

CLEMP

Camp Lejeune Family Member Program

User Help Guide

Department of Veterans Affairs
Chief Business Office Purchased Care

2015

Contents

- 2 Important Phone Numbers and Information
- 3 Helpful Tips
- 7 Section 2: Eligibility Requirements
- 9 Section 3: Obtaining Hospital Care And Medical Services
- 12 Section 4: Your Costs
- 13 Section 5: Other Health Insurance (OHI)
- 14 Section 6: Claim Filing Instructions
- 18 Section 7: Reconsideration And Appeals Requests
- 22 Section 8: Help Fight Fraud
- 23 Section 9: Notice Of Privacy Practices

Important Phone Numbers and Information

Name	Telephone Number
Your Doctor (Primary Care)	
Your Doctor	
Your Doctor	
Your Hospital	
Your Pharmacy	
Your Medications (To treat Camp Lejeune-related medical conditions)	
Covered Medical Conditions (Related to Camp Lejeune)	

Helpful Tips

Keep This User Guide

This user guide provides important information about the Department of Veterans Affairs' (VA) Camp Lejeune Family Member Program (CLFMP). You can also visit our website to find other helpful information, including an electronic copy of this guide: "A User Guide for the Camp Lejeune Family Member Program." Visit <https://www.clfamilymembers.fsc.va.gov> for more information. This user guide is not reprinted yearly. Occasionally, there will be a change that could impact your eligibility, benefits, or costs. When that happens, we will send you a notification of the change and ask you to add it to your user guide. Please remember that this user guide is only a guide. The "Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012" and regulations contain the authoritative rules for the CLFMP.

Where can I get additional information if I have questions about the CLFMP?

Information on how to apply for the CLFMP, program eligibility, claims payment, appeals, etc. can be found on <https://www.clfamilymembers.fsc.va.gov> or by calling the CLFMP Customer Service Center toll-free at 1-866-372-1144.

Talk to a customer service representative:

Camp Lejeune Toll Free Customer Service Center: 1-866-372-1144

Hours of Operation: Monday - Friday 7:30 a.m. - 4:00 p.m. (CST)

Visit the CLFMP Website: <https://www.clfamilymembers.fsc.va.gov>

At this website, you can download CLFMP forms, apply for the CLFMP electronically, update your other health insurance (OHI) information the CLFMP has on file, etc.

The following information is available on the CLFMP Website 24 hours a day, 7 days a week:

- CLFMP User Guide
- CLFMP Forms
- Frequently asked questions
- Fact sheets on the CLFMP

Note: To view and print forms, you must have a current version of Adobe Acrobat Reader. This is available to download for free from Adobe's Website (www.adobe.com/products/reader.html).

Mail and Fax:

Always include your name and phone number on each page when you write to us or send completed forms or medical bills when submitting a claim for reimbursement. Fax *or* mail your inquiry or documentation to:

Fax Number: 512-460-5536

Mailing Address:

U.S. Department of Veterans Affairs
Financial Services Center
PO Box 149200
Austin, TX 78714-9200

It is very important that you notify us if your address or phone number changes. Use the Camp Lejeune Family Member Program Information Update Form (VA Form 10-10068c) to complete this action **or call our toll free number at 1-866-372-1144 and provide your updated contact information to a customer service representative.**

Special Needs

For hearing impaired callers, please use the Federal Relay Operator at **1-800-877-8339**.

When English is not your first language, we can arrange for a third-party translator. When you call us, we will ask our translation service to participate in the phone call.

We can also provide you, on request, a copy of the CLFMP user guide in any language or Braille. It will take about six weeks to provide you the translated user guide from the time we receive your request.

Section 1: Background

Camp Lejeune Family Member Program and the Public Law

For portions of the 1950s through the 1980s, Veterans and family members living or serving at the U.S. Marine Corps Base Camp Lejeune in North Carolina were exposed to drinking water contaminated with chemicals known as volatile organic compounds, including industrial solvents and components of fuels.

On August 6, 2012, President Obama signed into law the *“Honoring America’s Veterans and Caring for Camp Lejeune Families Act of 2012.”* This law provides VA hospital care and medical services for Veterans who served on active duty at Camp Lejeune between August 1, 1953 and 1987. Eligible family members may receive reimbursement of medical bills for treatment of the 15 medical conditions cited in the law and any associated medical condition resulting from one of the 15 conditions.

The new law requires VA to reimburse family members (after all other insurers have reimbursed the individual’s claims) for treatment of the following 15 illnesses or conditions:

- Bladder cancer
- Breast cancer
- Esophageal cancer
- Female infertility
- Hepatic steatosis
- Kidney cancer
- Leukemia
- Lung Cancer
- Miscarriage
- Multiple myeloma
- Myelodysplastic syndromes
- Neurobehavioral effects
- Non-Hodgkin’s lymphoma
- Renal toxicity
- Scleroderma

How the CLFMP Process Works

You must first apply to the CLFMP by submitting an application and supporting documentation. Then, VA will review your application and determine your eligibility for the program (please see Section 2 for additional information). After your eligibility is determined, VA will be the final payer for hospital care and medical services related to the 15 covered conditions after payment(s) has been made by your other health insurance plan(s) (including CHAMPVA, Medicare, Medicaid, and TRICARE).

Please note: You are strongly urged not to alter or cancel your current health insurance as VA can only pay for hospital care and medical services for enrolled CLFMP family members for the 15 medical conditions listed above and any secondary medical condition resulting from one of the 15 conditions. If you stop or change your other health insurance coverage, you will not have health insurance coverage for preventive care and other medical, non-Camp Lejeune-related illnesses.

The CLFMP is not a comprehensive hospital care and medical services plan. CLFMP only covers those services necessary for the treatment of the 15 covered medical conditions listed in the *Honoring America's Veterans and Caring for Camp Lejeune Families Act* of 2012. **VA is the last payer of medical claims related to the 15 Camp Lejeune conditions. All other insurance coverage must be exhausted prior to submitting a claim for coverage under this program.** If you have no other health insurance, VA will be the primary payer for your medical bills but only for the 15 covered conditions listed in the law.

