U.S. Naval Hospital Naples

A Patient and Family Centered Health System

CAPT Justice M. Parrott, NC, USN

MTF Director/Commanding Officer

"We Keep Warfighters in the Fight"

USNH Naples, Italy

U.S. Naval Hospital Naples, Support Site

Branch Health Clinic, Capodichino ***Fleet Liaison Det. Landstuhl, Germany***

Preferred Provider Network, Naples area

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Emergencies

On-Base:

Dial 911 or +39-081-568-4911

Off-Base:

Dial +39-081-568-4911or find the nearest hospital!

- **118 is the Italian Emergency Number, only speak Italian.**
- **USNH ambulances do NOT operate off-base**

Outside of Naples Area:

International SOS (Tricare): +44 20-8762-8133

+44-20-8762-8384

- **No pre-authorization needed for emergency care**
- **Keep all receipts and documentation**
- **Notify your PCM as soon as possible**

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Access to Care

Who is eligible for Health & Dental care?

- Active Duty
- Active Duty Family

Space-Available Health Care ONLY

- DoD Civilian/Contractors
- Active Duty NATO
- Retirees & their Dependents
- Active Duty NATO Family

All Others/non-DoD: On-Site Emergency Care Only

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COVID-19 Testing

Support Site/Hospital Testing:

Location: Trailer outside of the Emergency Room

Hours: 0900-1000 – Testing

1200 – Test results available

Capo Clinic Testing:

Location: Tent on the "spine" to the right side of Clinic

Availability: Only if ordered by a healthcare provider

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Hours of Operation

OPEN 24 HOURS

Emergency Department

Inpatient Ward

"We Keep Warfighters in the Fight"

Hours of Operation

Outpatient Clinic (Support Site)

Monday – Friday	0800-1600
Tuesday	0800-1200

Capodichino Clinic

Monday – Friday	0800-1600
Tuesday	0800-1200

**** Closed weekends & US National Holidays****

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Hours of Operation

Pharmacy Hours

Support Site

Mon-Fri (Excluding Tuesday): 0800-1700

Tuesday: 0800-1400

Sat/Sun/Federal Holidays: 1300-1600 (For refill pickup ONLY that are already checked by a pharmacist).

BHC Capodichino

Mon – Fri (Excluding Tuesday): 0800-1600

Tuesday: 0800-1200

Sat/Sun/Federal Holidays: Closed

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Medical Services Available

- Family Medicine
- Internal Medicine
- Mental Health & Substance Abuse
- Medical Readiness
- Immunizations
- Health Promotions & Wellness
- Physical Therapy
- Anesthesia
- Multi-Service Ward
- Urgent & Emergency Care
- Orthopedics
- Case Management
- Pharmacy
- Children's Educational & Intervention Services
- Optometry
- Audiology
- Nutrition Services
- Laboratory
- Radiology
- **Dermatology
- **Urology
- **Podiatry
- Surgery
- Occupational Health
- Travel Medicine
- Ear, Nose & Throat
- Pastoral Care
- Dental
- Women's Health & Pregnancy
- Men's Health
- Ophthalmology

