

parent command, the nearest naval activity, or per OPNAVINST 6320.6, the nearest U.S. Embassy or consulate when hospitalized in a foreign medical facility to be notified as soon as possible of the circumstances requiring medical or dental attention in a non-Federal facility. The member will also assure (request the facility to make notification if unable to do so personally) that the following information is passed to the adjudication authority serving the area of the source of care (§ 732.20). This notification is in addition to the requirements of article 4210100 of the Military Personnel Command Manual (MILPERSMAN) or Marine Corps Order 6320.3B, as appropriate. The adjudication authority will then arrange for transfer of the member and, if appropriate, newborn infant(s), to a Federal facility or for such other action as is appropriate.

(i) Name, grade or rate, and social security number of patient.

(ii) Name of non-Federal medical or dental facility rendering treatment.

(iii) Date(s) of such treatment.

(iv) Nature and extent of treatment or care already furnished.

(v) Need or apparent need for further treatment (for maternity patients, need or apparent need for further care of infant(s) also).

(vi) Earliest date on which transfer to a Federal facility can be effected.

(vii) Telephone number of attending physician and patient.

(2) Should movement be delayed due to actions of the member or the member's family, payment may be denied for all care received after provision of written notification by the adjudication authority.

(3) The denial is § 732.18(a)(2) will be for care received after the member's condition has stabilized and after the cognizant adjudication authority has made a request to the attending physician and hospital administration for the member's release from the civilian facility. This notification must specify:

(i) Date and time the Navy will terminate its responsibility for payment.

(ii) That care rendered subsequent to receipt of the written notification is at the expense of the member.

(b) *Adjudication authority.* As soon as it is ascertained that a member is

being treated in a nonnaval facility, adjudication authorities must make the notifications required in MILPERSMAN, article 4210100.11. See part 728 of this chapter on message drafting and information addressees.

(1) Article 4210100.11 of the MILPERSMAN requires submission of a personnel casualty report, by priority message, to the primary and secondary next of kin (PNOK/SNOK) of Navy members seriously or very seriously ill or injured, and on those terminally ill (diagnosed and confirmed). While submission of the personnel casualty report to the PNOK and SNOK is a responsibility of the member's command, adjudication authorities must advise the member's command when such a member is being treated or diagnosed by non-Federal sources. The message will also request forwarding of the member's service and medical records to the personnel support detachment (PSD) supporting the activity in which the OMA is located. Additionally, the notification should contain a request for appropriate orders, either temporary additional duty (TEMADD) or temporary duty (TEMPDU).

(i) Request TEMADD orders if care is expected to terminate within the time constraints imposed for these orders.

(ii) Request TEMDU Under Treatment orders for members hospitalized in a NMTF within the adjudication authority's area of responsibility.

(2) Make prompt message notification to the member's commanding officer when apprised of any medical condition, including pregnancy, which will now or in the foreseeable future result in loss of a member's full duty services in excess of 72 hours. Mark the message "Commanding Officer's Eyes Only."

§ 732.19 Claims.

(a) *Member's responsibility.* Members receiving care are responsible for preparation and submission of claims to the cognizant adjudication authority identified in § 732.20. A complete claim includes:

(1) *NAVMED 6320/10, Statement of Civilian Medical/Dental Care.* In addition to its use as an authorization document, the original and three copies of a

NAVMED 6320/10 are required to adjudicate claims in each instance of sickness, injury, or maternity care when treatment is received from a non-Federal source under the provisions of this part. The form should be prepared by a naval medical or dental officer, when practicable, by the senior officer present where a naval medical or dental officer is not on duty, or by the member receiving care when on detached duty where a senior officer is not present.

(i) For nonemergency care with prior approval, submit the NAVMED 6320/10 containing the prior approval, after completing blocks 8 through 18.

(ii) For emergency care (or non-emergency care without prior approval), submit a NAVMED 6320/10 after completing blocks 1 through 18. Assure that the diagnosis is listed in block 10. If prior approval was not obtained, state in block 11 circumstances necessitating use of non-Federal facilities.

(iii) Signature by the member in block 17 implies agreement for release of information to the responsible adjudication authority receiving the claim for processing. Signature by the certifying officer in block 18 will be considered certification that documentation has been entered in the member's Health Record as directed in article 16-24 of MANMED.

(2) *Itemized bills.* The original and three copies of itemized bills to show:

(i) Dates on or between which services were rendered or supplies furnished.

(ii) Nature of and charges for each item.

(iii) Diagnosis.

(iv) Acknowledgment of receipt of the services or supplies on the face of the bill or by separate certificate. The acknowledgment must include the statement: "Services were received and were satisfactory."

(3) *Claims for reimbursement.* To effect reimbursement, also submit the original and three copies of paid receipts and an SF 1164. Claim for Reimbursement for Expenditures on Official Business, completed per paragraphs 046377-2 a and b of the Naval Comptroller Manual (NAVCOMPT MAN).

