Defense Health Agency - Great Lakes
DHA-GL Worksheet-01
Rev. 04/10/2017

MEDICAL ELIGIBILITY VERIFICATION:
RESERVE COMPONENT

Instructions: Member or unit representative completes Sections I and II. Unit representative completes and validates Section III, then faxes or mails this form and supporting documentation to DHA-GL.
Complete ALL Blocks

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the Defense Health Agency Great Lakes and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE Program and, E.O. 9397 (SSN), as amended.

PURPOSE: To collect information from Military Health System beneficiaries in order to determine their eligibility for coverage under the TRICARE Program.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a (b) of the Privacy Act of 1974, as 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 by DoD 6025.18-R. Permitted uses and discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of coverage.

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COMPLETE ALL BLOCKS

Section I Member Data

1. Branch of Service: ☐ USAR ☐ USNR ☐ USMCR ☐ USAFR ☐ ARNG ☐ ANG ☐ USCGR

2. Name (Last, First, MI):	3. Rank or Grade:	4. SSN:

5a. Address (street, apt #, city, state, & zip):	6. DOB (YYMMDD):
5b.Member Email Address:	7. Phone # (include area code):

Section II Illness/Injury Information

8. Date of injury/illness (YYMMDD):	9. Treated on (YYMMDD):	10. Duty Dates (YYMMDD): 10a. From: 10b.To:

11. Diagnosis or description of injury/illness and/or pharmacy claim (include DRG and/or ICD-10 Code):

Section III Current Unit Certification of Eligibility

12. Type of ORDERS: Weekend Drill Annual Training Other

13. Name of the nearest Military Treatment Facility:______________________________ which is _____ miles from the member's. ☐ place of duty or ☐ residence

14a. Unit Assignment (unit name, staff symbol, code, etc.):	14b. Unit UIC/OPFAC:
14c. Unit Address (street, bldg #, city, state, & zip):	14d. Unit Phone # (include area code):
15a. Unit POC - Medical Rep/Unit Administrator (name, rank and title):	15b. POC Phone # (include area code):
15c. Unit POC Department of Defense email address (.mil):	

16. **Certification**: I certify that this individual is eligible for care at government expense (CO or Medical Rep. signature):

Signature Printed Name: Date:

STOP Include all required documents!

You **must attach** the following:

Drill Attendance Sheet or Orders (for initial date of medical care)

Documents must match or cover the dates in block 8 above

FAX or Mail Information:

FAX this form/attachments to:

847-688-6460 or 7394 **OR**

MAIL this form/attachments to:

Defense Health Agency Great Lakes (DHA-GL)
Attn: Reserve Eligibility
2834 Green Bay Road Ste 304
Great Lakes, IL 60088