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THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE https://www.esd.whs.mil/Portals/54/Documents/DD/forms/dd/dd2569.pdf (Read Privacy Act Statement before completing this form.)							
the data needed, and completing and review burden, to the Department of Defense, Was of law, no person shall be subject to any pe	on of information is estimated to average 4 minutes per r wing the collection of information. Send comments regar shington Headquarters Services, at whs.mc-alex.esd.mb malty for failing to comply with a collection of information RETURN COMPLETED FORM TO REQUESTING MIL	response, ir rding this bu ox.dd-dod-in n if it does n	ncluding the time for re urden estimate or any formationcollections@ ot display a currently v	other aspect of this collectio mail.mil. Respondents shou valid OMB control number. F	n of information, inclu- Ild be aware that notw	ding suggestions for reducing vithstanding any other provision	
Collection from third-party payers; 42 U.S.C PURPOSE: DD Form 2569 collects individ ROUTINE USES: In addition to those discl pursuant to 5 U.S.C. § 552a(b)(3) as follow. Affairs, and Homeland Security for reimburs clearinghouses and insurance carriers relat Blanket Routine Uses, see the below hyper APPLICABLE SORN: EDHA 12, Third Par https://dpcdd.defense.gov/Priv	es for charging fees for care provided to civilians; retention C. Chapter 32, Third Party Liability For Hospital and Med ual's information to assist the Department of Defense ("I osures generally permitted under 5 U.S.C. § 552a(b) of s: to commercial insurance carriers and third parties invo sement of DoD provided medical services; to other perso red to converting medical and pharmacy claims to an ind	on and use lical Care; a DoD") in its the Privacy olved in sup ons or organ dustry-wide t	nd E.O. 9397 (SSN), ; recovery from third pa Act of 1974, as amen port of DoD's collection izations who may be format related to paym ha-12/	as amended. rties for medical care provid ded, these records may spe n activities for health care p liable for payment of DoD p nent of claims. For additional	ed to an individual in i cifically be disclosed o rovided; to the Depart rovided health care ar details as to routine to	a Military Treatment Facility. butside the DoD as a routine u ments of Treasury, Veterans id medical services; to data uses and exceptions to the Do	
	PATIEN		ORMATION				
1. PATIENT NAME (Last, First, Middle Initial)			2. SSN		3. DATE OF BIRTH (YYYY/MM/DD)		
4a. MAILING ADDRESS (Include ZIP Code)			1	b. HOME TELEPH	ONE NO.		
				5a. FAMILY MEM	BER PREFIX	b. SPONSOR SSN	
	INSURA		FORMATION				
7. ARE YOU ELIGIBLE FOR VE	TERANS AFFAIRS BENEFITS?						
by the MTF representative	rance card (e.g., Veterans Health Identifica e, please provide it and proceed to Item 8;				ugh (5) below.)		
(1) Member ID	Member ID (2) Plan ID				(3) Expiration Date (YYYY/MM/DD)		
(4) VA Facility Name (e.g., primary	y care/specialty clinic) that assists in coordina	ating you	r care				
(5) VA Facility Address and Tele	phone Number		()			
b. NO. (Proceed to Item 8.)							
	LTH INSURANCE? (This includes employ LEASE ATTACH COPY OF INSURANCE			efits, other commercia	al health insuran	ce coverage,	
a. YES. (Complete Item 9 al	nd the remaining sections below.)						
	ary and rely solely on TRICARE, Medicare,	, or Medi	caid. (Proceed to	o Item 13.)			
<i>'</i>	eneficiary. (Proceed to Item 12.)						
	ANCE INFORMATION. If you have an insute to Item 11; otherwise, please complete the			opied or scanned by	the MIF represe	entative,	
a. NAME OF POLICY HOLDER (Last, First, Middle Initial)			b. DATE OF BIRTH (YYYY/MM/DD)		c. RELATIONSHIP TO POLICY HOLDER		
d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER			e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER				
f. MEMBER ID	g. POLICY ID	h	. GROUP POLIC	CI ID	i. GROUP PL/	AN NAME	
j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE		POLICY EFFEC (YYYY/MM/DD)	TIVE DATE	m. POLICY EI		
n.(1) Pharmacy (Rx) Insurance C	Company Name, Address and Telephone I	Number					
(2) Rx Policy ID	(3) Rx Bin Number		(4) Rx PCN Number				

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c. NAME (Last, First, Middle Initial) d. SSN BIRTH (YYYYAMMOD) TO POUCY HOLDER c. NAME (Last, First, Middle Initial) d. SSN BIRTH (YYYAMMOD) TO POUCY HOLDER 12. MEDICARE OR MEDICADI INFORMATION a b MEDICARE MANAGED CARE PLAN NAME a <th>10. SECONDARY MEDICAL please provide it and proc</th> <th></th> <th></th> <th></th> <th></th> <th>ied or scanne</th> <th>d by the N</th> <th>MTF represen</th> <th>tative,</th>	10. SECONDARY MEDICAL please provide it and proc					ied or scanne	d by the N	MTF represen	tative,				
a. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER b. GROUP POLICY ID b. GROUP POLICY ID c. MEMBER ID c. MEMBER ID c. INSURANCE TYPE c. INSURANCE COmpany Name, Address and Telephone Number c. IPOLICY EFECTIVE DATE c. MPOLICY END DATE c. MARK (Ass. Name) c. INSURANCE COmpany Name, Address and Telephone Number c. (1) Pharmacy (Rs) Insurance Company Name, Address and Telephone Number c. (2) Rx Policy ID c. (3) Rx Bin Number c. (4) Rx PCN Numbe	a. NAME OF POLICY HOLDER (Last, First, Middle Initial)				b. DATE OF BIRTH (YYY								
