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
DIRECTORATE OF MEDICAL SERVICES PATIENT FORMS	NAVHOSPPNCLAINST 5213.6B	01 Oct 2015

LOCAL FORM TITLE *(Optional)*
URGENT CARE CENTER REGISTRATION

PRIVACY ACT STATEMENT: **AUTHORITY: TITLE 10 USC. SEC; EO 9397**

Principle Purposes: Information will be used to collect from private insurers for medical care provided to military dependents and retirees. Such monetary benefits accruing to the Military Medical Facility will be used to enhance health care delivery in the Medical Treatment Facility. Information will also be used by Military Treatment Facility staff and Champus. Fiscal Intermediaries to determine eligibility for care, deductibles, and closures.
Routine Uses: The information on this form will be released to your insurance company, and to Medical Treatment Facility staff, Champus FI's and providers.
Disclosures: Voluntary, however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services and in a higher cost to your for medical care.

Reason for Visit _____ **Time** _____

Patient Name _____ ☐ Male ☐ Female

Age _____ **Date of Birth** _____ **Status** ☐ Retired ☐ Active Duty ☐ Family member

Sponsor ID # _____

Branch of Service ☐ USN ☐ USMC ☐ USAF ☐ USA ☐ USACG ☐ Other _____

Active duty station _____

Home Phone _____ **Work Phone** _____

Cell Phone _____

Home Address _____

_____
City **State** **Zip**

Are you enrolled in Tricare Prime? ☐ YES ☐ NO ☐ UNSURE **If yes, Where?** _____

Do you have health insurance other than Medicare/Champus? ☐ YES ☐ NO ☐ UNSURE
If yes, please complete DD Form 2569 and provide insurance card to clerk.

Is your visit related to an injury or automobile accident? ☐ YES ☐ NO
Date of injury/accident _____

Signature _____ **Date** _____

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	