Defense Health Agency - Great Lakes
DHA-GL Worksheet-02
Rev. 3/15/2024

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 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.

REFERENCES: Governing Law- 10 U.S. Code § 1074a; and DODI 1241.01 - Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements

Defense Health Agency - Great Lakes DHA-GL Worksheet-02 Rev. 3/15/2024	**PRE-AUTHORIZATION REQUEST FOR MEDICAL CARE: RESERVE**

Instructions: Member or current unit representative completes Sections I and II. ONLY Unit representative or Commanding Officer completes and validates Section III; then email, mail, or fax 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. Full SSN:
5a. Address (street, apt #, city, state, & zip):	6. DOB (YYMMDD):	7. Phone # (include area code):
5b. Member email address:	8. TRICARE Region ◯ East ◯ West ◯ Unknown	

Section II Pre Authorization Request

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

11. Diagnosis (Include 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. 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

15. Name of the nearest Military Treatment Facility which is _____miles from the member's **residence.**

16a. Unit Name & Address (Unit name, staff symbol, code, etc.):	16b. Unit UIC/OPFAC:
17a. Unit POC - Medical Rep/Unit Administrator (Name, Rank and Title):	17b. POC Phone # (include area code):
17c. Unit POC United States Department of Defense email address (.mil):	

18. **Certification**: I certify this individual is eligible for this care at government expense (CO or Unit Rep. Digital CAC signature ONLY):
Signature: Printed Name: Date:

STOP Include all required documents!

You must include the following:

Service Approved LOD, Drill Attendance Sheet or Certified Orders **and** Clinical Documentation

Documents must match or cover the dates in blocks 9-10 above

Army Reserve and Army National Guard must submit Preauthorization through eMMPS/MedChart.

EMAIL, MAIL, or FAX INFORMATION

EMAIL this form/documents to: **(Preferred)**
dha.great-lakes.j-10.mbx.mmso-initial-lod-mma@health.mil
Note: this box can only accept emails from .mil addresses

MAIL this form/documents to:
Defense Health Agency Great Lakes (DHA-GL)
2834 Green Bay Road Ste 304
Great Lakes, IL 60088

FAX this form/documents to: **224-447-0153**