

FORT MEADE CLAIMS DIVISION

“AFFIRMATIVE CLAIMS PACKET”

Overview of Affirmative Claims

Imagine that you were recently involved in a car accident and were treated at a nearby medical treatment facility (MTF). Luckily, you sustained no life-threatening injuries, but you still spent a couple of days in the hospital. Upon discharge, you were able to return to work, but you had to schedule several follow-up treatments for your injuries. Finally, after all your treatments are finished, and everything appears to be back to normal, you receive a questionnaire from the Fort Meade Claims Division in the mail. You immediately want to know what the heck this questionnaire is about. Well, to answer your question, it's about an affirmative claim.

While a Soldier would not be charged for the medical treatments in the above scenario, there is still a cost to the Government. Each year, the Government spends millions of dollars on medical care for injuries sustained by Soldiers and their family members in accidents caused by negligent third parties. In these situations, the Government will try to recover the cost of the medical treatments from the negligent third party. These types of recoveries are accomplished through affirmative claims.

In addition to personnel claims and tort claims, our office also handles affirmative claims. When we receive notice that a Soldier and/or their dependents were involved in an accident, we try to acquire the medical records and bills for the treatment dates. We also investigate both the circumstances of the accident and the insurance held by each party involved. Subsequently, our office will try to recover the cost of medical care from the negligent party, their insurance company, or potentially even your insurance company. Any money recovered is returned to the MTF, TRICARE, or the Soldier's unit.

Please note that federal regulations require beneficiaries to cooperate in any investigation and provide the information requested by claims personnel. Remember that you're not just helping our office: you're helping yourself, your dependents, and the entire Army family.

This packet contains several documents associated with affirmative claims. Following this overview, you will find an Attorney Representation Agreement, Statement of Incident Report, and DD 2257. Please do not hesitate to contact our office if you have any questions over any of these documents. We are here to help, and, more importantly, we want to help.

ATTORNEY REPRESENTATION AGREEMENT AFFIRMATIVE CLAIMS

I, _____, Attorney at Law, represent _____, who sustained injuries in an accident on or about _____.

It is understood that pursuant to Title 42, United States Code, Sections 2651-2653, Title 10, United States Code, Section 1095, and state statutes and judicial decisions, the United States of America (hereinafter called the Government) has the right to recover the wages of a soldier who is unable to perform his or her military duties as the result of an injury as well as the reasonable value of care and treatment furnished or to be furnished by or for the Government to individuals entitled to such care and treatment when they suffer an injury or disease under circumstances that create tort or contractual liability on third parties, including insurance companies, to pay damages.

Title 42, United States Code, Sections 2651-2653, provides for an independent right of recovery by the Government for wages of a soldier and medical care furnished at Government expense due to the negligence of a third party. Under the provisions of Title 10, United States Code, Section 1095, the Government is entitled to recover from automobile insurance policies, including personal injury protection, medical payments, uninsured or under insured and liability coverages.

It is the Army's policy to authorize the attorney retained by an injured party to assert the claim of the Government as an item of special damages in the injured party's claim or suit. This form of proceedings will permit the attorney to control all aspects of the joint collection effort. It will also prevent any adverse effect occasioned by the Government's independent collection action or intervention in proceedings brought on behalf of the injured party.

Title 5, United States Code, Section 3106, prohibits the payment of a fee for representing the Government. Further, as the claim of the Government is an independent cause of action rather than a lien on any settlement or judgment obtained by the injured party, any contingent fee arrangement with the injured party applies only to his or her claim and not to the Government's portion of the recovery. In return for rendered assistance, however, the Army will furnish without cost available medical records (deriving from this incident) from U.S. Government medical facilities and, if possible, local Army medical personnel who have treated or are treating the injured party.

Recovery collected on behalf of the Government under the provisions of Title 42, United States Code, Sections 2651-2653, Title 10, United States Code, Section 1095 or any other legal theory should be made payable to the "Treasurer of the United States" and directed to this office.

I, _____, attorney at law, agrees to represent the Government under the terms and conditions in the following paragraphs:

(a) I understand that the recovery attorney must be consulted regarding any potential compromise of any portion of the Government's claim that has been assigned under this agreement and that the recovery attorney must agree with the proposed compromise.

