Third Party Recovery Program

Injury Information Form

**Privacy Act Statement**

**AUTHORITY:** Title 10 USC 1095 and Title 42 USC 2651-53

**GENERAL:** Pursuant to Army Regulation 27-40 and 40-16, Judge Advocate Personnel and Medical Department Personnel are required to obtain information concerning circumstances surrounding the injuries of persons receiving medical care at Government expense. These governing regulations apply equally to active or retired personnel and their dependents.

**PRINCIPAL PURPOSE:** Information will be used to collect from third party payers/private insurers for medical care provided to Active Duty personnel, Retirees and their dependents. Monetary benefits accruing to the Military Treatment Facility will be used to enhance health care delivery in the Medical Treatment facility.

**ROUTINE USES:** 1. Identify injured party and nature of injuries. 2. Identify other persons involved, including witnesses. 3. Determine the circumstances of incidents which give rise to personal injuries. 4. Determine the insurance coverage and places of medical treatment. 5. Social security number will be used for identification purposes when requiring information from other agencies.

**DISCLOSURE EFFECT:** Failure to provide requested information may result in the withholding of medical records pertaing to medical history, diagnosis, findings and treatment from injured party and his/her representatives.

 **SECTION I—PATIENT’S INFORMATION**

**Name of Patient Name/Rank of Sponsor**

**SSN SSN**

**Home Address Unit Address**

**Home Phone Number Duty Phone Number**

**Patient Status \_\_\_AD/Dependent \_\_\_ Retired/Dependent PCS/ETS Date**

**Relation to Sponsor \_\_\_Self \_\_\_Spouse \_\_\_Son \_\_\_Daughter \_\_\_ Other (specify)**

**Date of Injury**

 ***If you were injured in an auto accident, please fill out Section II below and Sections III, IV and V on back of form***

 ***If your injury was “on the job”, please fill out Section II and Section IV on back of form***

 ***If your injury was not auto accident or job related, please fill out Section II below only***

 **SECTION II**

**Please describe in detail what caused the injury. State who was involved, what happened, where it occurred, and if applicable, why you think it occurred.**

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 **SECTION III—AUTOMOBILE ACCIDENT INFORMATION**

**Date of Accident**

**Location of Accident (Street, City and State)**

**Were you the \_\_\_Driver \_\_\_Passenger \_\_\_Pedestrian**

**If not the driver, please give the full name, address and telephone of the driver**

**If more than one vehicle was involved, please give the other driver’s full name and address**

**Who was at fault?**

**Please provide the name, agency, address and telephone number of the police officer taking a report, if any**

 **SECTION IV—AUTOMOBILE INSURANCE INFORMATION**

 **(or insurance covering automobile if not patient/sponsor auto)**

**Patient/Sponsor Insurance**

**Company Address**

**Phone Number Name on Policy Policy Number**

**Other than Patient/Sponsor**

**Company Address**

**Phone Number Name on Policy Policy Number**

 **SECTION V—AUTOMOBILE INSURANCE INFORMATION OTHER VEHICLE**

**Company Address**

**Phone Number Name on Policy Policy Number**

 **SECTION VI—WORKER’S COMPENSATION INFORMATION**

**Employer Address**

**Phone Number**

**Name, Address and Phone of Worker’s Compensation Insurer**

**Did you report your injury to your employer? \_\_\_yes \_\_\_no**

 **CERTIFICATION**

**I certify the above information is true and correct top the best of my knowledge**

**Signature Date**