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ST2

# EJEMPLOS DE ESTADOS DE CUENTA TRICARE

## Ejemplo 1: Beneficios de Administradores del Gobierno de Palmetto

PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS  
TRICARE FOR LIFE  
P.O. BOX 7051  
CAMDEN, SC 29020-7051

**HUMANA.**  
Military Healthcare Services

**TRICARE EXPLANATION OF BENEFITS**  
This is a statement of the action taken on your TRICARE claim.  
Keep this notice for your records.

**Date of Notice:** September 18, 2005  
**Sponsor SSN:** 123-45-6789  
**Sponsor Name:** HARVEY HUNTER  
**Beneficiary Name:** HARVEY HUNTER

**Benefits were payable to:**  
**HARVEY HUNTER**  
426 BLUE FISH DR  
DAYTONA BEACH, FL 32115  
**TEAM PHYSICIANS OF FL**  
59023 MARLIN AVE  
DAYTONA BEACH, FL 32124

**Claim Number: 2249X9084-00-00**

Services Provided By/ Date of Services	Services Provided	Amount Billed	TRICARE Approved	See Remarks
TEAM PHYSICIANS OF FL 08/14/2005	1 Chest x-ray (71010)	38.00	8.87	1, 2, 3, 4, 5, 6
<b>Totals:</b>		<b>38.00</b>	<b>8.87</b>	


Claim Summary	Beneficiary Liability Summary	Benefit Period Summary
Amount Billed: 38.00	Deductible: 0.00	<b>Fiscal Year Beginning:</b>
TRICARE Approved: 8.87	Copayment: 0.00	October 01, 2004
Non-covered: 0.00	Cost Share: 0.00	Individual Family
Paid by Beneficiary: 0.00		Deductible: 0.00 0.00
Other Insurance: 7.10		Catastrophic Cap: 234.00
Paid to Provider: 1.77		
Paid to Beneficiary: 0.00		
Check Number:		

**Remarks**

- 1 - PAYMENT REDUCED DUE TO OTHER HEALTH INSURANCE.
- 2 - APPEAL RIGHTS FOR THIS SERVICE ARE WITH YOUR MEDICARE CARRIER. PLEASE SEE YOUR MEDICARE SUMMARY NOTICE FOR FURTHER INFORMATION.
- 3 - GREAT NEWS. YOUR TFL BENEFIT HAS PAID THE FULL AMOUNT. YOUR MEDICARE CARRIER HAS NOT PAID BY MEDICARE. YOUR BILL HAS BEEN PAID IN FULL.
- 4 - AMOUNT ALLOWED BY OTHER INSURANCE \$8.87
- 5 - THE OTHER INSURANCE FIELD ON YOUR EOB DISPLAY THE AMOUNT PAID BY YOUR MEDICARE CARRIER.

**CALL TOLL FREE 1-866-TFL-PGBA (1-866-835-7422)**

**THIS IS NOT A BILL**  
If you have questions regarding this notice, please call or write us at the telephone number/address listed above.

 **Page 1 of 2**

Total Charge

Medicare Payment


Medicare Approved Amount

# ST2

## TRICARE STATEMENT EXAMPLES (continuación)

**Ejemplo 2: TRICARE Sureste**

**Ejemplo 3: Administración WPS TRICARE**



**TRICARE**  
Southwest

P.O. BOX 8997  
MADISON, WI 53707-8997

BETTY SMITH  
3249 E. COURT ST  
DALLAS, TX 75001

**TRICARE SUMMARY**  
PAYMENT VOUCHER  
B119602845 C5

**TRICARE EXPLANATION OF BENEFITS**  
Administered by: Health Net Federal Services, Inc.

This is a statement of the action taken on your TRICARE claim. Keep this notice for your records. If you have any questions regarding your claim payment please call the appropriate number:

Beneficiaries: 1-800-406-2832  
Providers: 1-800-406-2833  
PAGE 1 OF 1

BAPTIST HEALTH MED CTR -- HE  
07/26/05

**THIS IS NOT A BILL**

SPONSOR NO 123456789  
PATIENT ACC # 0000000  
SPONSOR CHARLES S

PATIENT NAME: BETTY SMITH  
CLAIM NO: 2453967 19 32

PROVIDER	DATES	PROC	MOD	NO	TYP	BILLED	OWED	CODE
BAPTIST HEA	5/09/05	250	01	01		22.50	10.80	003
BAPTIST HEA	5/09/05	66821	LT	01	OC	950.00	456.00	003
<b>TOTAL</b>						<b>972.50</b>	<b>466.80</b>	

