CHAMPVA Guide

Helping you take an active role in your health care

VA HEALTH CARE

Defining EXCELLENCE in the 21st Century

IMPORTANT PHONE NUMBERS

NAME	TELEPHONE
Your Doctor (Primary)	
Your Doctor	
Your Doctor	
Your Hospital	
Your Pharmacy	

YOUR MEDICATIONS

CHAMPVA CHAMPVA Authorization	1-800-733-8387
Magellan Mental Health	1-800-424-4018
Meds by Mail (MbM) (See page 15 for the number of the servicing center for your state).	East 1-866-229-7389 West 1-888-385-0235 Refill System 1-888-370-1699
Medicare Helpline For help with questions about Medicare	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Social Security Administration For help with questions about Medicare, Social Security retirement benefits or disability benefits	1-800-772-1213 TTY 1-800-325-0778
Catamaran retail pharmacy network	1-888-546-5502

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Words that are in bold green print are defined on pages 80–84.

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The Affordable Care Act and CHAMPVA

The Affordable Care Act, also known as the health care law, was created to expand access to affordable health care coverage to all Americans, lower costs, and improve quality and care coordination. Under the health care law, people will have health coverage that meets a minimum standard (called “minimum essential coverage”). If you are enrolled in CHAMPVA, you don’t need to take additional steps to meet the health care law coverage standards. The health care law does not change CHAMPVA benefits or out-of-pocket costs. For additional information, visit VA’s website at **http://www.va.gov/aca**, or call 1-800-733-8387.

WELCOME!

Welcome to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)!

CHAMPVA shares the cost of certain medically necessary procedures and supplies with eligible beneficiaries. We do not have a network of health care providers, so you can visit most authorized providers. This guide contains the most important information you need to know.

If you have questions about CHAMPVA, or to obtain approval for any medical procedure that requires authorization (see page 18), please call us at 1-800-733-8387. Our phone system allows you to speak to a customer service representative directly, or you can select from other options to have important forms and other information mailed to you.

You can also obtain forms and other important information about CHAMPVA on our website, **http://www.va.gov/hac**

Our "home page" provides links to program guides, fact sheets and the forms you need to file a claim or to inform us of changes in any other health insurance you may have.

You can mail us with general questions at:

CHAMPVA
PO Box 469063
Denver CO 80246-9063

Claims can be filed by mailing them to:

CHAMPVA Claims
PO Box 469064
Denver CO 80246-9064

You should promptly inform us of changes in any other health insurance that you may have. You can call us at 1-800-733-8387, or write to:

CHAMPVA
PO Box 469063
Denver CO 80246-9063

You can also inform us of any changes in your address by calling 1-800-733-8387 or writing to:

CHAMPVA Eligibility
PO Box 469028
Denver CO 80246-9028

KEEP THIS GUIDE

This guide provides important information about CHAMPVA. The guide may also be found on our website at **http://www.va.gov/hac**

The guide is not reprinted yearly. Occasionally, there will be a change that could impact your eligibility, benefits or costs. When that happens, we will send you a notification and ask you to add it to your guide. Please remember this publication is only a guide. The law, regulations and policy manual are the authoritative guidance for CHAMPVA. The CHAMPVA Policy Manual can be found at **http://www.va.gov/hac/forbeneficiaries/champva/policymanual**

FINDING INFORMATION IN THIS GUIDE

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

Each section starts with a summary of the most important information in that section.

The Index begins on page 85 and is an alphabetical listing of the topics addressed in this guide, with corresponding page numbers.

Words and acronyms highlighted in green text in this guide are defined on pages 80–84.

APPLYING FOR CHAMPVA BENEFITS

Information on how to apply for CHAMPVA can be found on our website at **http://www.va.gov/hac** or by calling us at 1-800-733-8387.

CHANGE OF ADDRESS

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

Mail: CHAMPVA Eligibility
PO Box 469028
Denver CO 80246-9028

Phone: 1-800-733-8387

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

SPECIAL NEEDS

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

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

We can also provide, on request, a copy of the CHAMPVA Guide in any language, as an audio book, or in Braille. It will take about six weeks to provide the translated guide.

HELPING YOU TAKE AN ACTIVE ROLE IN YOUR HEALTH CARE

Our first priority is to keep you healthy. Studies have shown that patients who are well informed about their care and effectively communicate with their health care providers report better overall health. That's 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 can begin before your first appointment. Make a list of any prescription or over-the-counter (**OTC**) medications you take on a regular basis, as well as the dosages. Make a note of any symptoms you may be having, including duration, intensity and what, if anything, relieves the symptoms. Be sure to also make a list of any 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 explain any terminology or procedure you don't 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.

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?

Words that are in bold green print are defined on pages 80–84.

- 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?

SUGGESTIONS FOR LONG-TERM CARE ASSISTANCE

As you read about the benefits described in this guide, you will find that long-term care is not a covered CHAMPVA benefit. Long-term care, or **custodial care** as it is also known, can be provided in nursing homes, assisted living facilities, adult day care or at a patient's home. It involves assistance with activities of daily living or supervision of someone who needs assistance with walking, personal hygiene, using the toilet, dressing, cooking, feeding and medication.

Because neither CHAMPVA nor Medicare covers long-term or custodial care, we are providing you with some options that you might want to consider as you plan ahead.

Long-Term Care Insurance

This insurance is sold by private insurance companies and usually covers medical and nonmedical care to help you with such personal needs as bathing, dressing, using the bathroom and eating.

For more information about long-term care insurance, get a copy of "A Shopper's Guide to Long-Term Care Insurance" from your State Insurance Department or the National Association of Insurance Commissioners at **https://eapps.naic.org/forms/ipsd/Consumer_info.jsp**

Life Insurance Policies

Some insurance companies may allow you to use your life insurance policy to pay for long-term care. Ask your insurance agent how this works.

Personal Resources

You can use your savings to pay for long-term care. You may qualify for Medicaid after most of your personal resources have been used.

COMMENTS?

We are always looking for your feedback. If you have suggestions on ways we can improve this guide, please contact us at:

CHAMPVA Communications
PO Box 469060
Denver CO 80246-9060
E-mail: Please go to **http://ww.va.gov/hac/contact** and follow the directions for submitting e-mail via IRIS.

Words that are in bold green print are defined on pages 80–84.

Stay Eligible

CHAMPVA beneficiaries are the spouses, widow(er)s, or children of a qualifying Veteran sponsor.

You can lose your CHAMPVA eligibility:

- If you are eligible for Medicare Part A and you decline or drop Medicare Part B.
- Through divorce from the Veteran. (But divorce does not impact the eligibility of a birth or adopted child of a qualifying Veteran sponsor.)
- When a child turns 18, unless the child is enrolled as a full-time student in an accredited school.
- When a child, who has been a full-time student, turns 23 or loses full-time student status.
- When a child marries.
- If you are a stepchild of a qualifying Veteran sponsor, your parents divorce and you lose dependent status as determined by your VA Regional Office (VARO).

Eligibility for CHAMPVA benefits can be impacted by changes to your marriage status, eligibility for Medicare or TRICARE, and by the student status of children ages 18 to 23. Such changes must be reported to us immediately. Call us at 1-800-733-8387 or write us at:

CHAMPVA Eligibility
PO Box 469028
Denver CO 80246-9028

SPOUSE STATUS

A **spouse** loses CHAMPVA eligibility through divorce or annulment from the qualifying **Veteran sponsor**. Eligibility for CHAMPVA ends on midnight of the effective date of the divorce decree or annulment.

CHAMPVA AND MEDICARE

Your Medicare status has an impact on your eligibility for CHAMPVA benefits. **Beneficiaries** must enroll in Medicare 90 days prior to their 65th birthday. After you enroll in Medicare, you will receive a Medicare card indicating whether you have both Medicare Part A and Medicare Part B coverage. To continue your CHAMPVA eligibility, you MUST enroll in, and remain enrolled in, Medicare Part B.

When you receive your Medicare card, immediately send us a copy along with a CHAMPVA Other Health Insurance (**OHI**) Certification Form (**VA Form 10-7959c**) so we can take action to continue your CHAMPVA benefits without interruption.

When you have Medicare and CHAMPVA, Medicare will be your **primary** insurance. Bills for health care services must first be sent to Medicare. Medicare will electronically forward claims for CHAMPVA beneficiaries to us after they have processed them. For Medicare supplemental plans (usually referred to as Medigap plans), CHAMPVA will process the remaining portion of the bill after we receive the Medicare supplemental plan's **explanation of benefits** (**EOBs**). (If you have a Medicare supplemental plan, you may have to file a claim and the Medicare EOB with us yourself.)

We often receive questions regarding continued eligibility for CHAMPVA when there is also a Medicare entitlement, as well as questions about coverage and payment. It can seem complicated. The following questions and answers are offered in an effort to reduce any confusion.

Words that are in bold green print are defined on pages 80–84.

A brief overview of Medicare Parts A, B, C and D. (Only Parts A and B affect your CHAMPVA eligibility.):

- **Part A:** Premium-free hospital insurance. You are eligible for Part A coverage if you are age 65 or older or if you are under age 65 with certain disabilities.
- **Part B:** Outpatient insurance. You may be required to pay a premium. As of January 2007, Medicare Part B premiums are based on your yearly income.
- **Part C:** This is known as the Medicare Advantage Plan. It provides the benefits you would receive under both Parts A and B and is administered like an HMO. You must see an identified network provider.
- **Part D:** Prescription drug coverage. Cost for this will vary depending on the plan.

	Is Medicare Part B Required for CHAMPVA eligibility?
You are under age 65 and entitled to Part A	Yes
You were over age 65 when your spouse first became a **qualifying CHAMPVA sponsor** and you are entitled to Medicare	Yes
You were 65 or older prior to June 5, 2001, were otherwise eligible for CHAMPVA, and you only have Medicare Part A coverage	NO
You were 65 or older prior to June 5, 2001, were otherwise eligible for CHAMPVA, and you had Medicare Part A coverage and were enrolled in Part B as of June 5, 2001	Yes
You became 65 on or after June 5, 2001, and you are entitled to Medicare Part A	Yes

COMMON ELIGIBILITY QUESTIONS

If I am eligible for Medicare Part A, do I need Medicare Part B to also be eligible for CHAMPVA?

In almost all cases, the answer is yes. However, the answer to this question varies based on certain circumstances:

- Effective Oct. 1, 2001, CHAMPVA benefits were extended to beneficiaries age 65 and older. If you are entitled to Medicare Part A and are age 65 or older, you will most likely be required to have Medicare Part B to be covered by CHAMPVA.
- If you became eligible for CHAMPVA on or after June 5, 2001, you must have Medicare Part B.
- If you are under age 65 and eligible for Medicare Part A (to include the End Stage Renal Disease [ESRD] Program) you must have Medicare Part B.
- If you are over age 65 and were never eligible for *premium-free* Medicare Part A, you do not need Part B.

I am enrolled in Medicare Part B. Is there any time I can cancel Medicare Part B coverage and still be eligible for CHAMPVA?

- No. If you have Medicare Part B, do not cancel it. If you cancel Medicare Part B coverage, your eligibility for CHAMPVA benefits will end on the same day your Part B coverage ends.

I am a CHAMPVA beneficiary and will soon have my 65th birthday. What do I need to do so that my CHAMPVA benefits continue uninterrupted?

- In most cases, you can have all the paperwork done for enrollment into Medicare 90 days before your 65th birthday. *Make sure you enroll in Medicare Part B*. As soon as you receive your Medicare card that shows the dates your Medicare Parts A and B will begin, send a copy of the card to us along with our **Other Health Insurance** (**OHI**) Certification Form (**VA Form 10-7959c**). The form is available at: **http://www.va.gov/hac/forms** on our website.
- We will update your records when this information is received and issue you a new CHAMPVA Identification Card with an extended expiration date.

Can I use a VA Medical Center (VAMC) under the CHAMPVA In-house Treatment Initiative (CITI) program to obtain my care if I am Medicare eligible?

- No. CHAMPVA beneficiaries with Medicare cannot use a **VAMC** under our **CITI** program. If you are currently being seen at a VAMC, but will become entitled to Medicare soon, you will need to find a different health care provider.

Must I enroll in Medicare Part D, the prescription drug plan, to be eligible for CHAMPVA?

- No, you do not need to enroll in Medicare Part D to maintain your CHAMPVA eligibility. In fact, you would not be able to use the **Meds by Mail** program, which can provide your maintenance medications at no charge to you (no premiums, no deductibles and no co-payments).

Additional Information about Medicare and CHAMPVA Eligibility

- If you are required to have both Medicare Parts A and B to establish CHAMPVA eligibility, and you did not obtain Medicare Part B previously, you will need to contact the Social Security Administration to enroll in Part B. Your CHAMPVA eligibility can then be established on the effective date of your Medicare Part B.
- If you are 65 or over and live overseas, you must be enrolled in Medicare Part B, even though Medicare does not provide benefits for medical care received overseas. CHAMPVA will be the **primary payer** for the benefits, and you will receive the same level of coverage provided to those under age 65.

