THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

OMB No. 0720-0055 OMB approval expires 31 Aug, 2019

The public reporting burden for this collection of information is estimated to average 4 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350-3100 (0720-0055). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION.

RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1079b, Procedures for charging fees for care provided to civilian; retention and use of fees collected;1095, Health care services incurred on behalf of covered beneficiaries: collection from thirdparty payers; 42 USC. Chapter 32, Third Party Liability For Hospital and Medical Care; EO 9397 (SSN) as amended.

PURPOSE(S): Your information is collected to allow recovery from third parties for medical care provided to you in a Military Treatment FacilityROUTINE USE(S): Your records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurances providers, and other third parties in order to collect amounts owed to the Department of Defense. Your records may also be used and disclosed in accordance with 5 USC 552a(b) of the Privacy Act of 1974, a amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

		PATIEN [*]	TINFORMATION						
1. PATIENT NAME (Last, First, Middle	le Initial)		2. SSN 40		3. DATE OF BIRTH (YYYY/MM/DD)				
4a. MAILING ADDRESS (Include ZII	Code) APC)		b. HOME TELEPHONE NO. () 5a. FAMILY MEMBER PREFIX b. SPONSOR SS					
6a. PATIENT'S EMPLOYER'S NAM	ME			b. EMPLOYE	R TELEPHONE NUMBER DSN				
	10 10 10 10	INSURAN	CE INFORMATIO	N					
7. ARE YOU ELIGIBLE FOR VET	ERANS AFFAIR	RS BENEFITS?							
a. YES. (If you have an insuraby the MTF representative,	ance card (e.g., please provide	Veterans Health Ide it and proceed to Ite	entification Card (Vi em 8; otherwise, ple	HIC), Veterans (Choice Card), that can be copied or scanned tems 7.a.(1) through (5) below.)				
(1) Member ID		(2) Plan ID			(3) Expiration Date (YYYY/MM/DD)				
(4) VA Facility Name (e.g., primary ca	are/specialty clinic) that assists in coor	rdinating your care						
(5) VA Facility Address and Telepho	one Number								
b. NO. (Proceed to Item 8.)				-()-					
8. DO YOU HAVE OTHER HEALT and Medicare Supplement.)	H INSURANCE	? (This includes en	nployer health insui	rance benefits, c	other commercial health insurance coverage,				
a. YES. (Complete Item 9 and	the remaining	sections below.)							
b. NO, I am a DoD beneficiary	and rely solely	on TRICARE, Medic	care, or Medicaid.	(Proceed to Iten	n 13.)				
c. NO, but I am not a DoD ben	eficiary. (Proce	ed to Item 12.)							
 PRIMARY MEDICAL INSURANCE please provide it and proceed to 	CE INFORMATI	ON. If you have an rise, please complet	insurance card that e the blocks below.	t can be copied	or scanned by the MTF representative,				
a. NAME OF POLICY HOLDER (La	itial)	b. DATE OF	b. DATE OF BIRTH (YYYY/MM/DD) c. RELATIONSI HOLDER						
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER			e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER						
f. CARD HOLDER ID	g. POLICY ID		h. GROUP P	OLICY ID	i. GROUP PLAN NAME				
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE			FECTIVE DATI	m. POLICY END DATE (YYYY/MM/DD)				
n.(1) Pharmacy (Rx) Insurance Com	npany Name, Ad	ddress and Telepho	ne Number						
(2) Rx Policy ID	(3) Rx Bin Number		(4)	Rx PCN Number					

