THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

OMB No. 0720-0055 OMB approval expires

The public reporting burden for this collection of information is estimated to average 4 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, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350-3100 (0720-0055). 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 COMPLETED FORM TO THE ABOVE ORGANIZATION.

RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1079b, Procedures for charging fees for care provided to civilian; retention and use of fees collected;1095, Health care services incurred on behalf of covered beneficiaries: collection from thirdparty payers; 42 USC. Chapter 32, Third Party Liability For Hospital and Medical Care; EO 9397 (SSN) as amended.

PURPOSE(S): Your information is collected to allow recovery from third parties for medical care provided to you in a Military Treatment FacilityROUTINE USE(S): Your records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurances providers, and other third parties in order to collect amounts owed to the Department of Defense. Your records may also be used and disclosed in accordance with 5 USC 552a(b) of the Privacy Act of 1974, a amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.										
PATIENT INFORMATION										
1. PATIENT NAME (Last, First, Middle		2. SSN		3. DATE O	3. DATE OF BIRTH (YYYY/MM/DD)					
4a. MAILING ADDRESS (Include ZIP		b. HOME TEI	LEPHONE NO.							
				()						
		5a. FAMILY N	MEMBER PREFIX	b. SPONSOR SSN						
6a. PATIENT'S EMPLOYER'S NAM			b. EMPLOYER TELEPHONE NUMBER							
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INSURANCE INFORMATION										
7. ARE YOU ELIGIBLE FOR VETERANS AFFAIRS BENEFITS?										
a. YES. (If you have an insurance card (e.g., Veterans Health Identification Card (VHIC), Veterans Choice Card), that can be copied or scanned										
by the MTF representative, please provide it and proceed to Item 8; otherwise, please complete items 7.a.(1) through (5) below.)										
(1) Member ID		(2) Plan ID		(3) Expiration Date (YYYY/MM/DD)						
(4) VA Facility Name (e.g., primary care/specialty clinic) that assists in coordinating your care										
(5) VA Facility Address and Telephone Number										
(o) VIII dointy Madress and Telephone Humber										
b. NO. (Proceed to tem 8.)										
8. DO YOU HAVE OTHER HEALTH INSURANCE? (This includes employer health insurance benefits, other commercial health insurance coverage,										
and Medicare Supplement.)										
	a. YES. (Complete Item 9 and the remaining sections below.)									
·	b. NO, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. (Proceed to Item 13.) c. NO, but I am not a DoD beneficiary. (Proceed to Item 12.)									
9. PRIMARY MEDICAL INSURANCE			ranco card that	can be conied	or scannod by the	MTE representative				
please provide it and proceed to I				can be copied	or scarnied by the	with representative,				
a. NAME OF POLICY HOLDER (Las						c. RELATIONSHIP TO POLICY HOLDER				
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER			e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER							
f. CARD HOLDER ID	g. POLICY ID		h. GROUP PO	OLICY ID	i. GROUI	P PLAN NAME				
j. ENROLLMENT/PLAN CODE	k. INSURANC	CE TYPE	I. POLICY EF (YYYY/MM/D	FECTIVE DAT D)		CY END DATE //MM/DD)				
n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number										
(2) Rx Policy ID		(3) Rx Bin Number		(4)	(4) Rx PCN Number					

10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.												
a. NAME OF POLICY HOLDE	DATE OF BIRTH (Y	YYY/MM/DD)	c. RELATIONSHIP TO POLICY HOLDER									
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER												
e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER												
g. POLICY		D h	h. GROUP POLICY ID		i. GROUP PLAN NAME							
j. ENROLLMENT/PLAN COD	E k. INSURAN	I.	I. POLICY EFFECTIVE DATE (YYYY/MM/DD)		m. POLICY END DATE (YYYY/MM/DD)							
n. (1) Pharmacy (Rx) Insurance	I ce Company Name, ≀	Address and Telephone Nui	nber									
(2) Rx Policy ID		(3) Rx Bin Number		(4) Rx PCN	(4) Rx PCN Number							
11. ARE THERE OTHER FAM	IILY MEMBERS CO	I OVERED UNDER THIS POL	ICY HOLDER?									
a. YES (Complete 11cf.	and proceed to Iter	m 13.)	b. NO (Proceed to	Item 13.)								
c. NAME (Last, First, Middle Initial)	d. SSN	DATE OF F. RELATIONSHIP TO POLICY HOLDER	. NAME (Last, First, Middle Ir	nitial) d	e. DATE BIRT (YYYY/M	H TO POLICY						
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1 1	┸		$-\mathcal{U}$	ノ	-0 /							
12. MEDICARE OR MEDICA				<u>L</u>	•	•						
a. MEDICARE PART A NUM	/IBER b. MEDICAR	RE PART B NUMBER c	MEDICARE MANAG	ED CARE P	LAN NAME							
d. MEDICARE PART D NUM	AME e	e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE										
13. CERTIFICATION, RELEASE, AND ASSIGNMENT												
a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of \$250,000 or imprisonment for five years, or both.												
b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue												
of this act. c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in												
whole or in part by my third-party insurer. d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be												
paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles.												
e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of												
the Uniformed Service for services provided to me and/or my family member. f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.												
14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE						b. DATE (YYYY/MM/DD)						
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE						b. DATE (YYYY/MM/DD)						
16. ANNUAL PATIENT INSURANCE VERIFICATION												
 a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually. b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best 												
of my knowledge. 17a. SIGNATURE (Patient or Ad	b. DATE (YYYY/MM/DD)											
a. SISIATIONE (Falletil Of Al	J. DAIL (1111/A	וטטאווויייייייייייייייייייייייייייייייי										
18. VERIFICATION a. (1) Date (YYYY/MM/DD)	(2) Initials	b.(1) Date (YYYY/MM/DD)	(2) Initials	c.(1) Date	I (YYYY/MM/DD)	(2) Initials						