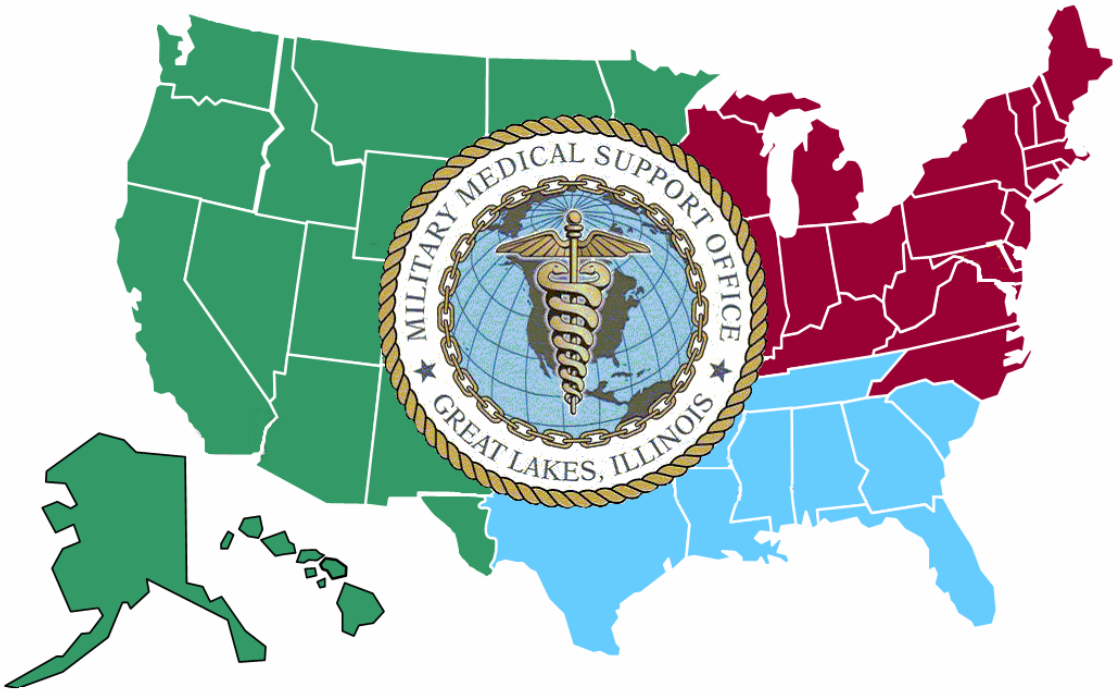
Military Medical Support Office

Great Lakes, IL



Process Guide

Military Medical Support Office (MMSO) Process Guide

This guide was developed to assist active duty, reservist, guard members, unit medical and command representatives with commonly used MMSO services (or processes).

How to Forward a Line of Duty Determination (LOD) to MMSO

Who This is For

National Guard and Reservist.

Background and purpose

Line of Duty Determinations (LOD) documents are used to document, establish, manage, and authorize civilian health care for eligible Reservist and National Guard members who are injured or became ill while on active duty.

The Military Medical Support Office (MMSO) is responsible for the authorization of civilian medical care for Reservist and National Guard members who are NOT in the catchment area of a Military Treatment Facility (MTF).

Note: The Coast Guard refers to a LOD as Notification of Eligibility (NOE).

Eligibility

Reservist and National Guard members who have been issued an LOD for an injury or illness that occurred while on active duty.

Filing Process

Follow these steps to forward a LOD to MMSO:

Step	Action
1	Respective service issues the LOD.
2	Unit medical representative completes MMSO Medical Eligibility Verification worksheet, MMSO Worksheet 01.
3	Unit medical representative forwards or FAXes the LOD, copy of orders or drill attendance sheet along with MMSO Medical Eligibility Verification worksheet to the following address/FAX: Military Medical Support Office Attn: Reserve Eligibility P.O. Box 886999 Great Lakes, IL 60088-6999 FAX: 847-688-6460 or 2134 Note: If service member needs follow-up medical care please see MMSO Process Sheet "How to Submit a Request for Pre-Authorization for Line of Duty Medical Care" topic.

