

# Humana Military Healthcare Services Electronic Media Claims (EMC) Questionnaire

Provider Name: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Provider number with which you bill your TRICARE claims: \_\_\_\_\_

Estimated <u>monthly TRICARE</u> claims volume:	Professional (HCFA 1500)	<input type="text"/>
	Institutional (UB92)	<input type="text"/>
	Drug	<input type="text"/>

1. Have you ever filed your TRICARE claims electronically?  YES  NO

2. Has anyone ever contacted you about sending your TRICARE claims electronically?  YES  NO

If yes, who? \_\_\_\_\_

3. Are you filing any other types of claims electronically?  YES  NO

If yes, please list the payers, clearinghouse, or billing services to which you are filing electronically (i.e. Medicare, specific BCBS plans, NEIC, etc.) \_\_\_\_\_

4. Do you have a computer?  YES  NO Do you have a modem?  YES  NO

5. Do you have access to the Internet?  YES  NO

6. Do you have a practice management system?  YES  NO

If yes, Vendor Name: \_\_\_\_\_ Vendor Phone #: \_\_\_\_\_ Software Name: \_\_\_\_\_

7. Can your system produce a file of claims in any of the following formats?

- HCFA 1500 or UB92 print file  YES  NO  DON'T KNOW
- National Standard Format (NSF)  YES  NO  DON'T KNOW
- ANSI 837  YES  NO  DON'T KNOW

8. If you are not currently submitting any claims electronically, do you know if your system has electronic claim capabilities?  YES  NO  DON'T KNOW

9. Are you interested in being able to submit your TRICARE Claims electronically?  YES  NO

10. Would you like for someone to call you to explain the options?  YES  NO

11. If not interested, what is the reason? \_\_\_\_\_

Please mail or fax completed questionnaire to:

Humana Military Healthcare Services  
Attention: EMC Dept. – 20<sup>th</sup> Floor  
P.O. Box 740062  
Louisville, KY 40201-7462  
Fax: (502) 580-2525

