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

(Read		Mar 31, 201 3			
The public reporting burden for this collection of and maintaining the data needed, and complete including suggestions for reducing the burden, the Pentagon, Washington, DC 20301-1155 (0704-C with a collection of Information if I does not disp RETURN COMPLETED FORM TO REQUESTIN	ng and reviewing the collection of information o the Department of Defense, Washington He 1323). Respondents should be aware that no lay a currently valid OMB control number. PLI any a currently valid OMB control number.	 Send comments regard adquarters Services, Ex twithstanding any other 	rding this burden estimate o ecutive Services Directorate, provision of law, no person si	r any other aspe Information Mar hall be subject to	ct of this collection of Information, agement Division, 1155 Defense any penalty for failing to comply
		ACT STATEMEN	IT		
AUTHORITY: Title 10 USC, Sectio PRINCIPAL PURPOSE(S): Informa patient. Such monetary benefits ac	ation will be used to collect from pri cruing to the MTF will be used to en	vate insurers for m nhan ce heaith care	delivery in the MTF.	-	
ROUTINE USE(S): In addition to the		d under 5 USC 552	a(b) of the Privacy Ac	t, the informa	ition on this form will be
released to your insurance compan DISCLOSURE: Voluntary. Failure	-	information may re-	sult in disgualification	for health ca	e services from MTFs.
	· _ ·				
1. PATIENT NAME (Last, First, Middle		2. SSN			BIRTH (YYYY/MMOD)
1. FATIENT NAME (185, FIS, MOUR	inuaij	2. 331		J. DATE OF	
4a. MAILING ADDRESS (Include ZIP	Code)		b. HOME TELEPHO		
48. MAILING ADDRESS (Include ZIP				INE NO.	
			5a. FAMILY MEMB PREFIX	ER b.	SPONSOR SSN
6a. PATIENT'S EMPLOYER'S NAM	E		b. EMPLOYER TEL	EPHONE N	UMBER
			()		
	. INSURANC		 DN	_	
7. DO YOU HAVE OTHER HEALT coverage, and Medicare Supplem		nployer health insur	ance benefits, other o	commercial h	ealth insurance
a. YES. (Complete Item 8 and	the remaining sections below.)				
b. NO, I am a DoD beneficiary	and rely solely on TRICARE, Media	care, or Medicaid.	(Proceed to Item 11.)		
c. NO, but I am not a DoD ben	eficiary. (Proceed to Item 12.)		<u> </u>		
8. PRIMARY MEDICAL INSURANC		insurance card that	it can be copied or sc	anned by the	MTF representative,
<u></u>	item 10; otherwise, please complet				
a. NAME OF POLICY HOLDER (La	st, First, Middle Iniŭal)	b. DATE OF	BIRTH (YYYY/MM/DD)	c. RELATI HOLDE	ONSHIP TO POLICY R
d. POLICY HOLDER'S EMPLOYER	'S NAME, ADDRESS AND TELEPI	HONE NUMBER			
			·		
e. INSURANCE COMPANY NAME,	ADDRESS AND TELEPHONE NU	MBER			
f. CARD HOLDER ID	g. POLICY ID	h. GROUP P			PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	I. POLICY E	FFECTIVE DATE	m. POLIC	Y END DATE
					<u> </u>
n. (1) PHARMACY (Rx) INSURANC	E COMPANY NAME, ADDRESS, A	AND TELEPHONE	NUMBER		
,					
			_		
(2) Rx POLICY ID	(3) Rx BIN NUMBER	र	(4) Rx PC	NNUMBER	

