


# ST2

## TRICARE STATEMENT EXAMPLES

### Example 1: Palmetto Government Benefits Administrators

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



**HARVEY HUNTER**  
426 BLUE FISH DR  
DAYTONA BEACH, FL 32115

**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 COST OF THIS SERVICE. 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.



Total Charge

Medicare Payment

Medicare Approved Amount


If information appears here the "Provider Accepted Assignment".

# ST2

## TRICARE STATEMENT EXAMPLES (continued)

Example 2: TRICARE Southwest

Example 3: WPS TRICARE Administration



**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	PROC	MOD	NO	TYP	BILLED	ALLOWED	CODE
BAPTIST HEALTH M	250	01	01		22.50	10.80	003
BAPTIST HEALTH M	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


**DEDUCTIBLE** 0.00      **TOTAL PAYABLE** 194.50      **INTEREST PAID** 0.00      **NET PAYMENT** 194.50

REMARKS: 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

**VOUCHER SUMMARY**

TOTAL PAYABLE	NET PAYMENT
194.50	194.50





**TRICARE**

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
1404 – 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>	

**CLAIM SUMMARY**      **BENEFICIARY SHARE**

TRICARE Amount Billed	\$1,480.98	Cost Share/Copay	\$0.00
TRICARE Allowed	\$300.80	Deductible	\$0.00
Medicare/Other Ins. Allowed	\$1,445.00	Beneficiary Responsibility	\$0.00
Medicare/Other Ins. Paid	\$1,379.20		
Medicare/Other Ins. Patient Responsibility	\$300.80		

**OUT OF POCKET EXPENSE:**

	Beginning Limit	Beginning October 1, 2003 Met to Date	Beginning October 1, 2002 Limit	Beginning October 1, 2002 Met to Date
Catastrophic Cap	\$3,000.	\$0.00	\$3,000.00	\$0.00
Individual Deductible	\$150.	\$50.00	\$150.00	\$0.00
Family Deductible	\$300.	\$0.00	\$300.00	\$0.00

**Remark Codes:**  
03: Payment has been made to the provider of care. 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

