

Survey Instrument – Assistance Reporting Tool (ART) Screenshots

Header (appears on every tab)

OMB control number: 0720-0060
Expiration: xx-xx-xxxx



Assistance Reporting Tool
BCAC & DCAO Portal

Thursday, 10/25/2012 12:10:29 PM, Session Time Remaining:
119:10

Welcome, Lenny Bonivento (GOV-CIV) [Log Out](#)

[Advanced Search](#)

CASES

REPORTS

SEARCH

SSN, Case #, DBN, or Last Name

All Cases ≤ 1 yr

Go

Footer (appears on every tab)

You have 60 days left before you have to change your password. [Change Password.](#)

PRIVACY ACT STATEMENT: This statement serves to inform you of the purpose for collecting personal information required by the Assistance Reporting Tool (ART) and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 38 U.S.C. 1781, Medical Care for Survivors and Dependents of Certain Veterans; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; E.O. 9397 (SSN), as amended; and Department of Defense Instruction 6015.23, October 30, 2002.

PURPOSE: Personally identifiable information is collected for the purposes of checking enrollment status and crosschecking benefit, claims and authorization determinations.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, the specific "Blanket Routine Uses" under 5 U.S.C. 552a(b)(3) apply to this collection. The information collected may be used to provide assistance to TRICARE beneficiaries for medical authorization and for claims assistance, including release to third-party payors, for remotely located service members and line of duty care. The information may also be used to track, reflect, and report beneficiary case workload and for review of suspected abuse or fraud, or any concern for program integrity or quality appraisal.

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but without the requested information, we may not be able to assist in case resolution and answers to questions/concerns will be generalities regarding the topic at hand.

FOR OFFICIAL USE ONLY: This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information, it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made.

AGENCY DISCLOSURE STATEMENT

The public reporting burden for this collection of information, 0720-0060 is estimated to average 15 minutes per response, 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 the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. 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.

Basic Information Tab

BASIC INFORMATION

CLAIMS/DEBT INFORMATION

DOCUMENTS

HISTORY

| | | | |
|---------------------|---|------------------------------------|---|
| Last Name | <input type="text"/> | Beneficiary's Current Plan/Program | <input type="text" value="Choose, if known"/> |
| First Name | <input type="text"/> | Beneficiary Category | <input type="text" value="Choose, if known"/> |
| Provider | <input type="text"/> | Sponsor's Branch of Service | <input type="text" value="Choose, if known"/> |
| SSN | <input type="text"/> | Sponsor's Rank/Grade | <input type="text" value="Choose, if known"/> |
| DoD Benefits Number | <input type="text"/> | Date Contacted | <input type="text" value="10/25/2012"/> |
| Date of Birth | <input type="text" value="MM/DD/YYYY"/> | How Contacted | <input type="text" value="Choose, if known"/> |
| Primary Phone | <input type="text"/> | Who Contacted You | <input type="text" value="Choose, if known"/> |
| Alternate Phone | <input type="text"/> | Other Individuals Contacted | <input type="text"/> |
| Street | <input type="text"/> | Problem Began In Region | <input type="text" value="Choose, if known"/> |
| City | <input type="text"/> | Problem Began In State/Country | <input type="text"/> |
| State | <input type="text" value="Choose, if known"/> | Problem Began In Zip | <input type="text"/> |
| Country | <input type="text" value="Choose, if known"/> | Case Region | <input type="text" value="Not Assigned"/> |
| Email | <input type="text"/> | | |

Claims/Debt Information Tab

BASIC INFORMATION

CLAIMS/DEBT INFORMATION

DOCUMENTS

HISTORY

Claim Information

| | | |
|----------------------|---|---------------------------------------|
| Date Claim Processed | <input type="text" value="MM/DD/YYYY"/> | |
| Claim Number | <input type="text"/> | |
| Date of Service | <input type="text" value="MM/DD/YYYY"/> | |
| Services Provided By | <input type="text"/> | |
| Provider Number | <input type="text"/> | <input type="text" value="-Select-"/> |
| Amount Billed | <input type="text"/> | <input type="text" value="-Select-"/> |
| Amount in Question | <input type="text"/> | <input type="text" value="-Select-"/> |

Debt Collection Information

| | | |
|---|----------------------|---------------------------------------|
| Collection Agency Name | <input type="text"/> | |
| Collection Agency POC | <input type="text"/> | |
| Collection Agency Number | <input type="text"/> | <input type="text" value="-Select-"/> |
| Collection Agency Acct/Ref Number | <input type="text"/> | |
| Misc. Costs (atty. fees, interest, etc) | <input type="text"/> | |

Case Findings

| | | |
|---------------------------|----------------------|---------------------------------------|
| Beneficiary Owes | <input type="text"/> | <input type="text" value="-Select-"/> |
| TRICARE Owes | <input type="text"/> | <input type="text" value="-Select-"/> |
| Provider Write-Off Amount | <input type="text"/> | <input type="text" value="-Select-"/> |

Documents Tab

BASIC INFORMATION

CLAIMS/DEBT INFORMATION

DOCUMENTS

HISTORY

Upload

* Maximum document size is 20 MB

Select the Document

Browse...

