STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY
TRICARE MANAGEMENT ACTIVITY

Please fill out this form to permit the United States to recover medical expenses from whoever caused your injury. Processing of your TRICARE claim will be suspended until you complete and return this form in the attached self-addressed envelope. Address questions to any Judge Advocate office or call toll free telephone number 1-800- ____ - _____.

SECTION I - GENERAL INFORMATION

1. SPONSOR'S SOCIAL SECURITY NUMBER:		ARMY		NAVY		AIR FORCE
		COAST GUARD		USPHS		NOAA

2.a. INJURED PATIENT'S NAME:

b. INJURED PATIENT'S ADDRESS:	c. TELEPHONE NUMBER:

3. DATE INJURY OCCURRED *(YYYYMMDD):*	**APPROXIMATE TIME OF INJURY:**

4. LOCALITY AND STATE WHERE INJURY OCCURRED:

SECTION II - TYPE AND CAUSE OF INJURY

☐ **5. TRAFFIC ACCIDENT.** *(Give name of at-fault driver and insurance company name. If you were a passenger in the accident vehicle, give name of driver and driver's insurance company.)*

☐ **6. SLIP/FALL, DOG BITE, MISHAP.** *(Give name of employer, business, municipality, or homeowner where injury occurred.)*

☐ **7. EXPLOSION.** *(Specify type of explosive, name and address of place where injury occurred.)*

☐ **8. ASSAULT.** *(Give name(s) of person(s) who assaulted you, and responding police department.)*

☐ **9. TOXIC SUBSTANCE.** *(Specify substance or drug name, and place where the incident occurred.)*

☐ **10. ON-THE-JOB INJURY.** *(Give name and address of employer, and cause of injury.)*

☐ **11. PRODUCT MALFUNCTION.** *(Give product name and place where the injury occurred.)*

☐ **12. MEDICAL MALPRACTICE.** *(Give date you first knew of the malpractice, doctor's name, and place where the malpractice occurred.)*

☐ **13. OTHER TYPE AND CAUSE OF INJURY.** *(Specify.)*

SECTION III - MISCELLANEOUS

14. LIST OF MILITARY MEDICAL FACILITIES THAT PROVIDED CARE FOR THIS INJURY, AND DATES OF TREATMENT:

15. HAVE YOU HIRED A LAWYER TO REPRESENT YOU REGARDING THIS INJURY?	☐ YES	☐ NO
a. LAWYER'S NAME AND ADDRESS:	b. LAWYER'S TELEPHONE NUMBER:	
16. DO YOU HAVE INSURANCE?	☐ YES	☐ NO
a. NAME OF INSURANCE PROVIDER(S):	b. INSURANCE TELEPHONE NUMBER(S):	

17. YOUR SIGNATURE	**18. DATE SIGNED** *(YYYYMMDD)*

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OMB No. 0720-0003
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IF A PREADDRESSED ENVELOPE IS NOT ENCLOSED WITH THIS FORM, PLEASE RETURN YOUR COMPLETED FORM TO EITHER OF THESE LOCATIONS:
(1) THE TRICARE (TMA) PROCESSOR WHO SENT YOU THE FORM; OR
(2) THE TRICARE (TMA) CLAIMS PROCESSOR FOR THE STATE/COUNTRY IN WHICH YOU RECEIVED THE MEDICAL CARE (the Health Benefits Advisor at your nearest military installation can provide you with this address).

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To collect information necessary to determine when third parties may be held liable for medical care resulting from your injuries and to permit TRICARE to seek recovery for the cost of such care from those parties.

ROUTINE USE(S): Your records may be disclosed outside of DoD on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE. This includes disclosures to the Departments of Health and Human Services and Homeland Security consistent with thir TRICARE administrative responsibilities, and to the Department of Veterans Affairs. Your records may also be disclosed to the Internal Revenue Service and private collection agencies in connection with recoupment claims. Your records may be used and disclosed 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. Applicable SORN: DTMA 04.
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, your failure to provide information may result in a claims processing delay and/or the denial of claims.

INSTRUCTIONS

We recently received a claim from you or your medical care provider for medical services required by (you/your family member) that indicate that the patient may have had an illness or injury related to an accident.

Payment of your claims has been suspended until we receive more information. Your claims, and any related claims that are subsequently received, will be denied if this form is not completed and returned within 35 days from the date of this letter.

This information is requested solely for the purpose of processing your TRICARE claim. It has no bearing on any legal action you may pursue as a result of your injury. All questions you may have concerning possible legal actions should be referred to an attorney. Do not execute a release or settle any personal injury claim you may have without notice to a military claims officer.

TRICARE Other Health Insurance (OHI) Questionnaire

PRIVACY ACT: Authority: 10 USC Chapter 55; 32 CPR Part 199; and E.O. 9397 (SSN), as amended. The information collected may be disclosed for routine uses including: coordination of benefits, claims processing, providing eligibility, enrollment, fraud and abuse reviews, third party liability, quality assurance and responding to general customer inquiries. Appropriate disclosures may be made to healthcare providers, peer review committees, government agencies consistent with their statutory administrative responsibilities under TRICARE, to the Department of Justice for representation of the Secretary of Defense in civil actions and to Congressional Offices in response to inquiries made on the request of the person to whom a record pertains. Disclosure is voluntary, however, failure to provide information may result in a delay or denial of your claim or inquiry.

Update your Other Health Information at www.myTRICARE.com to minimize any delay in processing claims.
You may fax a completed form to: 1-888-237-6262 or mail to: TRICARE North, PO Box 870159, Surfside Beach, SC 29587-9759.

TRICARE Sponsor's Name: _____ **TRICARE Sponsor's SSN/DBN:** _____

Policy Holder's Name (if different from above): _____

OHI Company Name: _____ **State:** _____ **Policy, Group or Plan #:** _____

OHI Phone Number: _____ **Is the OHI Coverage an HMO/PPO plan?** ❑Yes ❑No

OHI Coverage Effective Date: ____ / _____ / _____ **OHI Coverage Termination Date:** ____ / _____ / _____

Type of Coverage: ❑ Group ❑ Individual ❑ Medicare ❑ Supplemental ❑ Medicaid

Indicate if the policy covers the following: ❑ Pharmacy ❑ Dental ❑ Mental Health ❑ Vision

Please list all individuals covered by this policy, indicating effective or termination dates if different from the dates above.

Name	Date of Birth	OHI Effective Date	OHI Termination Date
_____	____ / _____ / _____	____ / _____ / _____	____ / _____ / _____
_____	____ / _____ / _____	____ / _____ / _____	____ / _____ / _____
_____	____ / _____ / _____	____ / _____ / _____	____ / _____ / _____

Important - If there was a break in OHI coverage, please include information about the previous OHI coverage.

Effective Date of previous coverage: ____ / ____ / _____ **Termination Date of previous Coverage:** ____ / ____ / _____

Name of Previous OHI Company: _____

Individuals covered by the previous policy:

Name	Date of Birth	Name	Date of Birth
_____	____ / ____ / _____	_____	____ / ____ / _____
_____	____ / ____ / _____	_____	____ / ____ / _____

The statements made above are true and correct to the best of my knowledge. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department of agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefit Advisors.

_____ **Signature** _____ **Date** _____ **Phone Number**

 Revision Date: 11-19-14