

TRICARE West Region
PO Box 202106
Florence SC 29502-2106
Fax: 844-730-1373



Request for Reimbursement of TRICARE Hospice Cap Amount
Period Ended – October 31, 2023

Hospice Provider Name: _____

Tax Identification Number: _____

_____ Number of TRICARE beneficiaries electing hospice care during the period
9/28/22 – 9/27/23.

_____ Dollar amount of total payments received and receivable for services furnished to
TRICARE beneficiaries during the cap period from 11/01/22 through 10/31/23, including
employed physician's services not of an administrative and/or general supervisory nature.

_____ Total reimbursement received and receivable for general and respite inpatient care
furnished to TRICARE beneficiaries for the period from 11/01/22 through 10/31/23.

_____ Aggregate number of TRICARE inpatient days for both general and respite inpatient
care for the period from 11/01/22 through 10/31/23.

_____ Aggregate number of TRICARE routine days for the period from 11/01/22
through 10/31/23.

_____ Aggregate number of TRICARE continuous home care hours for the period
11/01/22 through 10/31/23.

_____ Aggregate total number of days of hospice care provided to all TRICARE beneficiaries
for the period from 11/01/22 through 10/31/23.

Signature

Date

Title