Words that are in bold green print are defined on pages 80–84.

- CHAMPVA pharmacy benefits are considered a "creditable prescription drug plan." CHAMPVA beneficiaries who initially chose not to enroll in a Medicare Part D plan will not have to pay a late enrollment penalty if they choose to enroll in a Medicare drug plan during a later enrollment period.

CHAMPVA AND TRICARE

TRICARE is a health care program for active duty and retired uniformed Servicemembers and their families. If you become eligible for TRICARE benefits, you are no longer eligible for CHAMPVA, and you must notify us immediately of this change in your status. You may, for example, become TRICARE eligible when the **qualifying Veteran sponsor** is a retired reservist or National Guard member and begins to receive retired pay at age 60.

CHILD STATUS

A **child** loses eligibility for CHAMPVA when:

- The child (other than a **helpless child**) turns 18, unless enrolled in an accredited school as a full-time student.
- The child, who has been a full-time student, turns 23 or loses full-time student status.
- The child marries.
- The stepchild no longer lives in the household of the sponsor.

Impact of the Divorce or Remarriage of Parent on Child/Student Status

The eligibility for CHAMPVA of a birth or adopted child of the **qualifying Veteran sponsor** is not impacted by the parents' divorce or remarriage.

However, a stepchild of the qualifying Veteran sponsor will lose CHAMPVA eligibility if the parents divorce and that stepchild loses dependent status as determined by a **VARO**.

Requirements for Students (Age 18–23)

To establish student status, and retain CHAMPVA eligibility, an unmarried child between the ages of 18 and 23 must attend school full time. Schools include, but are not limited to, high school, vocational/technical schools, and undergraduate, graduate or postgraduate levels of study. The student can remain eligible for CHAMPVA until the date of graduation or until his or her 23rd birthday, whichever comes first. Please read the following information carefully to avoid an interruption of benefits.

Words that are in bold green print are defined on pages 80–84.

First certification of full-time school attendance after age 18: CHAMPVA will send a letter to the student 90 days prior to his or her 18th birthday that provides notification of the potential change in CHAMPVA eligibility. This letter will also outline the steps necessary to extend CHAMPVA eligibility:

- To avoid an interruption of CHAMPVA benefits for the summer break between high school and the first term of the continuing education program, the student must send us proof of intent to continue his or her education (e.g., a letter of acceptance from the educational institution). Once we receive that letter, we will cover the break between high school and the start of the first term of the continuing full-time education program.
- Within one month after the first term begins, the student must submit a school certification verifying full-time enrollment. If CHAMPVA does not receive verification, benefits will be terminated and any payments made by CHAMPVA after the student turned 18 will be subject to **recoupment**. The certification letter *(see illustration below)* should be on school letterhead and include:
  - Student's full name,
  - Student's Social Security number,
  - Exact beginning date and ending date of school term (month, date, year),
  - Projected graduation date (month, year),
  - Number of semester hours or equivalent certification of full-time status and
  - Title and signature of a school official.

CHAMPVA University

1234 W 000 Ave.
University City, CO 12345
Telephone: (123) 456-7890
Fax: (123) 456-7890
www.scl.edu

Enrollment Verification as of 01/12/2012

Name: Student Name SSN: 000-00-000

Enrollment History

Term	Career	Begin Date	End Date	Units	Status
2011 Fall	UGRD	08/20/2011	12/15/2011	12.00	Full-Time
2012 Spring	UGRD	01/13/2012	05/09/2012	14.00	Full-Time

Note:
Anticipated date of graduation is May 15, 2013.

REGISTRAR

Words that are in bold green print are defined on pages 80–84.

nruboc/bigstock.com

Recertification of full-time school attendance: The student will need to recertify his or her full-time enrollment status on an annual or more frequent basis. Students can recertify for a year by sending us a personal letter, stating they are attending full time, *if* the first certification letter from the educational institution listed the graduation date (month, year). If the original certification letter did not list the graduation date (month, year), the student must submit a recertification letter from the educational institution. A school recertification letter may then be required two to four times a year, depending on whether the educational institution is on a semester or quarter schedule. In addition, we will periodically check with the school to ensure the student is enrolled as a full-time student.

School breaks: CHAMPVA eligibility will not be interrupted during school breaks, as long as the student is enrolled as a full-time student during the terms prior to and following the break.

Withdrawal from school: If a student withdraws from school, their eligibility for CHAMPVA will be terminated for the entire school term. We must be notified of the withdrawal immediately.

Change in student status: Any claim paid by us after the date of loss of CHAMPVA eligibility will be considered invalid, and you will be held financially responsible for repaying in full the government and/or the health care provider for their services.

Disabling illness: If the student is disabled by an illness or injury while enrolled as a full-time student, and this prevents him or her from continuing as a student, eligibility may continue for six months after the disability ceases, for two years after the onset of the disability or until the 23rd birthday—whichever occurs first. Medical documentation is required to support that the illness or injury is of a disabling nature and that it prevents the student from attending school. Medical documentation must include diagnosis, prognosis, date of onset of the disability and the expected date the student will be able to return full time.

Requirements for Helpless Child Status

A **child** who, prior to reaching age 18, becomes permanently incapable of self-support may qualify as a **helpless child**. This determination is made by a **Veterans Affairs Regional Office** (**VARO**). Once helpless child status is determined, CHAMPVA benefits will continue without an age limitation unless the helpless child marries or loses "helpless child" status. If you believe your child may qualify as a helpless child, contact 1-800-827-1000 for assistance.

Impact of Marriage

If a child marries, regardless of whether he or she is under age 18, a full-time student or has helpless child status, that child will lose CHAMPVA eligibility as of midnight on the date of the marriage.

Words that are in bold green print are defined on pages 80–84.

We're here to help

We want to provide you with the best service possible. We have a number of ways to answer your questions and provide the forms and other information you need:

Our Customer Call Center can be reached at 1-800-733-8387, Monday through Friday, from 8:05 a.m. to 7:30 p.m. Eastern Time.

Our interactive voice response system is also available at the same phone number 24 hours a day, seven days a week. You can use our phone system to order CHAMPVA forms and applications, check your eligibility, the status of a claim, or check your annual deductible or annual catastrophic cap.

You can also obtain forms, applications and other information on our website: **http://www.va.gov/hac**

This information includes an electronic copy of the CHAMPVA Guide and the CHAMPVA Policy Manual.

You can contact us by e-mail by going to **www.va.gov/hac/contac**t and following the instructions for submitting e-mail via IRIS.

A warning: e-mail is not secure. We will not use e-mail to send you personal or sensitive information. Instead, we will call or mail the information to you.

Here are the addresses for sending forms to us:

CHAMPVA applications and school certifications:

CHAMPVA Eligibility
PO Box 469028
Denver CO 80246-9028

CHAMPVA Other Health Insurance (OHI) Form (VA Form 10-7959c):

CHAMPVA
PO Box 469063
Denver CO 80246-9063

Claims for medical services and supplies:

CHAMPVA Claims
PO Box 469064
Denver CO 80246-9064

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 guide doesn't answer your questions or provide the information you need, the following sources are available:

Interactive voice response (IVR) system

Phone Toll Free: 1-800-733-8387

Hours of Availability: 24 Hours a Day,
Seven Days a Week

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

Services available through this system are:

- Ordering CHAMPVA forms and applications: The prompts will instruct you to leave a voice mail request by providing 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 eligibility or the status of a payment.

Talk to a customer service representative

- Phone Toll Free: 1-800-733-8387, Monday through Friday (excluding holidays)
- Hours of operation: 8:05 a.m. to 7:30 p.m. Eastern Time
- We have a Virtual Hold system that allows us to call you back when our estimated wait time exceeds three minutes. That means you don't have to wait on hold.

http://www.va.gov/hac

The following information is available on our website 24 hours a day, seven days a week:

- The CHAMPVA Guide and Policy Manual, CHAMPVA forms and fact sheets and frequently asked questions.

CHAMPVA website will be changing

The CHAMPVA website will change in 2014 to a new website that will better serve you. The address for CHAMPVA's new website will be **http://www.va.gov/purchasedcare**. We will notify you when the change happens in Your Health, the twice-a-year CHAMPVA magazine for beneficiaries. And the old **http://www.va.gov/hac** website will automatically redirect users when we move to the new website, **http://www.va.gov/purchasedcare**

E-mail

Please go to **http://www.va.gov/hac/contact** and follow the instructions for submitting e-mail via IRIS.

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 in an e-mail. If you are requesting that type of information, we will call you or send the information through regular mail.

Note: To view and print forms, you must have Adobe Acrobat Reader installed on your computer. The reader is available to download for free via a link on our website.

Mail

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

CHAMPVA
PO Box 469063
Denver CO 80246-9063

WHERE TO GET FORMS AND PUBLICATIONS

Forms and publications are available to you through the customer service options identified on pages 10–11. When you use any of these options, make sure you provide your name and address.

WHERE TO SEND COMPLETED FORMS

CHAMPVA Other Health Insurance (**OHI**) Form (VA Form 10-7959c):

CHAMPVA
PO Box 469063
Denver CO 80246-9063

CHAMPVA Applications/School Certifications:

CHAMPVA Eligibility
PO Box 469028
Denver CO 80246-9028

Completed Claims for Medical Services and Supplies:

CHAMPVA Claims
PO Box 469064
Denver CO 80246-9064

Meds by Mail Order Form:

Cheyenne WY or Dublin GA
(see Pharmacy section)

Note: You can also provide **OHI** information by calling a customer service representative at 1-800-733-8387.

Where to get care

Always ask your health care providers if they accept CHAMPVA and, if they do, if they will file any claims with us for reimbursement of their services. If they're unfamiliar with CHAMPVA, have them call us at 1-800-733-8387. We can explain CHAMPVA to them.

If you need to find a provider that accepts CHAMPVA, try Medicare or TRICARE providers. (TRICARE is a health care program for active duty and retired military personnel and their dependents).

To locate a Medicare provider, go to: **http://www.medicare.gov**

Use one of the "Doctor, provider" links on that page.

For a TRICARE provider, go to: **http://www.tricare.mil/GettingCare/FindDoctor/Network.aspx**

We cover most medically necessary services and supplies when they are received from an authorized provider. We consider any provider to be authorized if they are performing services within the scope of their license.

You may also be able to obtain medical services at your local VA Medical Center (VAMC) or Community Based Outpatient Clinic (CBOC) under the CHAMPVA Inhouse Treatment Initiative (CITI). There is no cost share and no deductible, and more than half of all VAMCs participate. See this chapter for details.

We also offer several ways for you to obtain medications.

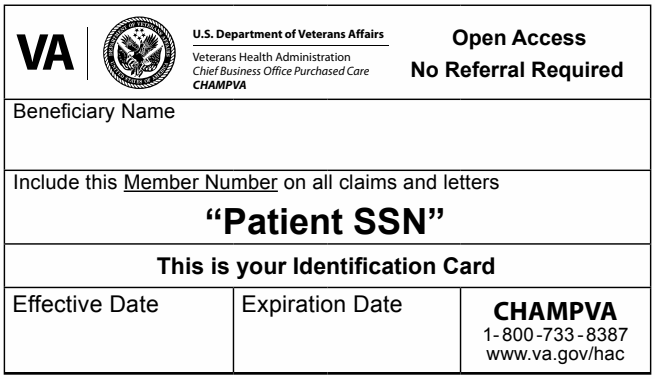
For nonurgent or maintenance medications, you can use our Meds by Mail program if you do not have any other pharmacy coverage. There are no co-payments, no deductibles and no claims to file. For forms and information, visit our website at **http://www.va.gov/hac/forms** or call us at 1-800-733-8387.

See additional details in this chapter.

You may also be able to use our Catamaran pharmacy network if you do not have other health insurance with pharmacy coverage. There are more than 66,000 pharmacies in the Catamaran national network. See the additional details in this chapter.

You can also use a nonnetwork pharmacy. Show your CHAMPVA Identification Card as proof of coverage. You will likely have to pay and then file a claim with us.

Each CHAMPVA-eligible family member receives an identification card. We changed our practice of displaying your Social Security number (SSN) 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 displaying the actual number.



VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Chief Business Office Purchased Care
CHAMPVA

Open Access
No Referral Required

Beneficiary Name

Include this Member Number on all claims and letters

"Patient SSN"

This is your Identification Card

Effective Date	Expiration Date	**CHAMPVA** 1-800-733-8387 www.va.gov/hac

FRONT

CHAMPVA pays after most other health plans. Include an explanation of benefits from other insurers. CHAMPVA is primary to Medicaid.

Once you become eligible for Medicare part A, you must obtain and maintain Medicare part B to remain eligible for CHAMPVA.

