

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

DEFENSE  
HEALTH AGENCY

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

Month DD, YYYY

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

Hello! The physician named above has been selected to participate in the TRICARE Select Survey of Civilian Providers (TSS-P), a very important survey effort for the Department of Defense. **TRICARE Select replaced TRICARE Standard and Extra as of January 1, 2018 –bringing together features of both Standard and Extra into a single plan.** 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 1-877-648-9563
- Complete the survey on the Internet by accessing the following URL (<http://www.health.mil/healthsurveys>) and selecting **“Survey #3: TRICARE Select Survey of Civilian Providers (TSS-P)”**

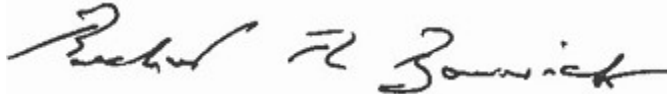
Your unique login name: xxxxxxxx

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], [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,



Richard R. Bannick, Ph. D., FACHE  
Decision Support Division/Defense Health Agency  
Office of the Assistant Secretary of Defense (Health Affairs)

Complete the Survey Online!  
<http://www.health.mil/healthsurveys>

Login name: <MIQ\_A>

Password: <password>



**SURVEY QUESTIONS ON REVERSE SIDE**

The public reporting burden for this collection of information is estimated to average five (5) minutes to complete, 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 the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil (0720-0031). 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. This Official DoD survey may be confirmed at the TRICARE website <https://health.mil/surveys>, click on Current Active Surveys, and find "Survey of Civilian Provider Acceptance of TRICARE Standard."

**PRIVACY ADVISORY STATEMENT**

Information is being collected for this Survey under the authority of the FY2015 National Defense Authorization Act (NDAA), Section 712 and will be used to help TRICARE health policy makers gauge civilian provider awareness and acceptance of the TRICARE Select 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 Select (formerly known as TRICARE Standard or Extra) 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 Select 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: [Insert Provider 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  I Don't Know  
 No

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 1-877-648-9563. 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.