

## DVA/DoD **MOA** Continued Stay Referral & Authorization for SCI/TBI/Blind Rehab

### PRIVACY ACT STATEMENT

**This statement serves to inform you of the purpose for collecting personal information required by the Defense Health Agency Great Lakes (DHA-GL) and how it will be used.**

**AUTHORITY:** 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE program; and E.O. 9397 (SSN), as amended.

**PURPOSE:** To collect information from Military Health System beneficiaries in order to determine their eligibility for coverage under the TRICARE Program.

**ROUTINE USES:** Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a (b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at:  
<http://dpcl.d.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx>.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

**DISCLOSURE:** Voluntary; however, failure to provide information may result in the denial of coverage.

**Instructions:** Referring MTF or VA Case Manager completes all information below and delivers this form to DHA-GL POC.

**Section I Patient Data**

1. Name (last, first, MI):	2. Rank/Grade:	3. DOB (MM/DD/YYYY):	4. SSN (full):
5. Branch of Service: <input type="checkbox"/> USA <input type="checkbox"/> ANG <input type="checkbox"/> USAF <input type="checkbox"/> USN <input type="checkbox"/> USMC (please X one) <input type="checkbox"/> USAR <input type="checkbox"/> ARNG <input type="checkbox"/> USAFR <input type="checkbox"/> USNR <input type="checkbox"/> USMCR			
6. Eligibility: <input type="checkbox"/> TPR <input type="checkbox"/> Prime-DMIS _____ <input type="checkbox"/> Not Enrolled			7. Tricare Region:
8. Home Address (street, city, state, zip)			8A. Home/Mobile Phone # (include area code)
9. Duty Station, POC, & Phone number:		9A. MTF CM following through MEB process & Phone (area code):	

**Section II Referral Information and Request**

10. Referral Type: <input type="checkbox"/> SCI <input type="checkbox"/> TBI <input type="checkbox"/> Blind <input type="checkbox"/> Initial <input type="checkbox"/> Continuation of Service	
11. Referring Facility: <input type="checkbox"/> MTF <input type="checkbox"/> VA (include address)	11A. POC Name & Phone # (include area code)
12. Accepting Facility: (include address)	12A. POC Name & Phone # (include area code)

<b>13. Diagnosis</b>	ICD-10 Code	Description

<b>14. Type Care</b>	<input type="checkbox"/> Inpatient	Admission Date (MM/DD/YYYY):	DHA-GL Authorization #:	Expiration date:
	<input type="checkbox"/> Outpatient	Dates of Service (MM/DD/YYYY): From: _____ To: _____	<input type="checkbox"/> Home Health <input type="checkbox"/> Other (explain):	<input type="checkbox"/> DME <input type="checkbox"/> Rent <input type="checkbox"/> Purchase <i>See attachments</i>

<b>15. Services</b>	CPT/HCPCS	Description of Services:	Duration (in days)	DHA-GL Authorization #:	Expiration Date (MM/DD/YYYY)

**Section III DHA GL POC**

16. DHA-GL POC Name:	Phone 888-647-6676 ext:	FAX: 847-688-6369
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