

**STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY
CHAMPUS**

Form Approved
OMB No. 0720-0003
Expires Sep 30, 1997

IF A PREADDRESSED ENVELOPE IS NOT ENCLOSED WITH THIS FORM, PLEASE RETURN YOUR COMPLETED FORM TO EITHER OF THESE LOCATIONS:

- (1) **THE CHAMPUS CLAIMS PROCESSOR WHO SENT YOU THE FORM; OR**
- (2) **THE CHAMPUS CLAIMS PROCESSOR FOR THE STATE/COUNTRY IN WHICH YOU RECEIVED THE MEDICAL CARE (the Health Benefits Advisor at your nearest military installation can provide you with this address).**

Public reporting burden for this collection of information is estimated to average 13.8 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 this burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0720-0003), Washington, DC 20503.

PRIVACY ACT STATEMENT

AUTHORITY: 42 U.S.C. 2651 - 2653; 10 U.S.C. 1079, 1085, 1086 and 1092; E.O. 9397; 38 U.S.C. 613.

PRINCIPAL PURPOSE(S): To assist in determining possible third party liability for medical supplies and services claims under CHAMPUS. Information requested is used in reviewing claims to obtain additional information to determine proper liability of third parties for claims and to facilitate possible recovery by the United States for improperly paid claims.

ROUTINE USE(S): Information may be given to the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to members of Congress with the consent of the individual involved. Appropriate disclosures may be made to other Federal, state, local and/or foreign law enforcement agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in a claims processing delay and may result in denial of the claim.

INSTRUCTIONS

According to information submitted with your recent CHAMPUS claim, you were treated for an injury of some kind. Because the claim form does not include information about how you were injured, we are asking that you also complete this form. The Federal Medical Recovery Act, 42 U.S.C. 2651-2653, allows the Government to be reimbursed for its costs of treating you, if you were injured in an accident caused by someone else. The Government can often recover its costs from (1) the person who caused the accident or that person's insurance company; or (2) the owner of the property where the accident occurred or the owner's insurance company. The Government also may be able to recover its costs from (1) any insurance company which insures your family for hospital and medical expenses; or (2) your employer's Worker's Compensation or other insurance, if you were injured at work.

If you were not treated for an injury, please describe the circumstances of your treatment in the Remarks section on Page 1. If you were treated for an injury but do not believe that someone else caused your injury, please describe in detail the circumstances surrounding your injury in the Remarks section on Page 1. If you use the Remarks section for either of these purposes, you do not need to complete the rest of the form. However, be sure to sign and return it according to the other instructions you have received.

This form is to be completed by persons who have received medical care at Government expense or by a responsible family member. In cases of young children, this form should be completed by a parent or guardian.

Answer all questions in as much detail as possible. The information you provide may be of great help to the Government and to you in recovering from the person who caused your injuries. We suggest you retain a copy of this form for your own use. **If injury resulted from an automobile accident, you must attach a copy of the official police report to this form and complete Sections I, IV and V. If injury did not result from an automobile accident, complete Sections I, III, and V.**

The words "None," "N/A," and "Unknown" should be inserted where appropriate.

Attach additional sheets where necessary to provide complete information.

Complete all items to the best of your knowledge. **BE SURE TO SIGN AND DATE THE FORM ON PAGE 3. RETURN IT WITHIN 10 DAYS.**

IMPORTANT

This information is requested solely for the purpose of processing your CHAMPUS reimbursement claim. It has no bearing on any legal action you may pursue as a result of your injury. All questions you may have regarding possible legal actions should be referred to an attorney. Do not execute a release or settle any personal injury claim you may have without notice to a military claims officer.

STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY CHAMPUS

SECTION I - GENERAL INFORMATION

1. SPONSOR

a. SPONSOR'S NAME (Last, First, Middle Initial) _____ b. SSN _____

2. INJURED BENEFICIARY

a. INJURED BENEFICIARY'S NAME (Last, First, Middle Initial) _____ b. AGE _____

c. RELATIONSHIP TO SPONSOR (X one)

<input type="checkbox"/> SELF	<input type="checkbox"/> NATURAL/ADOPTED CHILD	<input type="checkbox"/> STEPCHILD
<input type="checkbox"/> SPOUSE	<input type="checkbox"/> FORMER SPOUSE	<input type="checkbox"/> OTHER

d. HOME ADDRESS (Street, Apartment Number, City, State, ZIP Code) _____

e. SPONSOR'S ADDRESS (If different from injured beneficiary's) (Street, Apartment Number, City, State, ZIP Code) _____

TELEPHONE NO. (Include Area Code) _____

TELEPHONE NO. (Include Area Code) _____

SECTION II - REMARKS

3. USE THIS SECTION TO DESCRIBE IN YOUR OWN WORDS HOW YOU WERE INJURED.

SECTION III - NON-VEHICULAR ACCIDENTS

Complete if injuries did not result from a motor vehicle accident. If injuries resulted from a vehicular accident, go to Section IV.

4. LOCATION

a. SITE OF INJURY (Street/Place, City, County, State) _____

b. TIME (Hour) _____

c. DATE (YYMMDD) _____

A.M.
 P.M.

d. NAME AND ADDRESS OF OWNER OF PROPERTY WHERE INJURY OCCURRED _____

e. NAME OF OCCUPANT OF PROPERTY (If different from Owner) _____

5. PERSONS INVOLVED

a. NAME (Last, First, Middle Initial) _____

b. ADDRESS (Street, City, State, ZIP Code) AND TELEPHONE NO. (Include Area Code) _____

SECTION III - NON-VEHICULAR ACCIDENTS (Continued)

6. WITNESSES

a. NAME (Last, First, Middle Initial)	b. ADDRESS (Street, City, State, ZIP Code) AND TELEPHONE NO. (Include Area Code)

7. POLICE INVESTIGATION

a. WAS AN INVESTIGATION CONDUCTED? <i>(If Yes, state by whom (e.g., City/ State Police, Sheriff's Dept.))</i>	b. WAS ANYONE ARRESTED OR CITED AS CAUSING THE ACCIDENT? <i>(If Yes, give name and charge)</i>	c. DISPOSITION OF CASE <i>(e.g., Dismissal, Fine, Jail Sentence)</i>
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	
d. EXPLAIN IN YOUR OWN WORDS WHO WAS AT FAULT AND WHY		
e. WERE OTHER FAMILY MEMBERS INJURED IN THE ACCIDENT? <i>(If Yes, give name(s) and relationship)</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO		
f. WAS THE ACCIDENT WORK RELATED? <i>(If Yes, state circumstances)</i>		
<input type="checkbox"/> YES <input type="checkbox"/> NO		

8. INSURANCE

a. INSURANCE COMPANY OF OWNER OF PROPERTY WHERE INJURY OCCURRED <i>(e.g., Homeowner's Insurance Company)</i>	b. INSURANCE COMPANY OF PERSON WHO CAUSED ACCIDENT <i>(If different from item a.)</i>	c. YOUR OWN INSURANCE COMPANY
(1) COMPANY NAME	(1) COMPANY NAME	(1) COMPANY NAME
(2) ADDRESS <i>(Include ZIP Code)</i>	(2) ADDRESS <i>(Include ZIP Code)</i>	(2) ADDRESS <i>(Include ZIP Code)</i>
(3) POLICY NUMBER	(3) POLICY NUMBER	(3) POLICY NUMBER
(4) AMOUNTS AND TYPES OF COVERAGE	(4) AMOUNTS AND TYPES OF COVERAGE	(4) AMOUNTS AND TYPES OF COVERAGE

SECTION IV - VEHICULAR ACCIDENT
Attach a copy of the official police report to this form.

9. ADDITIONAL INFORMATION ON VEHICULAR ACCIDENT

a. INJURED BENEFICIARY'S AUTOMOBILE INSURANCE COMPANY	b. INSURANCE COMPANY'S ADDRESS <i>(Include ZIP Code)</i>			
c. INSURANCE COMPANY TELEPHONE NO. <i>(Include Area Code)</i>				
d. POLICY NUMBER	e. AMOUNTS AND TYPE OF COVERAGE			
	(1) LIABILITY	(2) MEDICAL PAYMENT	(3) UNINSURED MOTORIST	(4) NO FAULT
	S	S	S	S

