SAMPLE (Sponsor)

Patient Paid in Full THB 8,974.48

1. PATIENT'S NAME *(Last, First, Middle Initial)*
Doe, John J.

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)*
Sam Iam Post Office
P.O. Box 911
Nakon Nowhere 18230 Thailand

4. PATIENT'S RELATIONSHIP TO SPONSOR *(X one)*
[X] SELF [ ] STEPCHILD
[ ] SPOUSE [ ] FORMER SPOUSE
[ ] NATURAL OR ADOPTED CHILD [ ] OTHER *(Specify)*

5. PATIENT'S DATE OF BIRTH *(YYYYMMDD)*
19581128

6. PATIENT'S SEX *(X one)*
[X] MALE [ ] FEMALE

7. IS PATIENT'S CONDITION *(X both if applicable)*
If yes, see #7 in section below
As Applicable
ACCIDENT RELATED? [ ] Yes [X] No
WORK RELATED? [ ] Yes [X] No

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)*
[ ] INPATIENT? [ ] PHARMACY?
[X] OUTPATIENT?
[ ] 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.
[ ] YES [X] NO
As Applicable

b. TYPE OF COVERAGE *(Check all that apply)*
[ ] (1) EMPLOYMENT *(Group)* [ ] (3) MEDICARE [ ] (5) MEDICARE SUPPLEMENTAL INSURANCE [ ] (7) OTHER *(Specify)*
[ ] (2) PRIVATE *(Non-Group)* [ ] (4) STUDENT PLAN [ ] (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)*	f. DRUG COVERAGE?
INSURANCE 1				[ ] YES [ ] NO
INSURANCE 2				[ ] YES [ ] NO

Signer's relationship to patient.

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.

12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.

a. SIGNATURE Patient or Authorized Person	b. DATE SIGNED *(YYYYMMDD)*	c. RELATIONSHIP TO PATIENT
John J. Doe	20190715	Self

On or After Date of Medical Care

13. OVERSEAS CLAIMS ONLY: PAYMENT IN US CURRENCY?
As Applicable
Thai Baht
[X] No [ ] Yes
If using Direct Deposit, only USD is available.

HOW TO FILL O AMPUS FORM
You must attach an itemized bill (see front of f supplier for CHAMPUS to process thi

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's primary telephone number and secondary telephone number to include the area code.
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.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.
5. Enter patient's date of birth (YYYYMMDD).
6. Check the box for either male or female (patient).
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.
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.
8b. Check the box to indicate where the care was given.
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."
10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN) or Patients DoD Benefits Number (DBN).

u must report if the patient is covered by a include health coverage available through other family members. If the patient has supplemental TRICARE/CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.
NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. *The claims processor cannot process claims until you provide the other health insurance information.*
12. 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.
13. If this is a claim for care received overseas, indicate if you want payment in US currency.