Nonnaval Health Care Claim Form

1. Patient Name	2. Rank/Rate	3. Social Security No.	4. Birthdate	5. Date Filed

6. Patient Home Address

Street

City State Zip

7. Current Duty Station

Command UIC

Street

City State Zip

8. ☐USN ☐USNR* ☐USMC ☐USMCR* ☐Retired/Discharged (send copy of DD 214, pg 4)

☐Other (explain) _____

*if illness/injury occurred while on drill, annual, or inactive duty training, submit a copy of drill record, SF 600, orders, muster sheet, or leave and earning statement. After completion of active duty period, treatment from civilian health care providers requires an NOE (Notice of Eligibility), and prior approval from MEDDEN Affairs.

9. When you received treatment, were you ☐Leave ☐Liberty ☐UA ☐Terminal Leave ☐Appellate Leave (Send copy of appellate leave papers and military ID card (front and back)).

Dates From: _____ To: _____

10. Cause of injury or illness
- ☐ Motor vehicle accident
- ☐ Assault
- ☐ Other _____

11. Place of injury or illness
- ☐ Recreational activity
- ☐ Non-Government job
- ☐ Other _____

12. Emergency ☐ Yes ☐ No

Blanket Approval ☐ Yes ☐ No

Prior Approval issued by MEDDEN Affairs ☐ Yes Prior approval number: _____ ☐ No

13. Were you seen as a patient by a "military" medical or dental treatment facility (MTF or DTF) for this condition before obtaining treatment from a civilian health care provider? ☐ Yes ☐ No

If yes, provide dates: _____

14. Did the MTF or DTF refer you to the civilian health care provider? ☐ Yes ☐ No

If yes, name of referring MTF or DTF. _____

15. Diagnosis (what were you treated for)

16. Name of Provider:	Dates of Treatment:	Charges:

17. Have bills been paid? ☐ Yes ☐ No If yes, ☐ In Full ☐ In Part

If yes, by whom _____

If member paid, submit SF 1164, Claim for Reimbursement with the member's original signature and proof of payment (e.g., receipt or front and back of canceled check).

18. Patient's signature authorizes release of health care records related to this injury or illness to MEDDEN AFFAIRS. Signatures validate information provided.

Patient's Signature Home Phone Number Work Phone Number

Certifying Official's Printed Name (MEDREP, HBA or a Senior Officer) Certifying Official's Signature Phone Number

(See reverse for additional information)

Nonnaval Health Care Claim Form Information

1. Purpose of form. This form is used by eligible members of the U.S. Navy or Marine Corps, including reservists (on active duty or in training) to request payment or reimbursement for inpatient and/or outpatient medical or dental services provided by civilian healthcare providers.

2. When to file claim form. Submit claims immediately after treatment. Claims returned to the command or member for additional information must be submitted within 60 days or they will be closed. Closed claims may be reopened for consideration on a case-by-case basis. ***Delay in submitting claims could affect a member's credit rating.***

3. Who fills out the form? Patients are responsible for completing NAVMED 6320/10. For assistance, contact your command medical representative (MEDREP). If the patient or MEDREP need further assistance, contact the Naval Office of Medical/Dental Affairs at DSN 792-3950, commercial 708-688-3950, or toll free 1-800-876-1131.

4. What documents must you provide? Send the original and two copies of NAVMED 6320/10 and itemized bills. ***Balance due bills are not acceptable.*** Bills submitted on provider's letterhead must contain:

Providers name, address, and provider's tax identification number
Patient's name, SSN and date of birth
Date services or supplies were provided
Description of each service or supply
Charge for each service or supply

Submit inpatient institutional bills on ***Uniform Billing (UB) 92 form (payer copy).***

5. What information must be provided? Most of the information on this form is self-explanatory. Answer each item. If the information requested does not apply to the patient, indicate N/A (not applicable). ***An incomplete form will cause delays in processing and payment of your claim.***

6. How a member gets reimbursed (SF 1164). If payment was made directly to the Healthcare provider by the patient or representative, the patient must submit a Claim for Reimbursement for Expenditures on Official Business (SF 1164). Include the itemized bill and proof of payment (front and back of canceled check, receipt, or itemized bill showing a zero balance). ***Patient's original signature must be provided in block 10 of the SF 1164.***

7. Who must sign the NAVMED 6320/10? The patient and a certifying officer must sign. A certifying officer may be a MEDREP, health benefits advisor, or a Senior Officer. ***A certifying officer may not sign for his or her own claim.*** The certifying officer's signature validates the NAVMED 6320/10, and ensures the patient's health record reflects the civilian treatment received. Retired or discharged patients who are submitting claims for treatment received while on active duty should submit a copy of their DD 214 (page 4) in lieu of a certifying officer's signature.

8. Where to file the claim. Submit completed NAVMED 6320/10 with itemized bills and supporting documentation to: Officer in Charge, MEDDEN AFFAIRS, P.O. Box 886999, Great Lakes, IL 60088-6999.

Privacy Act Statement

Sections 6201, 6202, and 6203 of title 10 to the U.S. Code authorized collection of this information. The purpose of this information is to evaluate eligibility for civilian health benefits and to issue payment upon verification of eligibility. MEDDEN AFFAIRS uses the information to process health care claims for payment; for review of claims related to possible third party liability cases and initiation of recovery actions; for referral to professional review organizations to control and review providers medical care; for disclosure to third party contacts without the consent of the individual, to respond to inquiries from congressional offices made at the request of the covered individual; and for medical boards. Information must be provided if you expect to have the claim paid by the Government. Failure to provide information will result in denial or delay in payment of the claim.