NAVY MEDICINE REQUEST FOR PRIME SPECIALTY CARE TRAVEL OVER 100 MILES

PART I: PATIENT AND NON-MEDICAL ATTENDANT (NMA) INFORMATION VERIFICATION

1.a Patient name (Last, First, MI):	**1.b** Patient SSN:
1.c Patient phone:	**1.d** Patient email:
1.e Patient DOB:	**1.f** Patient home address:
2.a Today's date:	**2.b** Appointment date:
2.c TDY start date:	**2.d** TDY end date:
2.e Sponsor name (Last, First, MI):	**2.f** Family member prefix (FMP)/Sponsor SSN:
3.a NMA name (Last, First, MI):	**3.b** NMA SSN:
3.c NMA work number:	**3.d** NMA home number:
3.e NMA DOB:	**3.f** NMA home address:
3.g NMA is: Military Member ☐ U.S. Government Employee ☐ Other ☐	
3.h Branch of service	**4.a** Name of medical treatment facility (MTF):
4.b Is this non-emergency care? Yes ☐ No ☐	**4.c** Is this outpatient care? Yes ☐ No ☐
4.d Is this care appropriate and medically necessary? Yes ☐ No ☐	**4.e** Is this a follow up to a previous visit? Yes ☐ No ☐
5.a PCM's name (Last, First, MI):	
5.b PCM's signature and date: *By signing this block, I am certifying that an NMA is medically necessary or deemed appropriate to travel with an adult patient, 18 years of age or older.* *The PCM's signature is required in order for the NMA to receive travel allowances.*	

PART II: COMPLETED BY THE TRICARE MANAGEMENT/HEALTH BENEFIT OFFICE PROGRAM BENEFIT ADVISOR

6.a Destination/specialty care provider address:	**6.b** Is distance greater than 100 miles (one way)? Yes ☐ No ☐
6.c Is patient enrolled in TRICARE Prime to the MTF? Yes ☐ No ☐	**6.d** Referral number:
6.e Is government transportation practical? Yes ☐ No ☐	**6.f** DODT mileage from PCM to Specialty Provider:
7.a BCAC name (Last, First, MI):	**7.b** BCAC title:
7.c Beneficiary Counselling and Assistance Coordinator (BCAC) signature and date:	