



US FAMILY  
HEALTH PLAN  
A TRICARE Prime® Option

# PROVIDER

2026 PROVIDER SERVICES

# MANUAL





## US FAMILY HEALTH PLAN MANUAL DISCLAIMER

This manual and the policies and procedures contained herein do not constitute a contract and cannot be considered or relied upon as such. Further, the policies and procedures set forth herein may be altered, amended, or discontinued by US Family Health Plan at any time upon notice to the provider. The most current version of the Provider Manual is located on the Plan's website at [www.usfhp.net](http://www.usfhp.net). All terms and statements used in this manual will have the meaning ascribed to them by the US Family Health Plan and shall be interpreted by US Family Health Plan in its sole discretion.

*TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved.  
HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*

# TABLE OF CONTENTS

---

<b>I. Introduction &amp; Corporate Governance</b> .....	<b>6</b>
• <b>1.1 Plan Overview:</b> Mission, History, and the TRICARE Prime Model	
• <b>1.2 Service Area:</b> Catchment Areas (NY, NJ, PA, CT)	
• <b>1.3 The PCP Model:</b> Roles in Medical Coordination	
• <b>1.4 Manual Authority:</b> Contractual Integration and Annual Updates	
<b>II. Membership &amp; Eligibility Standards</b> .....	<b>7</b>
• <b>2.1 Beneficiary Criteria:</b> Active Duty, Retirees, and Survivors	
• <b>2.2 Age 65 Transitions:</b> Grandfathered Status vs. TRICARE for Life (TFL)	
• <b>2.3 ECHO Program:</b> Extended Care Health Option Eligibility & DEERS	
• <b>2.4 Eligibility Verification:</b> Online Portal and Member Services Protocols	
<b>III. Provider Network Operations</b> .....	<b>8</b>
• <b>3.1 Access &amp; Availability:</b> Appointment Wait-Time and Drive-Time Standards	
• <b>3.2 Credentialing &amp; Re-credentialing:</b> Application Criteria and CRC Review	
• <b>3.3 Provider Demographic Maintenance:</b> 30-Day Notification Requirements	
• <b>3.4 Dispute Resolution:</b> CRC Adverse Actions and Administrative Appeals	

*continued on next page*

<b>IV. Benefits &amp; Preferred Vendor Partners .....</b>	<b>10</b>
<ul style="list-style-type: none"> <li>• <b>4.1 Comprehensive Benefits:</b> Preventive, Inpatient, and Emergency Coverage</li> <li>• <b>4.2 Pharmacy (VytlOne):</b> 90-Day Maintenance Mail-Order Requirements</li> <li>• <b>4.3 Laboratory Services:</b> Preferred Network (BioReference, LabCorp, Quest)</li> <li>• <b>4.4 Durable Medical Equipment:</b> AdaptHealth Partnership and Authorizations</li> </ul>	
<b>V. Clinical Management &amp; Utilization (UM) .....</b>	<b>12</b>
<ul style="list-style-type: none"> <li>• <b>5.1 Prior Authorization:</b> Services Requiring Review and iExchange Submission</li> <li>• <b>5.2 Referral Guidelines:</b> PCP Coordination and Specialty Consultation Reports</li> <li>• <b>5.3 Mental Health:</b> In-House Management, ABA, and Transition of Care (PTOC)</li> <li>• <b>5.4 Nurse Advice Line:</b> 24/7 Clinical Triage and After-Hours Coverage</li> </ul>	
<b>VI. Population Health &amp; Care Management .....</b>	<b>14</b>
<ul style="list-style-type: none"> <li>• <b>5.1 Program Goals:</b> Whole-Person Care and Wellness Initiatives</li> <li>• <b>5.2 Risk Assessments:</b> Social Determinants of Health (SDOH) and HRA</li> <li>• <b>5.3 Evidence-Based Practice:</b> VA/DOD Clinical Practice Guidelines</li> <li>• <b>5.4 Care Management:</b> Nurse and Social Work Coordination for Complex and Chronic Illness</li> </ul>	

*continued on next page*

**VII. Claims, Billing & Reimbursement ..... 15**

- **7.1 Submission Guidelines:**  
CMS-1500/UB-04 Standards and Electronic Filing
- **7.2 Timely Filing Limits:**  
In-Network vs. Out-of-Network Requirements
- **7.3 Coordination of Benefits (COB):**  
OHI Processing and Medicare/ESRD Status
- **7.4 Corrected Claims:**  
90-Day Resubmission Windows and Coding Rules
- **7.5 EFT/ERA Registration:**  
Mandatory Electronic Fund Transfer Enrollment

**VIII. Quality Management & HEDIS ..... 16**

- **8.1 Quality Oversight**
- **8.2 Medical Record Standards:**  
Legibility, SOAP Format, and HIPAA Compliance
- **8.3 HEDIS Measurement:**  
Data Collection Methods and Provider Responsibilities
- **8.4 External Ratings:**  
CMS Care Compare and Leapfrog Hospital Monitoring

**IX. Grievances & Medical Necessity Appeals ..... 17**

- **9.1 Grievance Process:**  
Non-Claim Related Written Complaints and Resolution Timelines
- **9.2 Denied Claim Appeals:**  
90-Day Filing and Submission Addresses
- **9.3 Clinical Appeals:**  
Peer-to-Peer Reviews and Expedited Requests

**X. Privacy, Confidentiality, and Compliance ..... 18**

- **10.1 Protected Health Information: PHI**
- **10.2 Regulatory Compliance:**  
Mandated laws regarding healthcare delivery

**XI. Directory of Resources ..... 19**

- **11.1 Key Contact List:**  
Departments, Phone Numbers, and Email Directories
- **11.2 Important Links:**  
Portal Access, Manual Downloads, and Provider Forms



# SECTION I INTRODUCTION

US Family Health Plan (USFHP) at SVCMC, Inc. is a Department of Defense (DOD) Designated Provider of the TRICARE Prime® Health Program. For over 35 years, we have proudly served active-duty family members, military retirees and their families, and members of the National Guard and Reserve.



## The PCP Model:

Members are required to designate a Primary Care Provider (PCP) to serve as the principal coordinator of their care. The PCP oversees all aspects of the member's health needs, collaborating with specialists and facilities within our extensive regional network.

## Manual Authority:

This Provider Manual outlines rules, regulations, rights, and responsibilities. It is updated annually, and all interim updates are incorporated as part of your contract agreement with USFHP. The most current version is always available at [usfhp.net/for-providers](http://usfhp.net/for-providers).

## Contact Information:

- **Provider Network Team:** 800-241-4848
- **Email:** [provnetwork@svcmcnyc.org](mailto:provnetwork@svcmcnyc.org)

## SECTION II

# MEMBERSHIP & ELIGIBILITY



### Eligibility Criteria

To be eligible for USFHP, beneficiaries must meet one of the following:

- **Active-duty family members:** Spouses or unmarried dependents (until age 21, or 23 if a full-time student).
- **Military retirees & dependents:** (Until age 21, or 23 if a full-time student).
- **Survivors:** Family members of deceased active-duty members or retirees.

### Retiree Age 65 Rules

- **Grandfathered:** Enrolled on/before 9/30/2012 may stay after age 65 if enrollment is continuous.
- **Standard:** Enrolled on/after 10/1/2012 are automatically disenrolled at age 65 and moved to TRICARE for Life (TFL).

### Extended Care Health Option (ECHO)

ECHO is a supplemental benefit for members with special needs (moderate/severe intellectual disability, serious physical disability, or extraordinary psychological conditions).

- **Requirements:** Members must be entered in DEERS, enrolled in the **Exceptional Family Member Program (EFMP)** through their sponsor's service branch, and registered with a regional TRICARE contractor.
- **Prior Authorization:** All ECHO services require prior authorization.

### Eligibility Verification

- **ID Cards:** Members must present their USFHP ID card; however, the card does not guarantee coverage.
- **Verification Channels:** Providers **must** verify eligibility via the Online Provider Portal or by calling **Member Services at 800-241-4848**.
- **Liability:** Services rendered during a lapse in coverage are the financial responsibility of the patient.

## SECTION III

# PROVIDER OPERATIONS & GOVERNANCE



### Provider Rights and Responsibilities

- **No Gag Clauses:** You are free to discuss all treatment options with members.
- **Balance Billing:** Strictly prohibited for covered services. You may only bill the member if they signed a written agreement **in advance** for a non-covered service.
- **Non-Discrimination:** You must treat USFHP members with the same priority and quality as all other patients.

### Provider Credentialing

Providers and facilities are credentialed prior to participation and re-credentialed at least every **three (3) years**.

- **Practitioner Criteria:** Must be a TRICARE Authorized Provider with no federal sanctions, a current license, DEA/CDS certificate (if applicable), and professional liability insurance (\$1M/\$3M minimum).
- **Facility Criteria:** Includes state licensure, accreditation (for hospitals, ASCs, RTCs, etc.), and Medicare participation. Must be a TRICARE Authorized Provider; a current state license, registration or operating certificate, accreditation (hospitals, ASCs, RTC, etc.) and professional liability insurance.
- **Contact:** [credentialing@svcmcnny.org](mailto:credentialing@svcmcnny.org) or [ProvNetwork@svcmcnny.org](mailto:ProvNetwork@svcmcnny.org).

### Contractual Requirements

By joining the network, providers agree to:

- Provide primary care coverage **24/7**.
- **Hold Members Harmless:** No balance billing for covered services.
- **Medical Records:** Provide copies within 30 days for quality/UM monitoring.
- **Medicare Participation:** Must remain a Medicare participating provider.
- **Notifications:** Disclose any reduction or termination of privileges within **10 days**.

## Access & Availability Standards

Appointments must meet the following TRICARE standards:

<i>Emergency Care</i>	<i>Immediate</i>
Urgent/Acute Care	Appointment within 24 hours
Routine Office Visit	Appointment within 1 week
Well/Preventive Health Visit	Appointment within 4 weeks
Specialty Consultation / Procedure	Appointment within 4 weeks
Office Wait Time	30 Minutes or less

## Demographic Updates

Notify USFHP in writing within **30 calendar days** of changes to address, phone, email, or if you are no longer accepting new patients/panel is closed to new patients. Submit to [provnetwork@svmcny.org](mailto:provnetwork@svmcny.org).

## Dispute Resolution & Appeals

### Provider Dispute Resolution Process

This process handles disputes regarding Credentials Review Committee (CRC) actions or professional competency issues. (applies to in-network providers only)

- **Initial Notification:**  
Sent via secure email/certified mail detailing the reason for adverse action.
- **Timeline:**  
Written appeals must be received within **30 calendar days**.
- **Hearing Rights:**  
Providers may request an in-person or virtual hearing with legal counsel. Provider may submit relevant documentation in support of the dispute. Provider will be given 60 calendar days advanced written notice of the scheduled hearing. A final decision is issued within 60 calendar days of the hearing.

### Administrative Termination Appeals

For removals due to administrative reasons (e.g., low utilization), USFHP provides **90 calendar days notice**.

- **Appeal Window:**  
30 calendar days from the notice date.
- **Final Decision:**  
Written notice within 10 calendar days of the Plan's receipt of the appeal.

## SECTION IV

# BENEFITS & PREFERRED NETWORK VENDORS

---

### COVERED BENEFITS

USFHP provides standard TRICARE Prime benefits, including:

- **Preventive Care:**

- No-cost physicals
- Annual eye exams
- Preventive screenings

- **Core Services:**

- Hospitalization
- Maternity
- DME
- Urgent/Emergency care worldwide

- **Mental Health:**

- Diagnosis and treatment for PTSD
- Depression and anxiety
- Residential and outpatient levels of care

- **Point of Service (POS) Option:**

Members may see non-network TRICARE-authorized providers without authorization for office-based services, but they will incur significantly higher costs:

- **Deductible:** \$300 Individual / \$600 Family
- **Cost-Share:** 50% of the TRICARE allowable charge + up to 15% in provider coverages

- **24 Hour Nurse Advice Line:**

Members have access to 24/7 Clinical triage/and after-hours coverage.





## PREFERRED VENDORS

### Pharmacy Services (VytlOne)

Members are required to use **VytlOne** for maintenance medications.

- **Maintenance Prescriptions:** Must be written for a **90-day supply**
  - **Mail:** 416 South Tyler Street, Amarillo, TX 79101
  - **Fax:** 866-589-7656
  - **Phone:** 866-408-2459
- **Urgent/One-Time Prescriptions:** Members may use participating retail pharmacies for short-term needs (30-day supply or less)
- **Customer Service:** 800-687-0707

### Laboratory Services

To ensure quality and coverage, direct all outpatient referrals to preferred providers:

- **BioReference:** 800-229-5227
- **LabCorp:** 800-788-9091
- **Quest Diagnostics:** 888-277-8772

### Durable Medical Equipment (DME)

**AdaptHealth** is the preferred partner for equipment (oxygen, wheelchairs, diabetes/CGM supplies, etc.).

- **Prior Authorization:** Required for certain DME supplies.
- **Phone:** 844-679-1577 | **Fax:** 877-294-0989

## SECTION V

# CLINICAL MANAGEMENT & UTILIZATION



### Care Management Program

This program is for members with complex or chronic conditions requiring multidisciplinary coordination.

### Utilization Management (UM) & Prior Authorization

The Plan ensures medical necessity through prospective, concurrent, and retrospective reviews.

#### Services Requiring Prior Authorization

- **Inpatient Admissions:** All inpatient admissions (except for emergency admissions)
- **Imaging:** MRI, MRA, CT (with contrast), CTA, PET
- **Post-Acute:** Home Health, Hospice, SNF, DME
- **Mental Health:** ABA, RTC, PHP, IOP, Psychological Testing, ECT, TMS, and Esketamine (Spravato)
- **Procedures:** Specialty procedures and elective surgeries (e.g., laminectomies, cosmetic procedures)

All emergency hospital admissions require notification to the Plan and are subject to UM review. The hospital is responsible for notifying the Plan by telephone within forty-eight (48) hours of emergency admission or by the next business day. An admission will not be approved if the service could have been appropriately provided at a lower level of care (e.g., observation status).

### How to Request Authorization

#### 1. Provider Portal (iExchange): Preferred Method.

Allows 24/7 electronic submission and attachment of medical records.

Email [ProvNetwork@svcmcn.org](mailto:ProvNetwork@svcmcn.org) to set up an account.

#### 2. Fax: Submit the Prior Authorization Form and clinical notes to 866-337-8690.

## Referrals & Network Standards

### In-Network Referral Rules

- **Validity:**  
Referrals are valid for 6 months. The first visit must occur within **60 days**.
- **Documentation:**  
Referrals must be noted in the member's medical record. Do not send copies to the Plan. USFHP referral form can be found on the provider page of our website or a prescription is acceptable. Referrals must be noted in the member's medical record.
- **Specialist Responsibility:**  
If additional treatment is needed, the specialist must coordinate with the PCP for a new referral.
- **Clear Legible Reports (CLR):**  
Specialists must return a consultation report/note to the PCP within **30 days** (24 hours for urgent cases via phone/fax).



### Behavioral Health Care Management

Our Licensed Clinical Social Workers (LCSWs) provide "whole-person" coordination.

- **Referral Rule:**  
Members do not need a referral for routine outpatient visits with participating mental health providers. All other MH services require authorization.
- **Suicide Prevention Program:**  
Enhanced support and safety planning for high-risk members.
- **Social Work Care Management:**  
Assistance with community resources and caregiver support.