** shared asset with other MTFs in EUCOM**

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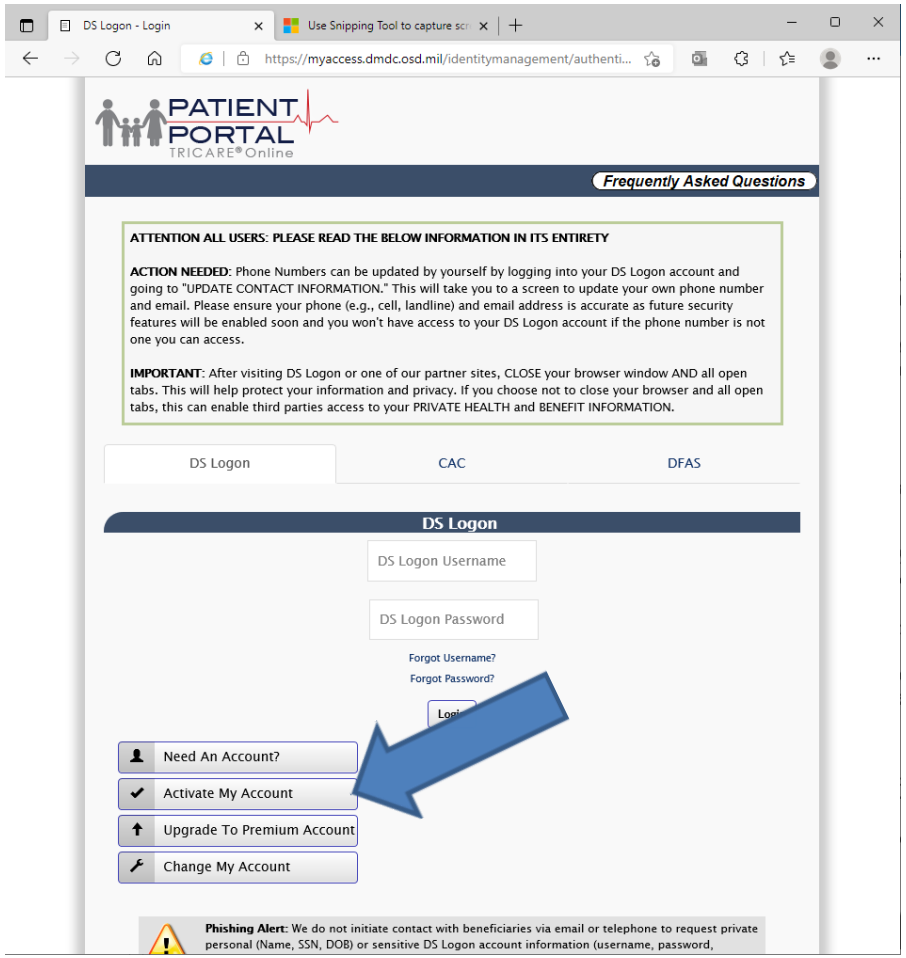
Tricare Online Sign Up



- https://www.tricareonline.com/
  - You can register for a Tricare Online account with one of the following:
    - Common Access Card (CAC)
    - Defense Self-Service Logon (DSL) username and password
    - Defense Finance and Accounting Service (DFAS) MyPay username and password

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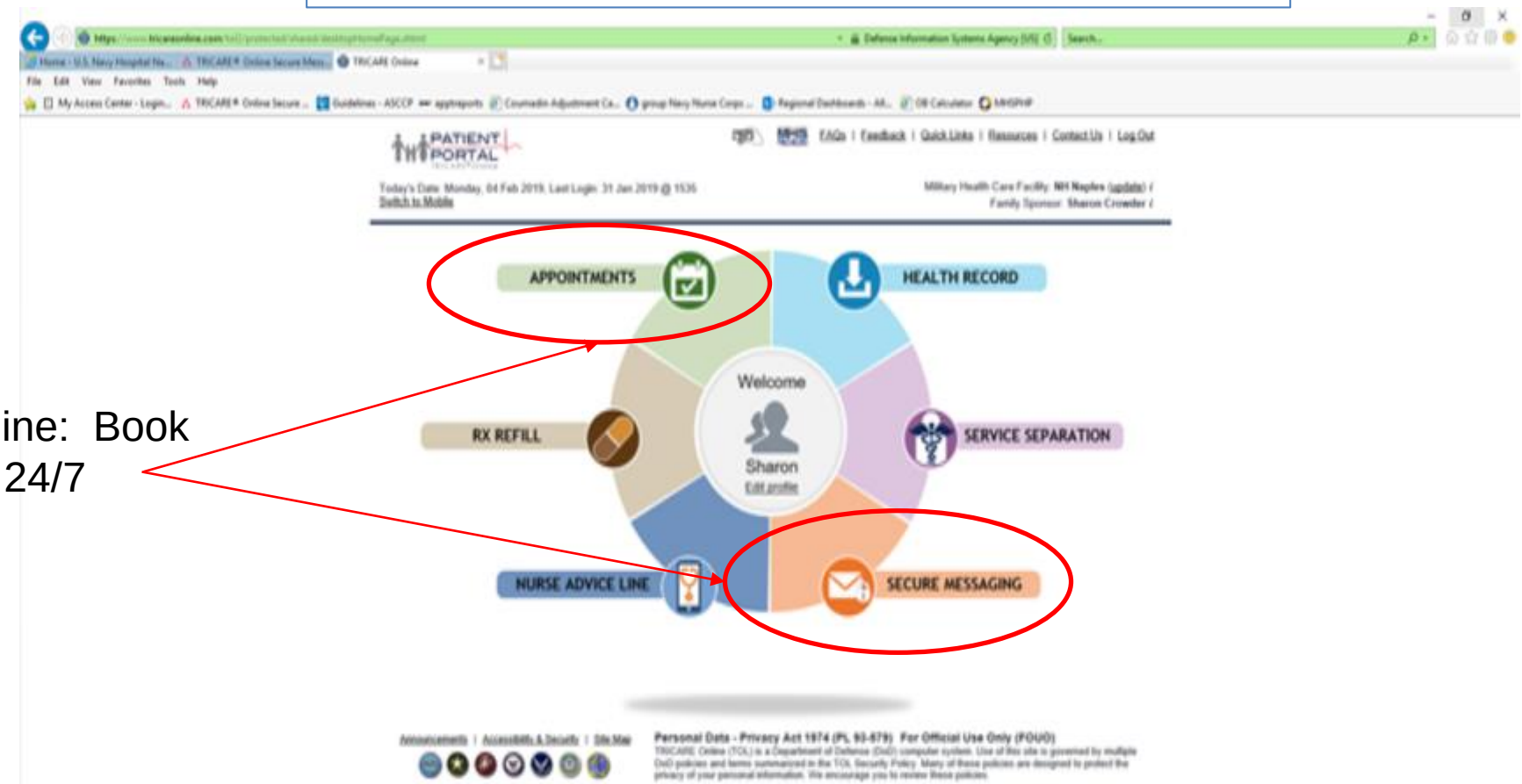
TRICARE ONLINE