	ER (Last, First, Mid	dle initial)	b. DATE OF BIRTH (YYYYMMDD)	c. RELATIONSHI HOLDER	P TO POLICY
POLICY HOLDER'S EMPL	OYER'S NAME, A	ADDRESS AND TELE	PHONE NUMBER			
INSURANCE COMPANY	NAME, ADDRESS	AND TELEPHONE N	UMBER			
CARD HOLDER ID	g. POLIC	YID	h. GROUP POLICY ID)	i. GROUP PLAN	NAME
ENROLLMENT/PLAN CO	DE k. INSUF	RANCE TYPE	I. POLICY EFFECTIV (YYYYMM/DD)	/E DATE	m. POLICY END (YYYY/MM/DD)	
. (1) PHARMACY (Rx) INSL	JRANCE COMPA	NY NAME, ADDRESS	AND TELEPHONE NUMBER	ι.		
2) Rx POLICY ID		(3) Rx BIN NUMB	ĒR	(4) Rx PCt	N NUMBER	
10. ARE THERE OTHER FA	MILY MEMBERS	COVERED UNDER T	HIS POLICY HOLDER?	1		
a. YES (Proceed to 10	c f.)		b. NO (Proceed a	to Item 12.)	<u> </u>	
c. NAME (Last, First, Middle Initial)	d. SSN	e. DATE OF f. RELATIO BIRTH TO POL (YYYY/MM/DD) HOLD	UCY c. NAME (Last, First, Middle	e <i>Inițial)</i> d	I. SSN . BIRT (YYYYM)	TO POLICY
11. MEDICARE OR MEDIC						
a. MEDICARE PART A NU	IMBER b. MEDI	CARE PART B NUMB	ER C. MEDICARE MANA	GED CARE P	LAN NAME	
a. MEDICARE PART A NU d. MEDICARE PART D NU			ER C. MEDICARE MANA e. MEDICAID NUMBE STATE			ME/ISSUING
d. MEDICARE PART D NU	IMBER AND PLAI		e. MEDICAID NUMBE STATE	ER/MANAGE	D CARE PLAN NA	
d. MEDICARE PART D NU 2. CERTIFICATION, RELE a. I certify that the informat United States Code, Sec b. I acknowledge that the a	IMBER AND PLAI ASE, AND ASSIG ion on this form is tion 1001, which uthority to bill think	N NAME NMENT true and accurate to th provides for a maximum d party payers has bee	e. MEDICAID NUMBE STATE he best of my knowledge. Fal m fine of \$250,000 or imprisor n conveyed to the medical fac	ER/MANAGE	D CARE PLAN NA formation is covere years, or both. Department of De	ed by Title 18, fense by Title 10.
 d. MEDICARE PART D NU 12. CERTIFICATION, RELE. a. I certify that the informat United States Code, Sec b. I acknowledge that the a United States Code, Sec of this act. 	IMBER AND PLAI ASE, AND ASSIG ion on this form is ction 1001, which uthority to bill thin ctions 1095 and 10	N NAME SMENT true and accurate to th provides for a maximum d party payers has bee 079b, and that no person	e. MEDICAID NUMBE STATE he best of my knowledge. Fal m fine of \$250,000 or imprisor n conveyed to the medical fac onal entitiement to reimburser	ER/MANAGEI sification of in ment for five cility within the ment or payme	D CARE PLAN NAI formation is covere years, or both. Department of De ent has been grant	ed by Title 18, ofense by Title 10, ed to me by virtue
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 d. MEDICARE PART D NU 12. CERTIFICATION, RELE. a. I certify that the informat United States Code, Sec D. I acknowledge that the a United States Code, Sec of this act. c. NON-DoD PATIENTS: I provided me and/or my i third-party insurer. d. NON-DoD MEDICARE F limited to patient copayn e. DoD BENEFICIARIES: 	IMBER AND PLAI ASE, AND ASSIG ion on this form is zition 1001, which juthority to bill thin zitons 1095 and 10 authorize and rec minor dependents PATIENTS: 1 ackr nents and deducti I hereby acknowle	N NAME INMENT true and accurate to the provides for a maximum d party payers has bee 079b, and that no person quest that the proceeds ACKNOWLEDGEME nowledge I am response bles. adge that the proceeds	e. MEDICAID NUMBE STATE he best of my knowledge. Fai m fine of \$250,000 or imprisor n conveyed to the medical fac onal entitiement to reimburser s of any and all benefits be pa ENT: I hereby agree to pay for	ER/MANAGED sification of in ment for five cility within the nent or payme id directly to th r any service r rvices not cov	formation is covere years, or both. Department of De ent has been grant ne MTF for healthc not covered in who rered by Medicare,	ed by Title 18, ofense by Title 10, ed to me by virtue are services le or in part by my including but not
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 d. MEDICARE PART D NU 12. CERTIFICATION, RELE. a. I certify that the informat United States Code, Sec of this act. c. NON-DoD PATIENTS: I provided me and/or my r third-party insurer. d. NON-DoD MEDICARE F limited to patient copayn e. DoD BENEFICIARIES: Service for services prov f. ALL PATIENTS: I authour released to my insurance 13a. PATIENT OR ADULT F 14a. IF PATIENT REFUSES a. If any Information on this and date at least annual 	IMBER AND PLAI ASE, AND ASSIG ion on this form is tion 1001, which juthority to bill third totons 1095 and 10 authorize and recominor dependents PATIENTS: 1 ackr nents and deductil I hereby acknowle vided me and/or m rize portions of my e carriers. AMILY MEMBER TO SIGN THIS F URANCE VERIFIE s form has change ly. tion on this form h	N NAME True and accurate to the provides for a maximum d party payers has been 079b, and that no person quest that the proceeds ackNOWLEDGEME howledge I am response bles. adge that the proceeds by family member. or medical records nece SIGNATURE ORM: MTF REPRESS CATION dd, a new form must be as been verified on the	e. MEDICAID NUMBE STATE he best of my knowledge. Fai m fine of \$250,000 or imprisor in conveyed to the medical fac onal entitiement to reimburser s of any and all benefits be pai ENT: I hereby agree to pay for ible for full payment of any se of any and all benefits shall b issary to support claims for rei ENTATIVE SIGNATURE	ER/MANAGED sification of in ment for five cility within the nent or payme id directly to th r any service r rvices not cov be paid directly imbursement f	D CARE PLAN NAM formation is covered years, or both. Department of De- ent has been grant the MTF for healthch not covered in who rered by Medicare, to the facility of the for the cost of care b. DATE (YYYY) b. DATE (YYYY) tital signature, veri	ed by Title 18, ifense by Title 10, ed to me by virtue are services le or in part by my including but not the Uniformed rendered to be MM/DD) MM/DD) fy with your initials ccurate to the best

THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES A OTHER HEALTH INSURANCE	CCOUNT/
(Read Privacy Act Statement before completing this form)	

The public reporting burden for this collection of and maintaining the data needed, and complet including suggestions for reducing the burden, Pentagon, Washington, DC 20301-1155 (0704- with e collection of information if it does not diag RETURN COMPLETED FORM TO REQUEST	ting and reviewing to the Department -0323). Responder play a currently vali	the collection of information: Se of Defense, Washington Headqu nte should be aware that notwiths d OMB control number. PLEASE	nd comments regar arters Services, Exe tanding any other p	ding this burden ex scutive Services Di rovision of law, no	stimate or a rectorate, ini person shall	ny other as formation N be subject	pect of this collection of in Anagement Division, 1155 to any penalty for failing to	formation, Defense
		PRIVACY ACT	STATEMEN	Т				
AUTHORITY: Title 10 USC, Section	ons 1095 and 1	1079b; Executive Order 93	397.					
PRINCIPAL PURPOSE(S): Inform						he Milita	ry Treatment Facility	(MTF)
patient. Such monetary benefits a								
ROUTINE USE(S): In addition to t		es generally permitted un	der 5 USC 552	a(b) of the Priv	acy Act,	the infor	mation on this form v	vill be
released to your insurance compar	•		- 49					
DISCLOSURE: Voluntary. Failure	a to provide col	·			cation for	health c	care services from M	1 ⊦s .
		PATIENT IN	ORMATION			_		
1. PATIENT NAME (Last, First, Middle	e Initial)		2. SSN		3.	DATE C	OF BIRTH (YYYY/MM	(DD)
4a. MAILING ADDRESS (include Zif				b. HOME TE	LEPHON	E NO.	<u> </u>	_
	,			()				
				5a. FAMILY	MEMBER	<u> </u>	b. SPONSOR SSN	
				PREFIX				
6a. PATIENT'S EMPLOYER'S NAM	ME			b. EMPLOY	ER TELE	PHONE	NUMBER	
				()				
· · · · · · · · · · · · · · · · · · ·				<u> </u>				
		INSURANCE I						
7. DO YOU HAVE OTHER HEALT coverage, and Medicare Supple		E? (This includes employ	er health insur	ance benefits,	other con	nmercial	health insurance	
a. YES. (Complete Item 8 and	d the remaining	g sections below.)						
b. NO, I am a DoD beneficiary	and rely sole	y on TRICARE, Medicare	, or Medicaid.	(Proceed to Ite	əm 11.)			
c. NO, but I am not a DoD ber	neficiary. (Pro	ceed to Item 12.)						
8. PRIMARY MEDICAL INSURAN please provide it and proceed to		-			d or scan	ned by th	he MTF representation	/e,
a. NAME OF POLICY HOLDER (La			·····	BIRTH (YYYY		c. RELA	TIONSHIP TO POLI	
				•	ŕ	HOLD	DER	
d. POLICY HOLDER'S EMPLOYER	R'S NAME. AD	DRESS AND TELEPHON						
e. INSURANCE COMPANY NAME	, ADDRESS A	ND TELEPHONE NUMBE	R				·	
f. CARD HOLDER ID	g. POLICY	ID	h. GROUP PC	DLICY ID		I. GROI	UP PLAN NAME	
I. ENROLLMENT/PLAN CODE	k. INSURAN			FFECTIVE DA		m POI		
,			(YYYY/MM				Y/MM/DD)	
				-		• •	-	
n. (1) PHARMACY (Rx) INSURANC	CE COMPANY	NAME, ADDRESS, AND	TELEPHONE	NUMBER				
(2) Rx POLICY ID		(3) Rx BIN NUMBER		(4)	Rx PCN	NUMBE	R	

