RESERVE COMPONENT MEDICAL COVER SHEET

MILITARY MEDICAL SUPPORT OFFICE 10 OCT 2003)

PATIENT DATA

LAST NAME:	*First Name*	*MI*	*Pay Grade*	*Social Security #*	*Date of Birth*

Branch of Service:

☐ USAR* ☐ USNR* ☐ USMCR* ☐ USAFR* ☐ ARNG* ☐ ANG* ☐ USCGR*

Patients Home Address:

_____

Street Address **City** **State** **Zip Code**

Home phone number (with Area Code):

TREATMENT INFORMATION (COMPLETE ALL 3 LINES FOR ALL ACTIONS)

Injury date: _____ **Treatment Date(s)**: _____ **Diagnosis**: _____

Duty Status at Time of Initial Episode: ☐ *IDT* ☐ *ADT* ☐ *AT* ☐ *ADSW* ☐ *PSRC* ☐ *UTA (Air Force Only)*

***NOE/LOD TYPE*:** ☐ Admin ☐ Informal ☐ Formal **Duty Dates From:** _____ **To:** _____

**For service members in an Inactive Duty status, appropriate eligibility documentation must be provided if treatment has been found to be a result of a service-connected injury.*

ACTION TYPE

☐ **Eligibility information attached** for:

☐ Emergency/Initial Episode

☐ Authorized follow-up visit: #_____ (Pre-Authorization Number issued by MMSO)

☐ **Pre-Authorization Request** (Treatment plan and provider information attached)

UNIT COMMANDER OR DESIGNATED REPRESENTATIVE CERTIFICATION OF ELIGIBILITY

Current Duty Station (Unit of Assignment) _____ _____

Unit /Command **UIC / OPFAC**

_____

Street Address **City** **State** **Zip Code**

DEERS address has been verified and updated at http://www.tricare.osd.mil/deers/default.cfm YES NO

Unit Phone Number (with Area Code) & POC (Name, Rank/Title):

Nearest Military Treatment Facility is located at_____,

_____ **miles from the reservist/guard's residence.**

I certify that this individual is eligible for this care at government expense.

_____

Signature	**Printed Name (CO or Medical Representative)**	**Phone number of Unit or Medical Representative**	**Date**

Mail this form and eligibility documents to:

MMSO, ATTN: Reserve Eligibility, PO BOX 886999, Great Lakes, IL 60088-6999

**Accepted eligibility documents:*

- ✓ Drill Attendance Sheet or Orders (only initial episode of care) for Coast Guard a CG-4436B or CG-4899
- ✓ Approved Line of Duty/NOE (All preauthorized follow-up care) with preauthorization number.

☐ **Return Receipt requested**: ***POC Name:*** ***Fax Number:***

Transmittal Letter Number# _____ **(Format YY – MM- Monthly Sequence #)**

USE SAME NUMBER FOR ALL PACKETS IN BATCH

Mail Medical Claim forms (HCFA 1500, UB 92) and ***if applicable*** DD Form 2642, (TRICARE Claim Form for Service Member Reimbursement – pharmacy or medical care – available on website) ***to the TRICARE Contractor based on where service member lives and not where the medical treatment is received*** **– GO TO www.tricare.osd.mil/remote for TRICARE Contractor's mailing address.**

Submit Dental Claims in accordance with the Dental Instruction at http://mmso.med.navy.mil