Non-network provider FAQs

Background

All TRICARE-authorized providers must meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers may include doctors, hospitals, ancillary providers and pharmacies that meet TRICARE requirements.

There are two types of TRICARE-authorized providers: network and non-network.

Non-network providers

Some non-network provider types are required to sign a participation agreement.

There are two types of non-network providers: participating and non-participating.

- **Participating non-network provider**: May choose to participate on a claim-by-claim basis. They have agreed to accept payment directly from TRICARE and accept the TRICARE-allowable charge (less any applicable patient costs paid by beneficiary) as payment in full.
- **Non-participating:** Beneficiaries may have to pay up-front for services rendered and file their own claims. These providers have not agreed to file claims on behalf of beneficiaries. Providers also have a legal right to charge up to 15% above the TRICARE-allowable charge for services (beneficiaries are responsible for paying this amount in addition to any applicable patient costs).

Search the TRICARE Maximum Allowable Charges by cross-code lookup (locality, state, catchment area or ZIP Code)

Are credentialing and certification the same thing?

No, credentialing is only required for network providers who are contracted with Humana Military.

All providers who render services to TRICARE beneficiaries MUST be TRICARE-authorized in each state where they provide services to file claims and receive payment for services. Certification ensures providers meet the licensing and certification requirements of TRICARE regulations and practice for that healthcare specialization. Once the certification process is complete, a provider is considered TRICARE-authorized.

For which TRICARE plans can non-network providers render services?

Non-network providers **can** treat TRICARE Select beneficiaries, including TRICARE Reserve Select (TRS), TRICARE Retired Reserve (TRR), TRICARE Young Adult (TYA) and TRICARE Overseas Program (TOP), as well as TRICARE For Life (TFL) beneficiaries, as long as the provider also accepts Medicare patients.

Non-network providers **should not** treat TRICARE Prime beneficiaries without first obtaining special, case-by-case approval.

What are some examples of when a beneficiary would see a non-network provider?

- When using TRICARE Select, TRS, TRR, TYA or if enrolled in TRICARE Prime Remote and there are no network providers available near the beneficiary's location
- If the beneficiary is enrolled in TRICARE Prime, a non-network provider can only be seen if:
  - The Point-of-Service (POS) option is utilized
  - It's approved by the regional contractor because no other providers were available
  - A non-network provider was seen in the Emergency Room (ER)

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How will using a non-network provider affect TRICARE beneficiaries?

TRICARE beneficiaries will have lower out-of-pocket costs when using a TRICARE-authorized network provider versus a TRICARE-authorized non-network provider. Providers can use the eligibility tool in self-service or the health plan costs page on TRICARE.mil/costs to learn more.

How can a non-network provider update demographic information?

Providers may use provider self-service to add or remove practitioners, update practice locations, make changes to phone, fax, email, name and much more.

The Provider information update request form can be used to submit updates not available electronically.

How should non-network providers file claims?

We strongly recommend that non-network providers file claims electronically with the appropriate HIPAA-compliant standard electronic claims format via provider self-service. For faster claims processing, providers should attach supporting documents when submitting electronic claims through self-service.

Please note that claims will be rejected if the National Provider Identifier (NPI) is not present in the correct location on the claim form or if there is a mismatch between the information in the National Plan and Provider Enumeration System (NPPES) and our claims system.

Utilizing third-party clearinghouses is also acceptable when filing claims. For more claims processing information for providers, visit the claims section of the provider handbook or visit HumanaMilitary.com.

What functions are non-network providers able to perform in provider self-service?

Non-network providers will have access to all of the features available in provider self-service. These services include but are not limited to:

- Submitting claims and checking claim status
- Verifying patient eligibility, benefits and claims
- Creating and updating referrals and authorizations
- Code lookup and profile management
- Demographic and roster updates

Network providers

Network providers have a signed contract with Humana Military (in addition to any applicable TRICARE participation agreements) and are contractually required to submit claims for beneficiaries for services rendered. Beneficiaries cannot file a claim themselves for services rendered by a network provider.

These providers may accept a copay/cost-share from beneficiaries prior to services rendered.

Note: Beneficiaries should not pay up-front for services rendered by a network provider unless it is their copay/cost-share.

Additional resources

- Provider webinars and educational content
- Provider self-service registration and log in
- Provider certification FAQs
- Health plan costs – Copays and cost shares

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