TRICARE PRIME TRAVEL BENEFIT/ COMBAT RELATED DISABILITY TRAVEL PATIENT INFORMATION WORKSHEET

Prime Network Enrollees
TRICARE Prime Travel Offices
PTB Phone #: 844-204-9351 PTB Fax #: 210-536-6176
PTB E-Mail: DHA.TRICAREPTB@mail.mil
Prime MTF Enrollees
Contact your MTF Prime Travel Office

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; Joint Travel Regulation Uniformed Service Members and DOD Civilian Employees.

PURPOSE: To document the requirement for specialty care and a Non-Medical Attendant to accompany the patient for travel 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 and the Internal Revenue Service to provide information subject to federal income tax, and banking establishments for the purpose of confirming billing or expense data, and your healthcare providers for the purpose of continuing care.

If you submit protected health information (PHI) using this form, it is 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 delayed or denied.

DATE: *(YYYYMMDD)* _____

PATIENT INFORMATION

DIRECT DEPOSIT INFORMATION:
*A Direct Deposit Form must be submitted once every fiscal year or upon any changes to the bank account on file.
*Current Fiscal Year Bank Account Information on file is valid for Patient (18 or older)? ☐ YES ☐ NO

PATIENT NAME: _____
PATIENT DATE OF BIRTH: _____
PATIENT DoD BENEFITS #: _____
PATIENT ADDRESS: _____
PATIENT CITY/STATE: _____
PATIENT ZIP CODE: _____
PATIENT DAYTIME PHONE NUMBER: _____
PATIENT EMAIL: _____

MILITARY SPONSOR'S INFORMATION

SPONSOR'S NAME: _____
SPONSOR DoD BENEFITS #: _____
SPONSOR STATUS: ☐ Active Duty Service Member (ADSM) ☐ Retiree (RET)
BRANCH OF SERVICE: ☐ USAF ☐ USA ☐ USCG ☐ USPHS ☐ USMC ☐ USN ☐ USSF

PRIMARY CARE MANAGER (PCM) INFORMATION

PCM NAME: _____
PCM ADDRESS: _____
PCM CITY/STATE: _____
PCM ZIP CODE: _____
PCM PHONE: _____

SPECIALTY CARE PROVIDER (SCP) INFORMATION

SCP NAME: _____
SCP ADDRESS: _____
SCP CITY/STATE: _____
SCP ZIP CODE: _____
SCP PHONE: _____
TYPE OF SPECIALTY: _____

MEDICAL APPOINTMENT INFORMATION

*Note: Use military time for Appointment Time(s) and Admission/Discharge Time(s).

TRAVEL DEPARTURE DATE: _____
TRAVEL RETURN DATE: _____
FIRST APPT DATE: _____ LAST APPT DATE: _____
FIRST APPT TIME: _____ LAST APPT TIME: _____
FIRST APPT: ☐ AM ☐ PM LAST APPT: ☐ AM ☐ PM
INPATIENT: ☐ YES ☐ NO
ADMISSION DATE/TIME: _____ _____ ☐ AM ☐ PM
DISCHARGE DATE/TIME: _____ _____ ☐ AM ☐ PM

SPECIALTY CARE REFERRAL/AUTHORIZATION INFORMATION

AUTHORIZATION NUMBER: _____
OTHER HEALTH INSURANCE (OHI): ☐ YES ☐ NO
PCM REFERRAL LETTER ATTACHED: ☐ YES ☐ NO
MODE OF TRAVEL ☐ POV ☐ RENTAL CAR ☐ AIR ☐ OTHER

NON-MEDICAL ATTENDANT (NMA) INFORMATION

*Please ensure a NMA medical necessity letter from the patient's doctor accompanies all NMA claims (for ALL adults 18 years or older).

NMA NAME: _____

NMA DoD BENEFITS #: _____

RELATION TO PATIENT: _____

NMA DAYTIME PHONE: _____

NMA EMAIL: _____

NMA FEDERAL EMPLOYEE UNDER DoD: ☐ YES ☐ NO

NMA GOVERNMENT EMAIL: _____

ACTIVE DUTY (AD) MILITARY: ☐ YES ☐ NO

DIRECT DEPOSIT INFORMATION:
*A Direct Deposit Form must be submitted once every fiscal year or upon any changes to the bank account on file.

*Current Fiscal Year (FY) Bank Account Information on file is valid for Non-Medical Attendant? ☐ YES ☐ NO

COMBAT RELATED DISABILITY TRAVEL (CRDT) ONLY

Phone # 844-204-9351 Fax #703-275-6258 E-mail: DHA.CRDT@mail.mil

CRDT DETERMINATION LETTER ATTACHED: ☐ YES ☐ NO

PCM REFERRAL LETTER ATTACHED (must have been issued within the past 12 months): ☐ YES ☐ NO

SCP PROVIDER TREATMENT CONFIRMATION LETTER ATTACHED: ☐ YES ☐ NO

TRICARE COVERED TREATMENT FOR VERIFIED COMBAT-RELATED INJURY: ☐ YES ☐ NO

OTHER HEALTH INSURANCE (OHI): ☐ YES ☐ NO

HAS THE VETERAN AFFAIRS (VA) REIMBURSED TRAVEL EXPENSES FOR THIS EPISODE OF CARE: ☐ YES ☐ NO

ADDITIONAL INFORMATION

*If you need extra space to provide any additional information within this document, use the space provided.

By signing you attest that all information provided on this form is accurate and valid.

CLAIMANT SIGNATURE _____ DATE: *(YYYYMMDD)* _____