a. NAME OF POLICY HOLDER	R (Last, First, Middl	e Initial)		b. D.	ATE OF BIRTH MY	YYMMDD)	c. RELAT	TIONSHIP	TO F	POLICY
							HOLD	ER		
1. POLICY HOLDER'S EMPLO	YER'S NAME, AL	DDRESS AI	ND TELEPHON	ie nui	MBER					
B. INSURANCE COMPANY NA	ME, ADDRESS	AND TELEF	HONE NUMBE	ER						
CARD HOLDER ID g. POLICY ID				h. Gf	ROUP POLICY ID		i. GROU	P PLAN N	AME	
. ENROLLMENT/PLAN CODE	k. INSURA	NCE TYPE			OLICY EFFECTIVE	DATE		CY END D //MM/DD)	ATE	
n. (1) PHARMACY (Rx) INSUR	ANCE COMPAN'	Y NAME, AI	DDRESS AND	<u>j</u> Telef	HONE NUMBER.					
2) Rx POLICY ID		(3) Rx Bl	N NUMBER			(4) Rx PCN	NUMBER	२		
0. ARE THERE OTHER FAM	LY MEMBERS C		INDER THIS P	OLICY	HOLDER?					
a. YES (Proceed to 10c.			<u></u>	TT	b. NO (Proceed to)	ltem 12.)	_			
c. NAME (Last, First, Middle Initial)	d. SSN	e. DATE OF BIRTH YYYY/MM/DD)	1. RELATIONSHIP TO POLICY HOLDER	a. N/	AME (Last, First, Middle Ini	tial) d.	SSN .	e. DATE (BIRTH (YYYYMM		RELATIONS TO POLICY HOLDER
						_		(1111)		
1. MEDICARE OR MEDICAL										
a. MEDICARE PART A NUM	BER D. MEDICA	ARE PAR	BNUMBER	С. М	EDICARE MANAGE	D CARE P	LAN NAM	E		
d. MEDICARE PART D NUM	BER AND PLAN	NAME				MANAGED	CARE PI	LAN NAM	E/ISS	UING
				S	TATE					
12. CERTIFICATION, RELEAS									ь т	- 40
a. I certify that the Information United States Code, Section	n 1001, which pr	ovides for a	maximum fine	of \$25	0,000 or imprisonm	ent for five y	ears, or b	oth.	•	
b. I acknowledge that the auth United States Code, Section										
of this act. c. NON-DoD PATIENTS: 1 au										
provided me and/or my mir third-party insurer.	•					•				,,
 d. NON-DoD MEDICARE PA limited to patient copayment 			n responsible fo	or full p	ayment of any servi	ces not covi	ered by M	edicare, in	ciudi	ng but not
e. DoD BENEFICIARIES: 1 h Service for services provid				y and a	all benefits shall be p	aid directly	to the fac	ility of the	Unifo	ormed
f. ALL PATIENTS: I authorize released to my insurance of	e portions of my n			to sup	port claims for reimt	oursement f	or the cos	t of care re	ender	ed to be
13a. PATIENT OR ADULT FAI		GNATURE					b. DATE		WDD))
	<u></u>	-								
14a. IF PATIENT REFUSES TO	J SIGN THIS FO	RM: MTFF	REPRESENTA	TIVE S	IGNATURE		b. DATE	E (YYYYM)	WDD))
15. ANNUAL PATIENT INSUF a. If any information on this for			n must be comr	leted 4	and signed Otherw	ise after ini	lial signat		with	vour initiale
and date at least annually. b. I certify that the information	-		-		-		-			•
of my knowledge. 16a. SIGNATURE (Patient or Ad	lutt Family Member)						b. DATI	E (YYYYM	WDD	<u> </u>
								• •		,
	(2) INITIALS	b.(1) DA	TE (YYYYMMZ))]	(2) INITIALS	c.(1) DATE		ו מסאא	(2)	NITIALS

THIRD PARTY C	OLLECTION	PROGRA	WMEDICAL	SERVICES	ACCOUNT/
	OTHER	HEALTH	INSURANC	E	

(Read Privacy Act Statement before completing this form.)