For Electronic Claims Filing please follow the instructions at: **www.va.gov/hac/forproviders** under "How to File a Claim."

For Mental Health/Substance Abuse Authorization
Call 1-800-424-4018—Authorization is required:
- After 23 outpatient mental health visits in a calendar year
- For all other mental health/substance abuse services

For Durable Medical Equipment (DME) Authorization
Call 1-800-733-8387—Authorization is required:
- 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 dollar amount, talk to your doctor about how and when to pay your part of the bill. If you have already paid your deductible or reached your catastrophic cap for the year, show your most recent CHAMPVA **Explanation of Benefits** (**EOB**) to your provider to verify that you have met one or both of these requirements for the year.

Words that are in bold green print are defined on pages 80–84.

CHAMPVA covers most **medically necessary** health care services, including ambulance service, 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: anesthesiologist, 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 (LCST), licensed practical nurse (LPN), marriage and family 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 (**VAMC**) or clinic through the CHAMPVA Inhouse Treatment Initiative (**CITI**), described in the following paragraph. You may also obtain medical services from non-VA providers.

VA MEDICAL PROVIDERS

Depending on whether your local VAMC or clinic participates in the CHAMPVA Inhouse Treatment Initiative (CITI) – pronounced “city” – and the type of services a VAMC has available, you may be able to receive all or a portion of your medical care 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 charge 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 and scroll down and click the CITI link. You will find a link to a list of participating VA medical facilities and their phone numbers.

- Or you can call, e-mail or write us (see pages 10 and 11 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 contact their patient administration section. Your CHAMPVA eligibility and **OHI** information will be reviewed. If you have Medicare, you will not be able to participate in the CITI program. Some VAMCs accept patients through the CITI program who have other types of health insurance, but it is the VAMC’s decision whether or not they will accept you.

Words that are in bold green print are defined on pages 80–84.

If you are a Veteran and a CHAMPVA **beneficiary**, you may be entitled to receive care through the VA health care system based on your Veteran status rather than as a CHAMPVA beneficiary. You will need to discuss this with the VA medical facility when you contact them about **CITI** participation.

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 at **http://www.tricare.mil/GettingCare/FindDoctor/Network.aspx** to locate a provider in your area. Ask that provider 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 one of the "Doctor, provider" links on that page.

Please call, e-mail or write us (contact information on pages 10 and 11) 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, confirm that they will accept CHAMPVA. Providers most often refer to this as accepting **assignment**. That means the provider will bill us directly for covered services, items and supplies. Doctors or other providers who accept assignment must accept the CHAMPVA **allowable amount** as payment-in-full 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 in cases where CHAMPVA is your only insurance, 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 send you our share of the allowable amount.

What 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 80–84.

When CHAMPVA Is Secondary Insurance

To obtain reimbursement in cases where CHAMPVA is your secondary insurance, you can ask the provider to file the claim and explanation of benefits (**EOB**) from the primary insurer electronically or in writing with CHAMPVA. If the provider is not able or willing to do that, you will need to submit the itemized bill, CHAMPVA Claim Form and the EOB from the primary insurer to CHAMPVA.

PHARMACY PROVIDERS

Meds by Mail (MbM)

This is by far the most cost-effective way for you to receive your nonurgent, maintenance medications. There is no enrollment and you automatically qualify for **MbM** if you **do not** have another health insurance plan with pharmacy coverage (including Medicare Part D). 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 servicing centers, and you are assigned to a servicing center based on where you live. Your servicing center will help you with the status of your prescription order, questions about medication availability and patient profile updates. You can order refills by calling our 24-hour automated refill phone line at 1-888-370-1699.

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, 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	Meds by Mail Servicing Center PO Box 9000 Dublin GA 31040-9000 Monday–Friday 8:05 a.m. to 7:30 p.m. (Eastern Time) 1-866-229-7389 Refills: 1-888-370-1699
Alaska, American Samoa, Arizona, Arkansas, California, Colorado, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Northern Mariana Islands, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming	Meds by Mail Servicing Center PO Box 20330 Cheyenne WY 82003-7033 Monday–Friday 8:05 a.m. to 7:30 p.m. (Eastern Time) 1-888-385-0235 Refills: 1-888-370-1699

Important facts to keep in mind when using MbM

- There is no enrollment required for **MbM**. To begin using MbM, fill out the MbM Prescription Order Form (**VA Form 10-0426**), available by visiting our website, at **http://www.va.gov/hac/forms** 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 a 90-day supply with up to three refills, if possible. If you need to begin taking the medication right away, ask your provider to write two prescriptions—a 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 mailed to the servicing center, (copied or faxed prescriptions cannot be filled at this time). Refills can be ordered through our 24-hour automated refill line at 1-888-370-1699.
- Maintenance medications (those you take 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 III, IV and V for controlled substances (your physician can tell you if the medication prescribed to you is on one of these schedules). Medications such as Duragesic Patches, Percocet, Percodan, Ritalin and Oxycontin, which are all Schedule II narcotics, are **NOT** available through MbM and must be filled at your local pharmacy.
- Refrigerated items cannot be sent to a PO Box and must be delivered directly to your home. If you do not have home delivery, you will have to use your local pharmacy and pay the cost share.
- Prescriptions sent to MbM are filled with generic medications, when available. Please ensure that your doctor authorizes generic substitution for **ALL** your medications.
- If your doctor prescribes a brand name medication and does not authorize a generic substitution AND only a generic equivalent is available through the MbM program, your prescription will be returned to you.
- When MbM does not have the medication that your doctor requested, MbM will attempt to contact your doctor to see if another medication that ***is*** available can be substituted for you. If your physician cannot be contacted, or requires that you take a medication that MbM does not have, your prescription will be returned to you.
- **Over-the-counter (OTC)** medications are not covered by CHAMPVA and cannot be obtained through MbM. The ONLY exception is for insulin and diabetic-related supplies, such as syringes, blood glucose monitors and blood glucose strips.
- You should still use your local pharmacy for urgent care medications or any that are not available through MbM.
- If your other health coverage is Medicare, and you have Medicare Parts A and B but did not enroll in Medicare Part D, you can use MbM.

Words that are in bold green print are defined on pages 80–84.

- If you obtain other health insurance in the future that includes a pharmacy benefit (including Medicare Part D), you will no longer be eligible to use MbM.
- Meds by Mail will not send prescriptions overseas or to an APO/FPO address.

If you need help with general information about MbM eligibility or applications for MbM, call us at: 1-800-733-8387.

CATAMARAN RETAIL PHARMACY NETWORK

Catamaran provides a retail network of 66,000 pharmacies across the United States and U.S. Territories. If CHAMPVA is your only pharmacy coverage, you will only pay a 25% cost share for your medication (after the annual outpatient deductible has been met), and there will be no claims for you to file. If you have other health insurance (**OHI**) that includes pharmacy coverage, you cannot use the Catamaran retail network of pharmacies. You will have to pay for the prescription and submit a claim to CHAMPVA for reimbursement. The only exception is if you have Medicare Part D. If you have Medicare Part D, your pharmacy may be able to electronically submit a claim through Catamaran resulting in no cost share for you at the pharmacy and no claims for you to file.

To obtain a Catamaran pharmacy identification card and information on local pharmacies in your area that are a part of the Catamaran network, call the following beneficiary number or go to Catamaran's website and follow the instructions listed below.

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

Website: **https://vahac.rxportal.sxc.com**

- 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.

Nonnetwork Retail Pharmacy

You can also choose a nonnetwork retail pharmacy. The CHAMPVA Identification Card is your proof of coverage for a nonnetwork pharmacy. A pharmacy that is not part of our Catamaran network most likely will 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. If you have other health insurance, you will also need to submit the **EOB** showing what the other health insurance paid on the claim or showing what your co-pay was for that prescription. Your pharmacist can provide you with a printed document that contains all required information that CHAMPVA needs to reimburse you for pharmacy claims. The information required is the 11-digit **National Drug Code** (**NDC**), the date the drug was dispensed, name and quantity of the drug, the drug’s retail value and the amount of your co-pay. We cannot process the claim without this information.

Words that are in bold green print are defined on pages 80–84.

The services and supplies we cover

CHAMPVA will only cover care that is medically necessary and appropriate. There may be limits on certain care, and some care is not covered at all.

In most cases, you do not need advance approval from us. But if your physician wants to obtain authorization for a medical service that requires it (see below), please contact us at 1-800-733-8387 or by writing to:

CHAMPVA
ATTN: Authorization
PO Box 469063
Denver CO 80247-9063

We cover a range of preventive services. See Page 46–49 for the list. And we cover a wide range of other medical services. See the list starting on page 20.

An alphabetical list of covered benefits can be found in the Index under Benefits on Page 85.

CHAMPVA will only cover care that is medically necessary and appropriate. Even if your physician tells you that you should receive certain care, CHAMPVA may not cover that care. There may be limits on certain care, and some care is not covered at all.

Care that goes on for a period of weeks, months, etc., may be medically reviewed periodically and medical documentation may be requested. Examples include physical therapy, medication, mental health services and skilled nursing services. 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 **FDA** approved for use in the U.S.

Note: If you choose to obtain health care services from a provider on Medicare's exclusion list, we will not pay for those services. To obtain a list of excluded providers, or to search for an excluded provider, use the Medicare exclusions link on the CHAMPVA website at **http://www.va.gov/hac/forbeneficiaries/champva** or access this information directly from the Department of Health and Human Services, Office of Inspector General website at: **http://exclusions.oig.hhs.gov**

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 other than those listed below. In that case, your physician should call CHAMPVA regarding the service(s) in question. Our customer service representatives will assist your physician with any questions they may have. You may also want to consider showing your provider this section of the guide. It describes the criteria for coverage of many services.

Words that are in bold green print are defined on pages 80–84.

Services that require authorization:

- **Durable Medical Equipment (DME)** with a purchase price or total rental of $2,000 or more (see page 28)
- Mental health care (approval needed from our mental health contractor)
  - Inpatient mental health care
  - Care at residential treatment facilities (RTF)
  - Alcohol/substance abuse
  - Care in Partial Hospital Programs (PHP)
  - Requests for extensions to our yearly limits on inpatient mental health care (see page 21)
  - 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

Exceptions to the authorization requirement:

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

When **OHI** has authorized a service, we do not require authorization for those same services. If Medicare denies coverage because their rules for coverage were not followed or medical necessity was not established, we will also deny coverage.

TO OBTAIN AUTHORIZATION FOR MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Mail: Magellan Behavioral Health
CHAMPVA
PO Box 3567
Englewood CO 80155

Phone:

1-800-424-4018 (domestic)
1-800-424-4685 (international)
1-314-387-4700 (international; can call collect if there is a problem connecting to the toll-free number)
1-800-424-4017 Fax for authorization requests

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

To obtain authorization for other services:

Mail: CHAMPVA Authorization
PO Box 469063
Denver CO 80246-9063

Phone: 1-800-733-8387

OTHER COVERED SERVICES

The following is an alphabetical list of services that are covered when medically necessary. 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**

BEHAVIORAL HEALTH SERVICES

CHAMPVA authorization through the mental health contractor, Magellan, is not required when your other health insurance (**OHI**) has already authorized the otherwise covered benefit.

