OMB NO.: XXXX-XXXX
EXPIRATION DATE: XX/XX/XXXX

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
[FOR REVIEWERS: MD/DO Mailing #1]

DEFENSE
HEALTH AGENCY

[Unique Provider ID Number] Month Date, 2015
FOR: [Insert Provider Name] [Credentials]
Street Address
City, State, and Zip

Dear BILLING MANAGER for [Insert Provider Name] [Credentials],

Hello! The physician named above has 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 physicians across the U.S. to determine whether military service members and their families have access to the health care they need. A substantial amount of health care to service members and their families is delivered by private, civilian physicians like [Insert Provider Name] [Credentials], and we need your help.

We are asking you to please answer the questions on the back of this letter on behalf of the physician above and return it ***within five days***. There are several ways to complete this survey, which should only take five minutes of your time:

- Complete the survey on the reverse side of this letter and return it via postal mail in the enclosed postage paid envelope
- Complete the survey on the reverse side of this letter and fax it to 1-800-409-7681
- Complete the survey on the internet at the following URL: http://www.dodcv08.com
  Your unique login name: xxxxxxxx **Your unique password:** xxxxxxxx

We recognize that there may be more than one provider in your office and ask that you complete the survey for the provider listed above. Since we may survey more than one provider in your office, please complete each survey for the appropriate provider named above. If you are not the appropriate person to answer these questions, please pass this on to the person in your office most familiar with the [Insert Provider Name] [Credentials]'s billing and insurance.

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 Ipsos between the hours of 8AM and 5PM Eastern Time at 1-800-228-6764.

Sincerely yours,

CAPT Jamie Lindly, MSC, USN
Chief, Decision Support

SURVEY QUESTIONS ON REVERSE SIDE

We estimate this survey will take an average five (5) minutes to complete, including the time for reviewing instructions, getting the needed data, and completing and reviewing the survey. You may send comments regarding our estimate or any other aspect of this survey, including suggestions for reducing the completion time, to Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division (OMB Number XXXX-XXXX). The OMB number above is currently valid, and you are not required to respond, unless this number is displayed. This Official DoD survey may be confirmed at the TRICARE website http://tricare.mil/tma/dhcape/, click on the Current Active Surveys, and find "Survey of Civilian Provider Acceptance of TRICARE Standard."

PRIVACY ADVISORY STATEMENT

Information collected for this Survey will be used to help TRICARE health policy makers gauge civilian provider awareness and acceptance of the TRICARE Standard health care benefit option, and provide aggregated input to improve the Military Health System. All information will be de-identified prior to being reported. Completing the Survey is voluntary; you may stop the Survey at any time and skip any questions you choose. There is no penalty if you choose not to respond, although maximum participation is encouraged so the data will be complete and representative.

Q1. Does [Insert Provider Name] [Credentials] provide treatment to patients through *private practice*? (Is he/she working in a setting where providers, individually or as a group, decide or influence which health insurance to accept?)

☐ Yes → (Go to Q2)
☐ No, does not provide treatment , or has retired→ (Thank you, please return the questionnaire)
☐ No, not in private practice → (Go to Q1a)

Q1a. What type of practice is [Insert Provider Name] [Credentials] in? (please choose one)

☐ Government: *Federal, State or other municipality*
☐ School, University or other academic institution
☐ Hospital staff
☐ Contractor providing services exclusively to government clients
☐ Rehab Facility, Nursing Home, or Home Health Provider
☐ Closed Panel HMO
☐ Other _____

Q2. Is [Insert Provider Name] [Credentials] *aware* of the TRICARE health care program?

☐ Yes
☐ No
☐ I Don't Know

Q3. As of today, is [Insert Provider Name] [Credentials] *a contracted member* of the TRICARE network of health care providers?

☐ Yes
☐ No
☐ I Don't Know

Q4. As of today, is [Insert Provider Name] [Credentials] *accepting new TRICARE Standard* patients?

☐ No →(Go to Q5)
☐ Yes, on a claim by claim basis only →(Go to Q6)
☐ Yes, for all claims →(Go to Q6)
☐ I Don't know →(Go to Q6)

Q5. If you answered "no" to Q4 below, why is [Insert Provider Name] [Credentials] *not accepting new TRICARE Standard* patients?

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

Q6. *What percentage of patients* seen by [Insert Provider Name] [Credentials] use *any form of TRICARE*? If unsure, please write down your best guess.

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

Q7. Does [Insert Provider Name] [Credentials] accept *Medicare patients*?

☐ Yes
☐ No
☐ I Don't Know

Q8. As of today, is [Insert Provider Name] [Credentials] accepting *new Medicare patients*?

☐ Yes → Thank you, please return the questionnaire
☐ No →(Go to Q9)
☐ I Don't Know →(Go to Q10)

Q9. If you answered "no" to Q8 above, why is [Insert Provider Name] [Credentials] *not accepting new Medicare patients*?

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

Q10. Does [Insert Provider Name] [Credentials] accept payment from government or private health insurance plans?

☐ Yes
☐ No

Q11. As of today, is [Insert Provider Name] [Credentials] accepting *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 Ipsos at 1-800-409-7681. 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.mil for assistance.