FORMAL APPEAL REQUEST
Defense Health Agency Great Lakes DHAGL

Instructions: Complete this form when submitting a formal appeal for denied medical care claim(s), denied pre-authorization request by the Defense Health Agency Great Lakes DHAGL only. See the DHAGL website for detailed instructions at http://www.tricare.mil/tma/greatlakes/

PRIVACY ACT STATEMENT

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the Defense Health Agency Great Lakes 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://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html.

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 discloses 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.

Defense Health Agency - Great Lakes DHA-GL Worksheet 03 Rev. 06/01/2014	**FORMAL APPEAL REQUEST** **Defense Health Agency Great Lakes DHAGL**

Instructions: Complete this form when submitting a formal appeal for denied medical care claim(s), denied pre-authorization request by the Defense Health Agency Great Lakes only. See the DHAGL website for detailed instructions at http://www.tricare.mil/tma/greatlakes/

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 # & Personal Email

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