

**STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY
DEFENSE HEALTH AGENCY**

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 PROCESSOR WHO SENT YOU THE FORM; OR
(2) THE TRICARE 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).

The public reporting burden for this collection of information, 0720-0003, is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

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 their 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://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx>. 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.

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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:		<input type="checkbox"/> ARMY	<input type="checkbox"/> NAVY	<input type="checkbox"/> AIR FORCE
		<input type="checkbox"/> COAST GUARD	<input type="checkbox"/> USPHS	<input type="checkbox"/> 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

<input type="checkbox"/>	5. TRAFFIC ACCIDENT. <i>(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.)</i>
<input type="checkbox"/>	6. SLIP/FALL, DOG BITE, MISHAP. <i>(Give name of employer, business, municipality, or homeowner where injury occurred.)</i>
<input type="checkbox"/>	7. EXPLOSION. <i>(Specify type of explosive, name and address of place where injury occurred.)</i>
<input type="checkbox"/>	8. ASSAULT. <i>(Give name(s) of person(s) who assaulted you, and responding police department.)</i>
<input type="checkbox"/>	9. TOXIC SUBSTANCE. <i>(Specify substance or drug name, and place where the incident occurred.)</i>
<input type="checkbox"/>	10. ON-THE-JOB INJURY. <i>(Give name and address of employer, and cause of injury.)</i>
<input type="checkbox"/>	11. PRODUCT MALFUNCTION. <i>(Give product name and place where the injury occurred.)</i>
<input type="checkbox"/>	12. MEDICAL MALPRACTICE. <i>(Give date you first knew of the malpractice, doctor's name, and place where the malpractice occurred.)</i>
<input type="checkbox"/>	13. OTHER TYPE AND CAUSE OF INJURY. <i>(Specify.)</i>

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?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
a. LAWYER'S NAME AND ADDRESS:		b. LAWYER'S TELEPHONE NUMBER:	
16. DO YOU HAVE INSURANCE?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
a. NAME OF INSURANCE PROVIDER(S):		b. INSURANCE TELEPHONE NUMBER(S):	
17. YOUR SIGNATURE		18. DATE SIGNED (YYYYMMDD)	