

ELIGIBILITY FOR MEDICAL CARE

INSTRUCTIONS

1. Prepare this form in triplicate when:
 - a. A DD Form 2, DD Form 2 (Ret), DD Form 1173, Form PHS-1866-1, or Form PHS-1866-3 (Ret) has been issued but is not in the beneficiary's possession at the time of treatment; and/or
 - b. The DD Form 2, DD Form 2 (Ret), DD Form 1173, Form PHS-1866-1, or Form PHS-1866-3 (Ret) is expired or confiscated due to mutilation; and/or
 - c. The beneficiary cannot demonstrate eligibility for medical care under the Defense Enrollment Eligibility Reporting System (DEERS) and requires emergent treatment. Note: Patients, requiring nonemergent treatment, who cannot demonstrate eligibility for medical care under DEERS are to be denied care unless a DEERS override is met.
2. At time of signing, patient or patient's sponsor must show positive identification.
3. Supply information for each item. Distribute as follows:
 - a. Original to patient administration office or outpatient administration officer, as appropriate.
 - b. Copy to patient's sponsor or patient.
 - c. Place copy as uppermost form in Health Record, right side. (Remove when proof of eligibility is presented.)

Section 1 — (MTF/DTF staff shall check one)

- A valid identification card cannot be provided.
 Identification card is expired and/or mutilated.
 Patient has failed a DEERS check. Reason: _____

Section 2 — (To be completed by the patient or sponsor)

Name of Beneficiary	Age	Status
Sponsor's Name, Grade or Rate, Status, Service	SSN	
Sponsor's Duty Station (Home Address if Retired)	Telephone: Work	
	Home	
Clinic or Specialty Service Rendering Treatment	Date of Treatment	

I certify the beneficiary is eligible for medical and dental care at this facility. I understand that a valid identification card or a certified DD Form 1172 (Application for Uniformed Services Identification and Privilege Card) must be presented to the patient administration officer or outpatient administration officer, as appropriate, *within 30 days* from this date. Furthermore, I understand that if eligibility is not established within this 30-day period, I will be billed at the established rate for treatment rendered.

Signature of Sponsor, Adult Dependent, Patient, or Guardian	Date
Signature and Title of Witness	Date

Section 3 — (Physician or provider shall check two)

- Health care was provided Care was emergent
 Health care was not provided Care was nonemergent

Provider's Name and Rank (<i>Print or Type</i>)	SSN
Provider's Signature	Date

Section 4 — (Patient Administration Officer (PAO) shall check one block)

- Eligibility verified utilizing _____
 Eligibility not verified. Referred for billing action.

PAO's Name and Rank (<i>Print or Type</i>)	SSN
Patient Administration Officer's Signature	Date