Patient Portal

TRICARE Online: Book appointments 24/7



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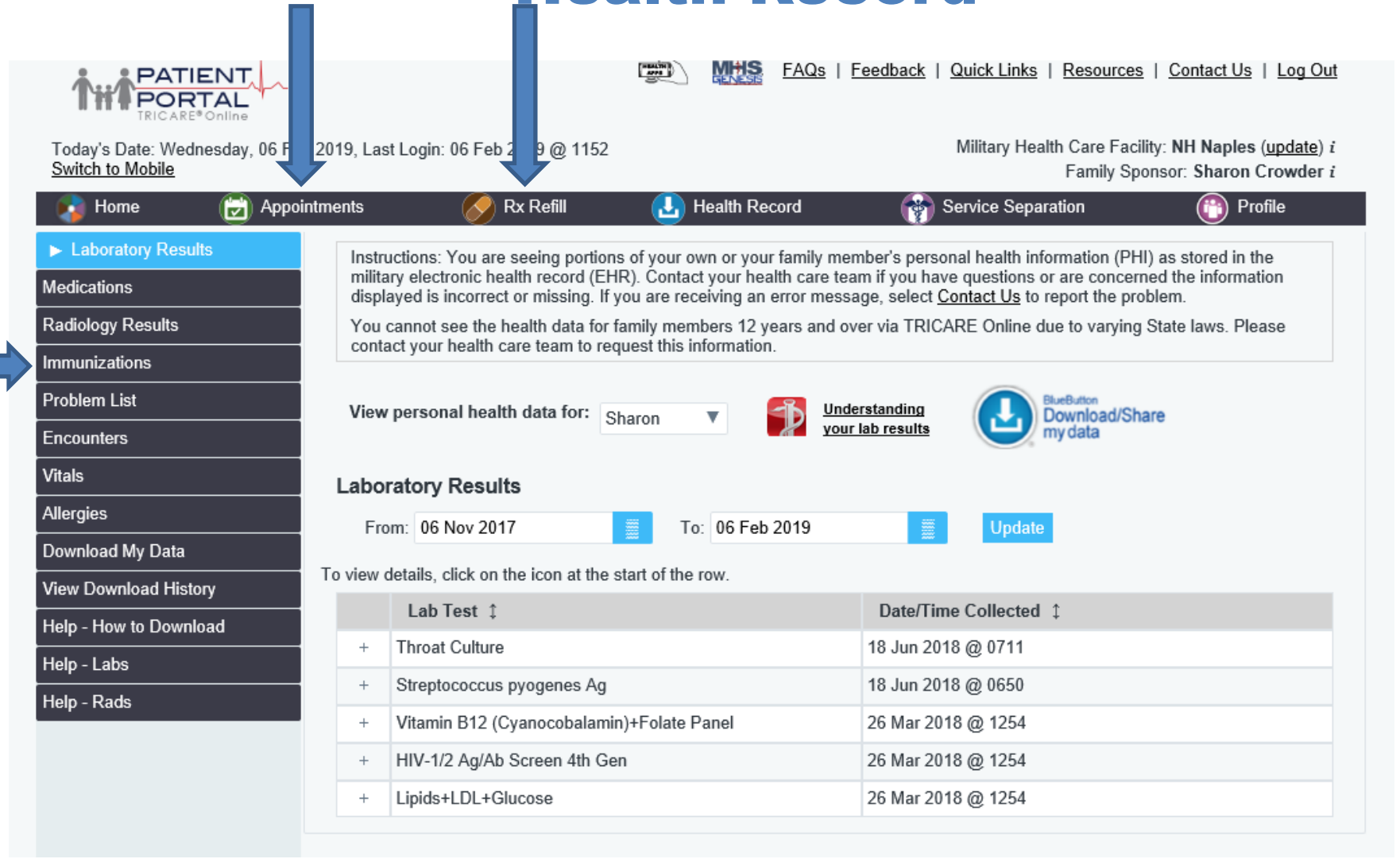
Superb Access to Care