(b) I understand that should it later become necessary for me to withdraw from this agreement, I will provide the recovery attorney reasonable notice of my intent so that the Claims Office may protect the Government's rights.

(c) I understand that if compromise or waiver of the Government's claim is requested at any time, it will be considered in view of the facts and circumstances of the case.

(d) I agree to furnish status reports on the injured party's case upon request or following significant developments in the case.

(e) I agree to include the Government's model allegation in pleadings filed in the case.

(f) I agree that the Government may at its option terminate this agreement and enter into negotiations with third parties or institute legal action against third parties upon 30 days written notice if:

(1) I fail to provide status reports within 30 days of request therefore or of a significant development in the case;

(2) The Government's model allegation is not included in the pleadings filed; or

(3) The applicable statute of limitations is 6 months or less from running, negotiations have not been concluded, the Government has not received full payment of its claim and suit has not been filed.

The above terms are acceptable to me. I agree to protect the Government's interests in this matter in accordance with the terms outlined in this agreement.

Date

Attorney at Law

The Government acknowledges that, _____, attorney at law is representing the Government's interest in the above case. The U.S. Army agrees to be bound by any judicial determination rendered by a court of competent jurisdiction.

Date

Recovery Attorney
Office of the Staff Judge Advocate
4217 Roberts Avenue, Suite 5030
Fort Meade, Maryland 20755-5030

If you elect to assert the Government's interest, the following clause is suggested for use in your complaint in filing suit:

"As a result of said injuries, the plaintiff has sustained, and in the future will continue to receive medical and hospital care and treatment furnished by the United States of America. Under the provisions of Title 42 United States Code, Sections 2651-2653 et seq. and Title 10 United States Code, Section 1095, and any other applicable statutes, the plaintiff, for the sole use and benefit of the United State of America and with its express consent, asserts a claim for the cost of said past treatment and the value of future car, as well as, for wages paid by the United States to active duty service members who were unable to perform their military duties due to injuries received as a result of defendant's negligence."

By using this clause, you can allege special damages without making or designating the United States as a party plaintiff to your cause of action.



STATEMENT OF INCIDENT - QUESTIONNAIRE -



DATA REQUIRED BY THE PRIVACY ACT OF 1974

(5 U.S.C., Section 552a)

1. **AUTHORITY:** The Federal Medical Care Recovery Act, 42 U.S.C., Section 651-3, Executive Order 9397, 10 U.S.C., Section 1095, 32 CFR, Part 220.12 (f), 5 U.S.C., Section 301, 44 U.S.C., Section 3101.
2. **PRINCIPAL PURPOSE(S):** To obtain information required enabling the United States to recover the reasonable value of Government-sponsored medical care furnished at its expense from third parties.
3. **ROUTINE USES:** a. Identify injured party and nature of injuries. b. Identify persons involved, including witnesses and other interested parties. c. Determine the circumstances of incidents, which give rise to personal injuries. d. Determine insurance coverage and source(s) of medical treatment. Information may be disclosed to civilian attorneys, insurance companies and other agencies to settle claims, and/or to the Department of Justice for use in litigation, and may be furnished to other components of the Department of Defense as required by regulation.
4. **MANDATORY OR VOLUNTARY DISCLOSURE:** MANDATORY DISCLOSURE. Failure to provide all pertinent information in a timely manner will result in the potential disqualification or suspension of all Government-sponsored health care at the discretion of the Secretary of Defense for Health Affairs, TRICARE, as well as the immediate withholding of military medical records pertaining to the incident from the injured beneficiary and/or their legal representative.

INSTRUCTIONS FOR COMPLETION

You must provide all information, which pertains to the circumstances of your injury. For sections, which do not apply to you, please mark "N/A" (Not Applicable) in the space provided. Attach documents supporting your statement. The regulation that requires completion of this form applies equally to active, retired, or separated United States military personnel and/or their family members.