Covered Services	Patient Pays	CHAMPVA Pays
ADD or ADHD: Attention Deficit Hyperactivity Disorder (ADHD) has coverage as outlined under Behavioral Health Outpatient Care listed below.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***CHAMPVA is Secondary or Tertiary:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Alcohol abuse (treatment for)**:** Authorization is required. Refer to **"Substance Abuse"** for specific benefit coverage.	Refer to **"Substance Abuse"** for benefit payment information	

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Behavioral Health Acute Inpatient Care: CHAMPVA requires authorization by mental health contractor for all inpatient acute psychiatric hospitalizations. The benefit limits the allowed number of inpatient days per fiscal year (October 1 through September 30). For adults, age 19 or older, the limit is 30 days. For children, ages 18 or younger, the limit is 45 days. Coverage exceeding the impatient limit is called a waiver. A waiver may be authorized only when the **beneficiary**'s treatment plan shows that it is psychologically necessary to continue at the acute level of care. Waivers need to be authorized by the mental health contractor. CHAMPVA benefits cover seven inpatient psychotherapy sessions/calendar week while a **beneficiary** is in an authorized inpatient acute psychiatric hospital.	**Inpatient Mental Health High Volume Facility** ***CHAMPVA is Primary Payer:*** • No Deductible • 25% Cost Share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Mental Health Low Volume Facility** ***CHAMPVA is Primary – Lesser of:*** • Per-day amount times the number of inpatient days, or • 25% of the billed amount ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	**Inpatient Mental Health High Volume Facility** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount **Inpatient Mental Health Low Volume Facility** ***CHAMPVA is Primary Payer:*** • Up to 100% of Allowed Amount minus patient per-day payment, or • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Behavioral Health Outpatient Care: The outpatient mental health benefit allows a total of 23 psychotherapy sessions in a fiscal year (October 1 through September 30), and no more than 2 sessions in a week (Sunday through Saturday), without an authorization. If additional psychotherapy sessions are needed then authorization by the mental health contractor needs to be obtained. Only psychotherapy sessions performed by a provider listed in the CHAMVPA Policy Manual, Chapter 2, Section 18.1 are covered. The types of sessions that are included in these limits are: individual, group, family, collateral, multiple family group and interactive group. Medication management, psychological evaluation, psychological testing, and electroconvulsive therapy are not included in these limits	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Drug Abuse (treatment for): Authorization is required. Refer to **"Substance Abuse"** for full benefit coverage.	Refer to **"Substance Abuse"** for benefit payment information	
Eating Disorders: Refer to **"Behavioral Health Outpatient Care"** for full benefit coverage.	Refer to **"Behavioral Health Outpatient Care"** for benefit payment information	

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
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 TRICARE approved or Medicare certified. Authorization is required from the CHAMPVA mental health contractor except when Medicare is the primary payer. In that case, when Medicare has authorized the care, the service does not require authorization through the CHAMPVA mental health contractor	***CHAMPVA is Primary Payer:*** • No Deductible • 25% cost share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Residential Treatment Center (RTC)**:** Benefit: 150 days per year. Authorization is required by the CHAMPVA mental health contractor at least three days before admission. The RTC must be accredited by The Joint Commission (TJC), or TRICARE certified, and must be state licensed and in compliance with state and federal regulations. Care in an RTC is covered for children and adolescents ages 18 and younger. Geographically distant family therapy (GDFT) is also covered when authorized by the mental health contractor.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Substance Abuse (treatment of): 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 rendered during that year. • **Outpatient rehabilitation** Limited individual, family and group therapy sessions are allowed. • **Detoxification** Detoxification is an inpatient service that requires authorization by the CHAMPVA mental health contractor. The service is limited to seven days per admission, which count toward the 30/45-day inpatient mental health limit. Detoxification will be approved only if it is performed under general medical supervision. • **Inpatient and partial hospitalization rehabilitation** 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. The facility must be TRICARE approved or Medicare certified.	**Inpatient Mental Health High Volume Facility** ***CHAMPVA is Primary Payer:*** • No Deductible • 25% Cost Share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Mental Health Low Volume Facility** ***CHAMPVA is Primary – Lesser of:*** • Per-day amount times the number of inpatient days, or • 25% of the billed amount ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	**Inpatient Mental Health High Volume Facility** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount **Inpatient Mental Health Low Volume Facility** ***CHAMPVA is Primary Payer:*** • Up to 100% of Allowed Amount minus patient per-day payment, or • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Behavior Health Services that are NOT covered	Patient Pays	CHAMPVA Pays
Learning Disorders: Such as reading disorders or dyslexia, mathematics disorders, disorders of written expression and/or learning disorders not otherwise specified.	100% of billed charges	Nothing
Marriage counseling		
Sex Changes, Therapy, or Sexual Behavior Modification		
Stress Management		

DENTAL SERVICES

Limited coverage requiring authorization. Coverage limited to dental treatments as part of the appropriate treatment of some other (non-dental) covered medical condition.

Covered Services	Patient Pays	CHAMPVA Pays
Adjunctive Dental Care: (extremely limited coverage) Covered only when the dental treatment is part of the appropriate treatment of some other (non-dental) covered medical condition.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Gingival Hyperplasia: When caused by prolonged medication therapy for conditions such as epilepsy or seizure disorders.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
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 the neoplasm, and the patient's age. Include a detailed description of the prosthetic treatment plan when applicable.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Mercury Hypersensitivity: The removal of dental amalgam mercury source is covered under the following conditions: • 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.		
Temporomandibular Joint Disease (TMD): Initial radiographs or other imaging technologies, up to four office visits, physical therapy for acute phase treatment only, and construction of occlusal splint.		
Dental Services that are NOT covered	**Patient Pays**	**CHAMPVA Pays**
Dental Care – routine	100% of billed charges	Nothing
Dentures or Partial Dentures (adding or modifying)		
Othodontia Care (braces)		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

DIABETIC SERVICES		
Covered Services	**Patient Pays**	**CHAMPVA Pays**
Diabetes Screening: Screenings can be covered when you have these risk factors: • High blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar. Screenings can also be covered if you have two or more of the following characteristics: • 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. Talk to your doctor for more information.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
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 bill).		
Eye Exam: Covered when there is a diagnosis of diabetes.		
Insulin and Diabetic related supplies: Covered benefit. Insulin pumps are also covered when the claim is accompanied by a **CMN** or doctor's order with the diagnosis of diabetes mellitus.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Foot Care Services: Very limited coverage; routine foot care services for peripheral vascular disease, metabolic, or neurological disease are covered (e.g. diabetes)	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Shoes for Diabetics: One pair of custom molded shoes (including inserts) per calendar year. One pair of extra-depth shoes (not including inserts provided with such shoes) per calendar year. Three pairs of multi-density inserts per calendar year.		
Diabetes Services that are NOT Covered	**Patient Pays**	**CHAMPVA Pays**
Weight Control Medication or weight reduction programs	100% of the billed charges	Nothing

DME SERVICES

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.

Covered Services	Patient Pays	CHAMPVA Pays
Barrier-free Lift: Claim should be accompanied by a **Certificate of Medical Necessity (CMN)** to include medical documentation. Medical documentation should show a history of inability to get out of bed and that there is no caregiver to get the patient in or out of bed. Home modifications are not covered.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Durable Medical Equipment (DME): DME must be ordered by a physician and be authorized by CHAMPVA if the cost (total rental or purchase) exceeds $2,000. Authorization must include the **CMN** or doctor's **DME** order. Additional documentation may also be required. Coverage may be authorized for customization, accessories, or supplies; maintenance by manufacturer's authorized technician; repair and adjustment; and or replacement needed as a result of normal wear or a change in medical condition.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Mastectomy Bras and Prostheses: Covers up to seven bras every 12 months; replacement of breast prostheses every 24 months.		
Orthopedic Braces and Other Appliances: Orthotic devices are covered when appropriate based on benefit policy and provided by an authorized provider. Covered orthotic devices include, but are not limited to, braces for the neck, arm, back and leg to assist in movement or to provide support to a limb. *(Orthopedic shoes are excluded from benefit coverage except for diabetics.)*		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Oxygen and related equipment (to include oxygen concentrators): Covered benefit requiring 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. 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.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Penile Implant/Testicular Prosthesis: For organic impotence, correction of a congenital anomaly or correction of ambiguous genitalia.		
Prosthetic Devices: Artificial limbs, eyes, voice and other prostheses, as well as **FDA**-approved surgical implants, are covered.		
Shoes for Diabetics: One pair of custom molded shoes (including inserts) per calendar year. One pair of extra-depth shoes (not including inserts provided with such shoes) per calendar year. Three pairs of multi-density inserts per calendar year.		
TENS (Transcutaneous electrical nerve stimulation)**, Neurostimulator:** Claim should be accompanied by **CMN** or doctor's order containing the diagnosis.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Wheelchair or Scooter (motorized): Claims 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.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Wig or Hairpiece: When needed during or after treatment for cancer (one per lifetime)		
Wound Vacuum-Assisted Closure (negative pressure wound therapy): 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.		
DME Services that are NOT Covered	**Patient Pays**	**CHAMPVA Pays**
Durable Medical Equipment (DME): Denied by Medicare and other health insurance as not medically necessary	100% of the billed charges	Nothing
Exercise Equipment		
Hearing Aids		
Hot Tubs		
Luxury or deluxe equipment		
Maintenance agreements/contracts		
Modifications to home or vehicle		
Orthotic shoe devices: Such as heel lifts, arch supports, shoe inserts, etc., unless associated with diabetes		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

DME Services that are NOT Covered *(continued)*	Patient Pays	CHAMPVA Pays
Spas	100% of the billed charges	Nothing
Vehicle Lifts: That are non-detachable and cannot be removed from one vehicle and used on another.		
Whirlpools		

EXTENDED CARE		
Covered Services	**Patient Pays**	**CHAMPVA Pays**
Cardiac rehabilitation programs: Limited to 36 sessions and normally completed within 12 months following a qualifying cardiac event	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Home Health Care: Coverage is limited to intermittent skilled level home care for a homebound patient. The care must be medically necessary and ordered by a physician and the care must be provided by a registered nurse, Licensed Practical Nurse (LPN) or Licensed Vocational Nurse.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Hospice: Care is covered for terminally ill patients who have a life expectancy of six months or less. The program is designed to provide care and comfort to patients and emphasizes supportive services such as pain control, home care and patient comfort. There are four levels on which reimbursement is based. They are: 1. Routine Home Care – reimbursed as routine home care when not receiving continuous care. 2. Continuous Home Care – minimum of 8 hours per 24 hour period. 3. Inpatient Respite Care – maximum of 5 days including day of admission but not including day of discharge. 4. General Inpatient Care – reimbursed at the inpatient rate when general inpatient care is provided. Full Hospice benefit information can be found in the CHAMPVA Policy Manual, Chapter 2, Section 16.4.	**Hospice Services** ***CHAMPVA is Primary, Secondary, or Tertiary Payer:*** • No Deductible • No Cost Share	**Home Hospice Care** ***CHAMPVA is Primary, Secondary, or Tertiary Payer:*** • Up to 100% of Allowed Amount **Hospice Inpatient Services** ***CHAMPVA is Primary:*** • Up to 100% of Allowed Amount **Hospice Inpatient Services** ***CHAMPVA is Secondary, or Tertiary Payer:*** • Up to 100% of Allowed Amount minus OHI payment

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
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. The skilled care can be provided in different settings, such as the patient's home, or a rehabilitation facility, depending on the amount and frequency of care needed and the severity of the illness.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Skill nursing facility (SNF): 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. Skilled care can be provided either in a hospital or in a separate facility. Skilled nursing care does not require authorization, but all claims for such services are subject to medical review. Claims should be accompanied by medical documentation that justifies this level of care. *NOTE: There must be a three-day inpatient qualifying stay prior to admission to an SNF.*	***CHAMPVA is Primary Payer:*** • No Deductible • 25% cost share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) ***Medicare is Primary:*** • 1–20 days $0 (in most cases) • 21–100 days $0 (in most cases) • >100 days 25% Cost Share	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount ***Medicare is Primary:*** • 1–20 days $0 (in most cases) • 21–100 days $0 (in most cases) • >100 days 75% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Extended Care Benefits that are NOT covered	Patient Pays	CHAMPVA Pays
Custodial Care	100% of the billed charges	Nothing
Housekeeping, homemaker and attendant services		
Services provided by a member of your immediate family or person living in your household		

FAMILY CARE SERVICES		
Covered Services	**Patient Pays**	**CHAMPVA Pays**
Birth Control: Family planning benefits are provided for intrauterine devices (IUDs), diaphragms, birth control pills, long-term reversible contraceptive implants, and sterilization (vasectomy or tubal ligation). Over the counter (**OTC**) forms of birth control are not a covered benefit	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Family Planning and Maternity: Coverage for treatment related to prenatal, delivery, and postnatal 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. Maternity benefits may not be restricted for any hospital length of stay in connection with childbirth for the mother or newborn child: • Following a normal vaginal delivery, to less than 48-hours • Following a cesarean section, to less than 96-hours	***Outpatient Services*** ***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services- Diagnosis Related Group (DRG) Based** ***CHAMPVA is Primary Payer:*** • No Deductible Lesser of: • Per-day amount times the number of inpatient days, or • 25% of billed amount, or • DRG rate ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services- Non-(DRG) Based** ***CHAMPVA is Primary Payer:*** • No Deductible • 25% Cost Share	***Outpatient Services*** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount **Inpatient Services- Diagnosis Related Group (DRG) Based** ***CHAMPVA is Primary Payer:*** Lesser of: • Up to 100% of Allowed Amount minus patient per day payment, or • 75% of Allowed Amount, or • Up to 100% of Allowed Amount minus the DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services- Non-(DRG) Based** ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Fetal Fibronectin Enzyme Immunoassay (to determine risk of preterm delivery)**:** Benefits are covered for pregnant women with indications of preterm delivery.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% cost share ***CHAMPVA is Secondary or Tertiary:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Genetic Testing During Pregnancy: To diagnose a disease or syndrome. The test must be medically appropriate and necessary.		
Infertility Testing and Treatment: Services include diagnostic testing, surgical intervention, hormone therapy and other covered procedures to correct the cause of infertility.		
Newborn Care: The newborn period is considered 0 to 30 days. Well-child care for newborns includes the routine care of the newborn in the hospital, newborn circumcision, and newborn screening as recommended by the American Academy of Pediatrics (AAP).		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Surgical Sterilization: Tubal ligation and vasectomy are covered. *(continued on page 39)*	**Outpatient Services** ***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services-Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** • No Deductible Lesser of: • Per-day amount times the number of inpatient days, or • 25% of billed amount, or • DRG rate *(continued on page 39)*	**Outpatient Services** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services-Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** Lesser of: • Up to 100% of Allowed Amount minus patient per-day payment, or • 75% of Allowed Amount, or • Up to 100% of Allowed Amount minus the DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount *(continued on page 39)*