How to Forward a Line of Duty Determination (LOD) to MMSO

-CONTINUED-

Results and follow up

Once the documentation has been submitted to MMSO, units may request authorization for follow-up LOD related medical care through the MMSO LOD section. Units should contact MMSO Customer Service regarding medical claims related to emergent or urgent care.

Enclosure

(1) MMSO Medical Eligibility Verification Worksheet, MMSO Worksheet 01

Point of Contact

If you have questions or need additional assistance beyond the information provided here, contact:

Division	Healthcare Support Services Branch
Position	Customer Service Representative
Phone	888-647-6676
Fax	847-688-6460 or 2134

Military Medical Support Office
MMSO Worksheet-01
Rev. 5/6/2011

MEDICAL ELIGIBILITY VERIFICATION
Reserve Component

Instructions: Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then mails or faxes this form and supporting documentation to MMSO (address/FAX # below). *All blocks must be completed.*
Note: Submit dental claims IAW the Dental Claim instructions on the MMSO Website http://www.tricare.mil/tma/MMSO

Section I – Patient Data

1. Branch of Service (✓ *one*) ☐ USAR ☐ USNR ☐ USMCR ☐ USAFR ☐ ARNG ☐ ANG ☐ USCGR

2. Name (last, first, MI):	3. Rank or Grade:	4. SSN

5. Address (street, apt #, city, state, & zip):	6. DOB (YYMMDD):
	7. Phone # (included area code):

Section II – Treatment Information

8. Date of injury/illness (YYMMDD):	9. Treatment occurred on (YYMMDD):	10. Duty Dates (YYMMDD): From: To:

11. Diagnosis or description of injury/illness and/or Pharmacy Claim (include ICD9 if available):

Section III – Unit Certification of Eligibility

12. Type of LOD/NOE (✓ *one*):

☐ Informal ☐ Formal ☐ Admin ☐ LOD OCONUS Emergency ☐ Post Deployment Health Assessment

13. Name of nearest Military Treatment Facility: _____ which is located _____ miles from the member's: ☐ place of duty or ☐ residence (✓ *one*).

14. Current Unit of Assignment (Unit name, staff symbol, code, etc.):	14A. Current Unit UIC/OPFAC
14B. Current Unit of Assignment Address (street, bldg #, city, state, & zip)	14C. Current Unit Phone # (include area code)
15. Unit POC (Name, Rank and Title):	15A. POC Phone # (include area code)

16. Certification: I certify that this individual is eligible for this care at government expense (CO or Medical Rep. signature):

_____ _____ _____
Signature Printed Name Date

STOP Make sure you have attached the appropriate documents!

Distribution
MAIL and FAX Information:

The following documents must be attached:
Documents should match/cover date in block 8. above.

☐ Approved LOD and/or NOE

☐ Drill Attendance Sheet or Orders (for initial date of care)
(for USCG: CG-4436B or CG4899)

MAIL this form/attachments to:
MMSO Attn: Reserve Eligibility
P.O. BOX 886999
Great Lakes, IL 60088-6999

FAX this form/attachments to:
847-688-6460 or 2134
Attn: Reserve Eligibility

How to Submit a Request for Pre-authorization for Line of Duty (LOD) Medical Care

Who This is For

National Guard and Reservist.

Background and purpose

MMSO is responsible for pre-authorizing all civilian medical care for eligible National Guard and Reservist who have been injured or became ill in the line of duty during a period of qualified duty and are not in the catchment area of a Military Treatment Facility (MTF).

Eligibility

You must meet the following criteria:

- National Guard or Reservist and have been issued a Line of Duty Determination (LOD) and are not in the catchment area of a MTF.
- Have an LOD on file at MMSO prior to requesting care. See MMSO process sheet "How to Forward a Line of Duty Determination (LOD) to MMSO" for complete instructions.

