# TRICARE OVERSEAS PROGRAM (TOP)
## GRIEVANCE FORM

### PRIVACY ACT STATEMENT

**AUTHORITY:** 10 U.S.C. 1079 and 1086, 32 U.S.C. Chapter 17; 32 CFR 199.17; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

**PRINCIPAL PURPOSE(S):** To obtain information necessary to permit individuals to investigate and respond to the complaint(s) or grievance(s) stated herein.

**ROUTINE USE(S):** In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and to other Federal, State, local, or foreign government agencies, and to private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.

**DISCLOSURE:** Voluntary; however, failure to provide information may result in the inability to respond due to lack of necessary information.

| **For Grievances regarding a Provider or Services return the form to:** | **For claims related issues contact us at the following:** |
|---|---|
| **Mail:** International SOS Government Services, LLC<br>TRICARE Reconsideration/Grievances Department<br>P.O. Box 762622<br>San Antonio, TX 78245<br><br>**Email:** TOPGlobalQualityAssu@internationalsos.com | **Phone:** +1 215-942-8393, Option 2 (Claims)<br>*(please visit the website for toll free numbers for your location)*<br>**Website:** www.tricare-overseas.com<br>**Mail:** TRICARE Overseas Program<br>Claims Appeals<br>P.O. Box 7992<br>Madison, WI 53707-7992 |

### CURRENT PERSONAL INFORMATION

| | | |
|---|---|---|
| **Name of Involved Beneficiary:** | | **Mailing Address:** |
| **Date of Birth:** | **Sponsor SSN / DoD Benefits Number (DBN):** | |
| **Email Address** ***(For individual submitting this grievance)*****:** | | **Country / Region:** |
| ***** Your Name, if you are not the involved Beneficiary:** | **Relationship to Beneficiary:** | **Day Phone:** |

** If you are not the involved beneficiary and the beneficiary is age 18 or older, the adult beneficiary must complete the enclosed Authorization to Disclose Form so we may respond directly to you. If we do not have authorization to disclose on file we must respond directly to the adult beneficiary.*

| | | | |
|---|---|---|---|
| **Name of Provider, International SOS Associate, or Department of Concern:** | | **Street Address** ***(if applicable)*****:** | |
| **Date(s) of Incident(s):** | **Phone:** | **E-mail** ***(of entity/subject of this grievance):*** | **Fax** ***(if known)*****:** |

### DESCRIBE YOUR GRIEVANCE

***Describe concern(s) – Please include what happened, when it happened, where it happened. Be specific about any statements made to you including the names of individuals that made the statements. Try to describe the events in the order in which they happened. You may attach additional pages or supporting documentation.***

| | |
|---|---|
| **Signature:** | **Date:** |

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## GRIEVANCE FORM: AUTHORIZATION TO DISCLOSE INFORMATION

I authorize Defense Health Agency (DHA) and/or International SOS, to disclose my information to a third party recipient as I designate below. Completion of this form is voluntary. If the form is not completed in its entirety, the requested information will not be disclosed to the recipient identified. This authorization is in compliance with Federal privacy regulations including the U. S. Department of Health and Human Services Privacy Rule at 45 CFR 164.508.

I authorize _____
***(Print or type name of authorized person)***

| ***Mailing Address of Authorized Person:*** *(if different from above)* | ***Email Address of Authorized Person:*** *(if different from above)* |
|---|---|
| | |

**to receive information on the following:**

| YES | NO | |
|---|---|---|
| ☐ | ☐ | All information related to my medical treatment and/or payment of TRICARE claims. |
| ☐ | | Information only related to my medical treatment and/or payment of TRICARE claims specifically for the care I received from_____on the date(s) of_____to_____. |
| ☐ | ☐ | Alcohol and substance abuse records.*_____*(Initial here to confirm, if applicable).* |

This information may include photocopies of medical records needed to adjudicate my claims for TRICARE benefits. If the purpose of this authorization is for a reason other than determining TRICARE claims payment, please describe below:

_____.

I understand that the protected health information I have authorized to disclose may be disclosed to and/or received by persons or organizations that are not health plans, health care providers or health care clearinghouses governed by federal privacy laws such as HIPAA. I also understand that such recipients may potentially re-disclose the protected health information, and that this re-disclosure is not protected by federal health information privacy laws.

I understand that if I have not specified an expiration date or event that this authorization will expire 12 months after the date this form is received unless revoked at an earlier date by either my personal representative or myself. I understand that I may revoke this authorization any time by sending a request in writing to **TRICARE Reconsideration/Grievances Department, P.O. Box 762622, San Antonio, TX 78245**, or email to **TOPGlobalQualityAssu@internationalsos.com**, except for actions already taken on my behalf based on this authorization. I also understand that payment, enrollment, nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. I am aware of my right to receive a copy of this authorization.

I understand that the completion of this form does not entitle the above person to act on my behalf in an appeal of a denial of TRICARE benefits.

Note: This form will be effective on the date this form is received. The expiration date will be 12 months from the date this form is received.

| **Sponsor's SSN / DoD Benefits Number (DBN):** | **Email Address of Person Giving Consent:** |
|---|---|
| **Patient's Name:** | **Date of Birth:** |
| **Signature of Person Giving Consent:** | **Date Signed:** |
| **PRINT Name of Person Giving Consent:** | **Mailing Address:** |

**NOTE:** If a patient's representative (such as Power of Attorney) signs the authorization, please attach documentation of the representative's authority.

**IMPORTANT:**
This form grants permission for information disclosed by telephone or correspondence about authorizations/referrals, claims, and enrollment only. It does NOT permit the person to see your claims on our website, www.tricare-overseas.com, or grant permission to make changes to your account. To grant permission for someone to see your claims information on the Website, you must do so within your account on www.tricare-overseas.com.

*This authorization will not apply to alcohol or substance abuse information unless specifically authorized above.

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