Health Record



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Medical Services for Non-Tricare Patients

Establish Care with Primary Care Medical Team

- Civilians are not typically screened prior to assignment to Naples
- Ensure the hospital or network facilities have what you need (i.e. medical specialists, medications, exams)

Enrollment in Health Care Delivery Plan (HCDP)

- RAPIDS Office on Capodichino can activate your HCDP
    - DSN: 626-5632 / 2940
- HCDP should be activated for the period of time you are scheduled to be serving OCONUS

All non-Tricare patients will receive a bill for health services rendered Bills can be paid at https://www.pay.gov/public/accesscode

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Healthcare Billing

- All patients who are not on Active Duty or NATO members are required to have a DD 2569 and a copy of their insurance card on file at the hospital's Uniformed Business Officer (UBO).
- This includes DoD Civilians, Contractors, Reserve Members, Active Duty Dependent Spouses and Children etc.
- Bills are submitted directly to the insurance provided. Having this information on file is necessary to ensure timely payment of bills.
- At 30-days unpaid bills accrue interest from the date it is issued.
- At 90-days unpaid bills are sent to collections.

Customer Relations

Have Something Nice to Say? Have a Concern?

Three easy ways to provide feedback:

- Interactive Customer Evaluation (ICE) survey
- JOES survey (mailed to you)
- Customer Relations Representatives in each department
  - Contact the quarterdeck to ask for the department's Customer Relations Representative at:
  - +39 (081) 811-6006

ICE
Interactive Customer Evaluation

Elizabeth Iwanczuk
Customer Service Representative
DSN: 629-4646 or +39-081-811-4646

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Medical Record Services

Medical Record Copies

- **At-the-window printing for immunization list, radiology & laboratory results**
- **Up to 30 days for complete records**

Civilian / non-DoD Records

PCS

- **All Medical and Dental records will be mailed**
  - Except Active Duty with orders to operational platforms
  - DHA-PM 6025.02 DoD Health Record

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Dental Eligibility

- Support Site Dental Clinic
  - Active duty and active duty dependents
- Capodichino Clinic
  - Active duty (working at Capodichino)

- ***Sick call/Emergency care**:* walk-in appointments for acute dental issues consisting of pain and infection are available Monday-Friday from 0800-0930 for all eligible beneficiaries, or visit the ER during weekends and holidays.

Dental Appointment

- In person or Phone:
  - Mon – Fri 0800 – 1600
  - **+39-081-811-6007/8**
  - **DSN: 314-629-6007/8**
    - New patient; Will be scheduled for a **new patient or "T-1" exam**.
      - Complete paperwork
      - Radiographs
      - Comprehensive clinical exam

- Due to the extensive nature of new patient exams, a cleaning appointment will be scheduled after the completion of your initial exam.
- Cleanings are offered based on *individual patient needs and risk factors* rather than a fixed schedule.
- Please call at least 24 hours in advance if you need to reschedule an appointment.

