Defense Health Agency - Great Lakes DHA-GL Worksheet-02 Rev. 04/10/2017	**PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE:** 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.

Defense Health Agency - Great Lakes
DHA-GL Worksheet-02
Rev. 04/10/2017

PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE: RESERVE COMPONENT

Instructions: Member or current unit representative completes Sections I and II. Unit representative completes and validates Section III; faxes or mails this form and supporting documentation to DHA-GL.
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):	7. Phone # (include area code):
5b. Member email address:	8. TRICARE Region ◯North ◯South ◯West	

Section II Pre Authorization Request

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

11. Diagnosis or description of injury/illness (ICD-10 Code):

12. Sent eligibility documents to DHA-GL on:_____.
If not sent, check which documents are attached (one or both): ◯ Line of Duty form (LOD) ◯ Orders/Attendance Roster.

13. List needed follow-up care or durable medical equipment (include CPT/HCPCS codes):

14. Specialty Requested:

15. Is a Medical Board in Process? ◯Yes ◯ No **If yes, note start date and Military Hospital/Clinic name:**

Section III Current Unit Certification of Eligibility

16. Name of the nearest Military Treatment Facility which is _____ miles from the member's. ◯place of duty or ◯residence

17a. Unit Name & Address (Unit name, staff symbol, code, etc.):	17b. Unit UIC/OPFAC:
18a. Unit POC - Medical Rep/Unit Administrator(Name, Rank and Title):	18b. POC Phone # (include area code):
18c. Unit POC United States Department of Defense email address (.mil):	

19. **Certification**: I certify this individual is eligible for this care at government expense (CO or Medical Rep. signature):
Signature Printed Name: Date:

STOP Include all required documents!

You **must attach** the following:

Service Approved LOD and Clinical Documentation

Documents must match or cover the dates in block 9 above

FAX or Mail Information:

FAX this form/attachments to:

847-688-7394 or 6369 **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