OMB CONTROL NUMBER: 0720-0055
OMB EXPIRATION DATE: XX/XX/XXXX

AGENCY DISCLOSURE NOTICE

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, at whs.mc-alex.esd.mbx.dd-dod-informationcollections@mail.mil. 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.

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 Facility
ROUTINE 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.

Please correct the errors and try again.

- Either Sponsor SSN or Sponsor DoD ID is required.

Patient Information

1. Patient Name (last, first, middle initial)			**2. SSN** or **DoD ID**		**3. DOB** (MM/DD/YYYY)
MONGOOSE45	SEAN660	S	XXX-XX-5302	or	11/16/1984

4a. Address		b. Home Telephone Number	4445551212
		5a. Family Member Prefix	20
City	BIRMINGHAM	State	ALABAMA
Country		Zip	68123
Patient Category	USN RET LOS ENLISTED		
Patient IEN	147258415		

b. Sponsor SSN or DoD ID

or

Email

6a. Patient Employer Name	b. Employer Telephone Number

Next Last Save Cancel

8. Primary 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 10; otherwise, please complete the blocks below.

a. Name of Policy Holder (last, first, middle initial): LANG91 | LEIGH34 JR |
b. DOB (MM/DD/YYYY): 01/02/1992
c. Relationship To Policy Holder: Child
Policy Holder SSN: XXX-XX-7551
Policy Holder Gender: Unknown

d. Policy Holder's Employer's Name, Address And Telephone Number

Policy Holder's Employer's Name: BALFOUR BEATTY INVESTMENTS
Address:
City: State: Country:
Zip: Telephone: 7775551212

e. Insurance Company Name, Address And Telephone Number

Insurance Company Name: BCBS OF FLORIDA
Address: PO BOX 1798
City: JACKSONVILLE State: FLORIDA Country:
Zip: 32231 Telephone: 8775552273

f. Card Holder ID	g. Policy ID	h. Group Policy ID	i. Group Plan Name
	ABC9046127845	471505	ABC CORPORATIO

j. Enrollment/Plan Code	k. Insurance Type (Code, Desc)	l. Policy Effective Date (MM/DD/YYYY)	m. Policy End Date (MM/DD/YYYY)
	GP GROUP POLICY	12/17/2013	

Policy IEN: 4

n. (1) Pharmacy (Rx) Insurance Company Name, Address, And Telephone Number

Pharmacy (Rx) Insurance Company Name: ARGUS PHARMACY SERVICES
Address: PO BOX 419019 DEPT 300
City: KANSAS CITY State: MISSOURI Country:
Zip: 64141 Telephone: 8885551212

(2) Rx Policy ID	(3) Rx BIN Number	(4) Rx PCN Number
90461278545	600428	03820000

☐ Policy Holder information for pharmacy is the same as medical?

Name of Policy Holder (last, first, middle initial): LANG91 | LEIGH34 JR |
DOB (MM/DD/YYYY):
Relationship To Policy Holder: Child

Policy Holder's Employer's Name, Address And Telephone Number

Policy Holder's Employer's Name: ARGUS
Address:
City: State: Country:
Zip: Telephone: 9995559999

Group Policy ID	Group Plan Name	Insurance Type (Code, Desc)	Policy Effective Date (MM/DD/YYYY)
0029023	ARGUS/ABC	GP GROUP POLICY	01/01/2011

Policy End Date (MM/DD/YYYY)	Policy IEN
	7

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9. 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 10; otherwise, please complete the blocks below.

a. Policy Holder Name (last, first, middle initial)	b. DOB (MM/DD/YYYY)	c. Relationship To Policy Holder

Policy Holder SSN	Policy Holder Gender

d. Policy Holder's Employer's Name, Address And Telephone Number

Policy Holder's Employer's Name					
Address					
City		State		Country	
Zip		Telephone			

e. Insurance Company Name, Address And Telephone Number

Insurance Company Name					
Address					
City		State		Country	
Zip		Telephone			

Is this secondary coverage Medicare/Medicaid?

- ○ a. **Yes,** (Complete Item 11 in addition to information in Item 9.)
- ◉ b. **No,**Item 11 is skipped.

f. Card Holder ID	g. Policy ID	h. Group Policy ID	i. Group Plan Name

j. Enrollment/Plan Code	k. Insurance Type (Code, Desc)	l. Policy Effective Date (MM/DD/YYYY)	m. Policy End Date (MM/DD/YYYY)

Policy IEN

n. (1) Pharmacy (Rx) Insurance Company Name, Address, And Telephone Number

Pharmacy (Rx) Insurance Company Name					
Address					
City		State		Country	
Zip		Telephone			

(2) Rx Policy ID	(3) Rx BIN Number	(4) Rx PCN Number

☐ Policy Holder information for pharmacy is the same as medical?

Name of Policy Holder (last, first, middle initial)	DOB (MM/DD/YYYY)	Relationship To Policy Holder

Policy Holder's Employer's Name, Address And Telephone Number

Policy Holder's Employer's Name					
Address					
City		State		Country	
Zip		Telephone			

Group Policy ID	Group Plan Name	Insurance Type (Code, Desc)	Policy Effective Date (MM/DD/YYYY)

Policy End Date (MM/DD/YYYY)	Policy IEN

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13a. Patient Or Adult Family Member Signature (By signing here I acknowledge that I agree to the pertinent statements in Item 12.)	b. Date (MM/DD/YYYY)
Start Signature Pad	
14a. If Patient Refuses To Sign This Form: MTF Representative Signature	b. Date (MM/DD/YYYY)
Start Signature Pad	

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