

TRICARE PRIME TRAVEL
CONFIRMATION OF SPECIALTY CARE

Patient Information -- To be completed by Patient <i>Return Completed Confirmation of Appointment with Claim and Receipts</i>
Patient Name: _____
Home Street Address: _____
City / State / Zip Code: _____
Phone and / or e-Mail: _____
Appointment(s) Information For This Trip Only -- To be completed by Specialty Care Provider (SCP)
Consultation / Treatment Date(s): _____ 1 st Appointment Date: _____ Last Appointment Date: _____ Hospitalization Date(s), If applicable: _____ <i>* For a post-operative patient, if required to remain in the immediate locale for necessary recovery and follow-on evaluation:</i> Beginning date of proximity requirement: _____ , Release date from proximity requirement: _____ .
Specialty Care Provider (SCP) Information
SCP Name: _____
Office Address: _____
City / State / Zip Code: _____
Phone and/or e-mail: _____
<i>This is to confirm that the subject patient received authorized specialty care as stated in the Appointment Information section above.</i> _____ SCP Signature _____ Date

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. Section 5701, 37 U.S.C. Sections 404 - 427, 5 U.S.C. Section 301, DoD FMR 7000.14-R, Vol. 9, and E.O. 9397.

PRINCIPAL PURPOSE(S): This record is used for reviewing, approving, accounting, and disbursing money for claims submitted by a Patient / Prime Travel beneficiary.

DISCLOSURE: Voluntary; however, failure to furnish the information requested may result in total or partial denial of the amount claimed.

PENALTY STATEMENT

There are severe criminal and civil penalties for knowingly submitting a false, fictitious, or fraudulent claim (U.S. Code, Title 18, Sections 287 and 1001 and Title 31, Section 3729).