INJURED PARTY

NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY #
HOME ADDRESS	HOME TELEPHONE	WORK TELEPHONE

MILITARY SPONSOR

BRANCH OF SERVICE	SPONSOR'S STATUS
(Check One): USA <input type="checkbox"/> USAF <input type="checkbox"/> USN <input type="checkbox"/> USMC <input type="checkbox"/> OTHER <input type="checkbox"/>	(Check One): Active Duty <input type="checkbox"/> Retired <input type="checkbox"/> ETS'd <input type="checkbox"/> Deceased <input type="checkbox"/>
NAME (Last, First, MI)	GRADE/RANK SPONSOR'S SSN
MILITARY UNIT MAILING ADDRESS (if sponsor is on active duty)	SPONSOR'S WORK PHONE

DETAILS OF THE INCIDENT

DATE	TIME _____ AM <input type="checkbox"/> PM <input type="checkbox"/>	COUNTY
STREET (if known)	CITY	STATE
DID THE POLICE RESPOND? YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>		MILITARY POLICE <input type="checkbox"/> CIVILIAN POLICE <input type="checkbox"/>
IF YES, NAME OF AGENCY	TRAFFIC ACCIDENT REPORT #	ACCIDENT REPORT ATTACHED? YES <input type="checkbox"/> NO <input type="checkbox"/>
WAS A TICKET ISSUED? YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>	IF YES, AGAINST WHOM?	CITED FOR

IN YOUR OWN WORDS, please describe in this block:

1) How your accident occurred: (Please PRINT):

▼ IMPORTANT: COMPLETE ALL APPLICABLE BLOCKS ON EACH PAGE, AND RETURN THE QUESTIONNAIRE TO: ▼

Installation Management Command
Office of the Staff Judge Advocate
Attn: Angela Coppedge-Jackson
4217 Roberts Avenue Suite 5030
Fort Meade, Maryland 20755-5030

MOTOR VEHICLE ACCIDENTS:

IMPORTANT: Notify your own insurance carrier even though the injured party was a pedestrian, a passenger in another vehicle, a victim of a "hit and run" incident, a bicyclist, or was involved in a one-vehicle accident. Failure to do so may jeopardize any right of recovery you have or the rights of the United States Government. Direct any questions to the military legal office coordinating recovery of the Government's claim.

I WAS A: DRIVER PASSENGER PEDESTRIAN BICYCLIST OTHER

YEAR	MAKE	MODEL
YOUR VEHICLE		
NAME OF DRIVER		ADDRESS
NAME OF OWNER (if different than the driver)		ADDRESS (if different than the driver)
INSURANCE COMPANY		ADDRESS
NAME OF CLAIMS ADJUSTER		CLAIMS ADJUSTER'S TELEPHONE NUMBER
POLICY NUMBER: ↙		CLAIM NUMBER: ↙
IS A COPY OF THE AUTO POLICY ATTACHED? : YES <input type="checkbox"/> NO <input type="checkbox"/>		
TYPES OF POLICY COVERAGE: Check [✓] those which apply and indicate coverage amounts:	<input type="checkbox"/> Personal Injury Protection (PIP) Coverage Amount? \$ _____	<input type="checkbox"/> Medical Payments (Med Pay) Coverage Amount? \$ _____
	<input type="checkbox"/> Uninsured/Underinsured Motorist (UM/UIM) Coverage Amount? \$ _____	

YEAR	MAKE	MODEL
THE OTHER VEHICLE		
NAME OF OTHER DRIVER		ADDRESS
NAME OF OTHER VEHICLE'S OWNER (if known)		ADDRESS
OTHER DRIVER'S INSURANCE COMPANY		ADDRESS
OTHER DRIVER'S CLAIMS ADJUSTER		CLAIMS ADJUSTER'S TELEPHONE NUMBER
POLICY NUMBER OF OTHER DRIVER: ↙		CLAIM NUMBER OF OTHER DRIVER: ↙
TYPES OF POLICY COVERAGE FOR OTHER VEHICLE: List specific coverage amounts.	LIABILITY COVERAGE: (Per Person/Per Accident) \$ _____ / \$ _____	*** NOTE: *** IF THIS WAS A MULTIPLE VEHICLE ACCIDENT, PLEASE LIST INFORMATION CORRESPONDING TO ANY AND ALL ADDITIONAL VEHICLES ON A SEPARATE SHEET.

