

**STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY  
TRICARE MANAGEMENT ACTIVITY**

*Form Approved  
OMB No. 0720-0003  
Expires May 31, 2007*

**IF A PREADDRESSED ENVELOPE IS NOT ENCLOSED WITH THIS FORM, PLEASE RETURN YOUR COMPLETED FORM TO EITHER OF THESE LOCATIONS:**

- (1) THE TRICARE (TMA) PROCESSOR WHO SENT YOU THE FORM; OR**
- (2) THE TRICARE (TMA) CLAIMS PROCESSOR FOR THE STATE/COUNTRY IN WHICH YOU RECEIVED THE MEDICAL CARE (the Health Benefits Advisor at your nearest military installation can provide you with this address).**

The public reporting burden for this collection of information is estimated to average 20 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services and Communications Directorate (0720-0003). 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.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.**

**PRIVACY ACT STATEMENT**

**AUTHORITY:** 42 U.S.C. 2651 - 2653; 10 U.S.C. 1079, 1085, 1086 and 1092; and E.O. 9397.

**PRINCIPAL PURPOSE(S):** To assist in determining possible third party liability for medical supplies and services claims under TRICARE (previously known as CHAMPUS). Information requested is used in reviewing claims to obtain additional information to determine proper liability of third parties for claims and to facilitate possible recovery by the United States for improperly paid claims.

**ROUTINE USE(S):** Information may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under TRICARE (formerly known as CHAMPUS); to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to members of Congress with the consent of the individual involved. Appropriate disclosures may be made to other Federal, state, local and/or foreign law enforcement agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE (formerly CHAMPUS).

**DISCLOSURE:** Voluntary; however, failure to provide information will result in a claims processing delay and may result in denial of the claim.

**INSTRUCTIONS**

We recently received a claim from you or your medical care provider for medical services required by (you/your family member) that indicate that the patient may have had an illness or injury related to an accident.

**Payment of your claims has been suspended until we receive more information. Your claims, and any related claims that are subsequently received, will be denied if this form is not completed and returned within 35 days from the date of this letter.**

This information is requested solely for the purpose of processing your TRICARE claim. It has no bearing on any legal action you may pursue as a result of your injury. All questions you may have concerning possible legal actions should be referred to an attorney. Do not execute a release or settle any personal injury claim you may have without notice to a military claims officer.

**STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY  
TRICARE MANAGEMENT ACTIVITY**

Please fill out this form to permit the United States to recover medical expenses from whoever caused your injury. Processing of your TRICARE claim will be suspended until you complete and return this form in the attached self-addressed envelope. Address questions to any Judge Advocate office or call toll free telephone number 1-800- \_\_\_ - \_\_\_\_.

**SECTION I - GENERAL INFORMATION**

1. SPONSOR'S SOCIAL SECURITY NUMBER:	ARMY	NAVY	AIR FORCE
	COAST GUARD	USPHS	NOAA

2.a. INJURED PATIENT'S NAME:	
b. INJURED PATIENT'S ADDRESS:	c. TELEPHONE NUMBER:

3. DATE INJURY OCCURRED (YYYYMMDD):	APPROXIMATE TIME OF INJURY:
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4. LOCALITY AND STATE WHERE INJURY OCCURRED:
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**SECTION II - TYPE AND CAUSE OF INJURY**

<input type="checkbox"/> 5. TRAFFIC ACCIDENT. <i>(Give name of at-fault driver and insurance company name. If you were a passenger in the accident vehicle, give name of driver and driver's insurance company.)</i>
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<input type="checkbox"/> 6. SLIP/FALL, DOG BITE, MISHAP. <i>(Give name of employer, business, municipality, or homeowner where injury occurred.)</i>
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<input type="checkbox"/> 7. EXPLOSION. <i>(Specify type of explosive, name and address of place where injury occurred.)</i>
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<input type="checkbox"/> 8. ASSAULT. <i>(Give name(s) of person(s) who assaulted you, and responding police department.)</i>
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<input type="checkbox"/> 9. TOXIC SUBSTANCE. <i>(Specify substance or drug name, and place where the incident occurred.)</i>
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<input type="checkbox"/> 10. ON-THE-JOB INJURY. <i>(Give name and address of employer, and cause of injury.)</i>
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<input type="checkbox"/> 11. PRODUCT MALFUNCTION. <i>(Give product name and place where the injury occurred.)</i>
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<input type="checkbox"/> 12. MEDICAL MALPRACTICE. <i>(Give date you first knew of the malpractice, doctor's name, and place where the malpractice occurred.)</i>
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<input type="checkbox"/> 13. OTHER TYPE AND CAUSE OF INJURY. <i>(Specify.)</i>
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**SECTION III - MISCELLANEOUS**

14. LIST OF MILITARY MEDICAL FACILITIES THAT PROVIDED CARE FOR THIS INJURY, AND DATES OF TREATMENT:
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15. HAVE YOU HIRED A LAWYER TO REPRESENT YOU REGARDING THIS INJURY?	YES	NO
a. LAWYER'S NAME AND ADDRESS:	b. LAWYER'S TELEPHONE NUMBER:	

16. DO YOU HAVE INSURANCE?	YES	NO
a. NAME OF INSURANCE PROVIDER(S):	b. INSURANCE TELEPHONE NUMBER(S):	

17. YOUR SIGNATURE	18. DATE SIGNED (YYYYMMDD)
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