MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
ADMISSIONS	NAVHOSPPNCLAINST 6010.9X	20 Jan 2016

LOCAL FORM TITLE *(Optional)*
CHARGE / THIRD PARTY INSURANCE INFORMATION SHEET

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PLEASE READ AND SIGN

The Naval Hospital is required by law to charge active duty members, dependents, retired officers and certain other categories of patients specified rates for **general nursing care for each day of hospitalization.** Each patient or his/her sponsor is obligated to pay these charges at the time of discharge or make arrangements for periodic payments.

The amount of the charge is determined by the patient's category (i.e., eligibility status) and the length of the hospital stay. Active duty members may pay subsistence charges upon discharge, request a voluntary pay checkage or make arrangements for scheduled payments. **Active duty members failing to do this will have the full amount owed collected by an involuntary pay package.** Persons determined to be ineligible for medical care at a military medical treatment facility will be charged the full reimbursement rate dependent on care received. There is no charge for retired enlisted personnel. Charges will be waived for family members or retirees who have a hospitalization insurance policy that pays for the claim. If claim is denied, charges will not be waived.

Non-insured daily charge as a _____ **will be** _____ **.**
NOTE: This charge changes each OCTOBER, as mandated by the SECNAV Comptroller.

(There is no family member rate change for Active Duty family members enrolled in Tricare Prime). Your (or your sponsor) are encouraged to anticipate these charges as you will be asked to pay your bill on the day you are discharged from the hospital. **Payment may be cash, check, Visa or MasterCard.** You are invited and encouraged to discuss any problems that you may have in paying your bill with the Collection Agent located on the first floor. The number is (850 505-6668.

Information concerning medical insurance policies you may have is solicited under the authority of Chapter 55, Title 10, U.S.C. Section 1095. It is being collected to assist the Navy in recovering the cost of medical care from your insurer or other liable third-party and will be used to operate the medical treatment facility. If the insurance, medical service or health plan of that payer includes a requirement for a deductible or co-payment by the beneficiary of the plan, then the amount the United States may collect for the third-party payer is the reasonable cost of care provided less the deductible or co-payment amount. You will not be required to pay the deductible or co-payment.

Do you have any group / medical insurance policy? ☐ Yes ☐ No

Please complete the DD FORM 2569 insurance information provided by the Admission Clerk.

I certify that the entries made by me are true, complete, and accurate to the best of my knowledge and belief and are made in good faith. I understand that a knowing and willful false statement on this form can be punished by fine or imprisonment or both.

Date	Signature of person completing form	Witness

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	