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
(continued from page 38) **Surgical Sterilization:** Tubal ligation and vasectomy are covered.	*(continued from page 38)* ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services-Non-DRG Based** ***CHAMPVA is Primary Payer:*** • No Deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	*(continued from page 38)* **Inpatient Services-Non-DRG Based** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Well-Child Care: Care up to six years of age to include routine physical examinations, immunizations, vision and hearing screenings, behavioral assessments and developmental assessments in accordance with the most current American Academy of Pediatrics (AAP) guidelines, and lab screenings.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Family Care Services NOT Covered	Patient Pays	CHAMPVA Pays
Abortion Counseling	100% of the billed charges	Nothing
Abortions: Except when a physician certifies that the life of the mother would be endangered if the fetus were carried to term.		
Artificial Insemination		
Birth Control OTC – **OTC** forms of birth control are not a covered benefit.		
Diagnostic Tests: To determine the sex or paternity of a **child**.		
Embryo Transfer		
Genetic Testing/Screening: Routine or demand genetic testing, or genetic tests performed to establish the paternity of a child, or sex of an unborn child, are excluded from coverage.		
In Vitro Fertilization		
Leaning Disorders: Such as reading disorders or dyslexia, mathematics disorders, disorders of written expression and/or learning disorders not otherwise specified.		
Marriage Counseling		
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).		
Reversal of Surgical Sterilization – tubal ligation or vasectomy.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

GENERAL MEDICAL SERVICES		
Covered Services	**Patient Pays**	**CHAMPVA Pays**
Ambulance Service: Covered when life-sustaining equipment is necessary for a medically covered condition. Air ambulance to the nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Trip reports may be required for consideration of payment.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Autologous Blood Collection (blood transfusion): This is the collection of the patient's own blood. Transfusion services are covered when there is a scheduled surgical procedure.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an Ambulatory **Surgery Center (ASC**) have no deductible • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Foot Care Services (very limited coverage): Routine foot care services for peripheral vascular disease, metabolic, or neurological disease are covered (e.g. diabetes)	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Morbid Obesity: Surgical correction of morbid obesity may be covered when one of the following conditions is met: • Patient's body mass index (BMI) is over 40, or • Patient's BMI is over 35 with serious medical conditions exacerbated or caused by obesity or • Second surgery (takedown) due to complications of previous surgical correction. Surgical procedures are limited to adjusted gastric banding (LAP-BAND); gastroplasty (stomach stapling); Roux-en-Y gastric bypass; and vertical banded gastroplasty and medically necessary revisions. (See benefits policy for specific exclusions.) Claims must be accompanied by the BMI, current height, weight, history of other medical conditions and history of other treatments tried and failed.	**Inpatient Services-Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** • No Deductible Lesser of: • Per-day amount times the number of inpatient days, or • 25% of billed amount, or • DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) *(continued on page 43)*	**Inpatient Services-Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** Lesser of: • Up to 100% of Allowed Amount minus patient per day payment, or • 75% of Allowed Amount, or • Up to 100% of Allowed Amount minus the DRG rate *(continued on page 43)*

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Morbid Obesity: Surgical correction of morbid obesity may be covered when one of the following conditions is met: • Patient's body mass index (BMI) is over 40, or • Patient's BMI is over 35 with serious medical conditions exacerbated or caused by obesity or • Second surgery (takedown) due to complications of previous surgical correction. Surgical procedures are limited to adjusted gastric banding (LAP-BAND); gastroplasty (stomach stapling); Roux-en-Y gastric bypass; and vertical banded gastroplasty and medically necessary revisions. (See benefits policy for specific exclusions.) Claims must be accompanied by the BMI, current height, weight, history of other medical conditions and history of other treatments tried and failed.	*(continued from page 42)* **Inpatient Services - Non-DRG Based** ***CHAMPVA is Primary Payer:*** • No Deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	*(continued from page 42)* ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services - Non-DRG Based** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Myofascial Pain Dysfunction Syndrome: 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.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

General Medical Services that are NOT covered	Patient Pays	CHAMPVA Pays
Experimental/investigational Services and Supplies	100% of the billed charges	Nothing
Foot Care Services of a routine nature, such as removal of corns and calluses.		
Hearing Examinations unless in connection with a covered illness/injury		
Hypnosis		
Naturopathic Services		
Private Hospital Rooms		
Sex Changes, Therapy, or Sexual Behavior Modification		
Transportation Services that do not require life sustaining equipment		
Weight Control Medication or Weight Reduction Programs		
Workers' Compensation Injuries		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

PHARMACY SERVICES		
Covered Services	**Patient Pays**	**CHAMPVA Pays**
Immunizations and Vaccines: When administered per Centers for Disease Control and Prevention recommendations and other specific factors. *Please see pages 47–49 for detailed immunization information.*	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) ***Received Through Meds by Mail (MbM)*** • Nothing	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Drugs and Medications: Covered drugs and medications must be approved by the Department of Health and Human Services' **Food and Drug Administration (FDA)** 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.		
Pharmacy Services that are NOT Covered	**Patient Pays**	**CHAMPVA Pays**
Drug Maintenance Programs: Where one addictive drug is substituted for another (such as methadone for heroin)	100% of the billed charges	Nothing
Drugs that are Not FDA Approved		
Group C Drugs for Terminally Ill Cancer Patients: These medications are available free from the National Cancer Institute through its registered physicians		
Immunizations for travel		
Over-the-Counter (OTC) 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)		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Pharmacy Services that are NOT Covered *(continued)*	Patient Pays	CHAMPVA Pays
Smoking Cessation Services: Medications and products	100% of the billed charges	Nothing
Vitamins: Except for prescription formulations of folic acid, niacin, and vitamins D, K, and B12 (injection) that are not available **OTC**.		

PREVENTIVE SERVICES (LIMITED COVERAGE)

The following services have limited coverage and must be medically necessary. In all cases, your physician will determine when it is medically necessary and appropriate for the medical services. None of these services are covered when provided as a routine service or part of an annual exam.

Covered Services	Patient Pays	CHAMPVA Pays
Bone Density Studies: When used to diagnose or monitor osteoporosis and osteopenia. When used for diagnosis, patient must be considered high-risk or presenting symptoms. When used for monitoring, bone density studies are limited to one per year. This service is not covered when used for routine screening	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Cancer Screening: When it is medically necessary and appropriate.		
Cardiovascular Screenings: When it is medically necessary and appropriate.		
Cholesterol Screening: When it is medically necessary and appropriate.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Colorectal Cancer Screenings: Annual screenings are covered one every 10 years for an average level of risk. Higher levels of risk may have additional benefits coverage. The level of risk will be determined by your physician.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Diabetes Screening		
Genetic Testing: To diagnose a disease or syndrome. The test must be medically appropriate and necessary.		
HIV Testing: When there has been HIV exposure or symptoms of possible infection, or if there is a pregnancy.		
Immunizations and Vaccines: When administered per Centers for Disease Control and Prevention recommendations and other specific factors. *Please see pages 47–49 for detailed immunization information.*		

CENTERS FOR DISEASE CONTROL RECOMMENDED CHILDHOOD IMMUNIZATION SCHEDULE

Vaccines are listed under routinely recommended ages. Columns indicate range of acceptable ages for immunization. Catch-up immunizations should be done during any visit when feasible.

Age → / Vaccine ↓		Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs	14-17 yrs
Hepatitis B	B1	X	X	X									
	B2		X	X	X								
	B3					X	X	X				X	
Diphtheria, Tetanus, Pertussis				X	X	X	X	X	X		X	X	X

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Age → Vaccine ↓	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4-6 yrs	11-12 yrs	14-17 yrs
Haemophilus Influenza type B			X	X	X	X	X	X		X		
Inactivated Polio			X	X	X	X	X	X		X		
Measles, Mumps, Rubella						X	X			X	X	X
Rotavirus			X	X	X							
Varicella						X	X	X	X	X	X	X
Meningococcal									X	X	X	X
Pneumococca			X	X	X	X	X	X	X	X	X	X
Hepatitis A						X	X	X	X	X	X	X
Influenza					X	X	X	X	X	X	X	X
Influenza FluMist Nasal Spray										X	X	X
HPV-Types 6, 11, 16, & 18 Recom-binant-Gardasil											X (age 9)	X

CENTERS FOR DISEASE CONTROL RECOMMENDED ADULT IMMUNIZATION SCHEDULE

Vaccines are listed under routinely recommended ages. Columns indicate range of acceptable ages for immunizations. Catch-up immunizations should be done during any visit when feasible.

Vaccine ↓ / Age →	18–24 yrs	25–64 yrs	65+ yrs
Influenza	X	X	X
Influenza FluMist Nasal Spray	X	X (to 49 yrs)	
Pnuemococcal	X	X	X
Meningococcal	X	X (to 55 yrs)	
Measles	X	X	
Mumps	X	X	
Rubella	X	X	

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Vaccine ↓ / Age →	18–24 yrs	25–64 yrs	65+ yrs
Varicella	X	X	X
Tetanus/Diphtheria (Td)	X	X	X
Polio	X	X	
Hepatitis B4	X	X	X
Hepatitis A	X	X	X
HPV-Types 6, 11, 16, & 18 Recombinant Vaccine Gardasil	X	X (to 26 yrs)	
Shingles (Herpes Zoster)		X (50–59 yrs)	X

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Mammograms: Ages 35-39 • One baseline mammogram • Annually, if your doctor determines you are at high risk. Age 40+ • Annually	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • 25% cost share ***If CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary:*** • Up to 100% of Allowed Amount
Pap Test and Pelvic Exam: For patients age 18 and older or those younger than 18 when recommended by a clinician.		
School-Required Physical: Physical examination for beneficiaries through the age of 17.		
Well-Child Care: Care up to six years of age to include routine physical examinations, immunizations, vision and hearing screenings, behavioral assessments and developmental assessments in accordance with the most current American Academy of Pediatrics (AAP) guidelines, and lab screenings.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

RECONSTRUCTIVE SURGERY

This benefit is very limited. Coverage can be provided to correct a serious birth defect, such as cleft lip/palate, to restore body form or function after an accidental injury or to improve appearance after severe disfiguration or extensive scarring from cancer surgery or breast reconstructive surgery following a mastectomy that is covered by CHAMPVA.

Covered Services	Patient Pays	CHAMPVA Pays
Ankyloglossia (surgery for total or complete tongue tie)**:** Surgery for tongue tie is covered in cases where total or complete ankyloglossia is documented.	**Outpatient Services** ***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services- Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** • No Deductible *(continued on page 51)*	**Outpatient Services** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services- Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** Lesser of: • Up to 100% of Allowed Amount minus patient per-day payment, or • 75% of Allowed Amount, or *(continued on page 51)*
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.		
Breast Reconstruction: Is a covered benefit to correct breast deformities related to verified congenital anomaly, as well as in the case of a medically necessary mastectomy.		
Breast Reduction (Reduction Mammoplasty): Very limited coverage. Claims must include physician documentation of a medical history of persistent symptoms present for at least one year.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
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, and other forms of attempted treatment.	*(continued from page 50)* Lesser of: • Per-day amount times the number of inpatient days, or • 25% of billed amount, or • DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services-Non-DRG Based** ***CHAMPVA is Primary Payer:*** • No Deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	*(continued from page 50)* • Up to 100% of Allowed Amount minus the DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services-Non-DRG Based** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
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		
Implants (surgical; very limited coverage) For silicone or saline breast implants, please contact the customer service center for more details.		
Panniculectomy (tummy tuck): (very limited coverage) A medical history should accompany the claim, as well as documentation of the complications experienced as a result of the enlarged pannus, such as skin rashes/infection, conservative treatments that were tried and failed and /or lower back pain attributed to pannus.		
Penile Implant/Testicular Prosthesis: For organic impotence, correction of a congenital anomaly or correction of ambiguous genitalia.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Cosmetic Services that are NOT Covered	Patient Pays	CHAMPVA Pays
Tattoo Removal	100% of the billed charges	Nothing
Cosmetic Drugs: (e.g. Retin A, Botox)		
Cosmetic Surgery		

TESTING SERVICES

In all cases, your physician will determine when these services are medically necessary and appropriate for your medical care.

