HEALTH CARE SERVICES or SUPPLIES

TRICARE Claim Checklist

PROVIDER'S Name: _____

PROVIDER'S Address: _____

Patient's Name: _____ Sponsor's SSN: _____

Date(s) of Service: _____

Diagnosis or Description of Symptoms. (*List all pertinent diagnosis.*)

1	
2	
3	
4	
5	
6	
7	

List each Item of Service or Supply:

Item of Service or Supply	**Number & Frequency of Service**	**Charges***
(**Charges are assumed to be in Thai Baht unless otherwise indicated.)*	***Total Paid:***	

Note: A completed and signed DD Form 2642 claim form, and copies of the applicable medical certificate or medical report and all itemized receipts showing payment for these services are required documentation when filing a claim with the TRICARE overseas claims processor. This checklist is only supplemental information that may be attached to the above required claims documentation. (1 Apr 08)

Privacy Act of 1974 (amended) applies.