Filing Process

Follow these steps to receive pre-authorization for civilian health care:

Step	Action
1	Member or unit medical representative finds a Network Provider who can provide the care. Note: Use the TRICARE Provider Directory to locate a Network Provider.
2	Unit medical representative completes a Pre-Authorization Request for Medical Care, MMSO Worksheet 02. Note: Ensure specific medical care requested (e.g. orthopedic visit and 3 f/u visits or 12 PT visits, etc.) is listed in block 13 of the MMSO Worksheet 02.
3	Unit medical representative mails or FAXes MMSO Worksheet 02 to the following address/FAX: Military Medical Support Office Attn: Medical Pre-Authorizations P.O. Box 886999 Great Lakes, IL 60088-6999 FAX: 847-688-7394

How to Submit a Request for Pre-authorization for Line of Duty (LOD) Medical Care *-CONTINUED-*

Results and follow up

Once all appropriate documentation has been received a pre-authorization will be issued by MMSO to the unit medical representative within seven (07) working days. If you haven't heard from MMSO within seven working days contact the Pre-Authorization department.

Enclosure

Pre-Authorization Request for Medical Care, MMSO Worksheet-02

Point of Contact

If you have questions or need additional assistance beyond the information provided here, contact:

Division	Medical Care Branch
Position	Customer Contact Representative
Phone	888-647-6676

Military Medical Support Office
MMSO Worksheet-02
Rev. 09/15/2011

PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE
Reserve Component

Instructions: Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then mails or faxes this form and supporting documentation to MMSO (address/FAX # below). *All blocks must be completed.*

Section I – Patient Data

1. Branch of Service (✓ *one*) ☐ USAR ☐ USNR ☐ USMCR ☐ USAFR ☐ ARNG ☐ ANG ☐ USCGR

2. Name (last, first MI):	3. Rank or Grade:	4. SSN
5. Patient Home Address (street, apt #, city, state, & zip):		6. DOB (YYMMDD):
		7. Phone #: (include area code)
		8. TRICARE Region (✓ *one*) ☐ *North* ☐ *South* ☐ *West*

Section II – Pre-Authorization Request

9. Date of injury/illness (YYMMDD):	10. Duty dates (YYMMDD): From: to:

11. Diagnosis or description of injury/illness (include ICD9 if available):

12. Eligibility documents were submitted to MMSO on: _____. If not, indicate what documents are attached by checking one or both of the following blocks: ☐ LOD *or* ☐ Orders/Attendance Roster.

13. List follow-up care requested:

14. Provider Name:

14a: Provider POC and Phone #:

15. Medical Board Information (Date & MTF name):

16. Profile information/Limited Duty Board Information:

Section III – Unit Certification of Eligibility

17. Name of nearest Military Treatment Facility: _____ which is located _____ miles from the reservist's/guard's ☐ place of duty or ☐ residence (✓ *one*).

18. Unit Name & Address (Unit name, staff symbol, code, street, bldg #, city, state, & zip etc.):	18A. Unit UIC/OPFAC
19. Unit POC (Name, Rank and Title):	19A. POC Phone # (include area code)

20. Certification: I certify that this individual is eligible for this care at government expense:

_____ _____ _____
Signature Printed Name Date

DISTRIBUTION

MAIL this form/supporting documents to:	**FAX** this form/ supporting documents to:
MMSO Attn: Medical Pre-Authorizations P.O. BOX 886999 Great Lakes, IL 60088-6999	**847-688-7394** Attn: Medical Pre-Authorizations

How to Submit a Formal Appeal to MMSO

Who This is For

Active duty, National Guard, and Reservist.

Purpose

This explains how an eligible member submits a formal appeal to the Military Medical Support Office (MMSO) to request:

- payment of a denied authorized medial care claim
- approval of a pre-authorization for medical care previously denied

Eligibility

To be eligible to submit a formal appeal to MMSO you must have been either denied a payment of medical care claim(s), or denied pre-authorization request(s) for authorized medical care, and meet the following criteria:

If…	then on date of care, MUST…
Active duty	be eligible in Defense Enrollment Eligibility Reporting System (DEERS), and not TRICARE enrolled to an MTF.
National Guard or Reservist	have an approved Line of Duty (LOD) on file at MMSO for the illness or injury.

Definition: Authorized health care: A medical treatment or procedure which is medically necessary.