### Specialized Clinical Programs

- **Post Transition of Care (PTOC):**  
Provides an in-home, virtual or telephonic nursing visit for members discharged from inpatient psychiatric care to ensure a safe transition home.
- **Applied Behavior Analysis (ABA):**  
Available for members with a definitive Autism Spectrum Disorder (ASD) diagnosis. Approved members are eligible for the ABA Care Management Program for help with provider matching.

# SECTION VI

## POPULATION HEALTH & WELLNESS

### Program Philosophy

Population health focuses on the health outcomes of the entire USFHP community rather than just individuals. Our goal is "whole-person" care, shifting the focus from **sick care** to **wellness and prevention**.

### Monitoring & Risk Assessment

- **Social Determinants of Health (SDOH):** Non-medical factors (housing, economic stability, education) that impact health. We use SDOH assessments to refer members to support services via our Care Management Team.
- **Health Risk Assessments (HRA):** A screening tool used to identify lifestyle risks, emotional health, and the need for preventive screenings.
- **Healthy People 2030:** USFHP aligns with these national science-based goals to eliminate health disparities and promote health equity.

### Clinical Guidelines & Federal Partnerships

- **VA/DOD Guidelines:**  
We endorse the evidence-based clinical practice guidelines developed by the VA and DOD to reduce practice variation and systemic errors.  
[Access Guidelines Here.](#)
- **National Disaster Medical System (NDMS):**  
A partnership for emergency medical response. Providers are encouraged to participate. [Learn More.](#)



# SECTION VII

## CLAIMS & BILLING

### Submission Guidelines

For successful adjudication, claims must be submitted on a **CMS 1500** or **UB04/CMS 1450** form.

- **Accuracy:** Forms must be typed (no handwriting) and include:
  - NPI and TIN
  - Valid codes: **ICD-10**, **CPT**, **HCPCS**, and **Taxonomy**
  - Member and Provider demographics
  - Place of service, unit counts, and applicable modifiers

### Timely Filing Requirements

Provider Status	Standard Claims	OHI/Secondary Claims
<b>In-Network</b>	60 days from Date of Service	60 days from Primary EOP
<b>Out-of-Network</b>	365 days from Date of Service	365 days from Primary EOB
<b>Corrected Claims</b>	90 days from EOP/Denial	90 days from EOP/Denial

**Member Protection:** Members are not financially liable for services denied due to late filing. Providers may not balance bill members for these denials.

### Electronic vs. Paper Filing

Providers must enroll in **Electronic Fund Transfer (EFT)** and encouraged to enroll in **Electronic Remittance Advice (ERA)**.

- **Electronic** (Submit via **Optum (Change Healthcare)** using **Payor ID 13407**).
- **Paper/Other Health Insurance (OHI):**  
All OHI/Secondary claims **must be submitted via paper** with an itemized primary EOB attached. Electronic OHI claims will be denied.

#### Mailing Address for Paper Claims:

US Family Health Plan  
Claims Department  
PO Box 14847  
Lexington, KY 40512

### Coordination of Benefits (COB)

USFHP is the **secondary payor** to all commercial health insurance and the **Federal Employee Health Benefits (FEHB)** Program.

#### USFHP is the Primary Payor except when:

- Patient has **ESRD** (ICD-10 N18.6) and is in the Medicare ESRD Program
- The condition is due to an accident covered by **Workers' Comp** or **No-Fault** auto insurance
- A service is covered by Medicare but **not** TRICARE

### Denied Claim Appeals

If you disagree with a payment determination, you may appeal in writing.

