OMB NO.: 0720-0031
EXPIRATION DATE: 07/31/2009

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

TRICARE MANAGEMENT ACTIVITY
HEALTH PROGRAM ANALYSIS AND EVALUATION DIRECTORATE

[Unique Provider ID Number]

FOR: [Title] [Insert Provider Name]
Street Address
City, State, and Zip

Date:

Dear [Title] [Insert Provider Name],

Hello! You have been selected to participate in a very important survey effort. In support of U.S. military men and women, Congress has directed the Department of Defense to survey civilian mental and behavioral health care providers across the U.S. to determine whether military service members and their families have access to the care they need. A substantial amount of mental and behavioral health care provided to our military and their families is delivered by private, civilian providers like yourself. The DoD has contracted Synovate to conduct this survey.

We are asking you to please answer the questions on the back of this letter and return it ***within five days***. We suggest that the survey be completed by the person in your office who is most knowledgeable about billing and insurance. We recognize that there may be more than one provider in your office and ask that this survey be completed for the provider listed above. There are several ways to complete this survey, which should only take five minutes of your time:

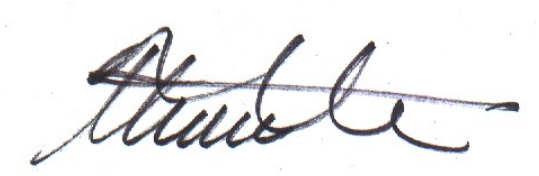
To complete the survey on the Internet, direct your browser to:http://www.synovatelink.com

Your unique login name is:	XXXXXXXX
Your unique password is:	XXXXXXXX

You may return the survey via fax to: 1-800-585-9446
You may also complete the survey and return it via postal mail in the enclosed postage paid envelope.

Thank you in advance for your cooperation and help as we examine this important issue that impacts our American service men and women. If you have questions about this survey, please call Synovate between the hours of 8 AM and 5 PM Eastern Time at 1-800-228-6764.

Sincerely yours,



Thomas V. Williams, Ph.D.
Director, Health Program Analysis and Evaluation Directorate
Office of the Assistant Secretary of Defense (Health Affairs) TRICARE Management Activity

SURVEY QUESTIONS ON REVERSE SIDE

Q1. Does [Title] [Insert Provider Name] provide treatment or counseling to patients through private practice?

☐ Yes → Go to Q2
☐ No → Thank you, please return the questionnaire.

Q2. What type of health care provider is [Title] [Insert Provider Name]? MARK ALL THAT APPLY.

☐ Certified Clinical Social Worker
☐ Certified Psychiatric Nurse Specialist
☐ Clinical Psychologist
☐ Certified Marriage and Family Therapist
☐ Pastoral Counselor
☐ Mental Health Counselor
☐ Other _____

Q3. Is [Title] [Insert Provider Name] *aware* of the TRICARE health care program?

☐ Yes
☐ No
☐ I Don't Know

Q4. Is [Title] [Insert Provider Name] a contracted member of the TRICARE network of health care providers?

☐ Yes
☐ No
☐ I Don't Know

Q5. As of today, is [Title] [Insert Provider Name] accepting new TRICARE Standard patients?

☐ No →(Go to Q6)
☐ Yes, on a claim by claim basis only →(Go to Q7)
☐ Yes, for all claims →(Go to Q7)
☐ I Don't know →(Go to Q7)

Q6. You answered "no" to the question above. Why is [Title] [Insert Provider Name] not accepting new *TRICARE Standard* patients?

Please list all the reasons. If you need additional space, please include a separate sheet of paper.

Q7. What percentage of patients seen by [Title] [Insert Provider Name] use any form of TRICARE? If unsure, please write down your best guess.

☐ None: [Insert Provider Name] has no TRICARE patients
_____ percent use some form of TRICARE.
☐ I Don't Know

Q8. Does [Title] [Insert Provider Name] accept any Medicare patients?

☐ Yes
☐ No
☐ I Don't Know

Q9. As of today, is [Title] [Insert Provider Name] accepting *new* Medicare patients?

☐ Yes → Thank you, please return the questionnaire.
☐ No →(Go to Q10)
☐ I Don't Know →(Go to Q11)

Q10. You answered "no" to the question above. Why is [Title] [Insert Provider Name] not accepting new Medicare patients?

Please list all the reasons. If you need additional space, please include a separate sheet of paper.

Q11. Does [Title] [Insert Provider Name] accept any insurance plans?

☐ Yes
☐ No

Q12. As of today, is [Title] [Insert Provider Name] accepting *any* new patients?

☐ Yes
☐ No
☐ I Don't Know

Thank you for taking the time to complete this survey. Please put this in the enclosed postage-paid envelope and return it to the Survey Processing Center or fax the survey to Synovate at 1-800-585-9446.

If you have any questions about TRICARE, its specific health plans, or the benefits it provides, please visit the TRICARE web site at www.tricare.osd.mil for assistance.

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Privacy Act Statement

According to the Privacy Act of 1974 (Public law 93-579), the Department of Defense is required to inform you of the purposes and use of this survey. Please read carefully.

Authority: Section 723(a) of the National Defense Authorization Act for Fiscal Year 2004 (Public Law 108-136; Section 711 of the National Defense Authorization Act for Fiscal Year 2006 (Public Law 109-163).

Purpose: Mandated by Congress, this confidential survey of civilian providers helps TRICARE health policy makers gauge civilian provider awareness and acceptance of the TRICARE Standard health care benefit option, and will provide valuable aggregated input to help improve the Military Health System.

Routine Uses: Those disclosures generally permitted under 5.U.S.C. 552a(b) of the Privacy Act.

Disclosure: Providing information in this questionnaire is voluntary. There is no penalty if you choose not to respond. However, maximum participation is encouraged so that data will be as complete and representative as possible. You may notice a number on this survey: this number is used only to let us know if you returned the survey to minimize sending you reminders.