How to Submit a Formal Appeal to MMSO - CONTINUED

Appeal Process

Follow these steps to submit a formal appeal to MMSO:

<table>
<tr><th>Step</th><th>Who does it</th><th>What happens</th></tr>
<tr><td>1</td><td>Member</td><td>Contacts Medical/Unit Representative for clarification, guidance, and assistance with denial of claim or pre-authorization request.</td></tr>
<tr><td>2</td><td>Medical/Unit Representative</td><td>Ensures the denial decision was made by MMSO, and not by a Military Treatment Facility (MTF) and is authorized health care.

Note: If the member's care is managed by an MTF, contact that MTF for appeal process.</td></tr>
<tr><td>3</td><td>Medical/Unit Representative</td><td>Contacts appropriate MMSO point of contact below via telephone or email for further information regarding the reason for denial:

<table><tr><th>If denial was for…</th><th>then contact…</th></tr><tr><td>claim payment</td><td>SPOC</td></tr><tr><td>pre-authorization</td><td>Nurse Consultant Section</td></tr></table></td></tr>
<tr><td>4</td><td>Medical/Unit Representative</td><td>Assists member in developing and mailing the appeal request package.</td></tr>
<tr><td>5</td><td>Member</td><td>Completes and mails the following appeal request package to MMSO at the below address:

• Formal Appeal Request Worksheet, MMSO-04
• Copy of the Explanation of Benefits (EOB), if applicable
• If Reservist, copy of orders and/or applicable LOD (if not on file at MMSO)

Mailing Address:
TRICARE Management Activity
Military Medical Support Office
Attn: Appeals
P.O. Box 886999
Great Lakes, IL 60088-6999</td></tr>
</table>

How to Submit a Formal Appeal to MMSO - CONTINUED

Results and follow up

If the appeal is denied, the reason for the denial and information on how to initiate a second level appeal will be provided in writing directly to the service member.

Point of Contact

If you have questions or need additional assistance beyond the information provided here, contact:

Division	Healthcare Support Services Branch
Position	Customer Service Representative
Phone	888-647-6676
Fax	847-688-6460

Military Medical Support Office
MMSO Worksheet-04
Rev. 09/15/2011

FORMAL APPEAL REQUEST

Military Medical Support Office

Instructions: Complete this form when submitting a formal appeal for denied medical care claim(s), denied pre-authorization request by the Military Medical Support Office (MMSO) only. See the MMSO website for detailed instructions at http://www.tricare.mil/mmso

1. Branch of Service *(please ✓ one)*
☐ USA ☐ USAF ☐ USN ☐ USMC ☐ ANG ☐ USCG
☐ USAR ☐ USAFR ☐ USNR ☐ USMCR ☐ ARNG ☐ USCGR

2. Name (last, first, MI):	3. Rank or Grade:	4. SSN (full)

5. Duty Location (Unit name and location)	6. Daytime Phone #(s) (include area code)

7. Type of Appeal *(please ✓ one)*: ☐ Denied Claim ☐ Denied Pre-authorization Request

8. Date of Injury/Illness (YYMMDD):	9. Date(s) of Care/Pre-authorization request (YYMMDD):

10. Unit/Command Medical POC:	10A. POC Phone # (include area code)

11. Appeal: Briefly state why the claim should be paid, or the denied pre-authorization should be approved:

Patient Signature:	Date Signed

Pharmacy Reimbursement for Guard and Reservist with Line of Duty (LOD) injuries or illness

Who This is For	National Guard and Reservist.
Background and purpose	MMSO in conjunction with Express Scripts Incorporated (ESI) began processing Retail Pharmacy reimbursements for National Guard and Reservist on 15 November 2004.
Eligibility	National Guard and Reservist who have pre-paid or have been billed for pharmaceuticals in conjunction with a Line of Duty Determination (LOD) injury or illness. Note: Over-the-counter drugs and any non-covered pharmaceuticals will not be reimbursed.

Process for Reimbursement

Follow these steps to get reimbursed for authorized pharmaceutical items:

Step	Action
1	Member completes and signs a CHAMPUS Claim - Patient's Request for Medical Payment, DD Form 2642.
2	Member provides claim printout or paid civilian pharmacy invoice with the following information: • Doctors Name • Drug Name • National Drug Code (NDC) number • Quantity • Cost share or amount charged • Date of service, and • Name of Retail Pharmacy
3	Obtain eligibility documentation that covers the date of injury and/or pharmacy, i.e. orders, attendance roster, or LOD if not already sent to/on file at MMSO.