Covered Services	Patient Pays	CHAMPVA Pays
Bone Mass Measurements: When used to determine if you are at risk for developing osteoporosis	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Cancer Screening: When it is medically necessary and appropriate		
Cardiovascular Screenings: When it is medically necessary and appropriate.		
Cholesterol Screening: When it is medically necessary and appropriate.		
Colorectal Cancer Screenings: Annual screenings are covered one every 10 years for an average level of risk. Higher levels of risk may have additional benefits coverage. The level of risk will be determined by your physician.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Words that are in bold green print are defined on pages 80–84.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Diabetes Screening: Screenings can be covered when you have these risk factors: • High blood pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or a history of high blood sugar. Screenings can also be covered if you have two or more of the follow characteristics: • 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. Talk to your doctor for more information	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Genetic Testing: To diagnose a disease or syndrome. The test must be medically appropriate and necessary.		
HIV Testing: When there has been HIV exposure or symptoms of possible infection, or if there is a pregnancy.		
Mammograms: Ages 35–39 • One baseline mammogram • Annually, if your doctor determines you are at high risk. Age 40+ • Annually		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Pap Test and Pelvic Exam: For patients age 18 and older or those younger than 18 when recommended by a clinician.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Allergy Testing & Treatment: Allergy testing and treatment are covered when appropriate, based on benefit policy. All claims for allergy testing must indicate the type and number of tests performed.		
CT Scans: When medically necessary and appropriate.		
Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS): Services covered when appropriate, based on benefit policy.		
Positron Emission Tomography (PET): Limited coverage, covered when appropriate based on benefit policy.		
Single Photon Emission Computed Tomography (SPECT): Limited coverage; covered when documentation by reliable evidence as safe, effective, and comparable or superior to standard of care (proven).		
Ultrasound: Ultrasounds for diagnosis, guidance and postoperative evaluation of surgical procedures are covered. 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.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Testing Services that are NOT Covered	Patient Pays	CHAMPVA Pays
Genetic Testing: Routine or demand genetic testing, or genetic tests performed to establish the paternity of a **child**, or sex of an unborn child, are excluded from coverage.	100% of the billed charges	Nothing

THERAPY SERVICES		
Covered Services	**Patient Pays**	**CHAMPVA Pays**
Biofeedback: Certain types of biofeedback therapy are covered when there is medical documentation that there has been no response to other conventional forms of therapy.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Kidney (Renal) Dialysis: Limited to periods of Medicare ineligibility (Medicare coverage of individuals with end stage renal disease [ESRD] begins 90 days from the date maintenance dialysis treatment begins, at which time CHAMPVA becomes a secondary payer).		
Occupational Therapy: Services must improve, restore, or maintain function, or minimize or prevent deterioration of the patient's condition in a reasonable and generally predictable period of time. The services must be prescribed by a physician, certified physician assistant, or a certified nurse practitioner, and be medically necessary.		
Physical Therapy: Physical therapy services may be prescribed by a physician, physician assistant or certified nurse practitioner. 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.		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

Covered Services *(continued)*	Patient Pays	CHAMPVA Pays
Radiation Therapy: Brachytherapy, fast neutron, hyperfractionated and radioactive chromic phosphate synoviorthesis are covered.	***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount
Speech Therapy: For physical impairments including: • 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 The Individuals with Disabilities Education Act (IDEA) requires schools to provide speech therapy services for children between ages 3–21. IF services are not available through the state, documentation from the state is required.		
Therapy Services that are NOT Covered	**Patient Pays**	**CHAMPVA Pays**
Acupuncture	100% of the billed charges	Nothing
Biofeedback: Treatment of ordinary muscle tension, psychosomatic conditions, hypertension or migraine headaches.		
Chiropractic Services		
Chronic Fatigue Syndrome		
Exercise Equipment		
Health Club Membership		
Whirlpools		
Workers' Compensation Injuries		

Services listed as a covered benefit do not guarantee payment as there may be specific guidelines for coverage. Please call customer service at 800-733-8387 for additional information. Services received in a VA Medical Center under the CITI program are exempt from beneficiary cost sharing. Yearly catastrophic cap protection limits beneficiary cost sharing to $3,000 annually.

TRANSPLANT SERVICES		
Covered Services	**Patient Pays**	**CHAMPVA Pays**
Pulmonary Rehabilitation Programs: Limited to pre- and postoperative lung or heart lung transplants and cardiopulmonary disease. **Transplants:** Authorization is required. 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 • Heart transplantation • Heart-kidney transplantation • Heart-lung transplantation • High Dose Chemotherapy (HDC) and stem cell transplantation • Kidney transplantation • Liver transplantation • Liver-kidney transplantation • Lung transplantation • Multivisceral transplantation • Pancreas Transplantation Alone (PTA) • Pancreas After Kidney (PAK) transplantation • Simultaneous pancreas-kidney transplantation • Pancreatic islet cell transplantation	**Outpatient Services** ***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services-Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** • No Deductible Lesser of: • Per-day amount times the number of inpatient days, or • 25% of billed amount, or • DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services - Non-DRG Based** ***CHAMPVA is Primary Payer:*** • No Deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	**Outpatient Services** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services-Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** Lesser of: • Up to 100% of Allowed Amount minus patient per-day payment, or • 75% of Allowed Amount, or • Up to 100% of Allowed Amount minus the DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services - Non-DRG Based** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount

VISION SERVICES		
Covered Services	**Patient Pays**	**CHAMPVA Pays**
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. **Eyeglasses & Contact Lenses:** Limited coverage. Covered when required after intraocular surgery, ocular injury or congenital absence of a human lens. **Medical Eye Exams:** Your physician will determine if an eye exam is required for a medical diagnosis.	**Outpatient Services** ***CHAMPVA is Primary Payer:*** • Deductible – $50 Individual $100 Family • Services received in an **Ambulatory Surgery Center (ASC)** have no deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services-Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** • No Deductible Lesser of: • Per-day amount times the number of inpatient days, or • 25% of billed amount, or • DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases) **Inpatient Services-Non-DRG Based** ***CHAMPVA is Primary Payer:*** • No Deductible • 25% Cost Share ***CHAMPVA is Secondary or Tertiary Payer:*** • Nothing (in most cases)	**Outpatient Services** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services-Diagnosis Related Groups (DRG) Based** ***CHAMPVA is Primary:*** Lesser of: • Up to 100% of Allowed Amount minus patient per-day payment, or • 75% of Allowed Amount, or • Up to 100% of Allowed Amount minus the DRG rate ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount **Inpatient Services-Non-DRG Based** ***CHAMPVA is Primary Payer:*** • 75% of Allowed Amount ***CHAMPVA is Secondary or Tertiary Payer:*** • Up to 100% of Allowed Amount

Words that are in bold green print are defined on pages 80–84.

Vision Services that are NOT Covered	Patient Pays	CHAMPVA Pays
Eye Examinations: (routine)	100% of the billed charges	Nothing
Eyeglasses:		
Contact Lenses:		

What CHAMPVA pays – and your share

You are responsible for an annual deductible plus your share—usually 25%—of our "allowable amount."

CHAMPVA's "allowable amount" is the most we will pay for a covered medical service or supply. That may be different from what your doctor bills for a medical procedure or supply. The allowable amount is often less.

Our allowable amount is generally the same as the allowable amounts paid by Medicare and TRICARE. (TRICARE is a Department of Defense health care program for active duty and retired military families.)

If your doctor accepts CHAMPVA, that is referred to as "accepting assignment." By accepting assignment, your doctor agrees to accept our allowable amount as payment in full. A provider that accepts assignment cannot bill you for the difference between our allowable amount and what they would normally bill.

If your doctor does not accept CHAMPVA, you will be responsible for the provider's entire bill. You can file a claim with us, but we will only pay 75% of our allowable amount. That means you could pay more if your provider does not accept CHAMPVA than you would if the provider does accept assignment.

You must pay an annual deductible; the deductible is $50 per person or $100 per family. Do not send us a check for your deductible–we will credit individual and family deductibles when we process the first claims each calendar year.

For covered outpatient services, we will pay up to 75 percent of our allowable amount (after your deductible has been met) and you are responsible for the remainder, which is known as your cost share. See page 62 for inpatient cost shares. The annual maximum that you and your family can incur is $3,000. If you or your family reach that limit, we will waive any cost share for the remainder of the year.

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

If your provider accepts **assignment**, which means the provider will accept CHAMPVA, the provider agrees to accept our **allowable amount** as payment in full. A provider cannot **balance bill** you, which means they cannot bill you for the difference between their normally billed amount and the CHAMPVA allowable amount.

If your provider does **not** accept assignment, you are responsible for paying your annual deductible, your cost share and any provider-billed amount that exceeds our total allowable amount. For care that **is not** covered by CHAMPVA, you will be responsible for the full bill.

ALLOWABLE AMOUNT

The allowable amount is the most we will pay for a covered medical service or supply. The CHAMPVA allowable amount is generally the same as TRICARE's or Medicare's allowable amount and is considered payment in full.

ANNUAL DEDUCTIBLE

The annual (calendar year) outpatient deductible is the amount you must pay before we pay for covered outpatient medical services or supplies. The deductible is $50 per **beneficiary** or a maximum of $100 per family per year. Once your deductible is satisfied, CHAMPVA will pay 75% of the allowable amount. As claims are processed for covered services, charges are automatically credited to individual and cumulative family 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**).

Words that are in bold green print are defined on pages 80–84.

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 on page 62 entitled *Cost Summary*.

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

CATASTROPHIC CAP

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 and your family can incur for CHAMPVA-covered services and supplies in a calendar year. Credits to the catastrophic cap are applied starting January 1 of each year and run through December 31. If you reach the $3,000 limit, you or your family's 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 we pay for your covered services. If you find an error, let us know immediately.

COVERAGE OUTSIDE THE UNITED STATES

If you live or travel overseas (excluding countries that are restricted or prohibited by the U.S. Department of Treasury), we provide the same benefits we would if you were in the U.S. Reimbursement for health care claims in foreign countries is based on reasonable and customary billed amounts. Your deductible and cost share will be the same as if you were in the U.S.

Claims written in English (billing and medical documentation) will be processed faster because we will not need to arrange for translation. If the billing and medical documentation is written in a foreign language, translation will be arranged at no cost to you. Our payments are made in U.S. dollars.

Words that are in bold green print are defined on pages 80–84.

COST SUMMARY—WHEN YOU HAVE NO OTHER HEALTH INSURANCE (OHI)

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 and Residential Treatment Centers	**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; or 2) 25% of billed amount; or 3) DRG rate
Inpatient Services: Non-DRG Based & SNF (Skilled Nursing Facility)	**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 (retail)	**YES**	25% of CHAMPVA allowable amount after deductible
Pharmacy Services (mail order–Meds by Mail or CITI)	**NO**	Nothing
Professional Services	**YES**	25% of CHAMPVA allowable amount after deductible

Words that are in bold green print are defined on pages 80–84.

WHEN CHAMPVA PAYS INCORRECTLY

We strive to be accurate, but there may be a time when CHAMPVA inadvertently makes an 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 that should have paid before the bill was submitted to us, when a provider bills us twice for the same service, the service is not a covered benefit, or if we mistakenly pay for services for you or a family member during a period of ineligibility. Should an overpayment occur, we are required to take action to get the money back from the person who received the erroneous payment. That's 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 can't 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 80–84.

When you have other health insurance

If you have other health insurance (OHI), in addition to CHAMPVA, you must keep us informed about any changes. You can do this by calling us at 1-800-733-8387, or by completing a CHAMPVA OHI Certification Form (VA Form 10-7959c). You can obtain the form on our website at: **http://www.va.gov/hac/forms**

When you have OHI, CHAMPVA may pay first, or it may pay as a secondary or final insurer. CHAMPVA only pays first if you have one of four types of OHI: Medicaid, Indian Health Services, State Victims of Crime Compensation Program or CHAMPVA supplemental health insurance.

If you have any other type of OHI, CHAMPVA will pay secondary and, if you have more than one OHI, CHAMPVA will pay after the other plans.

You must submit, or have your provider submit, any claim for services or supplies to your OHI first. After your OHI pays, you will receive an Explanation of Benefits (EOB) from them. The EOB must be submitted to us when you file your claim with us. (Medicare will now send us an EOB electronically after they process your claim, saving you from having to file the claim yourself.)

If you are in an HMO or PPO, we will pay any out-of-pocket expenses up to our allowable amount.

OHI CERTIFICATION

When you first applied for CHAMPVA we asked you to complete a CHAMPVA **OHI** Certification Form (**VA Form 10-7959c**). Any time there is a change in your OHI status, you must inform us of the change. Periodically we will ask for you to recertify your OHI status by completing the form and submitting it to us at the address below:

OHI Certification Forms:

CHAMPVA
PO Box 469063
Denver CO 80246-9063

If your OHI is Medicare, include a copy of your Medicare card.

If your OHI is a health maintenance organization (**HMO**) or preferred provider organization (**PPO**), include a copy of the plan's co-payment information and schedule of benefits.