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Orthodontic Care

- Orthodontic care is limited to Active Duty service members and qualifying dependents only.
  - Priority is given to Active Duty service members and dependent children.
- Case are selected based on the severity of orthodontic problems.
  - Impact on overall health and well-being, as well as, time left on station.
    - You must have at least 2 years remaining in the area to be eligible.

Hospital Points of Contact

LT Claire Gould, MSC, USN

Department Head, Patient Administration

DSN: 629-6215 or +39-081-811-6215

HMC Brooklyn Williams, USN

Leading Chief Petty Officer, Patient Administration

DSN: 629-6113 or +39-081-811-6113

Elizabeth Iwanczuk

Customer Service Representative

DSN: 629-4646 or +39-081-811-4646

Central Appointment Line:

DSN: 629-6000 or +39-081-811-6000

Option 2 for English;

Option 2 for Appointments;

Option 1 for Support Site, 2 for Capodichino 3 for Specialty care / Dental

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Updated January 2019

TRICARE® Overseas Program

Your TRICARE Benefit Outside the U.S.

TRICARE Overseas Program

Latin America and Canada
Canada, the Caribbean Basin, Central and South America, Puerto Rico and the U.S. Virgin Islands

Eurasia-Africa
Africa, Europe and the Middle East

Pacific
American Samoa, Asia, Australia, Guam, India, Japan, New Zealand, Northern Mariana Islands, South Korea and Western Pacific remote countries

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Keep DEERS Information Up To Date

Go to an **ID card office**. Find an office at **www.dmdc.osd.mil/rsl**.

Note: You must use this option to add family members in DEERS.

Log on to **http://milconnect.dmdc.osd.mil**.

Call **1-800-538-9552**.

Fax **1-831-655-8317**.

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TOP Prime

- TOP Prime is available to ADSMs and their eligible, command-sponsored family members who live with them near a military hospital or clinic.
  - **Enrollment: Enrollment is required.**
  - **Costs: No enrollment fees, but family members will pay cost-shares for prescriptions filled at overseas pharmacies.**
  - **Getting care: Get care from an assigned primary care manager at a military hospital or clinic in most cases. Referrals and/or pre-authorizations are required for specialty care.**

TOP Select

- TOP Select is available to command-sponsored and non-command- sponsored ADFMs, retired service members and their family members, survivors, and others living or traveling overseas.
  - **Enrollment: Enrollment is required.**
  - **Costs: No enrollment fee for ADFMs. Retirees, their families, and** others pay enrollment fees.
  - **Getting care: Seek care from any purchased care sector provider.***
    - Referrals aren't required for most health care services.
    - Pre-authorization is required for certain services.
    - Overseas providers aren't required to bill TRICARE for you.
    - Beneficiaries should expect to pay up front and file claims for reimbursement.

Note: ADSMs aren't eligible for TOP Select. Those enrolled in TOP Select in the Philippines and Panama are reimbursed based on government-provided foreign fee schedules.

* ***In the Philippines, you're encouraged to seek care from Philippine Preferred Provider Network providers.***

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TRICARE and Other Health Insurance

- If you have other health insurance (OHI):
  - Fill out a *TRICARE Other Health Insurance Questionnaire*: **www.tricare.mil/forms.**
  - Follow the referral and authorization rules for your OHI.
  - Maintain an up-to-date (within 12-months) DD 2569 on file with the Uniformed Business Office (UBO).
  - Tell your provider about your OHI and TRICARE.
- After your OHI pays, TRICARE will pay the lesser of:
  - The billed amount, minus the payment from your OHI
  - The amount TRICARE would have paid without OHI
  - The OHI copayment or deductible
- For services covered by Medicare, OHI, and TFL, TRICARE pays last.

INTERNATIONAL SOS
(ISOS)