- **Deadline:** Within **90 calendar days** of the initial denial or EOP
- **Response:** Generally issued within **30 calendar days** (maximum 90 calendar days)
- **Mailing Address for Appeals:**  
US Family Health Plan (SVCMC, Inc.)  
Claim Appeal  
530 Seventh Ave (10th Floor)  
New York, NY 10018-4878

## SECTION VIII

# QUALITY MANAGEMENT (QM)/HEDIS



### Program Scope

Guided by 32 CFR Part 199 and TRICARE Policy, our QM program uses **Continuous Quality Improvement (CQI)** to monitor safety and clinical outcomes.

- **Provider Role:** You must participate in investigations, allow site visits, and submit requested medical records within **30 days**.

### Medical Record Standards

Records must be organized, legible, and include:

- **SOAP Note** format (or equivalent)
- Unique patient identifiers (Name, DOB, Gender) on **every page**
- Up-to-date problem lists, medication reconciliation, and allergy documentation
- Signatures from a licensed professional including their **credentials**

### HEDIS (Healthcare Effectiveness Data and Information Set)

HEDIS MY 2026 includes 93 measures across six domains.

- **Data Collection:** Year-round (Administrative) and Jan–May (Hybrid/Medical Records).
- **How Providers Can Help:**
  - Document all anticipatory guidance and screenings
  - Submit accurate ICD-10 and CPT codes (this reduces the need for manual record audits)
  - Code for exclusions (e.g., total hysterectomy) to prevent unnecessary outreach
- Access our HEDIS Guidebook and HEDIS Provider Reference Guide
- **HEDIS Contact:** HEDIS@svcmcn.org

# SECTION IX

## GRIEVANCES AND MEDICAL NECESSITY APPEALS

---

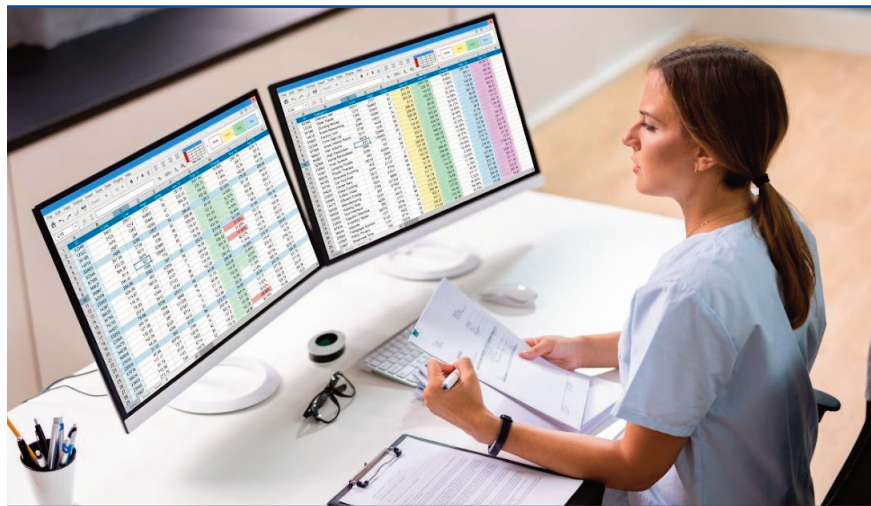
### The Appeals Process

#### 1. Medical Necessity Appeals (Pre-Service/Concurrent)

- **Peer-to-Peer:** If a request is denied, you may request a Peer-to-Peer review at 866-560-9069
- **Proper Appealing Party:** Per TRICARE policy, a network provider is not a proper appealing party unless:
  - Explicitly stated in your provider contract
  - The beneficiary appoints you as their representative in writing (signed by the member)
- **Expedited Appeals:** Must be filed within 3 calendar days of denial for a 72-hour turnaround

#### 2. Claims Appeals (Post-Service)

- **Deadline:**  
Submit in writing within  
**90 calendar days** of the EOP/Denial
- **Response:**  
Written determination within  
**30–90 calendar days**
- **Submission Address:**  
US Family Health Plan  
c/o Toney Healthcare Consulting  
3903 Northdale Blvd., Suite 220-E  
Tampa, FL 33624  
**Fax:** 866-337-8690



### Grievances & Appeals

#### Grievance Process

A grievance is a written complaint regarding non-claim issues, such as the quality of care, office wait times, or dissatisfaction with Plan services.