Please ensure that your provider understands that the CLFMP only covers treatment for one or more of the 15 Camp Lejeune primary conditions or an associated medical condition. Please give your provider a copy of the letter you received from us attached to your CLFMP ID-Card.

All claims submitted for reimbursement under the CLFMP must be for one or more of the 15 medical Camp Lejeune conditions or an associated medical condition and clearly indicated on the medical claim form.

Section 2: Eligibility Requirements

Family members who are related to a Camp Lejeune Veteran by birth, married to a Camp Lejeune Veteran, or were a legal dependent of a Camp Lejeune Veteran and resided (or were in utero) at Camp Lejeune for 30 days or more between August 1, 1953 and December 31, 1987 are qualified for the CLFMP. Out-of-pocket medical care costs will be covered by VA for qualified Camp Lejeune family members who have one of the 15 covered illnesses or conditions that VA determines was not a result from a cause other than the individual's residence at Camp Lejeune.

Who should apply for the Camp Lejeune Family Member Program?

If the Veteran	And	And	Then
Was on active duty stationed at Camp Lejeune for 30 days or more between August 1, 1953 and December 31, 1987	You were the spouse, related by birth, or dependent of the Veteran during that same period	You lived (or were in utero) on Camp Lejeune for 30 days or more between August 1, 1953 and December 31, 1987	You may meet the criteria for VA's Camp Lejeune Family Member Program. Complete the required application form to apply

Common eligibility questions

How do I start the CLFMP enrollment process?

The very first step in obtaining access to CLFMP medical benefits is to apply. To obtain the required forms, you can contact us and request the forms be mailed to you or you may complete an application online at <https://www.clfamilymembers.fsc.va.gov> for expedited processing. You can either submit your application through this Website or print it out and mail it to the address provided in this guide.

To qualify for the reimbursement of treatment for a covered medical condition, please include the information from your medical provider on the Treating Physician Report (VA Form 10-10068b) along with your CLFMP application. Fax or mail the physician-signed and completed form to the address provided in this user guide.

Once your application is received, VA will process and review your application to ensure that you fulfill the family member criteria in the law and will notify you of your enrollment status. If you are enrolled in CLFMP, VA will send you an enrollment package, which will detail your benefits based on the 15 conditions (listed at 38 U.S.C 1710(e)(1)(F)). Additionally, the package will outline benefits you are eligible for and will provide important information concerning how to submit claim(s) for reimbursement of your medical bills.

If you are not approved by VA for enrollment in the program, you will receive a letter telling you so and providing you with instructions on how to appeal VA's decision if you do not agree with it.

How will payments be made for the medical bills related to the 15 covered medical conditions? What am I responsible for?

If your medical provider attempts to bill you for any remaining balance after they are paid for treatment of a covered medical condition, either have them contact us regarding the remaining balance or you can forward the bill and any related medical documentation you received from the provider to us at the address indicated in this guide so we can pay it for you. As long as the bill is for treatment of a medical condition covered under the CLFMP, you will not be responsible for any balance. More information is provided in Section 6, Claim Filing Instructions.

If you have other health insurance (OHI), once your OHI pays their amount for care of one of the 15 Camp Lejeune conditions or an associated medical condition, VA will pay any remaining amount that you would otherwise be charged. **Please note:** VA will only pay the balance for treatment of the 15 Camp Lejeune conditions or an associated medical condition after OHI payments have been exhausted.

What happens if I do not have any OHI?

If you do not have OHI, VA may cover the entire cost of treatment for the 15 Camp Lejeune conditions. You will be responsible for medical bills that are not for health care services related to one of the 15 conditions covered in the law.

Please note: The CLFMP does not provide minimal essential coverage under the Affordable Care Act so you are encouraged not to cancel your health insurance if you have it.

Section 3: Obtaining Hospital Care And Medical Services

Reimbursement Information

The CLFMP will only cover hospital care and medical services that are determined to be medically necessary and appropriate for the covered condition. The fact that your physician tells you that you need certain care does not mean that the care is covered under the CLFMP. There may be limits on certain care, and some care is not covered at all.

We will periodically review any type of care that goes on for a long time (over a period of weeks, months, etc.), including physical therapy, medication, mental health services, and skilled nursing services and may request medical documents during the course of treatment. We will notify you when additional documentation or a treatment plan is needed from your medical provider.

The same limitations apply whether you reside in the U.S. or in another country. For example, if you reside or travel overseas, we will only cover medications that are FDA approved for use in the U.S.

Each eligible CLFMP family member will receive an identification card. The sample below shows that cards are issued with the phrase “Patient SSN” in the Member Number space rather than the actual number being displayed.

<p>Camp Lejeune Family Member Program (CLFMP) is payer of last resort to all other health insurance providers. Include an Explanation of Benefits (EOB) from other health care coverage when filing medical claims.</p> <p>Covered CLFMP medical conditions: For a list of covered medical conditions, billing, and reimbursement information, see our website at https://www.clfamilymembers.fsc.va.gov. They are also listed on the patient’s approval letter. Only treatment for one of these covered medical conditions or a consequential condition should be submitted for payment.</p>	  <small>U.S. Department of Veterans Affairs Veterans Health Administration Chief Business Office Purchased Care Camp Lejeune Family Member Program</small>		Open Access No Referral Required
	Beneficiary Name		
	Include this <u>Member Number</u> on all claims and letters		
	“Patient SSN”		
	This is your Identification Card		
Effective Date	Phone 1-866-372-1144/Fax 512-460-5536		https://www.clfamilymembers.fsc.va.gov

When you visit your doctor, bring with you your CLFMP Identification Card and letter explaining how to submit medical bills to VA for reimbursement. This will help your doctor’s billing department understand how to submit claims to VA for reimbursement. Since your copayment, cost share, or coinsurance for care will be covered by the CLFMP, show them the letter and talk to your doctor about how they should submit your bills. If you or your provider have questions, you can call the customer service representative toll-free number.