(4) *Notice of eligibility (NOE) and line of duty (LOD) determination.* When a reservist claims benefits for care received totally after the completion of either an active duty or active duty for training period, the claim should also include:

(i) An NOE issued per SECNAVINST 1770.3.

(ii) An LOD determination from the member's commanding officer.

(b) *Adjudicating authority's responsibility.* Reviewing and processing properly completed claims and forwarding approved claims to the appropriate disbursing office should be completed within 30 days of receipt. Advice may be requested from COMNAVMEDCOM (MEDCOM-333 (A/V 294-1127)) for medical or MEDCOM-06 (A/V 294-1250)) for dental on unusual or questionable instances of care. Advise claimants of any delay experienced in processing claims.

(1) *Review.* The receiving adjudication authority will carefully review each claim submitted for payment or reimbursement to verify whether:

(i) Claimant was entitled to benefits (i.e., was on active duty, active duty for training, inactive duty training, was not an unauthorized absentee, etc.). As required by part 728 of this chapter, a Defense Enrollment Eligibility Reporting System (DEERS) eligibility check must be performed on claims to all claimants required to be enrolled in DEERS.

(ii) Care rendered was due to a bona fide emergency. (NOTE: When questions arise as to the emergency nature of care, forward the claim and all supporting documentation to the appropriate clinical specialist at the nearest naval hospital for review.)

(iii) Prior approval was granted if a bona fide emergency did not exist. (NOTE: If prior approval was not obtained and the condition treated is determined to have been nonemergent, the claim may be denied.) Consideration should always be given to cases that would have received prior approval but, due to lack of knowledge of the program, the member did not submit a request.

(iv) Care rendered was authorized under the provisions of this part.

(v) Care rendered was appropriate for the specific condition treated. (NOTE: When questions arise regarding appropriateness of care, forward all documentation to a clinical specialist at the nearest naval hospital for review. If care is determined to have been inappropriate, the claim may be denied to the extent the member was negligent.)

(vi) Claimed benefits did not result from a referral by a USMTF. If the member was an inpatient or an outpatient in a USMTF immediately prior to being referred to a civilian source of care, the civilian care is supplemental and may be the responsibility of the referring USMTF. See § 732.11(p) for the definition of supplemental care.

(2) *Disapproval.* If a determination is made to disapprove a claim, provide the member (and provider of care, when applicable) a prompt and courteous letter stating the reason for the disapproval and the appropriate avenues of appeal as outlined in § 732.24.

(3) *Processing.* Subpart C contains the chargeable accounting classifications and Standard Document Numbers (SDN) to be cited on the NAVCOMPT 2277, Voucher for Disbursement and/or Collection, on an SF 1164 submitted per paragraph (a)(3) of this section, and on supporting documents of approved claims before submission to disbursing offices.

(i) For payment to providers of care, a NAV COMPT 2277 will be prepared and certified approved for payment by the adjudicating authority. This form must accompany the NAVMED 6320/10 and supporting documentation per paragraph 046393-1 of the NAVCOMPTMAN.

(ii) Where reimbursement is requested, the SF 1164 submitted per § 732.19(a)(3) will be completed, per paragraph 046377 of the NAVCOMPTMAN, and certified approved for payment by the adjudicating authority. This form must accompany the NAVMED 6320/10 and supporting documentation.

(c) *Amount payable.* Amounts payable are those considered reasonable after taking into consideration all facts. Normally, payment should be approved at rates generally prevailing within the geographic area where services or supplies were furnished. Although rates

specially established by the Veterans Administration, CHAMPUS, or those used in Medicare are not controlling, they should be considered along with other facts.

(1) *Excessive charges.* If any charge is excessive, the adjudication authority will advise the provider of care of the conclusion reached and afford the provider an opportunity to voluntarily reduce the amount of the claim. If this does not result in a proper reduction and the claim is that of a physician or dentist, refer the difference in opinions to the grievance committee of the provider's professional group for an opinion of the reasonableness of the charge. If satisfactory settlement of any claim cannot thus be made, forward all documentation to COMNAVMEDCOM (MEDCOM-333) for decision. Charges determined to be above the allowed amount or charges for unauthorized services are the responsibility of the service member.

(2) *Third party payment.* Do not withhold payment while seeking funds from health benefit plans or from insurance policies for which premiums are paid privately by service members (see § 732.22 for possible recovery of payments action).

(3) *No-fault insurance.* In States with no-fault automobile insurance requirements, adjudication authorities will notify the insurance carrier identified in item 16 of the NAVMED 6320/10 that Federal payment of the benefits in this part is secondary to any no-fault insurance coverage available to the potentially covered member.

(d) *Duplicate payments.* Adjudication authorities and disbursing activities should take precautions against duplicate payments per paragraph 046073 of the NAVCOMPTMAN.

§ 732.20 Adjudication authorities.

(a) *General.* Controlling activities for medical care in the United States are designated as "offices of medical affairs" (OMA) and for dental care, "offices of dental affairs" (ODA). NAVMEDCOMINST 6010.3 delineates responsibilities and functional tasks of OMAs and ODAs, including monthly reporting of receipt of claims and claims payment. Commanders of geographic