OMB No. 0704-0323 OMB approval expires Mar 31, 2013

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and maintai including su Pentagon, V with a collect	ning the data needed, and completi ogestions for reducing the burden, to	ing and reviewing o the Department 323). Responde izy a currently val	the collection of information. See of Defense, Washington Headqua hts should be aware that notwithat d OMB control number. PLEASE	nd comments regard inters Services, Exe canding any other p	ting this burden estima cutive Services Directo rovision of law, no pers	te or any other rate, information on shall be subje	rching existing data sources, gathering aspect of this collection of information, Management Division, 1155 Defense act to any penalty for failing to comply BOVE ORGANIZATION.
			PRIVACY ACT	STATEMEN	Γ		
	RITY: Title 10 USC, Sectio	ne 1095 and	1079h: Executive Order 93	97	•		
					dical care provid	ed to the Mili	tary Treatment Facility (MTF)
	Such monetary benefits ac		•		•		
•	•	-			•		ormation on this form will be
	to your insurance company		co generally permitted and				
	SURE: Voluntary. Failure	•	molete and accurate infor	nation may res	uit in disqualificat	ion for health	care services from MTFs
DISOEC			PATIENT INF				
	NT NAME (Last, First, Middle	Initiei)		2. SSN		3. DATE	OF BIRTH (YYYYMMDD)
	in Financi (Lost, First, Missio	maay					
4a. MAIL	ING ADDRESS (Include ZIP	Code)			b. HOME TELEP	HONE NO.	
	•				()		
					5a. FAMILY ME		b. SPONSOR SSN
					PREFIX	·	
6a. PAT	ENT'S EMPLOYER'S NAM	E			b. EMPLOYER	TELEPHON	
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	<u>.</u>				· · ·		
	OU HAVE OTHER HEALTH rage, and Medicare Supplem		E? (This includes employ	er health insura 	ance benefits, oth	er commerci	al health insurance
a. `	YES. (Complete Item 8 and	the remainIn	g sections below.)				
b.	NO, I am a DoD beneficiary	and rely sole	y on TRICARE, Medicare,	or Medicaid.	Proceed to item	11.)	
C, I	NO, but I am not a DoD ben	eficiary. (Pro	ceed to item 12.)				
	ARY MEDICAL INSURANC				can be copied o	scanned by	the MTF representative,
•	E OF POLICY HOLDER (La				BIRTH (YYYY/MM	(DD) c. REL	ATIONSHIP TO POLICY
			·····,				.DER
d. POLIC	CY HOLDER'S EMPLOYER	'S NAME, AD	DRESS AND TELEPHON	E NUMBER			
	RANCE COMPANY NAME,						
8. 1100	VANUE COMPANY NAME,	ADDRESS A		R			
f. CARD	HOLDER ID	g. POLICY	D	h. GROUP PC		i. GRO	DUP PLAN NAME
	ULLMENT/PLAN CODE	k. INSURAL					
J. ENRC	ILLMENT/FLAN CODE	K. INSURA	ICE ITPE		FECTIVE DATE		
				(YYYY/MM/		(rr	YY/MM/DO)
				_			
n. (1) PH	ARMACY (Rx) INSURANCI	E COMPANY	NAME, ADDRESS, AND	TELEPHONE	NUMBER		
(2) Rx P	OLICY ID		(3) Rx BIN NUMBER		(4) Ru	PCN NUMB	ER
							_

9.	SECONDARY MEDICAL I please provide it and proce					e copied or a	scanned by the	e MTF ne	presentative,	
8.	a. NAME OF POLICY HOLDER (Last, First, Middle initial) b. DATE OF BIRTH (YYYYMM/DD)								POLICY	
d.	POLICY HOLDER'S EMPL	OYER'S NAME, AL	DRESS AND T	ELEPHONE NU	IMBER					
e.	INSURANCE COMPANY N	AME, ADDRESS A	ND TELEPHON	NE NUMBER						
f.	CARD HOLDER ID	g. POLICY	ROUP POLICY ID		i. GROUP Pl	AN NAN	1E			
j.	ENROLLMENT/PLAN COD	DE k. INSURA	NCE TYPE		POLICY EFFECTIVE YYYY /MM/D D)	DATE	m. POLICY E		E	
n.	(1) PHARMACY (Rx) INSU	RANCE COMPAN	(NAME, ADDR	ESS AND TELE	PHONE NUMBER.					
(2)	Rx POLICY ID		(3) Rx BIN NU	JMBER		(4) Rx PCN	INUMBER			
10	ARE THERE OTHER FAI	MILY MEMBERS C	OVERED UNDE	ER THIS POLIC	Y HOLDER?					
	a. YES (Proceed to 10c	2 f.)			b. NO (Proceed to	ltem 12.)				
C.	NAME (Last, First, Middle Initial)	d. SSN	BIRTH TO	LATIONSHIP O POLICY C. N HOLDER	IAME (Last, First, Middle Ini	<i>itial)</i> d.	SSN	DATE OF BIRTH YY <i>MM/DD</i>)	f. RELATIONSHIP TO POLICY HOLDER	
	· · ·									
a	MEDICARE OR MEDICA	MBER b. MEDICA	ARE PART B NU							
d	. MEDICARE PART D NU	MBER AND PLAN I			e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE					
a b c d f.	 12. 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-DoD 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 PATIENTS: I acknowledge I am responsible for full payment of any services not covered by Medicare, including but not limited to patient copayments and deductibles. e. DoD 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 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. 									
	a. PATIENT OR ADULT F						b. DATE (YY	Y Y/MM/U		
14	IA. IF PATIENT REFUSES	TO SIGN THIS FO	RM: MTF REPF	RESENTATIVE	SIGNATURE		b. DATE (Y)	YY MM D	(D)	
8	 ANNUAL PATIENT INSULA. If any information on this and date at least annual b. I certify that the information of my knowledge. 	form has changed, y.	a new form mu	-	-		- ·	-	•	
10	Sa. SIGNATURE (Patient or)	Adult Family Member)					b. DATE (M	ΥΥ ΜΜ Ο	DD)	
Ľ	7. VERIFICATION a. (1) DATE (YYYYMM/DD)	(2) INITIALS	b.(1) DATE (YYYYMM/DD)	(2) INITIALS	c.(1) DATE)) (2)	INITIALS	
	D CODIL ACCO (DACI	A NO1 0040								

