OMB Control Number: 0720-0017
OMB Expiration Date:

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 1 hour per response for staff personnel and 30 minutes per response for a hospital official, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350-3100 (0720-0017). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

Sample Collection Instruments

The following information must be submitted in order to request reimbursement of CHAMPUS capital and direct medical information costs:

Hospital Name, Address:
Corporate Zip Code:
CHAMPUS Provider Number:
Medicare Provider Number:
Period Covered From: _____ To: _____
Total inpatient days:
    Total CHAMPUS inpatient days for dependents and retirees:
    Total CHAMPUS inpatient days for active duty claims:
Total capital cost:
Total direct medical education costs:
Total full-time equivalents:
    Residents:
    Interns:
Total inpatient beds:
Reporting date:

I certify that the information is accurate and based on the Medicare cost report submitted to HCFA. I understand that any changes resulting from an audit of the Medicare cost report will be reported to the fiscal intermediary within 30 days of notification.

_____
Signature

Sample Physician Acknowledgment Statement

Notice to Physicians: TRICARE/CHAMPUS payment to hospitals is based in part on each patient's principle and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

I acknowledge that I have received and understand the Notice to Physicians.

_____ _____

Signature **Date**