

MEDICAL CARE - THIRD PARTY LIABILITY NOTIFICATION

For use of this form, see AR 40-400; the proponent agency is the OTSG

1. IMPRINT OR TYPE PATIENT DATA (Same as items 2 thru 28, DA Forms 3647, 3647-1 or its equivalent)

2. HOME ADDRESS (Include ZIP code) AND TELEPHONE NUMBER (Non-military patients)

ITEMS MAY BE CONTINUED ON REVERSE (Identify by item number)

3. RECOVERY JUDGE ADVOCATE

4. NAME AND ADDRESS OF FACILITY SUBMITTING NOTIFICATION

5. TYPE OF NOTIFICATION

TRANSFER

REQUESTED BY THE RJA

SF 502 SUBMITTED TO THE RJA

YES

NO

6. DISPOSITION OR STATUS OF PATIENT

7. FEDERAL AGENCY SPONSORING PATIENT

8. DIAGNOSIS(ES)

9. CAUSE OF INJURY (How, when, and where)

10. PROGNOSIS (Include probable length of hospitalization and number of expected outpatient visits)

COMPUTATION OF CHARGES

11. MILITARY HOSPITAL CARE

TOTAL DAYS <i>a</i>	DAYS ABSENT <i>b</i>	NET DAYS <i>c</i>	RATE <i>d</i>	TOTAL <i>e</i>	PAID <i>f</i>	BALANCE <i>g</i>

12. MILITARY OUTPATIENT CARE

VISITS <i>a</i>	RATE <i>b</i>	TOTAL <i>c</i>	PAID <i>d</i>	BALANCE <i>e</i>

13. CIVILIAN SOURCE CARE

TYPE CARE <i>a</i>	NAME AND ADDRESS OF CIVILIAN SOURCE <i>b</i>	DATE <i>c</i>	CHARGE <i>d</i>

14. GRAND TOTAL (11g + 12e + 13d)

DATE

TYPED NAME AND GRADE OF PATIENT ADMINISTRATOR

SIGNATURE