


## Survey Instrument – Assistance Reporting Tool (ART) Screenshots

Header (appears on every tab)

**Assistance Reporting Tool**  
BCAC & DCAO Portal

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

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

[Advanced Search](#)

CASESREPORTS

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

Claims/Debt Information Tab

BASIC INFORMATION

CLAIMS/DEBT INFORMATION

DOCUMENTS

HISTORY

Claim Information

Date Claim Processed

MM/DD/YYYY

Claim Number

Date of Service

MM/DD/YYYY

Services Provided By

Provider Number

-Select-

Amount Billed

-Select-

Amount in Question

-Select-

Debt Collection Information

Collection Agency Name

Collection Agency POC

Collection Agency Number

-Select-

Collection Agency Acct/Ref Number

Misc. Costs (atty. fees, interest, etc)

Case Findings

Beneficiary Owes

-Select-

TRICARE Owes

-Select-

Provider Write-Off Amount

-Select-

Documents Tab

BASIC INFORMATION

CLAIMS/DEBT INFORMATION

DOCUMENTS

HISTORY

Upload

\* Maximum document size is 20 MB

Select the Document

Browse...

Document Name

Description

Upload

Scan

Scan a Document

4

Pre-authorization Tab

BASIC INFORMATION

CLAIMS/DEBT INFORMATION

DOCUMENTS

PRE-AUTHORIZATION

HISTORY

Pre-Auth Number

Received

10/25/2012

Auth Start Date \*

MM/DD/YYYY

Auth End Date \*

MM/DD/YYYY

Category \*

Inpatient

Outpatient

Admit Date

MM/DD/YYYY

Discharge Date

MM/DD/YYYY

Source of Care \*

Civilian

Provider

Facility

Auth Status \*

- Select -

Specific Site

Tracking

TBI

SCI

Blind

MOA Related Care

Combat Related Care

CBWTU

LOD Related Care

FFD Notification

Absent Sick Date

MM/DD/YYYY

Absent Sick MTF

ICD-9 Code \*

ICD-9 Description

[Code Lookup](#)

CPT/HCPCS \*

CPT/HCPCS Description

Denied Not Covered Service

[Add Another ICD-9 Diagnosis](#)

[Add Another CPT/HCPCS Code](#)

Fitness for Duty Tab

BASIC INFORMATIONCLAIMS/DEBT INFORMATIONDOCUMENTSFITNESS FOR DUTYHISTORY

Unit Identification Code

Unit Name

Unit Address

ICD-9 Diagnosis Code

ICD-9 Description

Code Lookup

Date of Service/Auth

MM/DD/YYYY

Date Letter Sent

MM/DD/YYYY

Line of Duty Tab

BASIC INFORMATIONCLAIMS/DEBT INFORMATIONDOCUMENTSLINE OF DUTYHISTORY

Date Of Injury

MM/DD/YYYY

Date Submitted

MM/DD/YYYY

Eligibility Start Date \*

MM/DD/YYYY

Contact Information

Eligibility End Date

MM/DD/YYYY

Qualifying Condition \*

LOD Type \*

- Select -

Document Type \*

- Select -

Document Date

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](#)