over

10. SECONDARY MEDICAL	INSURANCE INFO	RMATION.	. If you have ar	insurance c	ard that can	be copied o	r scanned	by the MT	F rep	oresentative,		
please provide it and proceas. NAME OF POLICY HOLDE		b. DATE OF		YY/MM/DD)	c. RELATIONSHIP TO POLICY							
							HOLDER					
d. POLICY HOLDER'S EMPLO	OYER'S NAME, ADI	DRESS AN	D TELEPHONE	ENUMBER								
e. INSURANCE COMPANY N	AME, ADDRESS AN	ND TELEP	HONE NUMBE	R								
f. CARD HOLDER ID	g. POLICY II		h. GROUP P	i. GROUP PLAN NAME								
j. ENROLLMENT/PLAN COD	ROLLMENT/PLAN CODE k. INSURANCE TYPE				I. POLICY EFFECTIVE DATE (YYYY/MM/DD)				m. POLICY END DATE (YYYY/MM/DD)			
n. (1) Pharmacy (Rx) Insurance	e Company Name,	Address an	d Telephone N	umber			K					
(2) Rx Policy ID		(3) Rx Bin	Number	(4) Rx PCN Number								
11. ARE THERE OTHER FAM	ILY MEMBERS CO	VERED U	NDER THIS PO	DLICY HÓLD	ER?							
a. YES (Complete 11cf	and proceed to Ite	m 13.)		V b. NO	Proceed to	Item 13.)						
c. NAME (Last, First, Middle Initial)	Last, First, Middle Initial) d. SSN e. DATE OF f. RELATIONSHII TO POLICY (YYYY/MM/DD) HOLDER			c. NAME (Last, First, Middle Initial) d			e, DATE OF BIRTH (YYYY/MM/DD)			RELATIONSHIP TO POLICY HOLDER		
									_			
									+			
12. MEDICARE OR MEDICA	ID INFORMATION											
a. MEDICARE PART A NUM		RE PART E	NUMBER	c. MEDICAI	RE MANAGI	ED CARE P	LAN NAM	E				
d. MEDICARE PART D NUMBER AND PLAN NAME e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE							UING					
13. CERTIFICATION, RELEA	SE, AND ASSIGNN	IENT										
I certify that the information United States Code, Sect	on on this form is tru	e and accu	rate to the best	of my knowle	edge. Falsif	ication of in	formation i	is covered	by Ti	itle 18,		
 b. I acknowledge that the au United States Code, Sect 	thority to bill third pa	arty pavers	has been conv	eved to the m	nedical facilit	y within the	Departme	ent of Defe	nse b	y Title 10, e by virtue		
of this act. c. NON-UNIFORMED SERV healthcare services provide	ded me and/or my m	l authorize ninor depen	and request that	at the proceed	is of any and ENT: I hereb	d all benefits by agree to p	s be paid o	directly to t y service n	he M ot co	TF for vered in		
whole or in part by my thin d. NON-DoD MEDICARE, N paid directly to the MTF for	MEDICAID AND VET	ERANS AF	FFAIRS PATIE	NTS: I autho	rize and req	uest that the	proceeds	of any an	d all I	benefits be ment of any		
services not covered by N	Medicare, Medicaid a	and Veteral	ns Affairs, inclu	ding but not I	imited to pat	ient copayn	nents and	deductible	s.			
e. UNIFORMED SERVICES the Uniformed Service for	BENEFICIARIES: r services provided t	I hereby ac	cknowledge that or my family me	t the proceed mber.	s of any and	I all benefits	shall be p	aid directl	y to t	ne facility of		
f. ALL PATIENTS: I authorize released to my insurance	ze portions of my me				ims for reim	bursement f	or the cos	t of care re	ender	ed to be		
14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE						b. DATE (YYYY/MM/DD)						
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE						b. DATE (YYYY/MM/DD)						
16. ANNUAL PATIENT INSU	RANCE VERIFICA	TION										
If any information on this and date at least annually	form has changed, a	a new form										
b. I certify that the information on this form has been verified on the date(s) specified below, and that all inform of my knowledge. 17a. SIGNATURE (Patient or Adult Family Member)							b. DATE (YYYY/MM/DD)					
Tra. SIGNATURE (Patient of A				J. 57116	- ()						
18. VERIFICATION a. (1) Date (YYYY/MM/DD)	(2) Initials	b.(1) Date	e (YYYY/MM/DD)	(2) Initi	als	c.(1) Date	(YYYY/MM	VDD)	(2) In	itials		

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Any protected health information (PHI) in your Permitted uses and disclosures of PHI include, DISCLOSURE: Voluntary. Failure to provide a	but are not limited	o, treatment, payment, and t	healthcare operations.			pplemented within DoD.				
		DATIENT	T INFORMATION							
1. PATIENT NAME (Last, First, Midd	dle Initial)	Lafavit	2. SSN		3. DATE OF	3. DATE OF BIRTH (YYYY/MM/DD)				
4a. MAILING ADDRESS (Include Z		b. HOME TELEPHONE NO.								
		5a. FAMILY ME	MBER PREFIX	b. SPONSOR SSN						
6a. PATIENT'S EMPLOYER'S NA	ME		,	b. EMPLOYER TELEPHONE NUMBER DSN						
		INSURAN	CE INFORMATIO	ON						
7. ARE YOU ELIGIBLE FOR VET	TERANS AFFA	IRS BENEFITS?								
a. YES. (If you have an insu by the MTF representative										
(1) Member ID		(2) Plan ID		(3) Expiration Date (YYYY/MM/DD)						
(4) VA Facility Name (e.g., primary of	care/specialty clin	ic) that assists in coor	rdinating your care							
(5) VA Facility Address and Teleph	one Number									
(3) VA Facility Address and Teleph	ione Number			, v						
b. NO. (Proceed to Item 8.)				- (-)						
8. DO YOU HAVE OTHER HEAL' and Medicare Supplement.)	TH INSURANC	E? (This includes en	nployer health insui	rance benefits, oth	her commercial he	alth insurance coverage,				
a. YES. (Complete Item 9 an	d the remaining	g sections below.)								
b. NO, I am a DoD beneficiar	y and rely solel	y on TRICARE, Medic	care, or Medicaid.	(Proceed to Item	13.)					
c. NO, but I am not a DoD be	neficiary. (Prod	ceed to Item 12.)								
PRIMARY MEDICAL INSURAN please provide it and proceed to		1.9 (33)(5)		26	r scanned by the M	TF representative,				
a. NAME OF POLICY HOLDER (L	ast, First, Middle	Initial)	b. DATE OF	BIRTH (YYYY/MM	(A/DD) c. RELATION HOLDER	ONSHIP TO POLICY				
d. POLICY HOLDER'S EMPLOYE TELEPHONE NUMBER	e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER									
f. CARD HOLDER ID	g. POLICY I	D	h. GROUP P	OLICY ID	i. GROUP	i. GROUP PLAN NAME				
j. ENROLLMENT/PLAN CODE	k. INSURAN	k. INSURANCE TYPE		I. POLICY EFFECTIVE DATE (YYYY/MM/DD)		m. POLICY END DATE (YYYY/MM/DD)				
n.(1) Pharmacy (Rx) Insurance Con	mpany Name, /	Address and Telephor	ne Number							
(2) Rx Policy ID (3) Rx Bin Number				(4) R	Rx PCN Number					

