

1. PATIENT'S NAME (Last, First, Middle Initial) Doe, Betty L.		2. PATIENT'S TELEPHONE NUMBER (Include Area Code) DAYTIME (123) 777-8888 EVENING (123) 777-9999									
3. PATIENT'S ADDRESS (Street, Apt. No., City, State, and ZIP Code) 123 My Street New City, ST 11111		4. PATIENT'S RELATIONSHIP TO SPONSOR (Check one) <input checked="" type="checkbox"/> SELF <input type="checkbox"/> STEPCHILD <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> FORMER SPOUSE <input type="checkbox"/> NATURAL OR ADOPTED CHILD <input type="checkbox"/> OTHER (Specify)									
5. PATIENT'S DATE OF BIRTH (YYYYMMDD) 19801225	6. PATIENT'S SEX (X one) MALE <input checked="" type="checkbox"/> FEMALE	7. IS PATIENT'S CONDITION (Check both if applicable) ACCIDENT RELATED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO WORK RELATED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW. High fever, Cough, Vomiting		8b. WAS PATIENT'S CARE (Check one) <input type="checkbox"/> INPATIENT? <input type="checkbox"/> PHARMACY? <input type="checkbox"/> OUTPATIENT? <input type="checkbox"/> DAY SURGERY?									
9. SPONSOR'S OR FORMER SPOUSE'S NAME (Last, First, Middle Initial) Doe, John J.		10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER 123-45-6789									
11. OTHER HEALTH INSURANCE COVERAGE <p>a. Is patient covered by any other health insurance plan or program? If yes, check the "Yes" block and complete blocks 11 and 12. Do not provide TRICARE/CHAMPUS information.</p> <p>Specify reason for patient's visit/care.</p> <p>b. TYPE OF COVERAGE (Check all that apply)</p> <table border="0"> <tr> <td><input type="checkbox"/> (1) EMPLOYMENT (Group)</td> <td><input type="checkbox"/> (3) MEDICARE</td> <td><input type="checkbox"/> (5) MEDICARE SUPPLEMENTAL INSURANCE</td> <td><input type="checkbox"/> (7) OTHER (Specify)</td> </tr> <tr> <td><input type="checkbox"/> (2) PRIVATE (Non-Group)</td> <td><input type="checkbox"/> (4) STUDENT PLAN</td> <td><input type="checkbox"/> (6) PRESCRIPTION DISCOUNT PLAN</td> <td></td> </tr> </table> <p>c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE (Street, City, State, and ZIP Code)</p> <p>d. INSURANCE IDENTIFICATION NUMBER</p> <p>e. INSURANCE EFFECTIVE DATE (YYYYMMDD)</p> <p>f. DRUG COVERAGE?</p>				<input type="checkbox"/> (1) EMPLOYMENT (Group)	<input type="checkbox"/> (3) MEDICARE	<input type="checkbox"/> (5) MEDICARE SUPPLEMENTAL INSURANCE	<input type="checkbox"/> (7) OTHER (Specify)	<input type="checkbox"/> (2) PRIVATE (Non-Group)	<input type="checkbox"/> (4) STUDENT PLAN	<input type="checkbox"/> (6) PRESCRIPTION DISCOUNT PLAN	
<input type="checkbox"/> (1) EMPLOYMENT (Group)	<input type="checkbox"/> (3) MEDICARE	<input type="checkbox"/> (5) MEDICARE SUPPLEMENTAL INSURANCE	<input type="checkbox"/> (7) OTHER (Specify)								
<input type="checkbox"/> (2) PRIVATE (Non-Group)	<input type="checkbox"/> (4) STUDENT PLAN	<input type="checkbox"/> (6) PRESCRIPTION DISCOUNT PLAN									
INSURANCE 1											
INSURANCE 2											
<p>REMINDER: Attach your other health insurance's Explanation of Benefits or pharmacy receipt showing the amount of cash paid, and the amount that you paid.</p> <p>12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.</p> <p>a. SIGNATURE John J. Doe</p> <p>b. DATE SIGNED (YYYYMMDD) 20090101</p> <p>c. RELATIONSHIP TO PATIENT Sponsor</p> <p>Choose the currency to be reimbursed in.</p> <p>13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>											
<p>HOW TO FILL OUT THE TRICARE/CHAMPUS FORM</p> <p>You can attach an itemized bill, fees, front of form, or attach your doctor/supplier for CHAMPUS to process this claim.</p> <p>Signature of patient or authorized person</p> <p>Date Signed</p> <p>Signer's relationship to the sponsor</p> <p>1. Enter patient's military ID Card. 2. Enter the patient's social security number to include the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided. 3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided. 4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent. 5. Enter patient's date of birth (YYYYMMDD). 6. Check the box for either male or female (patient). 7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity." This form may be obtained from the claims processor, BCAC, or TRICARE Management Activity. 8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident. 8b. Check the box to indicate where the care was given. 9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "Same." 10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN).</p> <p>Just report if the patient has coverage under TRICARE/CHAMPUS. Report Medicare supplemental insurance coverages. If there are other insurance coverages, attach a separate page.</p> <p>NOTE: All other health insurance plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance's Explanation of Benefits (EOB) or work sheet to this claim. The claims processor cannot process claims until you provide the other health insurance information.</p> <p>12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a, and sign the claim. Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.</p> <p>13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment available only in some local currencies.</p>											