

# Request for reimbursement of TRICARE hospice cap amount

**Period ended: October 31, 2025**

Hospice provider name: \_\_\_\_\_

Tax Identification Number (TIN): \_\_\_\_\_

\_\_\_\_\_ Number of TRICARE beneficiaries electing hospice care during the period 9/28/24 – 9/27/25.

\_\_\_\_\_ Dollar amount of total payments received and receivable for services furnished to TRICARE beneficiaries during the cap period from 11/01/24 through 10/31/25, including employed physician's services not of an administrative and/or general supervisory nature.

\_\_\_\_\_ Total reimbursement received and receivable for general and respite inpatient care furnished to TRICARE beneficiaries for the period from 11/01/24 through 10/31/25.

\_\_\_\_\_ Aggregate number of TRICARE inpatient days for both general and respite inpatient care for the period from 11/01/24 through 10/31/25.

\_\_\_\_\_ Aggregate number of TRICARE routine days for the period from 11/01/24 through 10/31/25.

\_\_\_\_\_ Aggregate number of TRICARE continuous home care hours for the period 11/01/24 through 10/31/25.

\_\_\_\_\_ Aggregate total number of days of hospice care provided to all TRICARE beneficiaries for the period from 11/01/24 through 10/31/25.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Title: \_\_\_\_\_

Mail the request to:

Humana Military  
PO Box 202147  
Florence, SC 29502-2147  
Fax: (877) 489-4920