:

- amount billed by the provider
- amount allowed by **CHAMPVA**
- amount not covered
- annual catastrophic cap accrual
- **beneficiary** deductible accrual
- CHAMPVA payment(s)
- date(s) of service
- description of service
- provider name
- remarks

When a provider files a claim, the EOB is sent to both you and the provider. When you file a claim, the EOB is sent only to you. When your health care service is received through a **VA** source (such as **Meds by Mail** or **CITI**), an EOB is not sent to you.

Words that are in bold green print are defined on pages 52–54.

VA Health Administration Center
 CHAMPVA
 PO Box 469064
 Denver, CO 80246-9064

1-800-733-8387
<http://www.va.gov/hac>

EXPLANATION OF BENEFITS
 CHAMPVA

You have the right to request reconsideration of adverse decisions involving timely filing, benefits, authorizations, medical necessity and reimbursement. The reason for the denial is indicated in "Rejection of Claims." To request reconsideration, submit a copy of this EOB with a written statement explaining your disagreement and attach any pertinent documentation to support your request. Mail your reconsideration to: Department of Veterans Affairs, Health Administration Center, Reconsideration and Appeals, PO Box 460948, Denver, Colorado 80246. Your reconsideration must be received by this office within one year of the date of the EOB statement.

Patient: DOE, JANIE D Date: 2/12/11
 Member #: PATIENT SSN

JANIE D DOE
 1234 ANY STREET
 METROPOLIS, IL 56789-1234

DEDUCTIBLE		
YR	INDIV	FAM
11	\$50.00	\$50.00
10	\$50.00	\$50.00
CAT CAP ACCRUAL		
11	\$127.34	
10	\$1995.61	

Information only, no check enclosed. Payment by EFT.

CONTROL NUMBER	PROVIDER	DATES OF SERVICE FROM TO	DESCRIPTION OF SERVICE CODE/MODIFIER/MULTIPLIER	AMOUNT BILLED	AMOUNT ALLOWED	AMT NOT COVERED	REMARKS/ CODES
BLE9157	XYZ MEM HOSP	08/10/10 08/10/10	11042 DEBRIDE SKIN/TISSUE	\$404.30	\$50.80	\$353.50	
		08/10/10 08/10/10	73562-RT X-RAY EXAM OF KN	\$140.00	\$30.31	\$109.69	
001412-315076 OHI PAID: \$43.61 PATIENT PAID: \$0.00 CLAIM TOTAL:				\$544.30	\$81.11	\$463.19	322 356 371 382 383
HAC PAYMENTS:		TO PROVIDER \$28.00		COST SHARE: \$9.50			
BLI8889	XYZ MEM HOSP	03/02/10 03/02/10	X1860 FACILITY FEES	\$134.35	\$35.38	\$134.35	
0014112287604 OHI PAID: \$60.76 PATIENT PAID: \$0.00 CLAIM TOTAL:				\$134.35	\$35.38	\$134.25	65
HAC PAYMENTS:		TO PROVIDER \$7.50		COST SHARE: \$2.50			
TOTAL PAYMENTS:		TO PROVIDER \$35.50		TO PATIENT \$0.00			

REMARKS/CODES:
 1/322: 1/356: REMINDER - MAIL CLAIMS TO: CHAMPVA, PO BOX 469064, DENVER, CO 80246-9064
 1/371: WHEN RESUBMITTING CLAIMS YOU MUST ATTACH THE CHAMPVA EOB FOR PROPER PROCESSING.
 1/382: AS OF 09/27/10 MEDICARE PART A and B EDI CLAIMS WILL BE FORWARDED TO CHAMPVA.
 1/383: MEDICARE HEALTH INSURANCE CLAIM NUMBER MUST BE ON FILE AT THE HAC TO FORWARD CLAIMS.
 65: DUPLICATE CLAIM - PREVIOUSLY PROCESSED AS AEL9451
 HV123456789

VA FORM 10-7959B
 JUL 2006

Department of Veterans Affairs

Page 1 of 1

A—Payment Information: Indicates who the payment was sent to, if any, and the method of payment.

B—Control Number(s): The CHAMPVA claim specific identifier (always starts with two alpha characters). This number is needed to look up the specific claim in the VA system.

C—Patient Control Number: Provider claim specific identifier (not always present).

D—Cost Share: Patient's payment responsibility.

E—Remarks/Codes: Codes associated with the description of service. A code in this column relates to the narrative description at the bottom of the EOB.

F—FMS Doc ID Number: This 11-digit number further assists in identifying payments.

YOU MAY REQUEST RECONSIDERATION OF:

- Benefit coverage
- Authorization requests
- Services
- Mental health appeals

NOTE: First level reconsiderations related to mental health care are completed by our mental health contractor—address on page 15 of the handbook.