Process for Reimbursement - continued

4	Complete MMSO Medical Eligibility Verification worksheet (MMSO Worksheet 01). Check pharmaceutical reimbursement in block #11.
5	Forward the DD Form 2642, pharmacy invoice, eligibility documentation, LOD, and MMSO Medical Eligibility Verification Worksheet to the following address or FAX: Military Medical Support Office Attn: RC Retail Pharmacy Reimbursement P.O. Box 886999 Great Lakes, IL 60088-6999 FAX: 847-688-6460

Results and follow up

If MMSO determines your pharmacy bill is related to your LOD injury or illness they will instruct ESI to process your claim for reimbursement. Within 30 working days, you will receive an Explanation of Benefits (EOB) statement with a reimbursement check from ESI.

References and websites

TRICARE website for the pharmacy program:
http://www.tricare.mil/pharmacy/

Point of Contact

If you have questions or need additional assistance beyond the information provided here, contact:

Division	Healthcare Support Services Branch
Position	Customer Service Representative
Phone	888-647-6676
Fax	847-688-6460

Military Medical Support Office
MMSO Worksheet-01
Rev. 5/6/2011

MEDICAL ELIGIBILITY VERIFICATION
Reserve Component

Instructions: Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then mails or faxes this form and supporting documentation to MMSO (address/FAX # below). *All blocks must be completed.*
Note: Submit dental claims IAW the Dental Claim instructions on the MMSO Website http://www.tricare.mil/tma/MMSO

Section I – Patient Data

1. Branch of Service (✓ *one*) ☐ USAR ☐ USNR ☐ USMCR ☐ USAFR ☐ ARNG ☐ ANG ☐ USCGR

2. Name (last, first, MI):	3. Rank or Grade:	4. SSN

5. Address (street, apt #, city, state, & zip):	6. DOB (YYMMDD):
	7. Phone # (included area code):

Section II – Treatment Information

8. Date of injury/illness (YYMMDD):	9. Treatment occurred on (YYMMDD):	10. Duty Dates (YYMMDD): From: To:

11. Diagnosis or description of injury/illness and/or Pharmacy Claim (include ICD9 if available):

Section III – Unit Certification of Eligibility

12. Type of LOD/NOE (✓ *one*):

☐ Informal ☐ Formal ☐ Admin ☐ LOD OCONUS Emergency ☐ Post Deployment Health Assessment

13. Name of nearest Military Treatment Facility: _____ which is located _____ miles from the member's: ☐ place of duty or ☐ residence (✓ *one*).

14. Current Unit of Assignment (Unit name, staff symbol, code, etc.):	14A. Current Unit UIC/OPFAC
14B. Current Unit of Assignment Address (street, bldg #, city, state, & zip)	14C. Current Unit Phone # (include area code)
15. Unit POC (Name, Rank and Title):	15A. POC Phone # (include area code)

16. Certification: I certify that this individual is eligible for this care at government expense (CO or Medical Rep. signature):

_____ _____ _____
Signature Printed Name Date

STOP Make sure you have attached the appropriate documents!

Distribution
MAIL and FAX Information:

The following documents must be attached:
Documents should match/cover date in block 8. above.

☐ Approved LOD and/or NOE

☐ Drill Attendance Sheet or Orders (for initial date of care)
(for USCG: CG-4436B or CG4899)

MAIL this form/attachments to:
MMSO Attn: Reserve Eligibility
P.O. BOX 886999
Great Lakes, IL 60088-6999

FAX this form/attachments to:
847-688-6460 or 2134
Attn: Reserve Eligibility

How to Get Reimbursed for Pre-Paid Out-of-Pocket Medical Bills

Who This is For

Active duty, National Guard, and Reservist.

Purpose

This topic explains how an eligible member can get reimbursed for authorized medical care that was pre-paid out-of-pocket.