As long as the medical care is not excluded in the Veteran medical benefits package, the CLFMP covers all medically necessary hospital care and medical services that are authorized under the existing law.

We pay for covered services and supplies when they are determined to be medically necessary and are received from an authorized provider. When providers are performing services within the scope of their license or certification, we consider them to be authorized. Some of the most common providers are: anesthetist (MD), audiologist, certified clinical social worker, certified nurse practitioner (NP or CNP), certified registered nurse anesthetist (CRNA), certified physician assistant (PA), certified psychiatric nurse specialist, clinical psychologist (PhD), doctor of osteopathy (DO), licensed practical nurse (LPN), medical doctor (MD), occupational therapist (OT), physical therapist (PT), physiologist, podiatrist (DPM), psychiatrist (MD), and registered nurse (RN).

Covered Health Care Services

The following information provides you with some of the most common services that will be covered for CLFMP family members. Basic care associated with the 15 Camp Lejeune covered conditions typically includes:

- Outpatient medical, surgical, and mental health care
- Inpatient hospital, medical, surgical, and mental health care
- Prescription drugs, medical, and surgical supplies.
- Emergency care
- Durable medical equipment including prosthetic and orthotic devices.
- Skilled nursing care, homemaker, and home health services when provided by a certified practitioner and clinically required by one of the 15 Camp Lejeune covered conditions. These services may include skilled services, adult day health care, case management, and assistance with activities of daily living (e.g., bathing and getting dressed) or instrumental activities of daily living (e.g., fixing meals and taking medicines)
- Reconstructive (plastic) surgery required as a result of a covered condition but not including cosmetic surgery that is not medically necessary
- Palliative care (including hospice) and non-institutional or institutional respite care
- Ambulatory surgery
- Transplants

CLFMP Excluded Health Care Services

The following services are **not** covered under the CLFMP:

- Hospital or health care services determined to be unrelated to one of the 15 Camp Lejeune conditions
- Abortions and abortion counseling
- In vitro fertilization
- Drugs, biologicals, and medical devices not approved by the Food and Drug Administration (FDA)
- Gender alterations
- Hospital and outpatient care for a family member who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to family members who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house)
- Nursing Home Care (residential services are not covered; however, palliative care services are covered)
- Membership in spas and health clubs
- Ambulance transport from home to medical facility

Family Members will be Reimbursed for Hospital Care and Medical Services Received from Their Private Providers

Family members who are enrolled in the CLFMP will receive hospital care and medical services by their private physicians. **Hospital care and medical services are not authorized and cannot be obtained from VA medical centers.** VA, as the last payer, will reimburse family members for the costs of hospital care and medical services

related to the 15 Camp Lejeune conditions. If you are a Veteran and are enrolled in the VA medical system, you *should not use this program* as a family member.

This allows family members to receive coordinated care from a single source rather than receiving care for CLFMP-covered conditions from VA and the remainder of their non-CLFMP care in the private health system.

When the CLFMP is Secondary Insurance

To obtain reimbursement for hospital care and medical services in cases where you indicated on your application form you have other health insurance and therefore CLFMP is your secondary insurance, you can ask the provider to file the claim and Explanation of Benefits (EOB) from the primary insurer electronically with CLFMP as the secondary payer. If the provider is not able or willing to do that, you will need to submit the itemized bill, the CLFMP Claim Form, and the EOB from the primary insurer to us at the address listed in this user guide.

Pharmacy

The CLFMP designed a formulary that shows potential drugs related to the treatment of the 15 Camp Lejeune conditions. If your prescription is not listed on the formulary, it may take additional time to verify the prescription is a treatment for one of the 15 Camp Lejeune conditions. Review the formulary at: <https://www.clfamilymembers.fsc.va.gov>.

For prescription coverage: The VA selected PrismRx, a wholly owned subsidiary of Heritage Health Solutions, Inc., as the Pharmacy Benefit Manager (PBM) for CLFMP. Please visit CLFMP PBM website at <http://clfmp.prismpbm.com/> to:

- Print your temporary pharmacy identification card
- Select a pharmacy near you
- Contact a PrismRx Pharmacy Customer Service Representative*.

Please present your temporary pharmacy identification card to the pharmacist. The information included on the temporary pharmacy identification card provides the pharmacist the information to properly file your claim.

PrismRx provides a Nationwide network of more than 65,000 pharmacies throughout the U.S. and its' territories. For your convenience, many of the pharmacies in the network provide:

- Drive-through pick-up window service
- Daily or emergency 24-hour pharmacy service
- A full array of vaccinations including the shingles and flu shots
- Expert compounding services tailored to your needs
- Pharmacy consultation services.

*The PrismRx Customer Care Center is available Monday through Friday, from 7:00 a.m. to 9:00 p.m. Central Standard Time (CST) and on Saturday from 10:00 a.m. to 3:00 p.m. CST to answer questions regarding CLFMP pharmacy plan benefits. To contact a Customer Care Representative, please call (855) 218-4613.

Section 4: Your Costs

As the last payer, VA will pay all out-of-pocket costs for hospital and medical services associated with the 15 Camp Lejeune medical conditions outlined in the law. If you receive a bill for treatment of a covered condition after it has been paid by your other health insurance, please ask your provider to submit the bill to VA for payment. VA will pay in accordance with its regulations governing non-VA care, which generally includes Medicare rates, for hospital care and medical services for CLFMP conditions covered by the law. If your medical provider has any questions, please have them contact our customer service department at 1-866-372-1144.

Coverage Outside of the United States

As the last payer, VA will reimburse Camp Lejeune family members who receive hospital care and medical services outside of the United States for any of the 15 Camp Lejeune conditions in the law. VA will pay up to the VA allowable amount to foreign medical providers. You must ensure that you and your foreign medical providers understand VA's reimbursement limitations prior to obtaining service. Claims written in English (billing and medical documentation) will be processed faster because we will not need to arrange for translation. If the billing and medical documentation is written in a foreign language, translation will be arranged at no cost to you. Our payments are made in U.S. dollars.

