HEALTH CARE SERVICES or SUPPLIES TRICARE Claim Worksheet

PROVIDER'S Name:		
PROVIDER'S Address:		
Detient's Name:		
Patient's Name:		
Sponsor's SSN (or DBN):		
Date(s) of Service:		
Diagnosis or Description of Symptoms. (List all pertinent diagnoses.)		
2		
3		
4		
5		
6		
List each Item of Service or Supply:		
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Item of Service or Supply	Number & Frequency of Service	Charges*
Item of Service or Supply	Frequency	Charges*
Item of Service or Supply	Frequency	Charges*
Item of Service or Supply	Frequency	Charges*
Item of Service or Supply	Frequency	Charges*
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<u>Note</u>: A properly completed and signed DD Form 2642 claim form, and copies of the associated medical certificate or medical report, and all itemized receipts with proof of payment for these services are required documentation when filing a TRICARE Overseas claims. This worksheet is an optional supplement that may be included with your claim. (1 January 2018)

Total Paid:

(*Charges are assumed to be in Thai Baht unless otherwise indicated.)