Eligibility

Active duty, National Guard and Reservist who pre-pay for authorized medical care or out-of-pocket costs must meet the following eligibility criteria:

If…	Then on date of care/bill, MUST…
Active duty	be eligible in Defense Enrollment Eligibility Reporting System (DEERS), and enrolled to the appropriate Primary Care Manager. Note: Errors in the DEERS database can cause problems with TRICARE claims, so it is critical to maintain your DEERS information. See "DEERS Enrollment" section below.
National Guard or Reservist	have a service endorsed Line of Duty (LOD) on file at MMSO for the illness or injury.

Note: To be reimbursed all health care must be a covered benefit or medically necessary.

How to Get Reimbursed for Pre-Paid Out-of-Pocket Medical Bills - CONTINUED

Process for Reimbursement

Follow these steps to get reimbursed for pre-paid medical bills:

Step	Action
1	Member completes and signs a CHAMPUS Claim - Patient's Request for Medical Payment, DD Form 2642
2	Forward the DD Form 2642, bill, and proof of payment (i.e. copy of paid receipt, cancelled check, credit card statement, etc) to the appropriate Managed Care Contractor for your region as follows:

Region	Mail to:
North	North Region Claims PGBA PO. Box 870140 Surfside Beach, SC 29587-9740 1-877-874-2273
South	TRICARE South Region Claims Department P. O. Box 7031 Camden, SC 29020-7031 1-800-403-3950
West	WPS/West Region Claims P.O. Box 77028 Madison, WI 53707-7028 1-888-874-9378

Results and follow up

When the appropriate documentation is received and processed by the Regional Managed Care Contractor a payment decision will be reflected on an Explanation of Benefits (EOB), normally within 30 working days of receipt.

References and websites

- TRICARE Operations Manual, chapter 19, Sections 1.4.1 and 3.8.3.
- http://www.tricare.mil/claims/whereclaim.cfm

DEERS enrollment

Follow one of the steps below to update your information in DEERS:

In person	Go to the nearest military personnel office or uniformed services ID card-issuing facility
Online	http://www.tricare.mil/deers/update-info.cfm
By Mail	Defense Manpower Data Center Support Office Attention: COA 400 Gigling Road Seaside, CA 93955-6771
Fax	DEERS 831-655-8317
Phone	800-538-9552 Monday-Friday, 6 a.m. to 3:30 p.m. PST

Point of Contact

If you have questions or need additional assistance beyond the information provided here, contact:

Division	Healthcare Support Services Branch
Position	Customer Service Representative
Phone	888-647-6676
Fax	847-688-6460

Military Medical Support Office
MMSO Worksheet-04
Rev. 09/15/2011

FORMAL APPEAL REQUEST

Military Medical Support Office

Instructions: Complete this form when submitting a formal appeal for denied medical care claim(s), denied pre-authorization request by the Military Medical Support Office (MMSO) only. See the MMSO website for detailed instructions at http://www.tricare.mil/mmso

1. Branch of Service *(please ✓ one)*
☐ USA ☐ USAF ☐ USN ☐ USMC ☐ ANG ☐ USCG
☐ USAR ☐ USAFR ☐ USNR ☐ USMCR ☐ ARNG ☐ USCGR

2. Name (last, first, MI):	3. Rank or Grade:	4. SSN (full)

5. Duty Location (Unit name and location)	6. Daytime Phone #(s) (include area code)

7. Type of Appeal *(please ✓ one)*: ☐ Denied Claim ☐ Denied Pre-authorization Request

8. Date of Injury/Illness (YYMMDD):	9. Date(s) of Care/Pre-authorization request (YYMMDD):

10. Unit/Command Medical POC:	10A. POC Phone # (include area code)

11. Appeal: Briefly state why the claim should be paid, or the denied pre-authorization should be approved:

Patient Signature:	Date Signed

How to get a Medical Bill removed from a Credit Report by MMSO

Who This is For

Active duty, National Guard, and Reservist.

Background and purpose

To assist members with resolving debt collection issues, the Under Secretary of Defense established Debt Collection Assistance Officer (DCAO) Programs at every Lead Agent Office and Military Treatment Facility worldwide.