When the CLFMP Pays Incorrectly

In the processing of thousands of claims each year, there may be an accidental overpayment to you or your provider, depending on who submitted the claim. This might happen when we are not aware that you have other health insurance that should have paid before the bill was submitted to us, when a provider bills us twice for the same service, or if we mistakenly pay for services during a period of ineligibility. Regardless of the incorrect payment reason, VA is required to take action to recoup the erroneous payment. This is done to ensure that your tax dollars are spent properly, according to the law.

If you were overpaid, you will receive a letter requesting repayment and explaining your rights under the law. You should respond to the request within 30 days. If you cannot afford to pay the money all at once, you may be able to make monthly payments. You will be asked for financial information if you request a waiver of the overpayment. Depending on the outcome of the review of that information, the debt might be reduced or waived. If you do not respond to our notification, action to collect the amount owed to VA will begin.

Section 5: Other Health Insurance (OHI)

OHI Certification

When you first apply for reimbursement for hospital care and medical services covered under the CLFMP, we ask you to include OHI information on the CLFMP Application Form (VA Form 10-10068). **Any time there is a change in your OHI status, you must inform us of the change. You may update your OHI information by completing a CLFMP Information Update Form 10-10068c or by calling our toll free number and providing the information to a customer service representative.** Periodically, we will ask for you to recertify your OHI status by returning the CLFMP Information Update Form (VA Form 10-10068c) to us or by calling our toll free number and providing the information to a customer service representative. Visit <https://www.clfamilymembers.fsc.va.gov> to download the form.

CLFMP as a Last Payer

Under the CLFMP, VA is a last payer after all other health insurance providers and any other third party liability (e.g. auto insurance, worker's compensation, etc.). Therefore, we pay after your OHI and, if you have more than one OHI (such as Medicare and Medicare supplemental plan), we pay after both plans. OHI complements the CLFMP; it does not prevent anyone from participating in the CLFMP. You may have another health plan through your employer, your spouse's employer, or other government program such as Medicare.

You or your health provider must file the claim with the other insurance plan **before** submitting it to us for payment. Upon receiving the Explanation of Benefits (EOB) from your OHI, you or the provider may file a CLFMP claim for any remaining balance. In addition to the EOB from the other health insurance, medical claims must include the provider's itemized billing statement.

The CLFMP and Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) Plans

If you have an HMO or PPO plan, we will pay your out-of-pocket expenses (your copayments, cost shares or coinsurance under the HMO/PPO) for CLFMP covered services.

Section 6: Claim Filing Instructions

It is important to fill out the CLFMP Claim Form correctly. In most cases, your provider will complete and send in the claim form for you. There are times that you will have paid for the medical service or supply and need to request reimbursement from us. A forgotten signature or other incorrect or missing information may slow down your claim or result in an initial rejection of the claim. We cannot process the claim until we have all the required information.

As the CLFMP is the last payer of medical claims for these conditions, all other insurance coverage must be exhausted prior to submitting a claim for coverage under this program. If you have no other health insurance, VA will be the primary payer for your medical bills for the 15 Camp Lejeune covered conditions. VA does not have the authority to pay for treatment of any other medical illnesses, injuries, or conditions.

Please ensure that your provider understands that the CLFMP only covers hospital care and medical services for one or more of the primary conditions or an associated medical condition as described in this user guide. Provide them with a copy of the letter you received from us attached to your CLFMP ID-Card.

Please note: Any claims submitted under the CLFMP must be treatment for one or more of the 15 Camp Lejeune medical conditions or an associated medical condition and be clearly indicated on the medical claim form. The International Classification of Diseases (ICD) code(s) for the covered primary medical condition must be included on the medical claim form if the treatment is for a CLFMP covered condition.

When You Submit the Claim (Instead of Your Provider)

You will need to send in the following items:

1. CLFMP Claim Form, VA Form 10-10068a (available by phone or on the CLFMP Website)
2. An itemized billing statement with the following information:
 - Full name, address, and tax identification number of the provider
 - Itemized charges for each service or supply
 - Diagnosis code(s)
 - Date and type of service or supply
3. When you have OHI, a copy of an EOB from the OHI

Tips for when you file claims

- Your name must be listed on the claim form exactly as it is on the CLFMP Identification Card
- Your CLFMP Member Number (your Social Security number) must be on the claim
- Keep copies of all receipts, invoices, and other documents
- If you do *NOT* use CLFMP Claim Form, VA Form 10-10068a, payment will be made directly to the hospital care or medical services provider instead of to you
- After billing your OHI, you can file with CLFMP for any remaining balance

Provider Submitted Claims

If your provider submits the claim **to us as the last payer**, they will either send it electronically or on a standardized paper form (CMS-1500 or UB-04). The ICD code(s) for the covered primary medical condition must be included on the medical claim form if the treatment is for a CLFMP covered condition.

