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TRICARE – QUESTIONS ABOUT INSURANCE BENEFITS
(TRICARE EAST/HUMANA MILITARY)

I am a ***"participating non-network"*** provider

Name: _____ Date: _____

Plan Name (e.g., Prime, Young Adult, etc.): _____

Relationship of Policy Holder to Client:

○ Self ○ Spouse ○ Child

Insured's ID #: _____

Insured's Group #: _____

If you are a **DEPENDENT** on another person's insurance policy please provide the following:

Policy Holder Name: _____

Policy Holder Date of Birth: _____

Policy Holder's Address (if different from your own):

PLEASE BRING A COPY OF YOUR UNIFORMED SERVICES ID CARD at the time of service.
(ID Cards may be Common Access Cards (CACs), military ID, or eligibility letters)

Steps to determine your benefits:

- Call the customer service number for your plan (800-444-5445) or go to www.humanamilitary.com. You will need to have your DOD Benefits number or sponsor ID.
- Ask about whether your plan includes coverage for outpatient mental health treatment.

  If no, you ***will not*** be able to use your insurance to pay for my services. In this case, I would recommend contacting customer service a second time to confirm the information you were provided during your initial inquiry was correct.

  If yes, inform them that you will be working with a provider who accepts Tricare health insurance. Tricare defines me as a ***participating non-network*** provider. Be sure that they have me identified as the provider with whom you will be working before moving forward. You can confirm that Tricare will be covering my services by providing them with the information included in the header of this document (name and NPI number). Once the representative has identified me as a covered provider, ask the customer service representative the following questions (on next page):

If it is confirmed that my services will be covered by your Tricare plan, ask the following questions:

Do I need a referral? ○**YES** ○**NO**

If yes, do I need to have the referral sent to Tricare prior to my 1st appointment? ○**YES** ○**NO**

If Tricare will provide coverage prior to getting a referral, how many sessions will they cover? #_____

How frequently do I need to have this referral updated? _____

Do I need pre-authorization for services? ○**YES** ○**NO**

If yes ask whether *you* are able to request the pre-authorization for services or if the provider must make the request? _____

If *you* are able to request the pre-authorization, what is the authorization number?

_____

If *the provider* needs to request the pre-authorization, what is the process for doing so (e.g., phone number, website, form, etc.)?

What is my copay/co-insurance? _____

Does my copay change based on the number of sessions I have had? ○**YES** ○**NO**

If yes, please describe how my copays change based on the number of sessions.

_____

Do I have an annual deductible that must be met? ○**YES** ○**NO**

If yes, has my deductible been met yet this year? ○**YES** ○**NO**

What is my annual deductible? _____

Are there a maximum number of visits allowed per year? ○**YES** ○**NO**

If yes, what is the maximum number? _____

Record the full name of the person you spoke with and the date of your telephone call.

Name: _____ Date: _____

Contact number: _____