

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE**  
**HEALTH AFFAIRS**  
[FOR REVIEWERS: MD/DO Mailing #2]

DEFENSE  
HEALTH AGENCY

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

Month Date, 2015

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

Hello! [Insert Provider Name] [Credentials] was randomly selected to participate in this very important effort. In support of the thousands of U.S. military men and women who are currently defending our communities at home and abroad, Congress is interested in whether family members of active duty military, and military retirees and their families, have sufficient access to the health care they need. Much of their care is delivered at military facilities; however, a substantial amount of health care is delivered by private, civilian physicians.

Congress has directed the Department of Defense's health benefits program called TRICARE to survey civilian providers across the U.S to determine the adequacy of private health care access for its military beneficiaries. The DoD has contracted Ipsos to conduct this survey. If there is more than one physician in your office, please complete each survey for the appropriate physician. If you are not the appropriate person to answer these questions, please pass this on to person in your office most familiar with the doctor's billing and insurance for completion. If you have already completed your survey and returned it to Ipsos, thank you and please excuse this reminder.

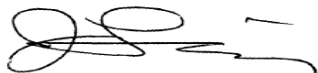
If you have not yet had a chance to respond, please take a few minutes now to answer the questions on the back of this letter on behalf of the physician and return it **within five days**. There are several ways to complete this survey, which should only take five minutes of your time:

- 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 [Insert Provider Name] [Credential]'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.

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**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.

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**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](http://www.tricare.mil) for assistance.