Tips for when your provider files claims:

- Claims submitted electronically are processed more quickly. If your provider can send the claims electronically and is not doing so, have your provider contact us
- An itemized billing statement on a CMS-1500 or UB-04 form is required with the following information:
 1. Full name, address, and tax identification number of the provider
 2. Address where payment is to be sent
 3. Address where services were provided
 4. Provider professional status (doctor, nurse, physician assistant, etc.)
 5. Specific date of each service provided. Date ranges are acceptable only when they match the number of services/units of services
 6. Itemized charges for each service
 7. Appropriate medical code (e.g. Current Procedural Terminology , Healthcare Common Procedure Coding System , International Classification of Diseases) for each service
- If your OHI was billed, provide a copy of their EOB detailing what they paid. Sometimes the definition or explanation of their codes is on the reverse of their EOB (please include a copy of that as well). If you have two OHIs (such as Medicare and a Medicare Supplemental Plan), we will need both EOBs to process your claim
- Medical records or notes must be submitted with the bill in some cases. Many of those services, such as skilled nursing, home health care, and some surgical procedures require medical documentation. If our clinicians have any questions regarding your eligibility or payment of a medical claim, we may contact your provider for additional information

Pharmacy Claims

The following information is required to reimburse you for prescriptions under the CLFMP, regardless of whether submitted by the pharmacy or by you:

An invoice/billing statement that includes:

- Name, address, and phone number of the pharmacy
- Name of prescribing physician
- Name, strength, quantity for each drug
- 11-digit National Drug Code (NDC) for each drug
- Charge for each drug
- Date prescription was filled

Please note: Ask your pharmacist to provide you with a printout showing all of the needed information. If you send us a claim, use CLFMP Claim Form, VA Form 10-10068a. If you send us a claim and you have OHI, your copayment, cost share or coinsurance amount must be included on your receipt

Where to File Claims

U.S. Department of Veterans Affairs
 Financial Services Center
 PO Box 149200
 Austin, TX 78714-9200

VA's Explanation of Benefits (EOB)

After a claim has been filed for your hospital care and medical services, you will receive an EOB from us in the mail. The EOB lists the details of the services you received and the amount you may be billed by your provider. If you paid for the service and submitted a claim for reimbursement, the EOB will tell you how we calculated our payment. The EOB contains the following information:

- Amount billed by the provider
- Amount allowed by the CLFMP
- Amount not covered (**Please note:** You will **not** be responsible for paying this amount.)
- CLFMP payment(s)
- Date(s) of service
- Description of service
- Provider name
- Remarks
- Amount paid by other health insurance plan or program

When a provider files a claim, the EOB is sent to both you and the provider. When you file a claim, the EOB is sent only to you.

Claim Filing Deadlines

VA cannot pay for hospital care or medical services received by family members prior to March 26, 2013, when VA received CLFMP appropriations from Congress.

Because the CLFMP is a new program and a number of claims may be for care of a covered medical condition received prior to the date of application, VA has two separate standards for filing timely claims:

- If you are a family member with Camp Lejeune residency from 1957-1987 and are requesting reimbursement for treatment received up to two years prior to the date on your award letter, you must file these medical claims within 60 days from the date on that letter to satisfy the timely claims filing criteria. If you are a family member with Camp Lejeune residency from **August 1, 1953 – December 31, 1956**, VA may only provide claims reimbursement for covered treatment received on or after December 16, 2014, if the claim(s) is filed within 60 days from the date on your award letter. Please note that by law, VA may not reimburse for Camp Lejeune related care prior to March 26, 2013, the date when Congress provided funding to CLFMP.
- **Care provided after applying to the CLFMP:** If the claim is for hospital care and medical services that are provided after we have approved your CLFMP application, then the claim must be filed within two years after the date of discharge from hospital care or the date that the medical services were rendered.

If you are submitting a claim for hospital care or medical services received in the past, these claims must be submitted within 60 days of the "Effective Date" on your ID card.

If you have been denied either a claim for CLFMP eligibility or a claim for CLFMP benefits, and that denial was overturned because you submitted additional information in support of the claim, a retroactive authorization will be made. You have 60 days to file a medical claim for care that was provided more than two years prior to the date the denial was overturned but not prior to March 26, 2013.

OMB Number 2900-0822
Burden Hours: 15 minutes
OMB EXP Date: 07/31/2018



Department of Veterans Affairs

Camp Lejeune Family Member Program Claim Form

Attention: After reviewing the following information, complete the form in its entirety (print or type only), and return with the itemized billing statements to the Department of Veterans Affairs, Financial Services Center, PO Box 149200, Austin TX, 78714-9200. Customer Service Center: 1-866-372-1144, Fax: 512-460-5536.

Claim form usage: This form is to be completed by the patient, sponsor, or guardian and is mandatory for all beneficiary claims. This claim form is NOT to be used for provider submitted claims.

Other health insurance (OHI): If OHI exists, attach OHI's Explanation of Benefits (EOB) to the provider's itemized billing statement(s). Dates of service and provider charges on EOB must match billing statements.

Timely filing requirement: Claims must be received no later than two years after the date of service or, in the case of inpatient care, within two years of the discharge date.

Itemized billing statements: An itemized statement must be attached and contain:

- patient name, date of birth, and Member Number (same as patient's Social Security number);
- provider name, degree, tax identification number (TIN), address and telephone number; and
- service dates, itemized charges and appropriate procedure/diagnosis codes for each service (i.e. CPT-4, HCPCS, and ICD-9-CM codes), including narrative descriptions. Pharmacy claims are to include name, quantity, strength, and NDC of each drug.

Section I - Patient Information

Last Name		First Name		MI	Social Security Number	
Street Address				<input type="checkbox"/> Check if New		Date of Birth (mm/dd/yyyy)
City	State	Zip Code	Telephone Number (include area code)			

Section II - Other Health Insurance (OHI) Information

By law, other coverage must be reported. If more space is needed, please continue in the same format on a separate sheet.

• Was treatment for a work-related injury or condition? <input type="checkbox"/> Yes <input type="checkbox"/> No • Was treatment for an injury or accident outside of work? <input type="checkbox"/> Yes <input type="checkbox"/> No • Are you covered by other primary health insurance to include coverage through a family member (supplemental or secondary insurance excluded)? <input type="checkbox"/> Yes (check type below and provide coverage information on the right) <input type="checkbox"/> employer sponsored (group) <input type="checkbox"/> private (non group) <input type="checkbox"/> Medicare (Part A or B) <input type="checkbox"/> other (specify) <input type="checkbox"/> no (proceed to Section III)	Name of Other Health Insurance (OHI)	
	OHI Policy Number	OHI Telephone Number (include area code)
	Name of Other Health Insurance (OHI)	
	OHI Policy Number	OHI Telephone Number (include area code)

Section III - Veteran Information

Last Name		First Name		MI	Social Security Number	
-----------	--	------------	--	----	------------------------	--

Section IV - Claimant Certification

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious, or fraudulent statements or claims.