ON-THE-JOB INJURY - & - WORKER'S COMPENSATION CLAIMS:

NAME OF BUSINESS/ORGANIZATION	ADDRESS
EMPLOYER'S INSURANCE COMPANY	ADDRESS
NAME OF CLAIMS ADJUSTER	CLAIMS ADJUSTER'S TELEPHONE NUMBER
WORKER'S COMPENSATION CLAIM NUMBER:	OTHER INFORMATION:

OTHER TYPES OF INCIDENTS:

INJURY OCCURRED AT:	MY HOME <input type="checkbox"/>	OTHER RESIDENCE <input type="checkbox"/>	SCHOOL <input type="checkbox"/>	PUBLIC PROPERTY <input type="checkbox"/>	PRIVATE PROPERTY <input type="checkbox"/>
NAME OF PROPERTY OWNER		ADDRESS			
NAME OF INSURANCE COMPANY		ADDRESS			
NAME OF CLAIM ADJUSTER		CLAIM ADJUSTER'S TELEPHONE NUMBER			
INSURANCE POLICY NUMBER: ↙		INSURANCE CLAIM NUMBER: ↙			

YOUR MEDICAL CONDITION

WERE YOU INJURED IN THE ACCIDENT? YES NO IF "YES," WHAT WERE YOUR INJURIES?

DESCRIBE HERE: 

IMPORTANT: (Please be specific when describing the nature and severity of your illness/injuries, being careful to include "Left" or "Right", when specifying the body location. Also indicate if any surgeries or tests have been performed or will be performed).

LIST BELOW THE NAMES OF MILITARY FACILITIES & DATES YOU WERE TREATED FOR THE ACCIDENT

LOCAL MILITARY FACILITIES	CLINIC(S) TREATED AT	OUTPATIENT (Dates of Visits)	INPATIENT (Dates of Stay)
Kimbrough Ambulatory Care Ctr, Fort Meade	◀ Which Clinic(s)?		
Walter Reed Army Medical Center, DC	◀ Which Clinic(s)?		
National Naval Medical Center – Bethesda	◀ Which Clinic(s)?		
Malcolm Grow U.S. Air Force Medical Center	◀ Which Clinic(s)?		
DeWitt Army Community Hospital, Fort Belvoir	◀ Which Clinic(s)?		
Kirk U.S. Army Health Clinic, APG, MD	◀ Which Clinic(s)?		
Other Military Facility (Please specify):	◀ Which Clinic(s)?		

LIST BELOW THE NAMES OF CIVILIAN FACILITIES & DATES YOU WERE TREATED FOR THE ACCIDENT:

CIVILIAN FACILITIES (or Doctor's Name)	CLINIC (S)	OUTPATIENT (Dates of Visits)	INPATIENT (Dates of Stay)

HAVE THE CIVILIAN MEDICAL BILLS BEEN PAID? NO <input type="checkbox"/> YES <input type="checkbox"/> (If "Yes," please specify <i>by whom</i>): ▶	ME <input type="checkbox"/>	ARMY <input type="checkbox"/>	TRICARE <input type="checkbox"/> (CHAMPUS)	INSURANCE <input type="checkbox"/>	ATTORNEY <input type="checkbox"/>	OTHER <input type="checkbox"/>
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IMPORTANT: Initial here if you received –NO– civilian medical treatment for this incident: _____
[initials]

MISCELLANEOUS INFORMATION (Required) PLEASE SPECIFY:

Do you <i>handcarry</i> your medical record? YES <input type="checkbox"/> NO <input type="checkbox"/>	▶ If "No", Where is it on file?
Are you still receiving treatment? YES <input type="checkbox"/> NO <input type="checkbox"/>	▶ If "No", When were you released? [date]:
Have you signed any release form? YES <input type="checkbox"/> NO <input type="checkbox"/>	▶ If "Yes", For whom?
Has property damage been paid? YES <input type="checkbox"/> NO <input type="checkbox"/>	▶ If "Yes", By whom?
Has personal injury been paid? YES <input type="checkbox"/> NO <input type="checkbox"/>	▶ If "Yes", By whom?
Were you placed on Quarters? [*] YES <input type="checkbox"/> NO <input type="checkbox"/>	▶ If "Yes", List dates:

[*] NOTE: Active Duty members who missed entire duty days -must- submit a copy of their Leave and Earning Statement (LES) and complete a "CERTIFICATION STATEMENT of Military Services Lost Due to Third Party Incident" -- attached).

