DVA/DoD **MOA** Continued Stay Referral & Authorization for SCI/TBI/Blind Rehab

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the Defense Health Agency Great Lakes (DHA-GL) 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 DVA/DoD MOA Worksheet-07a Rev. 11/01/2015	DVA/DoD **MOA** Continued Stay Referral & Authorization for SCI/TBI/Blind Rehab

Instructions: Referring MTF or VA Case Manager completes all information below and delivers this form to DHA-GL POC.

Section I Patient Data

1. Name (last, first, MI):	2. Rank/Grade:	3. DOB (MM/DD/YYYY):	4. SSN (full):

5. Branch of Service: *(please X one)*
☐ USA ☐ ANG ☐ USAF ☐ USN ☐ USMC
☐ USAR ☐ ARNG ☐ USAFR ☐ USNR ☐ USMCR

6. Eligibility: ☐ TPR ☐ Prime-DMIS _____ ☐ Not Enrolled	7. Tricare Region:
8. Home Address (street, city, state, zip)	8A. Home/Mobile Phone # (include area code)
9. Duty Station, POC, & Phone number:	9A. MTF CM following through MEB process & Phone (area code):

Section II Referral Information and Request

10. Referral Type: ☐ SCI ☐ TBI ☐ Blind ☐ Initial ☐ Continuation of Service

11. Referring Facility: ☐MTF ☐ VA (include address)	11A. POC Name & Phone # (include area code)
12. Accepting Facility: (include address)	12A. POC Name & Phone # (include area code)

13. Diagnosis

ICD-10 Code	Description

14. Type Care

☐ Inpatient	Admission Date (MM/DD/YYYY):	DHA-GL Authorization #:	Expiration date:
☐ Outpatient	Dates of Service (MM/DD/YYYY): *From:* _____ *To:* _____	☐ Home Health ☐ Other (explain):	☐ DME ☐ Rent ☐ Purchase *See attachments*

15. Services

CPT/HCPCS	Description of Services:	Duration (in days)	DHA-GL Authorization #:	Expiration Date (MM/DD/YYY)

Section III DHA GL POC

16. DHA-GL POC Name:	Phone 888-647-6676 ext:	FAX: 847-688-6369