

CERTIFICATION OF ELIGIBILITY FOR MEDICAL CARE

TO BE COMPLETED FOR ANY PATIENT NOT POSSESSING A VALID IDENTIFICATION CARD

INSTRUCTIONS: Prepare original and two copies. Send the original to Outpatient Administration Office. Place one copy in outpatient record. Give second copy to patient.

PATIENT _____
NAME DATE OF BIRTH RELATIONSHIP TO SPONSOR

PATIENT ADDRESS _____
STREET ADDRESS CITY STATE ZIP CODE

SPONSOR _____
NAME RANK/RATE

DUTY STATION _____
COMMAND/HOME STREET ADDRESS CITY STATE ZIP CODE

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

It is agreed that I will produce a valid dependent's identification care within thirty (30) calendar days of this date of this agreement. It is understood that failure to produce a valid identification card within thirty (30) days will result in the denial of routine medical care. It is further understood that your Fiscal Department will bill me, in accordance with NAVMED instruction P 5020, at the full reimbursement rate.

I certify that to the best of my knowledge and belief that the above information is true and correct, and that the patient named and described above is entitled to medical care in facilities of the United States Government.

PENALTY FOR FALSE, FICTITIOUS OR FRAUDULENT STATEMENTS

“Whosoever makes or presents, to any person, of officer in the civil, military or Naval service of the United States, or to any department of agency thereof, any claim to be false, fictitious or fraudulent, shall be fined not more than \$10,000 or imprisoned no more than five (5) years or both.” (10 USCMJ)

DATE

PATIENT/GUARDIAN SIGNATURE

WITNESS SIGNATURE