THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS

SEGMENT REPORTED *(X one)*
- ☐ INPATIENT
- ☐ OUTPATIENT

1. QUARTER ENDING *(YYYYMM)*	2. REPORTING MEDICAL TREATMENT FACILITY (MTF)	3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NO.

PART I

4. REPORTING PERIOD *(See Note 1)*

FISCAL YEAR (FY) (1)	NO. OF NON-ACTIVE DUTY INPATIENT DISPOSITIONS/VISITS (2)	NO. OF CLAIMS (3)	NO. OF COLLECTIONS (4)	NO. CLAIMS DIVIDED BY DISPOSITIONS/ VISITS (%) (5)	TOTAL $ AMOUNT BILLED/CHARGES (6)
a. CURRENT FY					
PRIOR YEAR (PY) b. PY 1					
c. PY 2					

	$ ADJUSTMENTS AND REFUNDS *(See Note 2)* (7)	$ AMOUNT COLLECTED PY 2 (8)	$ AMOUNT COLLECTED PY 1 (9)	$ AMOUNT COLLECTED CURRENT FY (10)	$ AMOUNT REMAINING UNCOLLECTED *(See Note 3)* *(6)-[(7)+(8)+(9)+(10)]* (11)
a. CURRENT FY					
b. PY 1					
c. PY 2					

PART II

REASON CODES	5. DISTRIBUTION OF REMAINING UNCOLLECTED AMOUNTS	6. UNCOLLECTED AMOUNTS SUBDIVIDED BY FY ($) *(See Notes 1 and 4)* a. FY	b. FY	c. FY
1	OPEN CLAIMS *(Requires additional follow-up action by Medical Treatment Facility for resolution)*			
2	TRANSFERRED TO EXTERNAL AGENT *(e.g., JAG) (Excluding Third Party Liability Cases)*			
	REASON CODES 3-7. THIRD PARTY REDUCED / DENIED PAYMENT FOR INVALID REASONS *(Requires additional debt collection/legal action)*			
3	MTF NOT A PARTICIPATING HOSPITAL			
4	PLAN EXCLUDES MILITARY HOSPITALS OR BENEFICIARIES			
5	PATIENT HAD NO OBLIGATION TO PAY			
6	INSURER PAID PATIENT DIRECTLY			
7	OTHER *(Explain)*			
	TOTAL OF ALL OPEN CLAIMS *(Reason Codes 1 through 7)*			
	REASON CODES 8-16. CLOSED CLAIMS. THIRD PARTY PAID IN FULL OR REDUCED/DENIED PAYMENTS *(No further action required because unpaid amount is not a valid claim)*			
8	AMOUNT OF COVERAGE *(i.e. plan pays less than 100%)*			
9	PATIENT NOT COVERED, CARE PROVIDED NOT COVERED, OR POLICY EXPIRED			
10	CHAMPUS AND/OR INCOME SUPPLEMENTAL PLANS			
11	MEDICARE SUPPLEMENTAL PLANS			
12	HEALTH MAINTENANCE ORGANIZATION (HMO) *(i.e. nonemergency out-of-plan care not covered)*			
13	MTF DID NOT COMPLY WITH UTILIZATION REVIEW PROCEDURES *(i.e. pre-admission screening, concurrent review, second surgical opinions, etc.)*			
14	REFUNDS			
15	PATIENT COPAYS AND DEDUCTIBLES			
16	OTHER *(Explain) (Example - third party provided lower prevailing rate vs. amount billed)*			
	TOTAL OF ALL CLOSED CLAIMS *(Reason Codes 8 through 16)*			

NOTES:

1. All activity for amounts claimed and collected shall be reported in the fiscal year that the services were rendered (i.e. care provided in FY 1989 will be reported as an FY 1989 claim and collection, regardless of the year payment is received). This requires cut-off billing for all inpatients at fiscal year end.
2. Amounts reported in Part I, Column (7) for each fiscal year shall equal the subtotal for Reason Codes 8-16 in Part II, for the respective fiscal years.
3. Amounts reported in Part I, Column (11) for each fiscal year shall equal the subtotal for Reason Codes 1-7 in Part II, for the respective fiscal years.
4. Each quarterly report shall be cumulative for the current and two prior fiscal years.

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