**OTHER INS. ALLOWED** \*\* 0.00  
**OTHER INS. PAID** 272.30  
**REDUCTION DAYS** 0  
**REDUCTION AMOUNT** 0.00  
**PAID BY PATIENT** 0.00


**DEDUCT** \*\* 0.00  
**COST-SHARE/COPAYMENT** 0.00  
**TOTAL PAYABLE** 194.50  
**INTEREST PAID** 0.00  
**NET PAYMENT** 194.50

**REMARKS**  
PAYMENT HAS BEEN MADE TO THE PROVIDER OF CARE.  
\$9.00 HAS BEEN ACCUMULATED TOWARD THE CHAMPUS FISCAL YEAR CATASTROPHIC CAP OF \$3,000.00 FOR THE FISCAL YEAR '04.  
ACCUMULATED INDIVIDUAL DEDUCTIBLE FOR FISCAL YEAR '04 IS \$0.00.  
ACCUMULATED FAMILY DEDUCTIBLE FOR FISCAL YEAR '04 IS \$0.00.  
CODE 003  
IF YOU ARE NOT SATISFIED WITH OUR DETERMINATION, YOU HAVE THE RIGHT TO REQUEST A REVIEW WITHIN 90 DAYS OF THE DATE OF THIS NOTICE.  
SEE ITEM FIVE ON REVERSE OF PAGE 1

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**VOUCHER SUMMARY**


TOTAL PAYABLE	NET PAYMENT
194.50	194.50



Total Charge

Medicare Approved Amount

Medicare Payment



ROBERT JONES  
1278 S. OAK ST  
BURKE, VA 22015

**TRICARE EXPLANATION OF BENEFITS**  
Administered by: WPS TRICARE Administration  
This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.

Page 1 of 1

Date of Notice	7/15/2005
Sponsor SSN	XXX-XX-8778
Sponsor Name	Robert M Jones
Patient Name	Robert Jones
Claim Number	2005098 7784916
Provider #	100708507 94045 A001
Provider Name	Baptist Health Med Ctr

If you have questions about this notice, Please call toll free at 1-866-773-0404. For TDD, call 1-866-773-0405. You can also visit us online at [www.tricare4u.com](http://www.tricare4u.com)

**THIS IS NOT A BILL**

SERVICES PROVIDED BY	DATE OF SERVICE	AMOUNT BILLED	TRICARE ALLOWED	REMARKS
Baptist Health M	5/12/05 – 05/12/05	\$800.00		003
14040 – 1 service				
Baptist Health M	5/12/05 – 05/12/05	\$670.00		003
17304 – 1 service				
Baptist Health M		\$205.00	\$158.08	003
17305 – 1 service				
<b>Total</b>		<b>\$1,680.00</b>	<b>\$1,480.98</b>	


<b>CLAIM SUMMARY</b>		<b>BENEFICIARY SHARE</b>	
TRICARE Amount Billed		TRICARE Allowed	
TRICARE Paid	\$1,480.98	Cost Share/Copay	\$0.00
Medicare/Other Ins. Allowed	\$300.80	Deductible	\$0.00
Medicare/Other Ins. Paid	\$1,379.20	Beneficiary Responsibility	\$0.00
Medicare/Other Ins. Patient Res	\$300.80		

**OUT OF POCKET EXPENSE:**

	Beginning Limit	Beginning October 1, 2003 Limit	Met to Date	Beginning October 1, 2002 Limit	Met to Date
Catastrophic Cap	\$3,000.00	\$3,000.00	\$6.00	\$3,000.00	\$0.00
Individual Deductible	\$150.00	\$150.00	\$0.00	\$150.00	\$0.00
Family Deductible	\$300.00	\$300.00	\$0.00	\$300.00	\$0.00

**Remark Codes:**  
Payment has been made to the provider of care.  
03: If you are not satisfied with our determination, you have the right to request a review within 90 days of the date of this notice. See item five on important notice page.

PAID TO	AMOUNT PAID	BENEFICIARY RESPONSIBILITY
Baptist Health Med-Ctr	\$300.80	\$0.00



Total Charge

Medicare Approved Amount

Medicare Payment