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THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES A	CCOUNT/
OTHER HEALTH INSURANCE	
(Read Privacy Act Statement before completing this form.)	

The public reporting burden for this collection o and maintaining the data needed, and complet including suggestions for reducing the burden, L Pentagon, Washington, DC 20301-1155 (0704- with a collection of Information if it does not disp RETURN COMPLETED FORM TO REQUESTIN	ing and reviewing to the Department 0323). Responder stay a currently vali	the collection of information: Se of Defense, Washington Headou hts should be aware that notwiths d OMB control number. PLEASE	nd comments regar arters Services, Exe itanding any other p	ding this burden ocutive Services rovision of law, r	estimate or Directorate, no person sh	any other Information	aspect of this collection of inform Management Division, 1155 Defe act to any penalty for failing to com-	ation, Inse
		PRIVACY ACT	STATEMEN	тт		_		
AUTHORITY: Title 10 USC, Section	ons 1095 and 1	1079b; Executive Order 9	397.					
PRINCIPAL PURPOSE(S): Inform	ation will be us	sed to collect from private	insurers for me	edical care p	rovided to	o the Mili	itary Treatment Facility (M	ΓF)
patient. Such monetary benefits ac	-			-				
ROUTINE USE(S): In addition to the		es generally permitted un	der 5 USC 552	a(b) of the P	rivacy Ac	t, the info	ormation on this form will t	e
released to your insurance compan DISCLOSURE: Voluntary. Failure	•	mplete and accurate infor	mation may res	ult in discual	lification f	for health	care services from MTEs	-
		·		·				
1. PATIENT NAME (Last, First, Middle	(nitial)		2. SSN		—-T	3. DATE	OF BIRTH (YYYYMMOD)	
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4a. MAILING ADDRESS (Include ZIP	Code)				ELEPHO			
	00007			()				
				5a. FAMIL		ER	b. SPONSOR SSN	
				PREFIX	K j			
6a. PATIENT'S EMPLOYER'S NAM	AE					EPHON	ENUMBER	
				()				
		INSURANCE I	NFORMATIO	N				
7. DO YOU HAVE OTHER HEALT coverage, and Medicare Suppler		E? (This includes employ	ver health insur	ance benefit	s, other c	ommerci	ial health insurance	
a. YES. (Complete Item 8 and		g sections below.)					<u> </u>	
b. NO, I am a DoD beneficiary	and rely sole	v on TRICARE Medicare	or Medicaid	(Proceed to)	ltem 11)			
c. NO, but I am not a DoD ben								
8. PRIMARY MEDICAL INSURANCE please provide it and proceed to		•		•	ied or sca	anned by	the MTF representative,	
a. NAME OF POLICY HOLDER (La	st, First, Middle	Initial)	b. DATE OF	BIRTH (YYY	Y/MM/DD)		ATIONSHIP TO POLICY	
						HOL	LDER	
d. POLICY HOLDER'S EMPLOYER	S NAME, ADI	DRESS AND TELEPHON	E NUMBER			<u></u>		
				•				
e. INSURANCE COMPANY NAME,	ADDRESS A		.					
f. CARD HOLDER ID	g. POLICY I	ID	h. GROUP PO	DLICY ID		I. GRO	OUP PLAN NAME	
j. ENROLLMENT/PLAN CODE	k. INSURAN	ICE TYPE	I. POLICY E	FFECTIVE D	DATE	m. PC	DLICY END DATE	
			(YYYY/MM	(DD)) m	(YY/MM/DD)	
n. (1) PHARMACY (Rx) INSURANC	E COMPANY	NAME, ADDRESS, AND	TELEPHONE	NUMBER				
(2) Rx POLICY ID		(3) Rx BIN NUMBER		Γ	(4) Rx PC		BER	