j. ENROLLMENT/PLAN CODE k. INSURANCE TYPE L. POLICY EFFECTIVE DATE (YYYYMMGDD) m. POLICY END DATE (YYYYMMGDD) n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number (4) Rx PCIN Number (4) Rx PCN Number (2) Rx Policy ID (3) Rx Bin Number (4) Rx PCN Number (1) Receive ID (3) Rx Bin Number (2) Rx Policy ID (3) Rx Bin Number (4) Rx PCN Number (4) Rx PCN Number (2) Rx Policy ID (3) Rx Bin Number (4) Rx PCN Number (1) Receive ID (1) Receive ID (2) Rx Policy ID (3) Rx Bin Number (4) Rx PCN Number (1) Receive ID (1) Receive ID (2) Rx Policy ID (3) Rx Bin Number (4) Rx PCN Number (1) Receive ID (1) Receive ID (2) Rx Policy ID (3) Rx Bin Number (4) Rx PCN Number (1) Receive ID (1) Receive ID (2) Rx Policy ID (3) Rx Bin Number (2) NO (Proceed to Rem 13.) (3) Rx Bin Number (3) NO (Proceed to Rem 13.) (3) Rx Bin Number (4) NED(CARE MANAGED CARE PLAN NAME (2) NED(CARE MANAGED CARE PLAN NAME (3) NO (Proceed to Rem 13.) (3) NO (Proceed to Rem 13.)	e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER												
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(2) Rx Policy ID (3) Rx Bin Number (4) Rx PCN Number 11. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER? . No (Proceed to Item 13.) . DATE OF a. YES (Complete 11c-f. and proceed to Item 13.) . D. NO (Proceed to Item 13.) . DATE OF a. NME (Last, First, Medie Integ) d. SSN In OLICY OF . NO (Proceed to Item 13.) c. NME (Last, First, Medie Integ) d. SSN In OLICY OF . NO (Proceed to Item 13.) c. NME (Last, First, Medie Integ) d. SSN In PLATONENE . NO (Proceed to Item 13.) c. NME (Last, First, Medie Integ) d. SSN In PLATONENE . NEDICARE a. MEDICARE OR MEDICAID INFORMATION . . MEDICARE MANAGED CARE PLAN NAME . c. MEDICARE PART D NUMBER AND PLAN NAME d. MEDICARE MANAGED CARE PLAN NAME/ISSUING . 13. CERTIFICATION, RELEASE, AND ASSIGNMENT a. Learthy that the Information on this form is true and accurate to the best of my knowledge. Falsification of Information is covered by Tifle 18, United States Code, Section 1001, which provides for a maximum fine of 3250,000 or imprisonment for five years, or both. . b. Lacknowledge that the authorize and request that the proceeds of any and all benefits being addrecity to the MTF for heathcare services provided to me and/or my family member. . Alchorize and request that the proceeds of any and all benefits benid addreci	j. ENROLLMENT/PLAN COD	E k. INSU	RANCE TYPI	≣		-							
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released to my insurance carriers. 14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE b. DATE (YYYY/MM/DD) 15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE b. DATE (YYYY/MM/DD) 16. ANNUAL PATIENT INSURANCE VERIFICATION a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually. b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.	 United States Code, Sectio b. I acknowledge that the auth United States Code, Sectio of this act. c. NON-UNIFORMED SERVIT healthcare services provide whole or in part by my third d. NON-DoD MEDICARE, ME paid directly to the MTF for services not covered by Me e. UNIFORMED SERVICES E the Uniformed Service for service 	n 1001, which prov hority to bill third pa ns 1095 and 1079b CES PATIENTS: I ad me and/or my mi -party insurer. EDICAID AND VETI healthcare service adicare, Medicaid a BENEFICIARIES: I services provided to	ides for a max rty payers has , and that no authorize and nor depender ERANS AFFA s provided to nd Veterans A hereby ackno me and/or m	ximum fine of \$250 s been conveyed to personal entitlements. A request that the p nts. ACKNOWLED IRS PATIENTS: I me and/or my fam Affairs, including bu owledge that the p y family member.	0,000 or imprisonment for f o the medical facility within ent to reimbursement or pa proceeds of any and all ber DGEMENT: I hereby agree authorize and request tha ily member. I acknowledgu at not limited to patient cop roceeds of any and all ben	ive years, or b the Departme yment has been hefits be paid of to pay for any t the proceeds e I am respons ayments and of efits shall be p	oth. ent of Defe en granted directly to y service i s of any ar sible for fu deductible paid direct	ense by Title d to me by vir the MTF for not covered in all benefits ull payment of es. tly to the facili	tue n be any ty of				
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 a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually. b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge. 	15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE							b. DATE (YYYY/MM/DD)					
17a. SIGNATURE (Patient or Adult Family Member) b. DATE (YYYY/MM/DD)	a. If any information on this fo and date at least annually.b. I certify that the information of my knowledge.	rm has changed, a on this form has b	new form mu		-	-	e and acc	curate to the b	pest				
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CUI when filled

PREVIOUS EDITION IS OBSOLETE.