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

OMB No. 0720-0003
OMB approval expires

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).

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.

N E E D S D D 6 7

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.

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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:**

4. LOCALITY AND STATE WHERE INJURY OCCURRED:

SECTION II - TYPE AND CAUSE OF INJURY

☐ **5. TRAFFIC ACCIDENT**. *(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.)*

☐ **6. SLIP/FALL, DOG BITE, MISHAP.** *(Give name of employer, business, municipality, or homeowner where injury occurred.)*

☐ **7. EXPLOSION.** *(Specify type of explosive, name and address of place where injury occurred.)*

☐ **8. ASSAULT.** *(Give name(s) of person(s) who assaulted you, and responding police department.)*

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☐ **9. TOXIC SUBSTANCE.** *(Specify substance or drug name, and place where the incident occurred.)*

☐ **10. ON-THE-JOB INJURY.** *(Give name and address of employer, and cause of injury.)*

☐ **11. PRODUCT MALFUNCTION.** *(Give product name and place where the injury occurred.)*

☐ **12. MEDICAL MALPRACTICE.** *(Give date you first knew of the malpractice, doctor's name, and place where the malpractice occurred.)*

☐ **13. OTHER TYPE AND CAUSE OF INJURY**. *(Specify.)*

SECTION III - MISCELLANEOUS

14. LIST OF MILITARY MEDICAL FACILITIES THAT PROVIDED CARE FOR THIS INJURY, AND DATES OF TREATMENT:

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)*