Document Name

Description

Scan

Scan a Document

Upload

Pre-authorization Tab

| BASIC INFORMATION | CLAIMS/DEBT INFORMATION | DOCUMENTS | PRE-AUTHORIZATION | HISTORY |
|---|---|-----------------------|----------------------|--|
| Pre-Auth Number | | | Specific Site | <input type="text"/> |
| Received | <input type="text" value="10/25/2012"/> | | Tracking | <input type="checkbox"/> TBI <input type="checkbox"/> SCI <input type="checkbox"/> Blind <input type="checkbox"/> MOA Related Care <input type="checkbox"/> Combat Related Care <input type="checkbox"/> CBWTU <input type="checkbox"/> LOD Related Care |
| Auth Start Date * | <input type="text" value="MM/DD/YYYY"/> | | FFD Notification | <input type="checkbox"/> |
| Auth End Date * | <input type="text" value="MM/DD/YYYY"/> | | Absent Sick Date | <input type="text" value="MM/DD/YYYY"/> |
| Category * | <input type="radio"/> Inpatient <input type="radio"/> Outpatient | | Absent Sick MTF | <input type="text"/> |
| Admit Date | <input type="text" value="MM/DD/YYYY"/> | | | |
| Discharge Date | <input type="text" value="MM/DD/YYYY"/> | | | |
| Source of Care * | <input type="text" value="Civilian"/> | | | |
| Provider | <input type="text"/> | | | |
| Facility | <input type="text"/> | | | |
| Auth Status * | <input type="text" value="- Select -"/> | | | |
| ICD-9 Code * | <input type="text"/> | ICD-9 Description | <input type="text"/> | |
| Code Lookup | | | | |
| CPT/HCPCS * | <input type="text"/> | CPT/HCPCS Description | <input type="text"/> | |
| Add Another ICD-9 Diagnosis | | | | |
| Denied Not Covered Service | <input type="checkbox"/> | | | |
| Add Another CPT/HCPCS Code | | | | |

Fitness for Duty Tab

| | | | | |
|--------------------------|---|-------------------|-------------------------|----------------|
| BASIC INFORMATION | CLAIMS/DEBT INFORMATION | DOCUMENTS | FITNESS FOR DUTY | HISTORY |
| Unit Identification Code | <input type="text"/> | | | |
| Unit Name | <input type="text"/> | | | |
| Unit Address | <input type="text"/> | | | |
| ICD-9 Diagnosis Code | <input type="text"/> | ICD-9 Description | <input type="text"/> | |
| | Code Lookup | | | |
| Date of Service/Auth | <input type="text" value="MM/DD/YYYY"/> | | | |
| Date Letter Sent | <input type="text" value="MM/DD/YYYY"/> | | | |

Line of Duty Tab

| | | | | |
|--------------------------|---|---------------------|---|----------------|
| BASIC INFORMATION | CLAIMS/DEBT INFORMATION | DOCUMENTS | LINE OF DUTY | HISTORY |
| Date Of Injury | <input type="text" value="MM/DD/YYYY"/> | Date Submitted | <input type="text" value="MM/DD/YYYY"/> | |
| Eligibility Start Date * | <input type="text" value="MM/DD/YYYY"/> | Contact Information | <input type="text"/> | |
| Eligibility End Date | <input type="text" value="MM/DD/YYYY"/> | | | |
| Qualifying Condition * | <input type="text"/> | LOD Type * | <input type="text" value="- Select -"/> | |
| Document Type * | <input type="text" value="- Select -"/> | | | |
| Document Date | <input type="text" value="MM/DD/YYYY"/> | | | |

Transitional Care for Service-related Conditions (1637) Tab

BASIC INFORMATION

CLAIMS/DEBT INFORMATION

DOCUMENTS

1637

HISTORY

If you deny a diagnosis as eligible for the 1637 benefit, please indicate a reason in the Diagnosis/Notes field.

ICD-9 Diagnosis Code

[Code Lookup](#)

Diagnosis/Notes

Decision

- Pending
 Approve
 Deny

If ICD-9 Code is
unknown, enter clinical
condition

[Another Diagnosis](#)