TRICARE PRIME TRAVEL BENEFIT / COMBAT RELATED DISABILITY TRAVEL - CONFIRMATION OF SPECIALTY CARE

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 5701-5757, Travel, Transportation, and Subsistence; 10 U.S.C. 135, Under Secretary of Defense (Comptroller); DoD Financial Management Regulation 7000.14-R, Vol. 9, Travel Policies and Procedures; C.F.R. 300-304, Federal Travel Regulation; and Joint Travel Regulation Uniformed Service Members and DOD Civilian Employees.

PURPOSE: To document the confirmation of specialty care appointment by the patient and provider under the TRICARE Prime Travel Benefit and Combat Related Disability Travel.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Collected information may be shared with federal and private entities arranging transportation and lodging for individuals authorized to travel at government expense on official business, the Internal Revenue Service concerning travel allowances subject to federal income tax, and banking establishments for confirming billing or expense data. Collected information may also be shared with your healthcare providers for continuing care.

If you submit protected health information (PHI) using this form, it is protected health information (PHI) protected by 45 CFR part 164 and 160 and state privacy laws; such information will only be used in accordance with said laws and regulations.

APPLICABLE SORN: DHRA 08 DoD, Defense Travel System (March 24, 2010, 75 FR 14142)
https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570689/dhra-08-dod/

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but your claim for travel benefits may be partially or fully denied.

I. PATIENT INFORMATION - To be completed by the Patient.
Return the completed Confirmation of Specialty Care with claim and itemized receipts.

1. PATIENT NAME *(Last, First, Middle Initial)*		
2. HOME ADDRESS		3. TELEPHONE
a. STREET	c. STATE	
b. CITY	d. ZIP CODE	4. EMAIL ADDRESS

II. APPOINTMENT(S) INFORMATION - To be completed by Specialty Care Provider (SCP) for this trip only.
Note: Use military time for Appointment Time(s)

5. 1st APPOINTMENT DATE *(YYYYMMDD)*	APPOINTMENT TIME(S):	
6. 2nd APPOINTMENT DATE *(YYYYMMDD)*	APPOINTMENT TIME(S):	
7. ADDITIONAL APPOINTMENT DATE *(YYYYMMDD)*	APPOINTMENT TIME(S):	
8. HOSPITALIZATION DATE(S), *if applicable*	ADMISSION DATE *(YYYYMMDD)*	DISCHARGE DATE *(YYYYMMDD)*

*** For a post-operative patient, if required to remain in the immediate locale for necessary recovery and follow-on evaluation:**

9. BEGINNING DATE *(YYYYMMDD)* OF PROXIMITY REQUIREMENT:	
10. RELEASE DATE *(YYYYMMDD)* FROM PROXIMITY REQUIREMENT:	

III. SPECIALTY CARE PROVIDER (SCP) INFORMATION - To be completed by the Patient or Specialty Care Provider (SCP).

11. SCP NAME		
12. OFFICE ADDRESS		13. TELEPHONE
a. STREET	c. STATE	
b. CITY	d. ZIP CODE	14. EMAIL ADDRESS

IV. ADDITIONAL INFORMATION - If you need extra space to provide any additional information within this document, use the space provided.

This is to confirm that the subject patient received authorized specialty care as stated in the Appointment Information section above.

15. SCP SIGNATURE:	16. DATE: