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

(Read Privacy Act Statement before completing this form.)

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The public reporting burden for this collection of information is estimated to average 3 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, Executive Services Directorate (0704-0323). 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 1095 and 1079b; Executive Order 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): In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, the information on this form will be released to your insurance company.

DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.

| | IAIIEN | IT INFORMATIO | N | | | | |
|--|--|-----------------------------------|----------------------------------|---|--|--|--|
| . PATIENT NAME (Last, First, Mid | ddle Initial) | 2. SSN | | 3. DATE OF BIRTH (YYYY/MM/DD) | | | |
| a. MAILING ADDRESS (Include 2 | ZIP Code) | | b. HOME TELEPHO | JE NO. | | | |
| | | | 5a. FAMILY MEMBE PREFIX | b. SPONSOR SSN | | | |
| a. PATIENT'S EMPLOYER'S NA | AME | | b. EMPLOYER TELEPHONE NUMBER () | | | | |
| | INSURAN | ICE INFORMATION | ON | | | | |
| DO YOU HAVE OTHER HEAD coverage, and Medicare Supp | LTH INSURANCE? (This includes e plement.) | mployer health insu | rance benefits, other co | ommercial health insurance | | | |
| a. YES. (Complete Item 8 a | and the remaining sections below.) | | | | | | |
| b. NO, I am a DoD beneficia | ary and rely solely on TRICARE, Med | dicare, or Medicaid. | (Proceed to Item 12.) | | | | |
| c. NO, but I am not a DoD b | peneficiary. (Proceed to Item 11.) | | | | | | |
| | ANCE INFORMATION. If you have a to Item 10; otherwise, please comple | | | nned by the MTF representative, | | | |
| NAME OF POLICY HOLDER (| (Last, First, Middle Initial) | b. DATE OF | BIRTH (YYYY/MM/DD) | c. RELATIONSHIP TO POLICY HOLDER | | | |
| | | | | HOLDER | | | |
| POLICY HOLDER'S EMPLOYE | EN O MANUE, ADDITION AND TELLI | | | | | | |
| | IE, ADDRESS AND TELEPHONE N | JMBER | | | | | |
| INSURANCE COMPANY NAM | IE, ADDRESS AND TELEPHONE N | | OLICYID | i CROUD DI AN NAME | | | |
| INSURANCE COMPANY NAM | | JMBER h. GROUP F | OLICY ID | i. GROUP PLAN NAME | | | |
| INSURANCE COMPANY NAM CARD HOLDER ID | IE, ADDRESS AND TELEPHONE N | h. GROUP F | EFFECTIVE DATE | i. GROUP PLAN NAME m. POLICY END DATE (YYYY/MM/DD) | | | |
| CARD HOLDER ID ENROLLMENT/PLAN CODE | g. POLICY ID | h. GROUP P I. POLICY E (YYYY/MM | EFFECTIVE DATE WDD) | m. POLICY END DATE | | | |

| 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. NAME OF POLICY HOLDER (Last, First, Middle Initial) | | | | | b. DATE OF BIRTH (YYYY/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 | a POLIC | g. POLICY ID | | | h. GROUP POLICY ID | | | i. GROUP PLAN NAME | | | | |
| | | | | II. GROOF TOLICT ID | | | 1. OK | 1. GROOT I EAR WAINE | | | | |
| j. ENROLLMENT/PLAN COD | ROLLMENT/PLAN CODE k. INSURANCE TYPE | | | I. POLICY EFFECTIVE DATE (YYYY/MM/DD) | | | _ | m. POLICY END DATE (YYYY/MM/DD) | | | | |
| n. (1) PHARMACY (Rx) INSU | RANCE COMPA | NY NAME, A | DDRESS AND | TELE | PHONE NUMBE | R. | | | | | | |
| | | | | | | | | | | | | |
| (2) Rx POLICY ID | | (3) Rx Bl | N NUMBER | | | (4) Rx | PCN NUME | RFR | | | | |
| (2) IXI OLIOT ID | | (5) 1(X B) | NOMBER | | | (4) 100 | T OIN INOINIE | JLIK | | | | |
| 10. ARE THERE OTHER FAI | | | INDER THIS P | OLIC. | | | | | | | | |
| a. YES (Complete 10c. | - e. and proceed t | | 4 DELATIONELIID | b. NO (Proceed to Item 12.) | | | | | - 05 | 4 DELATIONICHID | | |
| c. NAME (Last, First, Middle Initial) | d. <mark>SSN</mark> | e. DATE OF BIRTH (YYYY/MM/DD) | f. RELATIONSHIP TO POLICY HOLDER | c. N | IAME (Last, First, Mide | dle Initial) | d. SSN | e. DATE BIRT (YYYY/M | Ή | f. RELATIONSHIP TO POLICY HOLDER | | |
| | | (************************************** | | | | | | (******** | | | | |
| | | | | | | | | | | | | |
| 11. MEDICARE OR MEDICA | | | | <u> </u> | | | | | | | | |
| a. MEDICARE PART A NUI | MBER b. MEDIC | CARE PART I | B NUMBER | c. N | MEDICARE MAN | AGED CAR | RE PLAN NA | AME | | | | |
| d MEDICARE DART DAIL | MDED AND DLAN | LNIAME | | 0 1 | AEDICAID NII IME | DED/MANIA | CED CARE | DI ANI NIAN | AE/IC | CLIINIC | | |
| d. MEDICARE PART D NUMBER AND PLAN NAME | | | | | e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE | | | | | | | |
| | | | | | | | | | | | | |
| 12. CERTIFICATION, RELEATIONa. I certify that the information | on on this form is | true and accu | urate to the bes | t of m | y knowledge. Fa | alsification o | of information | n is covere | ed by T | Γitle 18, | | |
| United States Code, Sector b. I acknowledge that the au | | | | | | | | | fense | by Title 10, | | |
| United States Code, Sector of this act. | ions 1095 and 10 | 79b, and that | t no personal er | ntitlen | nent to reimburse | ement or pa | yment has t | been grante | ed to r | ne by virtue | | |
| c. NON-DoD PATIENTS: I provided me and/or my m | | | | | | | | | | | | |
| third-party insurer. d. NON-DoD MEDICARE P. | • | | | | | • | | | | | | |
| limited to patient copaym | ents and deductib | oles. | • | | , | | • | · | | J | | |
| 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. DA | b. DATE (YYYY/MM/DD) | | | | |
| 14a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE | | | | | | | b. DA | b. DATE (YYYY/MM/DD) | | | | |
| 45 ANNUAL BATISHT INC. | IDANIOE VERIEIC | ATION | | | | | | | | | | |
| a. If any information on this | form has changed | | must be compl | leted | and signed. Oth | erwise, afte | er initial sign | ature, verif | y 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. 16a. SIGNATURE (Patient or Adult Family Member) | | | | | | | b. DA | b. DATE (YYYY/MM/DD) | | | | |
| 17. VERIFICATION (2) INITIALS (2) INITIALS (2) INITIALS (2) INITIALS (2) INITIALS | | | | | | | | | | | | |
| a. (1) DATE (YYYY/MM/DD) | (2) INITIALS | D.(1) DA1 | ΓΕ (YYYY/MM/DI | <i>υ</i>) | (2) INITIALS | c.(1) D | PAIE (YYYY) | /MM/DD) | (2) I | NITIALS | | |