

MEDICAL CARE - THIRD PARTY LIABILITY NOTIFICATION

1. PATIENT DATA NAME: SSN: COMPONENT:	SPONSOR'S NAME: SPONSOR'S UNIT: DATE OF ACCIDENT:
--	---

2. HOME ADDRESS	3. HOME TELEPHONE
-----------------	-------------------

4. RECOVERY JUDGE ADVOCATE	5. NAME & ADDRESS OF FACILITY SUBMITTING NOTIFICATION Kimbrough Ambulatory Care Center ATTN: MCXR-PSD-PA 2480 Llewellyn Avenue Fort George G. Meade, MD 20755-5800
----------------------------	--

6. TYPE OF NOTIFICATION INITIAL FOLLOW UP FINAL REQUESTED BY SJA

7. DIAGNOSIS (ES)	8. PROGNOSIS/DISPOSITION OR STATUS OF PATIENT
-------------------	---

9. CAUSE OF INJURY

COMPUTATION OF CHARGES

10. MILITARY HOSPITAL CARE				
DRG CASE WEIGHT	ASA per RWP	TOTAL	PAID	BALANCE
<i>a</i>	<i>b</i>	<i>c</i>	<i>d</i>	<i>e</i>

11. MILITARY OUTPATIENT CARE					
NUMBER OF VISITS	CLINIC	RATE FOR CLINIC	TOTAL	PAID	BALANCE
<i>a</i>	<i>b</i>	<i>c</i>	<i>d</i>	<i>e</i>	<i>f</i>

12. TOTAL OUTPATIENT BALANCE:

13. GRAND TOTAL (10e + 12):

REMARKS

DATE	TYPED NAME AND GRADE OF PATIENT AFFAIRS OFFICIAL	SIGNATURE
------	--	-----------