ATTORNEY REPRESENTATION

NAME OF LAW FIRM	ADDRESS
ATTORNEY'S NAME	ATTORNEY'S TELEPHONE NUMBER & FAX NUMBER
CHECK THIS BOX: IF YOU HAVE -NOT- RETAINED THE SERVICES OF AN ATTORNEY CONCERNING THIS INCIDENT: <input type="checkbox"/>	

INJURED PARTY'S STATEMENT AND SIGNATURE

UNDER PENALTY OF PERJURY, I CERTIFY THAT THE FORGOING INFORMATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I hereby acknowledge receipt of the "Advice to Injured Party" form and understand that use of this information is authorized by law in pursuing medical claims in favor of the U.S. Government.

DATE SIGNED	INJURED PARTY'S SIGNATURE (Parent's Signature, if injured party is a minor.)
	

PLEASE ATTACH ANY & ALL AVAILABLE DOCUMENTS FOR REVIEW BY THE RECOVERY JUDGE ADVOCATE ATTORNEY:

- ▶ Traffic Accident Report
- ▶ Auto Accident Diagram
- ▶ Insurance Policy Copy
- ▶ Leave & Earning Statement (LES) [*]
- ▶ Handcarried Military Medical Record Copies
- ▶ Other Document(s)

MEDICAL RELEASE AUTHORIZATION

DATA REQUIRED BY THE PRIVACY ACT OF 1974

(5 United States Code, Section 552a)

1. **AUTHORITY:** The Federal Medical Care Recovery Act, 42 U.S.C., Section 2651-3, 10 U.S.C., Section 1095, 32 CFR, Part 220.12(f), 5 U.S.C., Section 301, 44 U.S.C., Section 3101.
2. **PRINCIPAL PURPOSE(S):** Authorization for release of medical record excerpts in order to document the claim of the United States Government against third parties for medical care recovery costs.
3. **ROUTINE USES:** Information may be disclosed to civilian attorneys, insurance companies and other agencies to settle claims, and/or to the Department of Justice for use in litigation, and may be furnished to other components of the Department of Defense as required by regulation.
4. **MANDATORY OR VOLUNTARY DISCLOSURE:** Voluntary. However, eligible recipients of Government sponsored medical treatment electing not to provide this information will be required to assign in writing any other claim against any other party as a result of the incident-giving rise to the Government's claim for the recovery of medical care costs.

Patient's Full Name: _____

Date Of Birth: _____

Military Sponsor's Name: _____

Military Sponsor's Social Security Number: _____

I, _____, request and authorize

you to furnish to the office handling the Government claim: (Check one, below ✓)

<input checked="" type="checkbox"/> US ARMY	Staff Judge Advocate, 4217 Roberts Ave Ste 5030, Claims Branch, Fort Meade, MD 20755-5030
<input type="checkbox"/> US AIR FORCE	Medical Cost Reimbursement Program (MCRP) Region 1, 2901 Falcon Lane, Room 213, McGuire AFB, NJ 08641
<input type="checkbox"/> US NAVY/MARINES	Naval Legal Service Office, 9620 Maryland Ave, Suite 100, Norfolk, VA 23511-2989

any and all medical, dental, psychological, and related information, including prescriptions and x-rays, requested concerning the third-party liability incident reported to have occurred on or around: _____.

It is understood that this information/documentation will be used solely and exclusively for the purpose of the full recovery of medical care costs for Government-sponsored civilian or military medical care provided as a result of this incident. Photocopies of this authorization shall have the same validity as the original. This authorization remains in effect unless rescinded in writing.

