Defense Health Agency - Great Lakes
DHA-GL Worksheet-02
Rev. 02/12/2016

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 faxes or mails this form and supporting documentation to DHA-GL (FAX number#/address below).
All blocks must be completed.

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://dpcld.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 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-02
Rev. 02/12/2016

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 faxes or mails this form and supporting documentation to DHA-GL (FAX number / address 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. 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):

11. Diagnosis or description of injury/illness and/or Pharmacy Claim (include ICD-10 Code):

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

13. List follow-up care requested:

14. Provider Name:

15. Is a Medical Board in Process? ☐ Yes ☐ No **If yes, provide date started and MTF name.**

16. Does Service member have a profile? ☐ Yes ☐ No **If yes, provide profile details.**

Section III Unit Certification of Eligibility

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

18a. Unit Name & Address (Unit name, staff symbol, code, etc.):	18b. Current Unit UIC/OPFAC:
19a. Unit POC (Med Rep/Unit Administrator) Name, Rank and Title:	19b. POC Phone # (include area code):

20. **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 h
the appropriate d

Distribution
FAX or Mail Information:

The following documents must be attached:
Documents should match/cover date in block 9 above.

-Service Approved LOD
-Clinical Documentation
-Profile Information (if applicable)

FAX this form/attachments to: **847-688-7394**
Attn: Reserve Eligibility

or

MAIL this form/attachments to: DHA-GL Attn: Reserve Eligibility
2834 Green Bay Road Ste 304
Great Lakes, IL 60088