THIRD PARTY COLLECTION PROGRAM - RECORD OF OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

Form Approved
OMB No. 0704-0323
Expires Dec 31, 2006

 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, Sec. 1095; EO 9397.
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 accruing to the MTF will be used to enhance health care delivery in the MTF.
ROUTINE USE(S): The information on this form will be released to your insurance company.
DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services.

1. PATIENT NAME *(Last, First, Middle Initial)*	2. SSN	3. DATE OF BIRTH *(YYYYMMDD)*	4. MARITAL STATUS *(X)* ☐ SINGLE ☐ MARRIED ☐ DIVORCED/WIDOWED

5a. STREET ADDRESS *(Include apartment number)*	b. CITY	c. STATE	d. ZIP CODE	6. HOME TELEPHONE NO. ( )

7. SPONSOR'S BRANCH OF SERVICE	8. SPONSOR FAMILY MEMBER PREFIX/ SSN	9a. SPOUSE NAME *(Last, First, Middle Initial)*

10a. PATIENT'S EMPLOYER NAME	b. TELEPHONE NUMBER ( )	b. SPOUSE'S EMPLOYER *(Name, Address and Telephone No.)*
c. EMPLOYER ADDRESS *(Include ZIP Code)*		

11. IS PATIENT'S CONDITION/APPOINTMENT RELATED TO AN ACCIDENT *(X one)* ☐ YES ☐ NO	a. DATE OF INJURY/ACCIDENT *(YYYYMMDD)*	b. CITY AND STATE WHERE ACCIDENT OCCURRED

c. TYPE OF ACCIDENT *(X)* ☐ AUTO ☐ BOAT ☐ HOME ☐ AIRPLANE ☐ WORKERS' COMPENSATION ☐ SLIP & FALL ☐ OTHER _____

d. BRIEFLY DESCRIBE HOW INJURY/ACCIDENT OCCURRED

e. INSURANCE COMPANY NAME	f. POLICY NUMBER	g. COMPANY ADDRESS *(Include ZIP Code)*

h. TELEPHONE NUMBER ( )	i. NAME OF POLICY HOLDER/INSURED	j. CLAIM NUMBER

12. DO YOU HAVE MEDICARE/MEDICAID *(X one)* ☐ YES ☐ NO			
a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICAID NUMBER	d. ISSUING STATE

13. ARE YOU COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY? *(Other than Medicare, Medicaid, TRICARE or TRICARE/CHAMPUS Supplement)*	☐ YES	☐ NO

14.a. PRIMARY MEDICAL INSURANCE COMPANY NAME	15.a. SECONDARY MEDICAL INSURANCE COMPANY NAME
b. ADDRESS *(Include ZIP code)*	b. ADDRESS *(Include ZIP code)*
c. TELEPHONE NUMBER ( ) / d. IDENTIFICATION NUMBER/GROUP NUMBER	c. TELEPHONE NUMBER ( ) / d. IDENTIFICATION NUMBER/GROUP NUMBER
e. POLICY HOLDER'S NAME *(Last, First, Middle Initial)*	e. POLICY HOLDER'S NAME *(Last, First, Middle Initial)*
f. SSN / g. DATE OF BIRTH *(YYYYMMDD)*	f. SSN / g. DATE OF BIRTH *(YYYYMMDD)*
h. POLICY HOLDER'S EMPLOYER NAME, ADDRESS AND TELEPHONE NO.	h. POLICY HOLDER'S EMPLOYER NAME, ADDRESS AND TELEPHONE NO.
i. EFFECTIVE DATE OF POLICY *(YYYYMMDD)*	i. EFFECTIVE DATE OF POLICY *(YYYYMMDD)*

16. FAMILY MEMBERS COVERED BY ABOVE POLICIES *(Use additional pages if necessary)*

a. NAME *(Last, First, Middle Initial)*	b. SSN	c. DATE OF BIRTH *(YYYYMMDD)*	a. NAME *(Last, First, Middle Initial)*	b. SSN	c. DATE OF BIRTH *(YYYYMMDD)*

17. CERTIFICATION. I certify that the above information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by 18 USC 1001, which provides for a maximum fine of $10,000 or imprisonment for five years, or both. For non-DoD beneficiaries, the below signature authorizes and requests that the proceeds of any and all benefits be paid directly to the Military Treatment Facility (MTF) for health care services provided me and/or my minor dependents. This signature authorizes Medical Service Account (MSA) patients' release of medical information (medical records) for claims.

a. SIGNATURE	b. DATE *(YYYYMMDD)*

Reset