Statement of Competent Medical Authority for Medical Travel – Family Member (FM)

Section I Patient information

Name:		E-mail:
Date of Birth:	Phone:	DEROS:
Sponsor's Name/Rank:		Sponsor's Unit:
Non-medical Attendant's Name:		Relationship to Patient:
I authorize clinic staff to securely send this form to me	Yes	No, I prefer to be called and pick form up from clinic
Signature of patient:		Date:

Section II CMA Certification (To be Completed by the *Referring* Provider *Prior to Travel)*

Referring Clinic:		Treatment is medically necessary:	No	Yes
Treatment is:	Urgent- 24-72 hours	Priority – 7 working days	Routine - 28 days	Delayed until after DEROS
Is a non-medical attendant (NMA) medically required?	No	Yes, because:		
Has provider informed patient or patient/guardian on CMA requirements and procedures?			No	Yes
Signature & stamp of referring provider:			Date:	

Section III Referring Medical Treatment Facility Review/Approval

Is care available on the Local Network?	No	Yes, explain why travel is recommended:
Is the referred/clinic more than 100 miles away from patient's assigned clinic?	No	Yes
Is Telehealth available for this encounter?	No	Yes, explain why not used:
The most appropriate location is:		
Concur/Non-Concur:		Date:
(Referral Management Office or delegate's name and rank)	*(signature)*	

After Referral Management's concurrence/non-concurrence, take completed CMA form back to your MTF Patient Administration Division (PAD) prior to travel. **

MTF PAD Signature acknowledging receipt. ______________________________Date________________________

Section IV Validation of Kept Appointment from Clinic (required for reimbursement)

I validate that the patient attended the following appointment:

Appointment date:	Appointment Time:	Clinic:
(Validator's First and Last Name)	*(signature)*	*(phone #)*

*IAW the JTR, family members are reimbursed actual expenses only. All receipts must be kept and submitted for reimbursement regardless of the amount.