- **Timeline:**  
USFHP will provide a written response within **60 calendar days**
- **Interim Updates:**  
If a resolution takes longer than 30 calendar days, you will receive an interim letter explaining the delay
- **Submission Channels:**  
**Fax:** 212-356-4949  
**Email:** usfamily@svcmcnyc.org  
(Note: emails containing PHI must be encrypted)

## SECTION X

# PRIVACY, CONFIDENTIALITY & COMPLIANCE



### Protected Health Information (PHI)

All providers must adhere to HIPAA, the Privacy Act, and DOD regulations.

- **Member Rights:** Members have the right to a Notice of Privacy Practices (NPP), the right to inspect/copy records, and the right to request an accounting of disclosures.
- **Minimum Necessary:** Access to PHI must be limited to the minimum information necessary to perform a specific job function.

Under HIPAA, data collection for HEDIS is permitted and health plan requests for medical records do not require additional patient consent or authorization. USFHP is considered a “covered entity” and data used for treatment, payment, and healthcare operations may be disclosed without member consent. HEDIS falls under “healthcare operations.”

<https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>  
See 45 CFR 164.506 (c)(4).

In addition, USFHP utilizes the “minimum necessary rule” by requesting the minimum protected health information (PHI) required to accomplish the purpose.

<https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/minimum-necessary-requirement/index.html>  
See 45 CFR 164.502 (b) and 164.514 (d).

### Regulatory Compliance

Providers must comply with all federal laws regarding healthcare delivery:

- **False Claims Act:** Prohibits submitting false claims to the government for payment
- **Anti-Kickback/Social Security Act:** Prohibits offering bribes or rebates to influence referrals for federally funded services
- **Stark Law (Federal Anti-Referral):** Prohibits providers from referring patients to entities (Lab, PT, DME, etc.) in which they have a financial or ownership interest
- **Whistleblower Protections:** Employees have the right to report illegal conduct without fear of retaliation (Sarbanes-Oxley)

# SECTION XI

## DIRECTORY OF RESOURCES

Department / Service	Contact Method
<b>Member Services (Eligibility, Benefits)</b>	usfamily@svcmcnyc.org
<b>Provider Relations / Contracting</b>	provnetwork@svcmcnyc.org
<b>Credentialing &amp; Provider Maintenance</b>	credentialing@svcmcnyc.org
<b>Claims Inquiry</b>	claimsinquiry@svcmcnyc.org
<b>HEDIS</b>	hedis@svcmcnyc.org
<b>24/7 Nurse Advice Line</b>	800-241-4848
<b>Authorizations &amp; Appeals (Toney Health Care)</b>	866-337-8690 - Fax
<b>Authorization Peer-to-Peer</b>	866-560-9069

### Preferred Vendor Partner Directory

- **Pharmacy (VytlOne):**  
800-687-0707  
vytlone.com
- **DME (AdaptHealth):**  
844-679-1577  
Fax: 877-294-0989  
AdaptHealth
- **BioReference Labs:**  
800-229-5027  
bioreference.com
- **LabCorp:**  
800-788-9091  
labcorp.com
- **Quest Diagnostics:**  
888-277-8772  
questdiagnostics.com

### Online Portals & Quick Links

- **Main Provider Resource Page:**  
[usfhp.net/for-providers/](http://usfhp.net/for-providers/)
- **Provider Portal Guide:**  
Download PDF Guide
- **Prior Authorization Form:**  
Available on the USFHP Website



# *Serving the Families that Serve Ours...*



**US FAMILY  
HEALTH PLAN**  
A TRICARE Prime® Option



530 SEVENTH AVENUE • 10TH FLOOR • NEW YORK, NY 10018-4854

1-800-241-4848 • [www.usfhp.net](http://www.usfhp.net)