

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

Section I Patient information										
Name & DODID:					E-mail:					
Date of Birth:			Phone:			DEROS:				
Sponsor's Name/Rank:					Sponsor's Unit:					
Non-medical Attendant's Name :					Relationship to Patient & DOD ID					
I authorize clinic staff to securely send this form to me			<input type="checkbox"/> Yes		<input type="checkbox"/> 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:			<input type="checkbox"/> No		<input type="checkbox"/> Yes
Treatment is:	<input type="checkbox"/> Urgent- 24-72 hours		<input type="checkbox"/> Priority – 7 working days		<input type="checkbox"/> Routine - 28 days		<input type="checkbox"/> Delayed until after DEROS			
Is a non-medical attendant (NMA) medically required?				<input type="checkbox"/> No		<input type="checkbox"/> Yes, because:				
Has provider informed patient or patient/guardian on CMA requirements and procedures?							<input type="checkbox"/> No		<input type="checkbox"/> Yes	
Signature & stamp of referring provider:							Date:			
Section III Referring Medical Treatment Facility Review/Approval										
Is care available on the Local Network?			<input type="checkbox"/> No		Yes, explain why travel is recommended:					
Is the referred/clinic more than 100 miles away from patient's assigned clinic?					<input type="checkbox"/> No		<input type="checkbox"/> Yes			
Is Telehealth available for this encounter?			<input type="checkbox"/> No		Yes, explain why not used:					
The most appropriate location is:										
Concur/Non-Concur:								Date:		
<i>(Referral Management Office or delegate's name and rank)</i>					<i>(signature)</i>					
**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:				
<i>(Validator's First and Last Name)</i>					<i>(signature)</i>			<i>(phone #)</i>		
*IAW the JTR, family members are reimbursed actual expenses only. All receipts must be kept and submitted for reimbursement regardless of the amount.										