TRICARE OVERSEAS PROGRAM
BENEFICIARY SIGNATURE ON FILE FORM

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079 and 1086, 32 U.S.C. Chapter 17; 32 CFR 199.17; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain information necessary for the correct processing of your medical related claims, medical management, signature on file requirements, other health insurance information and release of medical information.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and to other Federal, State, local, or foreign government agencies, and to private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.

DISCLOSURE: This form is voluntary. However, in lieu of this form, beneficiaries must then submit a signature at patient intake or with the actual claim to be filed. Failure to do so may result in incorrect processing or denial of the claim.

Purpose of the Beneficiary Signature on File Form

ALL TRICARE Overseas Program (TOP) Providers are **required** to collect a signature from their TRICARE patients (beneficiaries) prior to submitting a claim. It is recommended that TOP Providers collect the signature at the first appointment (for each episode of care) and to keep the patient's signature on file (i.e., within the TRICARE patient's records/files).

By signing the "Beneficiary Signature on File Form", the beneficiary is validating:

1. That the medical services from the provider were rendered,
2. That all future claims for this episode of care are submitted on their behalf, and
3. Authorization to release medical information to International SOS for the purposes listed above.

On the Standard U.S. Government Claim Form CMS 1500 **AND** the Claim Development Worksheet (CDW), a patient signature is required to ensure accurate processing and payment. Rather than the beneficiary having to sign the Claim Form every time a claim is submitted on his or her behalf, the TOP Provider can indicate on the CMS 1500 Claim Form or the CDW that they hold a "signature on file." An actual signature is then no longer required.

TOP Providers may indicate "Signature on File" or "SOF" in the relevant fields of the claim forms and have their claim processed, only if the patient has signed the "Beneficiary Signature on File Form."

Institutions that are submitting a UB-04 Claim Form are required to have a permanent hospital record containing a release statement on behalf of the beneficiary. Institutions are encouraged to follow this procedure, to ensure compliance with TRICARE Overseas Program (TOP) "Signature on File" requirements.

International SOS further recommends that the TOP Provider collect details of the patient's sponsor details at the same time. The TOP Provider will need these details when completing the CMS 1500, CDW and UB-04 Claim Forms.

*** This section is to be completed by the TRICARE beneficiary ONLY***

RELEASE OF MEDICAL INFORMATION

In accordance with privacy protection regulations, this notice informs you of the purpose of the form and how it will be used. Please read it carefully.

PRINCIPAL PURPOSE(S): This form is to provide International SOS with a means to request information for correct processing of your medical related claims, medical management, signature on file requirements, other health insurance information and release of medical information.

DISCLOSURE: Voluntary. Failure to sign the signature on file form will result in the non-release of the protected health information.

I hereby authorize Joy Center ***to complete any necessary insurance***

Name of Health Care Provider

Claim Forms on my behalf and the release of my medical and/or insurance information to _____

AND International SOS ***for the purposes of medical management, claim processing and any post-payment reviews.***

Please note: *Your signature will be kept on file and shall be referred to when insurance Claim Forms are submitted for health care services you have received.*

TRICARE OVERSEAS PROGRAM

BENEFICIARY SIGNATURE ON FILE FORM

BENEFCIARY DETAILS	
Beneficiary Full Name:	**Sponsor SSN or DoD Benefits Number (DBN):**
Full Name of Legal Guardian or Parent (if applicable):	**Sponsor's Full Name:**

SIGNATURE and DATE _____

Patient/Authorized Person

Note: *If the patient is incapable of signing or under the age of 18, a parent or legal guardian must sign in the patient's place. In such cases, the parent or legal guardian is considered the "authorized person."*

PLEASE ENSURE YOU KEEP THIS FORM IN THE PATIENT FILE

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