I certify that the above information and attachments are correct and represent actual services, dates, and fees charged. (Sign and date on right.) If certification is signed by a person other than the patient, complete the information the signature and date.	Signature (type if electronic)		Date
	Last Name		MI
Street Address			
City	State	ZIP Code	Telephone Number (include area code)

Section 7: Reconsideration And Appeals Requests

You may ask for an informal reconsideration or a formal appeal for denials of:

- CLFMP eligibility determinations
- Benefit coverage (service/supply) decisions which are not specifically excluded by Camp Lejeune regulation or program policy
- Timely filing of an untimely filed claim or an untimely request for reconsideration

For a reconsideration or appeal to be considered, you must submit the request in writing within one year of the date VA's EOB was sent to you (in the case of a denial of a service or benefit) or one year from the date of the initial letter notifying you of a denial of eligibility to us at:

U.S. Department of Veterans Affairs
Financial Services Center
CLFMP Appeals
PO Box 149200
Austin, TX 78714-9200

- Identify why you believe the original decision is in error,
- Include a copy of VA's EOB or determination letter, and
- Submit any new and relevant information not previously considered.

You have the right to ask us to reconsider an initial denial determination within one year of date of the denial letter by submitting a written statement requesting "reconsideration" of our initial decision, explaining the reason for the disagreement, and providing any new or relevant information. If the reason for the reconsideration request is not identified, the request will be returned to you with no further action. If this initial denial determination is not overturned, a second denial letter will be sent along with your additional appeal rights. This informal process is generally much faster than the formal VA appeals process identified below, which can be extensive.

Please note that if you wish to forego the reconsideration process outlined above, you may send your formal appeal to us to submit it to the Board of Veterans' Appeals (BVA) on your behalf. Please note that if the appeal information is not complete or if supporting information is not provided, BVA may return the appeal to you without further consideration. To file a formal appeal, it needs to be within one year of the date of the initial denial letter by filing a "Notice of Disagreement." A Notice of Disagreement is a letter from you stating you disagree with our decision. If you appeal to the BVA, a "Statement of the Case" outlining the facts, applicable law, and reason for our decision will be provided to you, along with the appropriate forms required of the BVA. We will also enclose VA Form 4107VHA, Your Rights to Appeal Our Decision that outlines this process in further detail.

If you wish to file an informal reconsideration request or a formal Appeal/Notice of Disagreement, please send it to the address at the top of the denial letter.

Please note: If the reason for the request is not identified, it will be returned to you with no further action.

We will not consider reconsideration requests or appeals regarding:

- Medical providers sanctioned or excluded by the Department of Health and Human Services (HHS) or the Office of Inspector General (OIG).
- Providers that may be sanctioned for failure to maintain proper medical credentials, fraud and abuse, default on public loans or various other reasons. Only the sanctioned provider or appointed representatives can appeal this decision, and that appeal must go to HHS-OIG.
- Benefits that are specifically excluded by Federal regulation.

Requests that relate to the following situations will not receive a formal review, but will be reprocessed when the missing information is received or when you notify us the bill has been resubmitted with a correction.

- Claim denials for missing code information: Current Procedural Terminology , Health care Common Procedure Coding System, International Classification of Diseases, and National Drug Code .
- Decisions on claims where we are requesting more information before an action is taken on your claim. Examples of this may include claim denials requesting medical documentation, operative reports, treatment plans, or a certificate of medical necessity.
- Claim denials requesting an EOB from an OHI.
- Billing errors (e.g., incorrect date of service, incomplete or missing procedure codes and/or billed charges) where a corrected bill is submitted to modify the original claim.

**YOUR RIGHTS TO APPEAL OUR DECISION**

After careful and compassionate consideration, a decision has been reached on your claim. If we were not able to grant some or all of the VA benefits you asked for, this form will explain what you can do if you disagree with our decision. If you do not agree with our decision, you may:

- Start an appeal by telling us you disagree with our decision.
- Give us evidence we do not already have that may lead us to change our decision.

This form will tell you how to appeal and how to send us more evidence. You can do either one or both of these things.

HOW CAN I APPEAL THE DECISION?

How do I start my appeal? To begin your appeal, write us a letter telling us you disagree with our decision. This letter is called your "Notice of Disagreement." If we denied more than one claim for a benefit, please tell us in your letter which claims you are appealing. *Send your Notice of Disagreement to the address included on our decision notice letter.*

How long do I have to start my appeal? **You have one year to start an appeal of our decision.** *Your* letter saying that you disagree with our decision must be postmarked (or received by us) within one year from the date of *our* letter denying you the benefit. In most cases, you cannot appeal a decision after this one-year period has ended.

What happens if I do not start my appeal on time? If you do not start your appeal on time, our decision will become final. Once our decision is final, you cannot get the VA benefit we denied unless you either:

- Show that we were clearly wrong to deny the benefit **or**
- Send us new evidence that relates to the reason we denied your claim.

What happens after VA receives my Notice of Disagreement? We will either grant your claim or send you a Statement of the Case. A Statement of the Case describes the facts, laws, regulations, and reasons that we used to make our decision. We will also send you a VA Form 9, "Appeal to Board of Veterans' Appeals," with the Statement of the Case. If you want to continue your appeal to the Board of Veterans' Appeals (the Board) after receiving a Statement of the Case, you must complete and return the VA Form 9 within one year from the date of our letter denying you the benefit **or** within 60 days from the date that we mailed the Statement of the Case to you, *whichever is later*. If you decide to complete an appeal by filing a VA Form 9, you have the option to request a Board hearing. Hearings often increase wait time for a Board decision. It is not necessary for you to have a hearing for the Board to decide your appeal. It is your choice.

Where can I find out more about the VA appeals process?

