

**RESERVE COMPONENT MEDICAL COVER SHEET  
MILITARY MEDICAL SUPPORT OFFICE (11 Jan 02)**

1. Patient's LAST NAME	First Name	MI.	2. Pay Grade	3. SSN	4. Date of Birth
5. Branch of Service:					
<input type="checkbox"/> USAR* <input type="checkbox"/> USNR* <input type="checkbox"/> USMCR* <input type="checkbox"/> USAFR* <input type="checkbox"/> ARNG* <input type="checkbox"/> ANG* <input type="checkbox"/> USCGR*					
* For service members in an Inactive Duty status, appropriate eligibility documentation must be provided if treatment has been found to be a result of a service-connected injury.					
6. Current Duty Station (work location)			7. Patient's Home Address:		
Command _____		UIC / OPFAC _____	Street Address _____		
Street Address _____			City _____	State _____	Zip Code _____
City _____	State _____	Zip Code _____	Home phone number (with Area Code) _____		
8. Type of Care: One cover sheet per Emergency Room episode of care or preauthorization number.					
Emergency/Initial Episode			Diagnosis: _____		
Pre-Authorization (Treatment plan attached)			Treatment Date(s): _____		
Pre-Authorization Number issued by MMSO for follow-up visit: # _____					
9. When you received treatment, were you on:    IDT    ADT    AT    ADSW    UTA (Air Force Only)					
Duty Dates From: _____		To: _____		NOE/LOD : <input type="checkbox"/> ADMIN <input type="checkbox"/> INFORMAL <input type="checkbox"/> FORMAL	
10. Checklist for submitting medical claims:					
<ul style="list-style-type: none"> <li>• Drill Attendance Sheet or Orders (only initial episode of care) for Coast Guard a CG-4436B or CG-4899</li> <li>• Approved Line of Duty (All preauthorized follow-up care)</li> <li>• Medical Claim (HCFA 1500, UB 92)</li> <li>• DD Form 2642, (TRICARE Claim Form for Service Member Reimbursement – pharmacy or medical care) if applicable (available at <a href="http://www.tricare.osd.mil">http://www.tricare.osd.mil</a>)</li> <li>• Possible Third Party Claim (i.e. injury caused by another person, or patient covered by other insurance). Copy of DD 2527 located at <a href="http://mms0.med.navy.mil">http://mms0.med.navy.mil</a></li> </ul>					
Dental Claims are submitted in accordance with the Dental Instruction at <a href="http://mms0.med.navy.mil">http://mms0.med.navy.mil</a> with the drill attendance sheet or NOE/LOD.					
11. I certify that this individual is eligible for this care at government expense. Patient referred by:					
SELF		SPONSOR'S COMMAND		DOD MEDICAL TREATMENT FACILITY	
UNIFORMED SERVICES FACILITY			DEPARTMENT OF VETERAN AFFAIRS MEDICAL CLINIC		
COAST GUARD CLINIC/SICKBAY			OTHER _____		
Nearest Military Treatment Facility is located at _____,					
_____ miles from the reservist/guard's residence.					
Signature _____		Printed Name (CO or Medical Representative)		Phone number of _____ Unit or Medical Representative	
				Date _____	