

1. PATIENT'S NAME (Last, First, Middle Initial) Doe, Betty L.		2. PATIENT'S TELEPHONE NUMBER (Include Area Code) Primary 011) 66-2-888-7777 Secondary 011) 66-81-888-9999	
3. PATIENT'S ADDRESS (Street, Apt. No., City, State, and ZIP Code) Le Premier Unit 8/36 105 Sukhumvit Soi 49 Bangkok 10120 Thailand		4. PATIENT'S RELATIONSHIP TO SPONSOR (X one) <input type="checkbox"/> SELF <input type="checkbox"/> STEPCHILD <input checked="" type="checkbox"/> SPOUSE <input type="checkbox"/> FORMER SPOUSE <input type="checkbox"/> NATURAL OR ADOPTED CHILD <input type="checkbox"/> OTHER (Specify)	
5. PATIENT'S DATE OF BIRTH (YYYYMMDD) 19600514	6. PATIENT'S SEX (X one) <input type="checkbox"/> MALE <input checked="" type="checkbox"/> FEMALE	7. IS PATIENT'S CONDITION (X both if applicable) If yes, see #7 in section below ACCIDENT RELATED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No WORK RELATED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No As Applicable	
8a. DESCRIBE ILLNESS, INJURY OR SYMPTOMS THAT REQUIRED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW. High fever, cough, vomiting. Specify reason for patient's visit.		8b. WAS PATIENT'S CARE (X one) <input type="checkbox"/> INPATIENT? <input type="checkbox"/> PHARMACY? <input checked="" type="checkbox"/> OUTPATIENT? <input type="checkbox"/> DAY SURGERY?	
9. SPONSOR'S OR FORMER SPOUSE'S NAME (Last, First, Middle Initial) Same		10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER OR DOD BENEFITS NUMBER (DBN) DBN is on Back of Military ID Card	
11. OTHER HEALTH INSURANCE COVERAGE a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? For patients overseas this includes National Health Insurance. If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO As Applicable			
b. TYPE OF COVERAGE (Check all that apply) <input type="checkbox"/> (1) EMPLOYMENT (Group) <input type="checkbox"/> (3) MEDICARE <input type="checkbox"/> (5) MEDICARE SUPPLEMENTAL INSURANCE <input type="checkbox"/> (7) OTHER (Specify) <input type="checkbox"/> (2) PRIVATE (Non-Group) <input type="checkbox"/> (4) STUDENT PLAN <input type="checkbox"/> (6) PRESCRIPTION PLAN			
	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE (Street, City, State, and ZIP Code)	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE (YYYYMMDD)
INSURANCE 1			<input type="checkbox"/> YES <input type="checkbox"/> NO
INSURANCE 2		Signer's relationship to patient.	<input type="checkbox"/> YES <input type="checkbox"/> NO
REMINDER: Attach your other health insurances's Explanation of Benefits or pharmacy receipt that indicates the actual drug cost, amount the OHI paid, and the amount that you paid. As Applicable			
12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.			13. OVERSEAS CLAIMS ONLY: PAYMENT IN US CURRENCY? Thai Baht <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
a. SIGNATURE <i>Patient or Authorized Person</i> Betty L. Doe	b. DATE SIGNED (YYYYMMDD) 20190101	c. RELATIONSHIP TO PATIENT Self	
HOW TO FILL OUT CHAMPUS FORM You must attach an itemized bill (see front of form) to the claim. On or After Date of Medical Care If using Direct Deposit, only USD is available.			
<p>1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.</p> <p>2. Enter the patient's primary telephone number and secondary telephone number to include the area code.</p> <p>3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.</p> <p>4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.</p> <p>5. Enter patient's date of birth (YYYYMMDD).</p> <p>6. Check the box for either male or female (patient).</p> <p>7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity." Download the form at https://tricare.mil/forms.</p> <p>8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident.</p> <p>8b. Check the box to indicate where the care was given.</p> <p>9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."</p> <p>10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN) or Patients DoD Benefits Number (DBN).</p> <p>11. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a. and sign the claim. Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.</p> <p>13. If this is a claim for care received overseas, indicate if you want payment in US currency.</p>			