- You can find a "plain language" pamphlet called "How Do I Appeal," on the Internet at: http://www.bva.va.gov/How_Do_I_Appeal.asp.
- You can find the formal rules for the VA appeals process in title 38, Code of Federal Regulations, Part 20. You can find the complete Code of Federal Regulations on the Internet at: <http://www.ecfr.gov>. A printed copy of the Code of Federal Regulations may be available at your local law library.

YOUR RIGHT TO REPRESENTATION

Can I get someone to help me with my appeal? Yes. You can have a Veterans Service Organization representative, an attorney-at-law, or an "agent" help you with your appeal. You are not required to have someone represent you. It is your choice.

- Representatives who work for accredited Veterans Service Organizations know how to prepare and present claims and will represent you. You can find a listing of these organizations on the Internet at <http://www.va.gov/vso>.

- A private attorney or an "agent" can also represent you. VA only recognizes attorneys who are licensed to practice in the United States or in one of its territories or possessions. Your local bar association may be able to refer you to an attorney with experience in veterans' law. An agent is a person who is not a lawyer, but who VA recognizes as being knowledgeable about veterans' law. Contact us if you would like to know if there is a VA accredited agent in your area.

Do I have to pay someone to help me with my appeal? It depends on who helps you. The following explains the differences.

- Veterans Service Organizations will represent you for free.
- Attorneys or agents can charge you for helping you under some circumstances. Paying their fees for helping you with your appeal is your responsibility. If you do hire an attorney or agent to represent you, one of you must send a copy of any fee agreement to the following address within 30 days from the date the agreement is executed: Office of the General Counsel (022D), 810 Vermont Avenue, NW, Washington, DC 20420. *See* 38 C.F.R. 14.636(g). If the fee agreement provides for the direct payment of fees out of past-due benefits, a copy of the agreement must also be filed with us at the address included on our decision notice letter. *See* 38 C.F.R. 14.636(h)(4).

GIVING VA ADDITIONAL EVIDENCE

You can send us more evidence to support a claim whether or not you choose to appeal

NOTE: Please direct all new evidence to the address included on our decision notice letter. You should not send evidence directly to the Board at this time. You should only send evidence to the Board if you decide to complete an appeal and, then, you should only send evidence to the Board after you receive written notice from the Board that they received your appeal.

If you have more evidence to support a claim, it is in your best interest to give us that evidence as soon as you can. We will consider your evidence and let you know whether it changes our decision. Please keep in mind that we can only consider new evidence that: (1) we have not already seen and (2) relates to your claim. You may give us this evidence either in writing or at a personal hearing with your local VA office.

In writing. To support your claim, you may send documents and written statements to us at the address included on our decision notice letter. Tell us in a letter how these documents and statements should change our earlier decision.

At a personal hearing. You may request a hearing with an employee at your local VA office at any time, whether or not you choose to appeal. We do not require you to have a local hearing. It is your choice. At this hearing, you may speak, bring witnesses to speak on your behalf, and hand us written evidence. If you want a local hearing, send us a letter asking for a local hearing. Use the address included on our decision notice letter. We will then:

- Arrange a time and place for the hearing
- Provide a room for the hearing
- Assign someone to hear your evidence
- Make a written record of the hearing

WHAT HAPPENS AFTER I GIVE VA EVIDENCE?

We will review any new evidence, including the record of the local hearing, if you choose to have one, together with the evidence we already have. We will then decide if we can grant your claim. If we cannot grant your claim and you complete an appeal, we will send the new evidence and the record of any local hearing to the Board.

Section 8: Help Fight Fraud

Combating fraud and abuse takes a cooperative effort. Please help us by reviewing your EOB to be sure that the services billed were reported properly. If you see a service or supply billed to us that you did not receive, please report it immediately in writing to the address in this user guide. Indicate in your letter that you are filing a potential fraud complaint and document the following facts:

- The name and address of the provider
- The name of the beneficiary who was listed as receiving the service or item
- The claim number
- The date of the service in question
- The service or item that you do not believe was provided
- The reason why you believe the claim should not have been paid and any additional information or facts showing that the claim should not have been paid.

Detection Tips

You should be suspicious of practices that involve:

- Providers billing for services that you did not receive.
- Providers billing for services or supplies that are different from what you received.

Whom do I contact if I suspect fraud, waste, or abuse?

VA Chief Business Office Purchased Care
ATTN: Program Integrity
PO Box 469060
Denver CO 80246-9060

Prevention Tips

- Always protect your CLFMP ID Card. Know to whom you are giving your CLFMP member number. Do not provide your member number to someone over the phone *if they contact you via telephone*.
- Be skeptical of providers who tell you that a particular item or service is not usually covered by us, but they know how to bill for the item or service to get it paid.

Section 9: Notice Of Privacy Practices

The VA Notice of Privacy Practices briefly describes:

- How your health information may be used and disclosed
- Your rights regarding your health information and
- Our legal duty to protect the privacy of your health information

What Does Your Health Information Include?

Any information we create or receive about you and your past, present, or future:

- Physical or mental health condition
- Health care
- Payment for medical services

How We May Use and Disclose Your Health Information

In most cases, your written authorization is needed for us to use or disclose your health information. The following reasons are examples where federal law may allow us to use and disclose your health information without your permission:

- Treatment
- Public Health
- Abuse Reporting
- Payment
- Judicial or Administrative Proceedings
- Services
- When Required by Law
- Health care Operations
- Health or Safety Activities
- Family Members or Others Involved in Your Care
- Health care Oversight
- Correctional Facilities
- Workers' Compensation
- Eligibility and Enrollment for VA Benefits

Department of Veterans Affairs Summary Notice

All other uses and disclosures of your health information will not be made without your prior written authorization.

Your Privacy Rights

- Review your health information
- Obtain a copy of your health information
- Request that your health information be amended or corrected

- Request that we provide your health information to you in an alternative way or at an alternative location in a confidential manner
- An accounting or list of disclosures of your health information
- Receive our *VA Notice of Privacy Practices* upon request.