For a reconsideration to be considered, you must:

- Submit the request in writing within one year of the date of the **EOB**, in the case of a denial of a service or benefit, or one year from the date of the letter notifying you of a denial of eligibility or service to us at:

CHAMPVA
ATTN: Appeals
PO Box 460948
Denver CO 80246-0948

- Identify why you believe the original decision is in error,
- Include a copy of the EOB or determination letter and
- Submit any new and relevant information not previously considered.



After reviewing your request and supporting documentation, a written decision will be sent to you advising you of the decision. If you still disagree with the decision, you may request a second review. That request for review must be received within 90 days of the date of the initial decision. Identify why you believe the decision is in error and include any additional relevant information. Second level appeal determinations are final decisions and cannot be appealed again.

We will not reconsider claims submitted regarding:

- The cost share or amount of an individual's deductible. By law, this amount is payable by you.
- The **allowable amount** based on a payment methodology.
- Medical providers sanctioned or excluded by the Department of Health and Human Services (DHHS) or the Office of Inspector General (OIG).
 - Providers may be sanctioned for failure to maintain proper medical credentials, fraud and abuse, default on public loans or various other reasons. Only the sanctioned provider or appointed representatives can appeal this decision, and that appeal must go to DHHS-OIG.
- Benefits that are specifically excluded by regulation.

Words that are in bold green print are defined on pages 52–54.

Words that are in bold green print are defined on pages 52–54.

Combating fraud and abuse takes a cooperative effort. Please help us by reviewing your **EOB** to be sure that the services billed to us were reported properly. If you see a service or supply billed to us that you did not receive, please report it immediately in writing. Indicate in your letter that you are filing a potential fraud complaint and document the following facts:

- name and address of the provider
- name of the **beneficiary** who was listed as receiving the service or item
- claim number
- date of the service in question
- service or item that you do not believe was provided
- reason why you believe the claim should not have been paid
- any additional information or facts showing that the claim should not have been paid.

DETECTION TIPS

You should be suspicious of practices that involve:

- providers who routinely do not collect your cost share (co-payment)
- providers billing for services that you did not receive
- providers billing for services or supplies that are different from what you received

If you suspect fraud, waste or abuse, contact us at:

Mail: **CHAMPVA**
Purchased Care/Program Integrity
PO Box 461307
Denver CO 80246-5307

Phone: **1-877-733-7927**

PREVENTION TIPS

Always protect your **CHAMPVA** Identification Card and know to whom you are giving your CHAMPVA member number. Do not provide your member number to someone over the phone *if they call you*. Be skeptical of providers who tell you that a particular item or service is not usually covered by us, but know how to bill for the item or service to get it paid.

Words that are in bold green print are defined on pages 52–54.

The **VA Notice of Privacy Practice** briefly describes:

- how your health information may be used and disclosed,
- your rights regarding your health information and
- our legal duty to protect the privacy of your health information.

For a more complete description of our privacy practices, you should carefully review the *Notice of Privacy Practices* that is available on our website at http://www.privacy.va.gov/privacy_resources.asp.

YOUR HEALTH INFORMATION

Any information we create or receive about you and your past, present or future:

- physical or mental health condition
- health care
- payment for medical services

How We May Use and Disclose Your Health Information

In most cases, your written authorization is needed for us to use or disclose your health information. However, federal law allows us to use and disclose your health information without your permission for the following purposes:

- treatment
- eligibility and enrollment for VA benefits
- public health
- research (with strict limitations)
- abuse reporting
- workers' compensation
- patient directories
- payment
- law enforcement
- judicial or administrative proceedings
- services
- correctional facilities
- coroner or funeral activities (with limitation)
- when required by law
- health care operations
- health care oversight
- National security
- health or safety activities
- military activities
- family members or others involved in your care (with limitations)



Words that are in bold green print are defined on pages 52–54.

DEPARTMENT OF VETERANS AFFAIRS SUMMARY NOTICE

All other uses and disclosures of your health information will not be made without your prior written authorization.

Your Privacy Rights

- Review your health information.
- Obtain a copy of your health information.
- Request that your health information be amended or corrected.
- Request that we not use or disclose your health information.
- Request that we provide your health information to you in an alternative way or at an alternative location in a confidential manner.
- An accounting or list of disclosures of your health information.
- Receive our **VA Notice of Privacy Practices** upon request.

Changes

We reserve the right to change the *VA Notice of Privacy Practices*. In the event that happens, we will send a copy of the revised notice to your last address of record within 60 days of any change. The revised privacy practices will apply to all of your health information we already have, as well as to the information we receive in the future.

Complaints

If you are concerned that your privacy rights have been violated, you can file a complaint to the Veterans Health Administration (VHA) or to the secretary of the U.S. Department of Health and Human Services. To file a complaint with VHA you may contact your VA health care facility privacy officer, the VHA privacy officer, or VHA via "Contact the VA" at <http://www.va.gov>. Complaints do not have to be in writing, although it is recommended. You will not be penalized or retaliated against for filing a complaint.