 SECONDARY MEDICAL IN: please provide it and proceed 						e copied or	scanned by the M	ir repr	esentative,		
a. NAME OF POLICY HOLDER (Last, First, Middle Initial)					TE OF BIRTH (YY	YY /MM/DD)	c. RELATIONSHIP TO POLICY HOLDER				
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER											
e. INSURANCE COMPANY NA	ME, ADDRESS A	ND TELEP	HONE NUMBE	R							
f. CARD HOLDER ID	g. POLICY I	g. POLICY ID h. GROUP POLICY ID i. GROUP PLAN NA						i name	ME		
. ENROLLMENT/PLAN CODE	ENROLLMENT/PLAN CODE k. INSURANCE TYPE				DLICY EFFECTIVE YYY /MM/DD)	m. POLICY END DATE (YYYY/MM/DD)					
n. (1) PHARMACY (Rx) INSUR	ANCE COMPANY	'NAME, Al	DDRESS AND	TELEF	HONE NUMBER.						
(2) Rx POLICY ID		(3) Rx Bl	N NUMBER	(4) Rx PCN			NUMBER				
10. ARE THERE OTHER FAMI	LY MEMBERS C	OVERED U	INDER THIS P	OLICY	HOLDER?						
a. YES (Proceed to 10c	· f.)				b. NO (Proceed to	Item 12.)					
c. NAME (Last, First, Middle Initial)	NAME (Last, First, Middle Initial) d. SSN (YYYY/MM/DD) blrth (YYYY/MM/DD)					NAME (Lest, First, Middle Initial) d			I. RELATIONSHI TO POLICY HOLDER		
11. MEDICARE OR MEDICAI				1. 14							
a. MEDICARE PART A NUM	SER D. MEDICA		BNUMBER	С. М	EDICARE MANAGI	ED CARE P	LAN NAME				
d. MEDICARE PART D NUM	BER AND PLAN N	NAME			EDICAID NUMBER	/MANAGED) CARE PLAN NA	ME/ISS	SUING		
12. CERTIFICATION, RELEAS											
a. I certify that the information United States Code, Sectio	on this form is tru	ue and acci						ed by T	ïtle 18,		
b. I acknowledge that the auth	nority to bill third p	arty payers	has been conv	veyed 1	o the medical facili	ly within the	Department of De	efense l ed to n	by Title 10, ne by virtue		
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-DoD 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 min third-party insurer.											
d. NON-DoD MEDICARE PA limited to patient copaymer			n responsible fo	r full p	ayment of any servi	ces not cov	ered by Medicare,	includ	ing but not		
e. DoD BENEFICIARIES: I h	ereby acknowledg	e that the j	proceeds of any	y and a	ll benefits shall be i	paid directly	to the facility of th	ne Unif	ormed		
Service for services provide f. ALL PATIENTS: I authorize	e portions of my m	nedical reco	ider. ords necessary	to sup	port claims for reim	bursement f	or the cost of care	rende	red to be		
released to my insurance carriers.)					
14a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE b. DATE (YYYY/MM/DD)											
16. ANNUAL PATIENT INSUR											
a. If any information on this for and date at least annually.	orm has changed,	a new form	-		-		-	•	-		
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. 16a. SIGNATURE (Patient or Adult Family Member) b. DATE (YYYY/MM/DD)											
IVA. GIGITA I UNE (Patient of Ad	un Ferniy WichDer)							MMUDD	7		
17. VERIFICATION a. (1) DATE (YYYY/MM/DD)	(2) INITIALS	b.(1) DA	ΤΕ (ΥΥΥΥΛΜΜΟ	(O)	(2) INITIALS	c.(1) DATI	E (YYYYMMDD)	(2)	NITIALS		
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THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACC OTHER HEALTH INSURANCE	COUNT/
(Read Privacy Act Statement before completing this form)	