Changes

We reserve the right to change the *VA Notice of Privacy Practices*. In the event that happens, the revised privacy practices will apply to all of your health information we already have, as well as to the information we receive in the future. We will send a copy of the revised notice to your last address of record within 60 days of any change.

Complaints

If you are concerned that your privacy rights have been violated, you can file a complaint to VA or to the secretary of the U.S. Department of Health and Human Services. To file a complaint with VA you may contact a Veterans Health Administration (VHA) privacy officer via “Contact the VA” at www.va.gov. Complaints do not have to be in writing, although it is recommended. You will not be penalized or retaliated against for filing a complaint.

Requesting Or Releasing Information From Your Record

How do I get a copy of my record?

Use **VA Form 10-5345a**, *Individual’s Request for a Copy of Their Own Health Information* (available by phone or on the Web), to request that a copy of your record or a copy of a document in your record to be sent to you.

Use **VA Form 10-5345**, *Request for and Authorization to Release Medical Records or Health Information*, if you want us to send a copy of your record or a copy of a specific document in your record to a person or entity other than yourself. For example, this form is used if you want your information to go to a legal office.

How do I let the CLFMP know that I want to allow them to discuss claims and eligibility information from my file with an individual of my choosing?

Use **VA Form 10-5345**, *Request for and Authorization to Release Medical Records or Health Information* and print the words “Recurring Disclosure Authorization” in the *Authorization* block if you want us to discuss your claim and eligibility information with a person who regularly assists you in handling your hospital care and medical services needs such as your spouse, adult child, or friend.

Comments?

If you have suggestions on ways we can improve this user guide, please contact VA at:

1-866-372-1144

Or

U.S. Department of Veterans Affairs
Financial Services Center
PO Box 149200
Austin, TX 78714-9200

OMB Number 2900-0822
 Burden Hours: 30 minutes
 OMB EXP Date: July 31, 2018



Camp Lejeune Family Member Program Information Update Form

Department of Veterans Affairs, Financial Services Center
 PO Box 149200, Austin TX 78714-9200
 Customer Service Center: 1-866-372-1144 FAX: 512-460-5536

Family Member

Last Name	First Name	MI	Social Security Number
Email Address	Is this a change of address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a phone number change? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street Address	City	State	Zip Code
Permanent address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary address? <input type="checkbox"/> Yes <input type="checkbox"/> No from _____ to _____		
Please indicate if you would like to receive correspondence via <input type="checkbox"/> email <input type="checkbox"/> regular mail			
Phone Number (include area code)	Alt Phone Number (include area code)		

Health Care Coverage Update

Is this an update to your previous health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has your previous health care coverage ended? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes , please complete the following. If No , Please continue with next section.
Name of prior health care coverage: _____
Effective Date (MMDDYYYY) _____
End Date (MMDDYYYY) _____
Other health care coverage: _____
Effective Date (MMDDYYYY) _____
End Date (MMDDYYYY) _____

Do you have health care coverage? Yes, please complete the following No, continue with next section
Note: This includes coverage you may have through an employer, spouse, significant other or federal/state health care benefit plan.

Please complete the following (check all that apply and provide the effective date(s).)

- Medicare Part A Effective Date (MMDDYYYY) _____
- Medicare Part B Effective Date (MMDDYYYY) _____
- Medicare Advantage Effective Date (MMDDYYYY) _____
- Medicare Part D Effective Date (MMDDYYYY) _____
- Medicaid/State Assistance Effective Date (MMDDYYYY) _____
- TRICARE Effective Date (MMDDYYYY) _____
- CHAMPVA Effective Date (MMDDYYYY) _____

Please complete the following if you have other health care coverage not identified above.

Name of Primary Insurance: _____	Effective Date (MMDDYYYY) _____	___ HMO ___ PPO
Name of Secondary Insurance: _____	Effective Date (MMDDYYYY) _____	___ HMO ___ PPO
Does your health care coverage provide Pharmacy benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>		

Certification

I give permission for my personal information to be used by appropriate Federal Government agencies and Federal Government contractors.

By my signature I attest that I have answered the questions truthfully and that I understand the following: Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to gain enrollment in the Camp Lejeune Family Member Program to which that person is not entitled is subject to civil and/or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I certify that the above information is correct and true to the best of my knowledge and belief. (Sign and date on below.)

Signature	Date
-----------	------

If certification is signed by a person other than an applicant, complete the following:

Last Name	First Name
-----------	------------

Mailing Address

City	State	Zip Code	Telephone Number (include area code)
------	-------	----------	--------------------------------------

This form may be faxed to 512-460-5536 or mailed to:

Department of Veterans Affairs

Financial Services Center

PO Box 149200

Austin, TX 78714-9200

NOTE: This form is to be used for updating your address, phone and/or health care coverage.

Directions for Camp Lejeune Family Member, representative or POA: please complete all fields that require updating.

The Paperwork Reduction Act: This information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. The purpose of this data collection is to determine eligibility for benefits.

Privacy Act Information: The authority for collection of the requested information on this form is 38 USC 1787. The purpose of collecting this information is to determine your eligibility for reimbursement of health care related to conditions determined to result from contaminated water while you resided at Camp Lejeune, North Carolina, for a period of at least 30 days. The information you provide may be verified by computer matching programs with authoritative sources such as the Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA), Department of Defense (DoD), Defense Enrollment Eligibility Reporting System (DEERS), Centers for Medicare & Medicaid Services (CMS) or any other applicable authoritative source at any time. You are requested to provide your social security number as your VA record is filed and retrieved by this number. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, it may delay or result in denial of your request for Camp Lejeune Family Member Program benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled. The responses you submit are considered private and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records number 23VA16. For example, information including your social security number may be disclosed to the Department of Defense, contractors, trading partners, health care providers and other suppliers of health care services to determine your eligibility for medical benefits and payment for services

