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, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (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.

PATIENT INFORMATION

1. PATIENT NAME *(Last, First, Middle Initial)*	**2. SSN**	**3. DATE OF BIRTH** *(YYYY/MM/DD)*

4a. MAILING ADDRESS *(Include ZIP Code)*	b. HOME TELEPHONE NO. ( )	
	5a. FAMILY MEMBER PREFIX	b. SPONSOR SSN
6a. PATIENT'S EMPLOYER'S NAME	b. EMPLOYER TELEPHONE NUMBER ( )	

INSURANCE INFORMATION

7. DO YOU HAVE OTHER HEALTH INSURANCE? *(This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)*

- ☐ a. **YES.** *(Complete Item 8 and the remaining sections below.)*
- ☐ b. **NO**, I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. *(Proceed to Item 11.)*
- ☐ c. **NO**, but I am not a DoD beneficiary. *(Proceed to Item 12.)*

8. PRIMARY 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	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*

n. (1) PHARMACY (Rx) INSURANCE COMPANY NAME, ADDRESS, AND TELEPHONE NUMBER		
(2) Rx POLICY ID	(3) Rx BIN NUMBER	(4) Rx PCN NUMBER

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	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*

n. (1) PHARMACY (Rx) INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER.

(2) Rx POLICY ID	(3) Rx BIN NUMBER	(4) Rx PCN NUMBER

10. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

☐ a. **YES** *(Proceed to 10c. - f.)* ☐ b. **NO** *(Proceed to Item 12.)*

c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER	c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER

11. MEDICARE OR MEDICAID INFORMATION

a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICARE MANAGED CARE PLAN NAME

d. MEDICARE PART D NUMBER AND PLAN NAME	e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE

12. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of $250,000 or imprisonment for five years, or both.

b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

c. NON-DoD PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.

d. NON-DoD MEDICARE PATIENTS: I acknowledge I am responsible for full payment of any services not covered by Medicare, including but not limited to patient copayments and deductibles.

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 reimbursememt for the cost of care rendered to be released to my insurance carriers.

13a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE	b. DATE *(YYYY/MM/DD)*
14a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE	b. DATE *(YYYY/MM/DD)*

15. ANNUAL PATIENT INSURANCE VERIFICATION

a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify 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. DATE *(YYYY/MM/DD)*

17. VERIFICATION a. (1) DATE *(YYYY/MM/DD)*	(2) INITIALS	b.(1) DATE *(YYYY/MM/DD)*	(2) INITIALS	c.(1) DATE *(YYYY/MM/DD)*	(2) INITIALS

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