REQUESTING OR RELEASING HEALTH INFORMATION

- Use **VA Form 10-5345a**, *Individual's Request for a Copy of Their Own Health Information* (available by phone or on the Web), to request a copy of your record or a copy of a document in your record to be sent to you.
- Use **VA Form 10-5345**, *Request for and Authorization to Release Medical Records or Health Information*, if you want us to send a copy of your record or a copy of a specific document in your record to a person or entity other than yourself. For example, this form is used if you want your information to go to a legal office.
- Use **VA Form 10-5345**, *Request for and Authorization to Release Medical Records or Health Information* to inform the **PC@HAC** that you want to allow them to discuss claims and eligibility information from your file with an individual of your choosing.
 - Print the words "Recurring Disclosure Authorization" in the Authorization block, if you want us to discuss your claim and eligibility information with a person who regularly assists you in handling your medical care needs, such as your spouse, adult child or friend.
- Use **VA Form 10-5345a**, *Individual's Request for a Copy of Their Own Health Information*, to get access to online information about your file.
 - Print the words "PC@HAC ON-LINE" in the Signature block, to obtain access to selected information from your **CHAMPVA** record about yourself through a secure, online Internet connection.

Additional information about PC@HAC On-Line is at our website under "Beneficiaries, CHAMPVA."

Mail all requests for health information from your record to:

CHAMPVA
PO Box 469028
Denver CO 80246-9028

Words that are in bold green print are defined on pages 52–54.

Words that are in bold green print are defined on pages 52–54.



Adjunctive	The treatment is a necessary part of approved care for a covered medical condition.
Allowable Amount	The amount we pay plus your cost share.
Assignment	When you go to a medical provider, find out if the provider will accept CHAMPVA. Providers most often refer to it as accepting assignment. What that means is the provider will bill us directly for covered services, items and supplies. Doctors or providers who agree to accept assignment cannot try to collect more than the CHAMPVA deductible and cost share amounts from you.
Balance Billing	Balance billing is inappropriate. When the provider accepts assignment, it is an agreement to accept the Department of Veterans Affairs allowable amount as payment in full. You are not responsible for paying the difference between the provider's billed amount and our determined allowable amount.
Beneficiary	An approved primary family caregiver.
Centers for Disease Control (CDC)	The major United States government agency for disease prevention based in Atlanta, Georgia.
Certificate of Medical Necessity (CMN)	A document provided by your physician that indicates the medical necessity for the care or services prescribed as part of your treatment plan.
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs

CITI	CHAMPVA Inhouse Treatment Initiative. CITI is a voluntary program that allows for the treatment of CHAMPVA beneficiaries at VA Medical Centers. There is no cost share for the CHAMPVA beneficiary treatment at a VA Medical Center. Each VA medical center that participates in the CITI program offers different services based on unused capacity.
Current Procedural Terminology (CPT)	The purpose of this terminology is to provide a uniform language that will accurately describe medical, surgical and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients and third parties. CPT is the most widely accepted nomenclature for the reporting of physician procedures, services and billing purposes under government and private health insurance programs.
Diagnosis Related Groups (DRG)	A system that hospitals use to classify the resources used to treat a specific condition or related condition based on the clinical needs of the patient. The DRG determine the reimbursement to the hospital.
Durable Medical Equipment (DME)	Medical equipment used in the course of treatment or home care, including such items as crutches, knee braces, prostheses, wheelchairs, hospital beds, etc. Health coverage levels for DME often differ from coverage levels for office visits and other medical services.
Explanation of Benefits (EOB)	A form that provides details of what was paid and the amount of payment.
FDA	Food and Drug Administration
Formulary	A health plan's list of preferred drugs based on evaluations of the drugs' effectiveness, safety and cost.
HCPCS	Healthcare Common Procedure Coding System

High Volume	Residential and treatment centers that have 25 or more mental health discharges annually are considered high-volume facilities.
Low Volume	Treatment centers that have fewer than 25 mental health discharges annually are considered low-volume facilities.
Medical Necessity	<p>Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that we determine:</p> <ul style="list-style-type: none"> • are appropriate to diagnose or treat the patient’s condition, illness or injury; • are consistent with standards of good medical practice in the U.S.; • are not primarily for the personal comfort or convenience of the patient, the family or the provider; • are not a part of or associated with the scholastic education or vocational training of the patient and • in the case of inpatient care, cannot be provided safely on an outpatient basis.
Meds by Mail (Mbm)	A pharmacy mailing service that provides a safe, easy and cost-free way for eligible CHAMPVA beneficiaries to receive nonurgent maintenance medications delivered directly to their homes.
National Drug Code (NDC)	An 11-digit code used to identify pharmaceuticals.
Over-the-Counter Medications	Medications that do not require a prescription.
PC@HAC	Purchased Care at the Health Administration Center (PC@HAC), which administers CHAMPVA.
Recoupment	Collection of a debt owed to the government.
VA	Department of Veterans Affairs
VAMC	VA Medical Center

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Department of Veterans Affairs
 Purchased Care at the Health Administration Center
 CHAMPVA / Primary Family Caregiver
 PO Box 469063
 Denver CO 80246-9063