The public reporting burden for this collection of and maintaining the data needed, and complet including suggestions for reducing the burden, Pentagon, Washington, DC 20301-1155 (0704- with a collection of Information if II does not data RETURN COMPLETED FORM TO REQUESTION	ting and reviewing to the Department -0323). Responder play a currently vali	the collection of information: Si of Defense, Washington Headqu nts should be aware that notwith id OMB control number. PLEASI	and comments regain uarters Services, Existencing any other p	rding this burden estimate o soutive Services Directorate provision of law, no person a	r any other a , Information hall be subjec	spect of this collection of information, Management Division, 1155 Defense t to any penalty for failing to comply				
		PRIVACY AC	T STATEMEN	тт						
AUTHORITY: Title 10 USC, Section	ons 1095 and	1079b; Executive Order 9	397.							
PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF)										
patient. Such monetary benefits ac	-			-						
ROUTINE USE(S): In addition to the		es generally permitted ur	nder 5 USC 552	a(b) of the Privacy A	t, the infor	mation on this form will be				
released to your insurance compar DISCLOSURE: Voluntary. Failure	•	mplete and accurate info	mation may res	sult in disqualification	for health	care services from MTFs.				
		PATIENT IN	FORMATION							
1. PATIENT NAME (Last, First, Middle	s Initial)		2. SSN		3. DATE	OF BIRTH (YYYY/MM/DD)				
4a. MAILING ADDRESS (Include ZIF	Code)		·	b. HOME TELEPHO						
	0000		U. HOME TELEPHONE NO.							
				5a. FAMILY MEMB	b. SPONSOR SSN					
				PREFIX						
62. PATIENT'S EMPLOYER'S NAM	Æ			b. EMPLOYER TE	EPHONE	NUMBER				
				()						
		INSURANCE	INFORMATIC)N						
7. DO YOU HAVE OTHER HEALT coverage, and Medicare Suppler		E? (This includes emplo	yer health insur	ance benefits, other o	commercia	I health insurance				
a. YES. (Complete Item 8 and		g sections below.)								
b. NO, I am a DoD beneficiary	/ and rely sole	v on TRICARE. Medicare	or Medicaid.	(Proceed to Item 11)						
c. NO, but I am not a DoD ber										
8. PRIMARY MEDICAL INSURAN			urance card tha	t can be copied or sc	anned by t	he MTF representative				
please provide it and proceed to	Item 10; other	wise, please complete th		•						
a. NAME OF POLICY HOLDER (La	b. DATE OF	BIRTH (YYYYMMUDD	ATIONSHIP TO POLICY DER							
d. POLICY HOLDER'S EMPLOYER	d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER									
e. INSURANCE COMPANY NAME,	, ADDRESS A	ND TELEPHONE NUMB	ER							
f. CARD HOLDER ID	g. POLICY	In								
	f. CARD HOLDER ID g. POLICY ID h. GROUP POLICY ID I. GROUP PLAN NAME									
J. ENROLLMENT/FLAN CODE	j, ENROLLMENT/PLAN CODE (k. INSURANCE TYPE			I. POLICY EFFECTIVE DATE m. POLICY END DATE (YYYYMM/DD) (YYYY/M/M/DD)						
n. (1) PHARMACY (Rx) INSURANCE COMPANY NAME, ADDRESS, AND TELEPHONE NUMBER										
(2) Rx POLICY ID		(3) Rx BIN NUMBER		(4) Rx PC	(4) Rx PCN NUMBER					
1										

 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. NAME OF POLICY HOLDER (Last, First, Middle Initial)					ATE OF BIRTH (YY	YY/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											
f. CARD HOLDER ID g. POLICY ID					ROUP POLICY ID		i. grou	P PLAN N	IAME		
ENROLLMENT/PLAN CODE K. INSURANCE TYPE					I. POLICY EFFECTIVE DATE (YYYY/MM/DD)			m. POLICY END DATE (YYYY/MM/DD)			
n. (1) PHARMACY (Rx) INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER.											
(2) Rx POLICY ID		(3) Rx Bl	NNUMBER			(4) Rx PCN	NUMBER	2	_		
10. ARE THERE OTHER FAMI	LY MEMBERS CO	VERED U	NDER THIS PO	DLIC	HOLDER?	_					
a. YES (Proceed to 10c	·f.)				b. NO (Proceed to i	ltem 12.)					
c. NAME (Lest, First, Middle Initial)	(Last, First, Middle Initial) d. SSN e. DATE OF f. RELATIONSHIP BIRTH TO POLICY c. NAME (Lest, First, Middle Initial) d. (YYYY/MM/DD) HOLDER						SSN .	e. DATE (BIRTH (YYYYMM		I. RELATIONSHIP TO POLICY HOLDER	
11. MEDICARE OR MEDICAL							_				
a. MEDICARE PART A NUMBER b. MEDICARE PART B NUMBER c. MEDICARE MANAGED CARE PLAN NAME											
d. MEDICARE PART D NUMBER AND PLAN NAME e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE											
 12. CERTIFICATION, RELEASE, AND ASSIGNMENT a. I certify that the information on this form is true and accurate to the best of my knowledge. Faishfication 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-DoD 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 PATIENTS: I acknowledge I am responsible for full payment of any services not covered by Medicare, including but not limited to patient copayments and deductibles. e. DoD 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 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. 											
13a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE b. DATE (YYYY/MM/DD))				
14a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE b. DATE (YYYYMM/DD))				
 ANNUAL PATIENT INSURANCE VERIFICATION 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. 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. 											
16a. SIGNATURE (Patient or Adult Family Member) b. DATE (YYYY/MM/DD)						» "					
17. VERIFICATION a. (1) DATE (YYYYMM/DD)	2) INITIALS	b.(1) DA	TE (YYYYMMD	0)	(2) INITIALS	c.(1) DATE	(YYYYMI	WDD)	(2)	NITIALS	

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