Correspondence Address:
TRICARE WEST REGION CLAIMS CORRESPONDENCE
P.O. BOX 202100
FLORENCE, SC 29502 2100

TRICARE SUMMARY PAYMENT VOUCHER

HEALTH NET FEDERAL SERVICES
A Wholly Owned Subsidiary of Centene Corporation

TRICARE

Questions?
www.TRICARE-West.com OR
OR 1-844-866-9378

Date of Remittance: APRIL 08, 2022 **NPI/Provider Number:** 01111111111 **Check Number:** 002222222222

Patient Account Number / Patient's Name	Rendering Provider NPI	SSN	Dates of Service Begin	Dates of Service End	Procedure	APC #	# of Srvcs	Total Charges	Allowed Covered Charges	Reason Code	Message Code	Patient's Cost Share	Patient's Copay	TRICARE Payment
001111111		1111	111021	111021	0914 90791 GT		001	1,050.00	140.59	P90051,2,3,4,		0.00	0.00	140.59
JOHN							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
SMITH		TOTALS FOR CLAIM NUMBER XXXXXXXXX-00-00 >>>						1,050.00	140.59			0.00	0.00	140.59
												PATIENT'S RESPONSIBILITY		0.00
001111111		1111	111821	112321	0905 S9480 GT		001	1,900.00	311.40	P90051,2,3,4,		0.00	0.00	311.40
JOHN							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
SMITH			111821	112321	0905 S9480 GT		001	1,900.00	311.40	P90051,2,3,4,		0.00	0.00	311.40
							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
			111821	112321	0905 S9480 GT		001	1,900.00	311.40	P90051,2,3,4,		0.00	0.00	311.40
							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
		TOTALS FOR CLAIM NUMBER YYYYYYYYY-00-00 >>>						5,700.00	934.20			0.00	0.00	934.20
												PATIENT'S RESPONSIBILITY		0.00
001111111		1111	112421	112421	0915 90853 GT TOTALS FOR		001	900.00	21.65	P90051,2,3,4,		0.00	0.00	21.65
JOHN							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
SMITH		CLAIM NUMBER JJJJJJJJJ-00-00 >>>						900.00	21.65			0.00	0.00	21.65
												PATIENT'S RESPONSIBILITY		0.00
002222222		2222	111021	111021	0915 90853		001	900.00	21.65	1,2,3,4,		0.00	21.65	0.00
JANE							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
DOE		TOTALS FOR CLAIM NUMBER AAAAAAAAA-00-00 >>>						900.00	21.65			0.00	21.65	0.00
												PATIENT'S RESPONSIBILITY		21.65
002222222		2222	110821	110821	0914 90791 GT		001	1,050.00	140.59	1,2,3,4,		0.00	0.00	140.59
JANE							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
DOE		TOTALS FOR CLAIM NUMBER VVVVVVVVV-00-00 >>>						1,050.00	140.59			0.00	0.00	140.59
												PATIENT'S RESPONSIBILITY		0.00
002222222		2222	112221	112421	0905 S9480 GT		001	1,900.00	311.40	1,2,3,4,		0.00	0.00	311.40
JANE							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
DOE			112221	112421	0905 S9480 GT		001	1,900.00	311.40	1,2,3,4,		0.00	0.00	311.40
							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
			112221	112421	0905 S9480 GT		001	1,900.00	311.40	1,2,3,4,		0.00	0.00	311.40
							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
		TOTALS FOR CLAIM NUMBER DDDDDDDD00-00 >>>						5,700.00	934.20			0.00	0.00	934.20
												PATIENT'S RESPONSIBILITY		0.00
003333333		3333	111021	111021	0914 90837 GT		001	950.00	121.13	1,2,3,4,		0.00	0.00	121.13
ADAM							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
JONES		TOTALS FOR CLAIM NUMBER HHHHHHHHH-00-00 >>>						950.00	121.13			0.00	0.00	121.13
												PATIENT'S RESPONSIBILITY		0.00

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Date of Remittance: APRIL 08, 2022 **NPI/Provider Number:** 0111111111 **Check Number:** 002222222222

Patient Account Number / Patient's Name	Rendering Provider NPI	SSN	Dates of Service Begin	Dates of Service End	Procedure	APC #	# of Srvcs	Total Charges	Allowed Covered Charges	Reason Code	Message Code	Patient's Cost Share	Patient's Copay	TRICARE Payment
466666666		4444	111521	111621	0914 90837 GT		001	950.00	121.13	1,2,3,4,		0.00	0.00	121.13
TINA							001	0.00	0.00	5,6,7,8		0.00	0.00	0.00
TURNER		TOTALS FOR CLAIM NUMBER VVVVVVVVV-00-00 >>>						950.00	121.13			0.00	0.00	121.13
													PATIENT'S RESPONSIBILITY	0.00

TRICARE OUTPATIENT HOSPITAL SUB-TOTAL >>> 2,413.49

Total Charges	Allowed Covered Charges	Cost Share	Copay	Deductible	TRICARE Payment
17,200.00	2,435.14	0.00	21.65	0.00	2,413.49

TRICARE Payment	2,413.49
Interest	0.00
Federal Tax Withheld	0.00
Offset	0.00
Check Amount	2,413.49