Transitional Care for Service Related Conditions Application Worksheet

Former Service Member must provide the following information:

Name: _____

Social Security Number: _____

Date of Birth: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Telephone Number: (Home/Work/Cell/Other) _____

Telephone Number: (Home/Work/Cell/Other) _____

Condition (s) for which medical treatment is being requested: _____

_____

How is/are this/these condition(s) related to your time on Active Duty (please attach supporting documentation)?

_____

_____

Dates of qualifying Service: _____

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Provider Checklist & Instructions

The following information should be provided by the medical provider evaluating and/or treating the Former Service Member's specific condition(s):

Provider Name: _____

Provider Specialty: _____

Provider NPI Number: _____

Provider Address: _____

Provider City: _____

Provider State: _____

Provider Zip Code: _____

Provider Telephone Number: _____

Diagnosis ICD-9 Code (for each qualifying condition): _____

Diagnosis Description (for each qualifying condition): _____

Clinical history and Plan of Treatment (For each qualifying condition, please be as specific as possible in the treatment plan including all CPT and HCPCS codes as appropriate as well as the anticipated duration of treatment)

_____

_____

_____

_____

_____

Based on your evaluation and proposed treatment plan, for each qualifying condition supporting documentation should indicate whether the condition may be fully resolved within 180 days.

Please note that under Section 1637 of the National Defense Authorization Act of 2008 any condition(s) must be resolvable within 180 days in order to qualify for this benefit. **If the condition(s) cannot be fully resolved within 180 days, he/she will not be accepted into this program, and he/she should seek alternative options for treatment and payment.**