Date Signed

x

Patient's Signature
(Parent's Signature if Injured Party is a Minor)



CERTIFICATION STATEMENT

OF MILITARY SERVICES LOST DUE TO THIRD PARTY LIABILITY INCIDENT (ACTIVE DUTY ONLY)

STATUTORY AUTHORITY

The Federal Medical Care Recovery Act, 42 United States Code, § 2651 (as amended by Section 1075 of the FY 1997 Authorization Act, Public Law No. 104-201) allows the United States Government to recover the "costs of pay" from an insurer when an active duty member is negligently injured by another and, as a result, is unable or unavailable to perform their assigned military duties (for complete duty days). This amendment also permits such recovery without a finding of tort liability in no-fault jurisdictions. The authority to collect the costs of pay relating to lost military services is pursuant to the amendments made in Section 1075 and applies to costs of pay ("wages") lost by the Government on or after the date of the enactment of this Act, which is September 23, 1996, regardless of whether the incident giving rise to the claim occurs prior to that date. Such a claim for lost military pay/services as a result of this incident is that of the United States, and not that of the injured service member.

IMPORTANT: Send completed form to the military legal office handling assertion of the Government's claim.

INJURED PARTY (Last, First, MI)	RANK	DATE OF ACCIDENT	U.S. CLAIM NUMBER

ITEMIZATION OF DUTY DAYS MISSED

As a result of the above-captioned incident, I, as an active duty service member, was unable and/or unavailable to perform my assigned military duties for complete duty days during the specific time period(s) listed below:

MEDICAL STATUS	NUMBER OF DAYS	DATE(S)
Quarters Status (issued by a military physician)		
"Off Work Excuse" (issued by a civilian physician)		
Military Inpatient Hospital Stay		
Civilian Inpatient Hospital Stay		
Same Day Surgery Stay		
Convalescent Leave Status		
Subsisting Elsewhere Status (pending a Medical Evaluation Board)		
Individual duty days missed in their entirety due to traveling to, and/or submitting to, necessary medical treatment or tests as a result of the incident: - Soldier unavailable for recall to perform assigned military duties as a result of this incident:		
OTHER: (Specify)		
I LOST NO TIME AWAY FROM MILITARY DUTIES AS A RESULT OF THIS THIRD PARTY LIABILITY INCIDENT (CHECK HERE): <input type="checkbox"/>		
TOTAL DUTY DAYS MISSED AS A RESULT OF THE INCIDENT:		

I WAS ASSIGNED TO THE FOLLOWING MILITARY UNIT DURING THE TIME PERIOD(S) INDICATED:

(Information will be used to ensure proper return of funds to the appropriation supporting the installation to which the service member was assigned)

NAME OF UNIT	MAILING ADDRESS	TELEPHONE NUMBER
NAME OF UNIT BUDGET OFFICER	BUDGET OFFICER'S PHONE NUMBER	

CERTIFICATION STATEMENT

UNDER THE PENALTY OF PERJURY, I have completed this form and certify that the information I have provided is true and complete to the best of my knowledge and belief. I further acknowledge that Federal Laws (18 United States Code, Sections 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States of America. I understand that this information will be used by the Government to pursue and recover the "costs of pay" relating to military services lost as a result of the incident from the legally-responsible party and/or insurance company.

INJURED SOLDIER'S SIGNATURE	DATE SIGNED

REMINDER: Please attach a legible copy of a DFAS Form 702 Leave and Earnings Statement (LES).

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

*Form Approved
OMB No. 0720-0003
Expires May 31, 2007*

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).

The public reporting burden for this collection of information is estimated to average 20 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, Executive Services and Communications Directorate (0720-0003). 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: 42 U.S.C. 2651 - 2653; 10 U.S.C. 1079, 1085, 1086 and 1092; and E.O. 9397.

PRINCIPAL PURPOSE(S): To assist in determining possible third party liability for medical supplies and services claims under TRICARE (previously known as CHAMPUS). Information requested is used in reviewing claims to obtain additional information to determine proper liability of third parties for claims and to facilitate possible recovery by the United States for improperly paid claims.

ROUTINE USE(S): Information may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under TRICARE (formerly known as CHAMPUS); to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to members of Congress with the consent of the individual involved. Appropriate disclosures may be made to other Federal, state, local and/or foreign law enforcement agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, 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 (formerly CHAMPUS).

DISCLOSURE: Voluntary; however, failure to provide information will result in a claims processing delay and may result in denial of the claim.

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.

**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

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