You can also call our toll-free number at 1-800-733-8387 and provide the information to a customer service representative.

CHAMPVA AS PRIMARY PAYER

If you qualify for one of the four types of health insurance listed below, we will pay first as the **primary insurer**. Those plans are:

Medicaid

In those instances where Medicaid may have made payment for medical services and supplies first, we will reimburse the appropriate Medicaid agency for the amount we would have paid in the absence of Medicaid benefits, or the amount paid by Medicaid, whichever is less.

Words that are in bold green print are defined on pages 80–84.

State Victims of Crime Compensation Program

If you are eligible under a State Victims of Crime Compensation Program, CHAMPVA will pay first.

Indian Health Services (IHS)

If you are eligible under Indian Health Services, CHAMPVA will pay first.

CHAMPVA Supplemental Health Insurance

There are a number of companies that offer CHAMPVA supplemental policies. After we make a payment for health care services, your remaining out-of-pocket expenses, such as deductibles and co-payments, often are payable by the **supplemental insurance** policy. If you have a policy that was specifically obtained for the purpose of supplementing CHAMPVA, we will compute the **allowable amount**, pay the claim, and then you can submit the balance due on the claim to your supplemental insurer.

We do not endorse one supplemental insurance policy over another, and you should carefully consider your family's needs for the additional coverage. Additional information about supplemental health plans can be obtained from Federal Publishing at **http://www.federalpublishing.com** (Federal Publishing is not affiliated with the government, and we do not endorse their products or services.)

CHAMPVA AS SECONDARY PAYER OR PAYER OF LAST RESORT

In all other cases, CHAMPVA is a **secondary payer** or payer of last resort: we pay after your **OHI** and, if you have more than one **OHI** (such as Medicare and a Medicare supplemental plan), we pay after both plans. Having OHI complements the CHAMPVA program; it does not prevent anyone from using it. You may have another health plan through your employer, your spouse's employer, or other government program such as Medicare. In most cases when you have **OHI** and CHAMPVA, there is no cost to you at all. When there is a cost to you, it is most often because you have exhausted your other health insurance benefits so the **OHI** is no longer making payment for a service or benefit period. In that case, when the medical service or supply is a covered benefit under CHAMPVA, we would pay up to our allowable amount.

You or the provider must file the claim with the other insurance plan before submitting it to us for payment. Upon receiving the **EOB** from the other insurer, you or the provider may file a CHAMPVA claim for any remaining balance. In addition to the EOB from the other health insurance, claims (billings) must include the provider's itemized billing statement.

Words that are in bold green print are defined on pages 80–84.

CHAMPVA AND OTHER HEALTH INSURANCE (OHI)

If you have an **OHI** plan, we will pay your out-of-pocket expenses (your co-payments under the OHI) for CHAMPVA covered services up to our **allowable amount**.

It is important to be aware that when you have OHI and CHAMPVA, you must follow your OHI's rules and procedures for covered services. If OHI denies a claim because you do not follow their rules, or if OHI determines the service is not medically necessary or appropriate, we will not pay for that care.

The only exception: If your OHI denies your claim as a non-covered service and it is a covered service with CHAMPVA, or your OHI benefits have been exhausted, it is possible that CHAMPVA can pay on your claim.

If you or your provider does not agree with the OHI decision regarding payment or nonpayment, an appeal of the decision must be made with your OHI prior to appealing to CHAMPVA.

We do not pay any OHI premiums including Medicare premiums.

CHAMPVA AND WORKERS' COMPENSATION

We do not pay for medical care for the treatment of a work-related illness or injury when benefits are available under a workers' compensation program. You must apply for workers' compensation benefits. If you exhaust your workers' compensation benefits, we will then pay for covered services and supplies. Provide a copy of the final decision of the workers' compensation claim to avoid any delay in payment of future claims.

CHAMPVA AND ACCIDENTAL INJURIES

If you are involved in an accident (such as an auto accident), you or your medical provider is required to file a medical claim with your (or the other person's) insurance before submitting it to us. This is called **third-party liability (TPL)** and means that someone else is legally responsible for your medical care. When we receive the **EOB** from the insurance company, you may file a CHAMPVA claim for any remaining balance.

Words that are in bold green print are defined on pages 80–84.

CLAIM-FILING DEADLINES

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. If you disagree with a timely filing denial you must file an appeal. Please refer to Section 8 for appeal instructions.

If you have been granted retroactive CHAMPVA eligibility, you have 180 days after your initial CHAMPVA Identification Card is issued to file claims with dates of service on or after you CHAMPVA effective date. Your effective date can be found on the lower left corner of your CHAMPVA Identification Card.

In most cases, your medical provider will complete and file your claim form with us for the services you received. But there will be times when you will have paid for the medical service or supply and need to request reimbursement from us. If you file your own claim, it is important to fill out the claim form completely and correctly. A mistake, a forgotten signature or other missing information can slow down your claim or result in an initial rejection of the claim. We can't process the claim until we have all the correct information.

WHEN YOU SUBMIT THE CLAIM

You will need to send in three items:

1. CHAMPVA Claim Form (**VA Form 10-7959a**). These forms are available by phone or on the Web.
2. An itemized billing statement from your provider on a **CMS 1500** (doctor/professional) or **UB-04** (hospital/institutional) claim form containing the same information listed in the "Provider Submitted Claims" section on the next page (page 68). Ask your provider to itemize the bill on the appropriate form. (Copies of these forms are reproduced for illustration purposes only on Page 69–70).

Filing a claim

The easiest way to file a claim for reimbursement is to have your provider do it for you. Providers know what is required and, in most cases, will file electronically, which means faster processing and payment.

If you file the claim yourself, here is what you need to do:

- Obtain a CHAMPVA Claim Form (VA Form 10-7959a) by calling us at 1-800-733-8387. You can also obtain the form from our website at: **http://www.va.gov/hac/forms**
- It is very important that your name appear on the form exactly as it is on your CHAMPVA Identification Card. And be sure to date and sign the form. We CANNOT process your claim without your signature.

Include the following information with the claim form (your health care provider may be able to quickly print out this information for you):

- The full name and tax identification number of your provider
- The address where payment should be sent, and the address where the services were provided
- The provider's professional status (doctor, nurse, etc)
- Specific date of the service
- Appropriate medical code for each service (see this chapter for details)

If you have other health insurance (OHI), file your claim with them first and send us the explanation of benefits (EOB) from that insurer.

For pharmacy claims, ask the pharmacy to file the claim for you. If you file, we need a completed and signed CHAMPVA Claim Form, the name, address and phone number of the pharmacy, the name of the prescribing physician, the name, strength and quantity of each drug, the 11-digit National Drug Code (NDC) for each drug, the charge for each drug and the date the prescription was filled. If you have other health insurance, make sure your co-payment amount is included on your receipt.

Send claims to:
CHAMPVA Claims
PO Box 469064
Denver CO 80246-9064

3. When you have other health insurance (**OHI**), an explanation of benefits (**EOB**) from the other health insurer.

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.
- Separate claim forms are required for each CHAMPVA **beneficiary** in your household.
- After billing your other health insurance and receiving their EOB, you can file with CHAMPVA for any remaining balance.
- If you do **NOT** use a 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** *[examples on pages 69–70]*).

Tips for when your provider files claims

- Claims submitted electronically are processed more quickly. If your provider can send the claims electronically and is not doing so, have your provider contact us.
- 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
  - Itemized charges for each service
  - Appropriate medical code (**ICD-9/10, CPT, HCPCS**) for each service
- If your OHI was billed, provide a copy of their EOB detailing what they paid. (Sometimes the definition or explanation of their codes is on the reverse of their EOB – please include a copy of that as well). If you have two OHIs (such as Medicare and a Medicare Supplemental plan), we will need both EOBs to process your claim.

Medical records or notes must be submitted with the bill in some cases. The guide notes many of those services, like skilled nursing, home health care and some surgical procedures that require medical documentation.

Words that are in bold green print are defined on pages 80–84.

CMS 1500 (Doctor/Professional) Claim Form

For illustration only; obtain a completed form from your provider.

PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 2. 3. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE

1. 2. 3. 4. 5. 6.

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

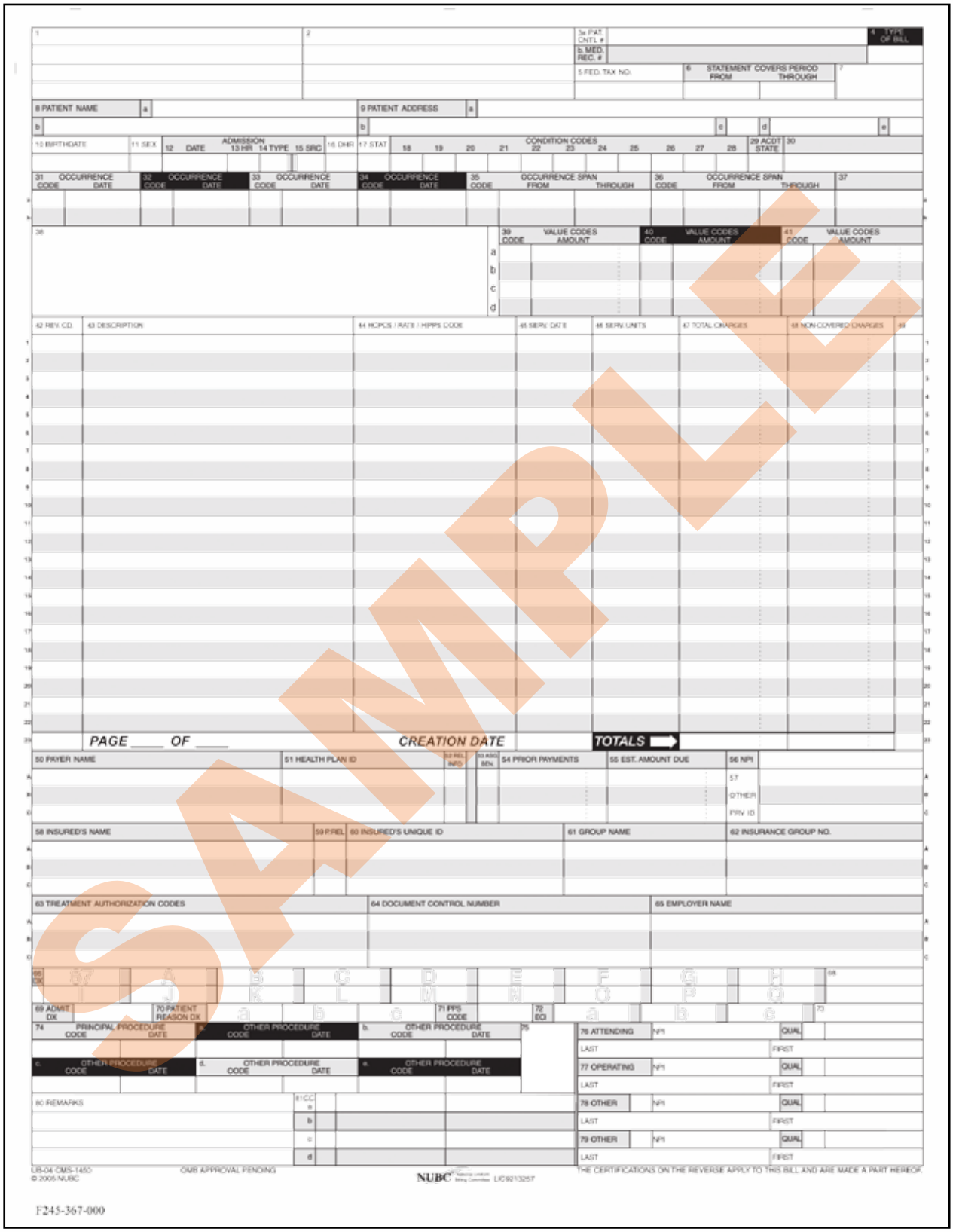
PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

SAMPLE

UB-04 (Hospital/Institutional) Claim Form

For illustration only; obtain a completed form from your provider.



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 a CHAMPVA Claim Form (**VA Form 10-7959a**).
- If you send us a claim and you have other health insurance, your co-payment amount must be included on your receipt.

WHERE TO MAIL CLAIMS

CHAMPVA Claims
PO Box 469064
Denver CO 80246-9064

EXPLANATION OF BENEFITS (EOB)

After a claim has been filed for your health care service, you will receive an Explanation of Benefits (**EOB**) from us in the mail. The EOB (see illustration on page 72) 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** and family deductible accrual
- CHAMPVA payment(s)
- date(s) of service
- provider name
- remarks
- amount paid by other health insurance plan or program

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 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 80–84.

Sample Explanation of Benefits (EOB)

CHAMPVA Program
ATTN: Claims
PO BOX 469064
Denver, Colorado 80246-9064
1-800-733-8387 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: VETERAN NAME Date: 2/12/08
Member #: PATIENT SSN DOB: 9/15/52

VETERANS ADMINISTRATION
ATTN: Accounts Receivable
HOSPITAL #000 (000G)

Deductible

YR	Indiv	Family
08	$ 50.00	$ 50.00
07	$ 50.00	$ 50.00

CAT Cap Accrual

08	$ 59.20
07	$ 2795.75

Information only, no check enclosed.

Control Number	Dates of Service From	To	Description of Service Code/Modifier/Multiplier	Amount Billed	Amount Allowed	Amt Not Covered	Remarks/Codes
SA00000	09/04/07	09/04/07	00000-0000-00	$ 10.00	$ 10.00	$ 0.00	
000X000XXX OHI PAID: $ 0.00		PATIENT PAID:	$ 0.00	CLAIM TOTAL:	$ 10.00	$ 10.00	
HAC PAYMENTS: TO PROVIDER	$ 7.50	COST SHARE: $ 2.50					

TOTAL PAYMENTS: TO PROVIDER: $ 7.50 TO PATIENT $ 0.00

REMARKS/CODES:
1/356: REMINDER - MAIL CLAIMS TO: CHAMPVA, PO BOX 469064, DENVER, CO 80246-9064
HV123456789

A Information only, no check enclosed.
B SA00000
C 000X000XXX
D HAC PAYMENTS: TO PROVIDER
E HV123456789
F COST SHARE: $ 2.50
G Remarks/Codes
H OHI PAID: $ 0.00

VA FORM 10-7959B
JUL 2006

Department of Veterans Affairs

Page 1 of 1

A – Information only, no check enclosed: Indicates that a U.S. Treasury check is not enclosed. When there is a payment, this will read "Check Enclosed."

B – Control Number(s): CHAMPVA claim specific identifier (always starts with two alpha characters).

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

D – Amount Paid: Amount paid by us to your provider.

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

F – Cost Share: Patient's payment responsibility.

G – Remarks/Codes: A code in this column relates to the narrative description below.

H – OHI Paid: Amount paid by other health insurance, including adjustments applied as a result of agreements between the provider and the OHI.

YOU MAY APPEAL DENIALS OF:

CHAMPVA Appeals
PO Box 460948
Denver CO 80246-0948

- Eligibility determinations
- Benefit coverage
- Authorization requests
- Services
- Second-level mental health appeals (Note: first-level appeals related to mental health care are completed by our mental health contractor—address on page 19 of the guide).

For an appeal 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.
- 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.

NOTE: If the reason for the appeal is not identified, the request will be returned to you with no further action.

After reviewing your appeal and supporting documentation, a written decision will be sent to you. 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 appeal 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 consider appeals regarding:

- The cost share or amount of an individual or family'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), 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 80–84.

Appeal requests that relate to the following situations will not receive a formal review, but will be reprocessed when the missing information is received or when you notify us the billing has been resubmitted with a correction. This includes:

- Claim denials for missing code information: Current Procedural Terminology (**CPT**), Healthcare Common Procedure Coding System (**HCPCS**), Internal Classification of Diseases (**ICD 9/10**) and National Drug Codes (**NDC**).
- Decisions on claims where we are requesting more information before an action is taken on your claim. Examples of this may include claim denials requesting medical documentation, operative reports, treatment plans or a certificate of medical necessity.
- Claim denials requesting an **EOB** from an **OHI**.
- Billing errors (e.g., incorrect date of service, incomplete or missing procedure codes and/or billed charges) where a corrected bill is submitted to modify the original claim.
- Determinations of a Veteran's service-connected disability rating must be submitted to the local servicing **VARO**. The VARO determines the service-connected rating, and a challenge regarding their determination must be submitted to them.

Combating fraud 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:

- The name and address of the provider
- The name of the **beneficiary** who was listed as receiving the service or item
- The claim number
- The date of the service in question
- The service or item that you do not believe was provided
- The 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

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

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

Fax: 1-303-398-5295

DETECTION TIPS

You should be suspicious of:

- 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

PREVENTION TIPS

- Always protect your CHAMPVA Identification Card. Only give your CHAMPVA member number to people you know or are familiar with.
- Be skeptical of providers who tell you that a particular item or service is not usually covered by us, but that they know how to bill for the item or service to get it paid.

Words that are in bold green print are defined on pages 80–84.

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

The VA Notice of Privacy Practices 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 detailed Notice of Privacy Practices that is available at: **http://www.privacy.va.gov/privacy_publications.asp**

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)

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, 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. We will send a copy of the revised notice to your last address of record within 60 days of any change.

Complaints

If you are concerned that your privacy rights have been violated, you can file a complaint with the VHA or with 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 INFORMATION FROM MY RECORDS

Use **VA Form 10-5345a**, *Individual's Request for a Copy of Their Own Health Information*, to request that a copy of your record, or a copy of a document in your record, be sent to you. (The form is available by phone or on the Web.)

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, use this form 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* 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. Print the words "Recurring Disclosure Authorization" in the Authorization block.

Use **VA Form 10-5345a**, *Individual's Request for a Copy of Their Own Health Information*, to obtain access to selected information from your CHAMPVA record through an online Internet connection. Print the words "CHAMPVA ON-LINE" in the signature block. Additional information about CHAMPVA On-Line is at our website at: **http://www.va.gov/hac**

Mail all requests for health information from your record to:

Mail: CHAMPVA Eligibility
PO Box 469028
Denver CO 80246-9028

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA10P2 "Patient Medical Record - VA" and in accordance with the Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☐ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPA

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USE

NOTE: ADDITIONAL ITEMS OF I

AUTHORIZATION: I certify that this request has be accurate and complete to the best of my knowledge. I in writing, at any time except to the extent that action h Release of Information Unit at the facility housing the information may be accomplished without my further authorization will automatically expire: (1) upon satisf under the following condition(s):

I understand that the VA health care practitioner's other VA benefits or, if I receive VA benefits, their made at a VA Regional Office that specializes in be

DATE (mm/dd/yyyy) SIGNATURE OF PATIENT OR PER

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security

VA FORM JUL 2013 **10-5345**

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

INDIVIDUALS' REQUEST FOR A COPY OF THEIR OWN HEALTH INFORMATION

PRIVACY ACT AND PAPERWORK REDUCTION ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form. The purpose of this form is to provide an individual the means to make a written request for a copy of their information maintained by the Department of Veterans Affairs (VA) in accordance with 38 CFR 1.577.

The information on this form is requested under Title 38, U.S.C. 501. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled.

VETERAN'S LAST NAME- FIRST NAME- MIDDLE INTIAL	SOCIAL SECURITY NO.	DATE OF BIRTH

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be copied/printed, giving the dates or approximate dates covered by each

FACILITY WHERE TREATED:	DATES OF TREATMENT:

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☐ OTHER *(Specify)*

COPY OF HEALTH INFORMATION IS TO BE DELIVERED TO THE INDIVIDUAL

☐ IN-PERSON ☐ BY MAIL, TO ADDRESS BELOW *(include City, State & ZIP)* PHONE NO.

PATIENT SIGNATURE	DATE *(mm/dd/yyyy)*

NOTE: If signed by someone other than the patient, indicate the authority (e.g., guardianship or power of attorney) under which request is made.

VA FORM MAY 2005 **10-5345a**

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. That means 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 VA 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	A CHAMPVA-eligible spouse, widow(er) or child. Beneficiaries may also be referred to as dependents.
Centers for Disease Control and Prevention (CDC)	The major United States government agency for disease prevention based in Atlanta, Georgia.
Certificate of Medical Necessity (CMN)	A Certificate of Medical Necessity (CMN) is 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
Chief Business Office Purchased Care (CBOPC)	Administers CHAMPVA
Child	Includes birth, adopted, stepchild or helpless child as determined by a VA regional office (VARO).
CITI	The acronym for CHAMPVA Inhouse Treatment Initiative, a program that permits CHAMPVA beneficiaries to receive care at participating VA medical centers.

Coordination of Benefits	We must be aware of other health insurance (OHI) to know when there may be double coverage. If we know this, we can ensure that there is not a duplication of benefits paid between the other health insurance coverage and CHAMPVA. The explanation of benefits (EOB) from the OHI provides the documentation for us to coordinate benefits and pay your claim appropriately.
Current Procedural Terminology (CPT)	An American Medical Association nomenclature that provides a uniform language or system of codes that describes medical, surgical and diagnostic services. It provides 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.
Custodial Care	Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These services include but are not limited to: • Personal care, such as help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing; • homemaking, such as preparing meals or special diets; • moving the patient; • acting as companion or sitter; • supervising the medication that can usually be self-administered; or • treatment or services that any person could be able to perform with minimal instruction, including but not limited to recording temperature, pulse and respiration, or administration and monitoring of feeding systems.
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, wheelchairs, hospital beds, prostheses, 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.
Healthcare Common Procedure Coding System (HCPCS)	Health care procedure codes used for billing purposes. The HCPCS is divided into two principal subgroups: Level 1 codes are based on the American Medical Association's Current Procedural Terminology (see above). Level 2 codes are used primarily to identify products, supplies and services not included in the CPT codes, such as ambulance services and durable medical equipment.
Health Maintenance Organization (HMO)	An organization that provides comprehensive health care to voluntarily enrolled individuals and families in a particular geographic area by member physicians with limited referral to outside specialists.
Helpless Child	A child who, before the age of 18, becomes permanently incapable of self-support and is rated as a helpless child by a Veterans Affairs Regional Office (VARO).
High Volume	Residential and treatment centers that have 25 or more mental health discharges annually are considered high-volume facilities.
Internal Classification of Diseases	The ICD-9-CM (clinical modification) used within the VA is The World Health Organization's official system of assigning codes to diagnoses and procedures associated with hospital utilization and mortality in the United States. The ICD-9-CM serves as a useful tool to classify morbidity data for indexing medical records, medical care review and ambulatory and other medical care programs as well as for basic health statistics. ICD-9-CM codes are currently in use with expectations to implement ICD-10 codes in 2013.

Low Volume	Treatment centers that have fewer than 25 mental health discharges annually are considered low-volume facilities.
Medical Necessity	Services, drugs, supplies or equipment provided by a hospital or covered provider that we determine: • 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 and easy way for eligible CHAMPVA beneficiaries to receive nonurgent maintenance medications delivered directly to their homes at no charge.
NDC	National Drug Code, used to identify pharmaceuticals.
Non-Peak Hour	Period of time that call volume is most often less than other times of the day.
OHI	Other health insurance, such as Medicare or a commercial health insurance policy.
Over-the-Counter Medications (OTC)	Medications that do not require a prescription.
Payer	Provides payment for a covered medical procedure or supply. A primary payer pays on the claim first; secondary payers and payers of last resort, if available, pay after the primary payer.
Preferred Provider Organization (PPO)	An organization providing health care that gives economic incentives to the individual purchaser of a health-care contract to patronize certain physicians, laboratories and hospitals that agree to supervision and reduced fees.

Primary Payer	A health insurance plan that will pay first on the bills for service. These are typically major medical health plans.
Qualifying Veteran Sponsor	A Veteran who is in receipt of a VARO award that establishes eligibility for CHAMPVA benefits for his/her dependents. These dependents cannot be entitled to Department of Defense TRICARE benefits.
Recoupment	Collection of a debt owed to the government.
Secondary Payer	A health insurance plan that pays after the primary payer has determined what they will pay on the claim.
Service-Connected	A VARO determination that a Veteran's illness, injury or death is related to military service
Spouse	The wife or husband of a qualifying Veteran sponsor.
Supplemental Insurance	A health insurance plan that pays after the primary payer has determined what they will pay on the claim. We will pay before a CHAMPVA supplemental policy, but after a Medicare supplemental policy.
Survivors	Widow(er)s and dependent children
Third Party Liability (TPL)	The term "third party" means any of the following: a federal entity, state or political subdivision of a state, an employer or an employer's insurance carrier, automobile accident reparations insurance carrier, person or entity obligated to provide, or to pay the expenses of, health services under a health-plan contract.
VA	Department of Veterans Affairs
VAMC	VA Medical Center
VARO	Veterans Affairs Regional Office
Widow(er)	The surviving spouse of a qualifying Veteran sponsor.

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Notice of intent to conduct computer matching: Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches. Pursuant to 5 USC 552a, the Privacy Act of 1974, as amended, and the Office of Management and Budget Guidelines on the Conduct of Matching Programs, notice is hereby given of the VA's intent to conduct computer matches with Centers for Medicare and Medicaid Services (CMS). Data from the proposed matches will be utilized to verify Medicare entitlement for applicants and recipients for CHAMPVA benefits, whose eligibility for CHAMPVA is based upon entitlement for Medicare.

Notes

Notes

Notes

U.S. Department of Veterans Affairs

Veterans Health Administration
Chief Business Office Purchased Care

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