DD FORM 2569, SEP 2016

PREVIOUS EDITION IS OBSOLETE.

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10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative,											
please provide it and proceed to Item 11; otherwise, please complete the blocks below. a. NAME OF POLICY HOLDER (Last, First, Middle Initial) b. DATE OF BIRTH (YYYY/MM/DD) c. RELATIONSHIP TO POLICY											
a. NAME OF POLICY HOLDER (Last, First, Middle Initial)				b. D	HOLDER					OLIO1	
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER											
e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER											
f. CARD HOLDER ID a. POLICY ID h. GROUP POLICY ID							i. GROU	D DI AN I	JANAE		
f. CARD HOLDER ID g. POLICY ID					NOOF FOLIOT ID		61.66. 1 2 11 12 11.2				
j. ENROLLMENT/PLAN COD	E k. INSUR	ANCE TYPE		I. POLICY EFFECTIVE DATE			m. POLICY END DATE				
and the contraction and the second substitute of the contraction and the contraction to the contract to the contract to				C	YYY/MM/DD)	(YYYY/MM/DD)					
n. (1) Pharmacy (Rx) Insurance	ce Company Name	e, Address a	nd Telephone N	lumbe	r						
(2) Rx Policy ID		(3) Rx Bir	n Number			(4) Rx PCN	Number				
11. ARE THERE OTHER FAM	ALL V MEMBERS	COVERED II	INDED THIS D	21.103	VUOLDERS						
			INDER THIS PO	./		(tom 12.)					
a. YES (Complete 11ci	and proceed to I	e. DATE OF	f. RELATIONSHIP	_	b. NO (Proceed to	item 13.)		e. DATE	OF T	f. RELATIONSHIP	
c. NAME (Last, First, Middle Initial)	d. SSN	BIRTH (YYYY/MM/DD)	TO POLICY HOLDER	c. N	AME (Last, First, Middle In	nitial) d.	SSN	BIRTH (YYYY/MM/DD)		TO POLICY HOLDER	
		(TTTT/MANUEL)	HOLDER		The second secon			(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		
				. v							
 MEDICARE OR MEDICA MEDICARE PART A NUM 			R NI IMRED	c M	EDICARE MANAGE	ED CARE P	ΔΝ ΝΔΜ	F	-		
a. WEDICARE PART A NOP	VIBER D. WEDIC	ANE PART	BINOMBER	Ç. IV	EDICARE MANAGE	LD OAKL I	DAIL INAM	_			
d. MEDICARE PART D NUI	d. MEDICARE PART D NUMBER AND PLAN NAME e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING									UING	
					STATE						
13. CERTIFICATION, RELEA	SE. AND ASSIG	MENT	150-0-05-0-0								
a. I certify that the information	on on this form is t	rue and accu							by T	itle 18,	
United States Code, Sect b. I acknowledge that the au	thority to bill third	party pavers	has been conv	eved	to the medical facilit	ty within the	Departme	nt of Defe	nse l	by Title 10,	
United States Code, Sect of this act.	ions 1095 and 10	79b, and that	t no personal er	ntitlem	ent to reimburseme	nt or payme	nt has bee	en granted	to n	e by virtue	
or this act. c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for											
healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in											
whole or in part by my third-party insurer. d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be											
paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any											
services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles. e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of										he facility of	
the Uniformed Service for	r services provide	d to me and/	or my family me	mber							
 f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers. 											
14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE b., DATE MYY MM/DD)											
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE							b. DATE (YYYY/MM/DD)				
16. ANNUAL PATIENT INSU	RANCE VERIFIC	ATION			and singer of Others		ial sianati	usa wasifu	with	veus initiala	
If any information on this and date at least annually	٧.									201 - 2003 - 200 - 2003 - COL - 2003 - 200 - 2003	
b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best											
of my knowledge. 17a. SIGNATURE (Patient or A	dult Family Member)		-			b. DATE	(YYYY/M	M/DD,		
18. VERIFICATION	(2) Initials	b.(1) Dat	e (YYYY/MM/DD)		(2) Initials	c.(1) Date	(YYYY/MM	(DD)	(2) Ir	nitials	
a. (1) Date (YYYY/MM/DD)											