DCAOs provide priority assistance when presented documentation verifying that collection action has been started or that negative information is reflected on a member's credit report as a result of late or non-payment for authorized health or dental care received through TRICARE.

Note: While DCAOs cannot provide legal advice or act as beneficiary advocates, they will take all measures necessary to ensure each case is thoroughly researched and that beneficiaries are provided with written findings and assistance in the minimum time possible.

Eligibility

The following personnel may seek assistance via the Military Medical Support Office (MMSO) DCAO to resolve debt collection issues:

If…	Member, must…
Active Duty	be enrolled in TRICARE Prime Remote (TPR) at the time of the authorized care/debt incurred.
National Guard and Reservist	have been issued a Line of Duty Determination (LOD) at the time of care/debt incurred. Note: The LOD must be on file at MMSO prior to requesting assistance. See "How to Forward a Line of Duty Determination (LOD) to MMSO" topic sheet for complete instructions.

How to get a Medical Bill removed from a Credit Report by MMSO - CONTINUED

How to Request Assistance

Follow these steps to receive assistance from the MMSO DCAO:

Step	Action
1	Member completes the following forms: • Authorization For Disclosure of Medical or Dental Information, DD Form 2870 • Notice of the Role of the DCAO form Note: MMSO must have these forms to legally contact the credit bureau and/or collection agencies involved.
2	Member FAXes or mails the following documentation to MMSO DCAO: • DD Form 2870 • Notice of the Role of the DCAO form • Copy of the final notice letter from the collection agency/credit bureau, stating this information has been noted on the member's credit report • LOD (if appropriate) Mail: Military Medical Support Office Attn: Debt Collection Action Officer P.O. Box 886999 Great Lakes, IL 60088-6999 FAX: 847-688-6460 Note: If the MMSO DCAO does not receive all the information listed above from the member, the DCAO will send the member a letter requesting information needed to pursue the case.

How to get a Medical Bill removed from a Credit Report by MMSO - CONTINUED

Results and follow up

Once a complete package is received, the MMSO DCAO will contact the credit bureau/collection agency and requests a 60-day hold until TRICARE pays the claim. Once paid by TRICARE, a notice goes to the credit bureau/collection agency with information pertaining to the date of the check and check number. The letter also requests that the negative credit information be removed within 14 days.

If the care in question is not covered by TRICARE, or the member was ineligible, the MMSO DCAO will send a letter to the member stating the facts.

Website

Contact information for DCAOs can be found on the TRICARE web site at:

http://www.tricare.osd.mil/dcao/DCAO_Dir.doc

Enclosures

- Notice of the Role of the DCAO form
- Authorization For Disclosure of Medical or Dental Information, DD Form 2870

Point of Contact

If you have questions or need additional assistance beyond the information provided here, contact:

Position	Debt Collection Assistance Officer (DCAO)
Phone	888-647-6676, ext 6649
Fax	847-688-6460

NOTICE OF THE ROLE OF THE DEBT COLLECTION ASSISTANCE OFFICER

ACKNOWLEDGEMENT

I, _____, understand that the role of the Debt Collection Assistance Officer (DCAO) is one of researching TRICARE claims that are the basis for an underlying debt. The DCAO has my consent to contact all necessary agencies – including military personnel offices, military treatment facilities, TRICARE Lead Agent offices, the TRICARE Management Activity (TMA), managed care support contractors, creditors who have issued bills, even debt collection agencies if appropriate – in order to research the TRICARE claim involved. The DCAO will assist me in understanding the basis for the underlying debt. The DCAO will coordinate with TMA to provide an official determination as to the appropriate resolution of a TRICARE claim.

I acknowledge and understand that the DCAO is NOT acting as my advocate in assisting me regarding the pending debt collection action. In addition, I acknowledge that the DCAO is NOT acting as my legal representative in this matter. In the event the DCAO determines that the debt appears to be valid, I have the right to continue to challenge the correctness of the debt, including exercising my TRICARE appeal rights. I understand I have the right to seek legal assistance through my legal assistance officer or private attorney.

_____ DATE: _____

_____
PRINTED NAME AND SOCIAL SECURITY NUMBER

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*
☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER *(Specify)*
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	

DD FORM 2870, DEC 2003

Reset