

## SURGICAL PRE-AUTHORIZATION WORKSHEET

**Instructions:** Member or unit representative completes Section I and III, and physician completes Section 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://dpclid.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 disclosures 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.