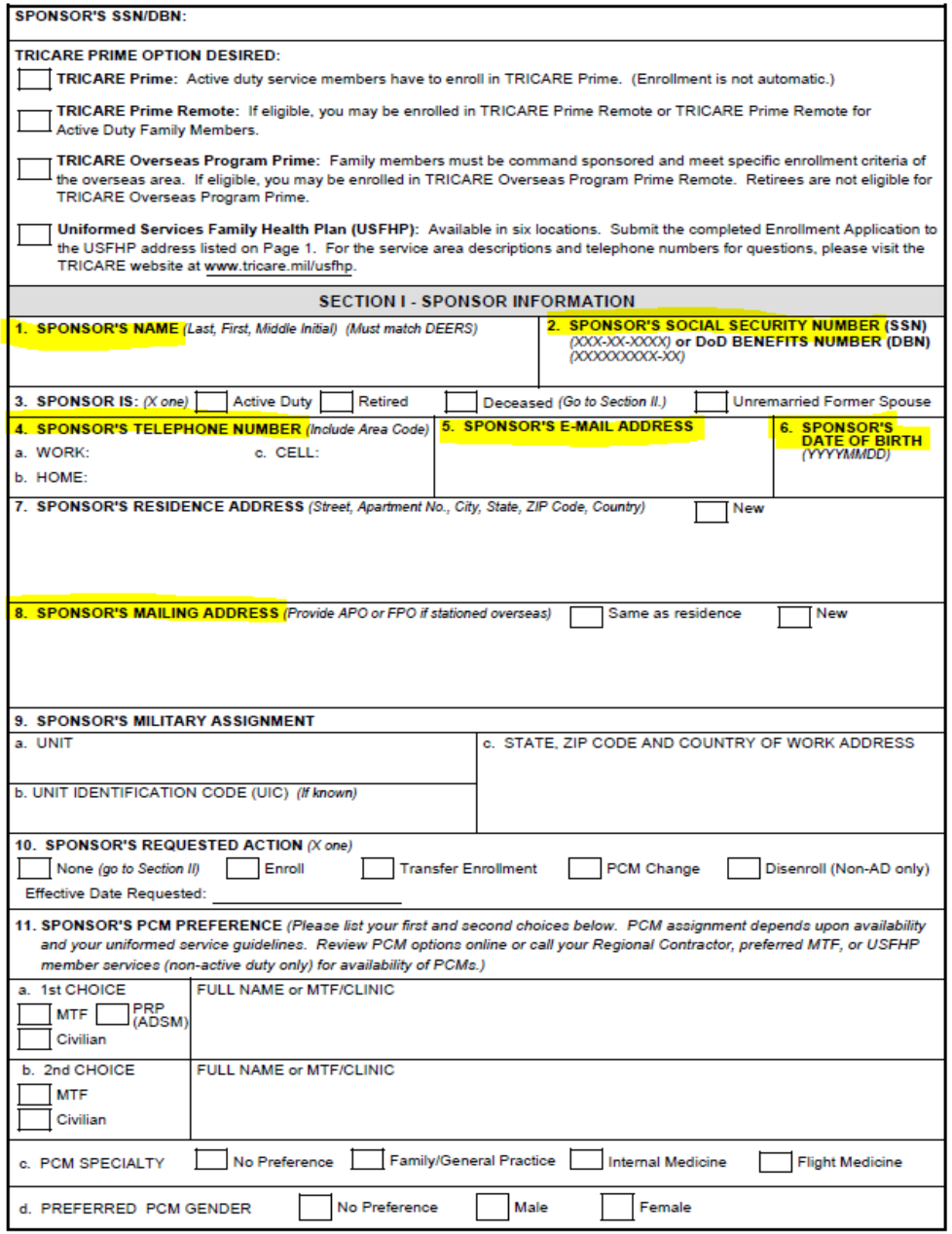
EURASIA/AFRICA EUROPEAN REGION

+44 20-8762-8133 or +44-20-8762-8384

(open 24 hours a day, 7 days a week, 365 days a year)

Anywhere outside of the NAPOLI area, you MUST contact ISOS to coordinate Urgent and/or Emergent Care within 24 hours of being seen

- Name
- SSN
- Phone Numbers
- Personal E-mail
- Date of Birth
- FPO Address
- Unit Information
- Support Site or Capo?



SPONSOR'S SSN/DBN:

TRICARE PRIME OPTION DESIRED:

☐ **TRICARE Prime:** Active duty service members have to enroll in TRICARE Prime. (Enrollment is not automatic.)

☐ **TRICARE Prime Remote:** If eligible, you may be enrolled in TRICARE Prime Remote or TRICARE Prime Remote for Active Duty Family Members.

☐ **TRICARE Overseas Program Prime:** Family members must be command sponsored and meet specific enrollment criteria of the overseas area. If eligible, you may be enrolled in TRICARE Overseas Program Prime Remote. Retirees are not eligible for TRICARE Overseas Program Prime.

☐ **Uniformed Services Family Health Plan (USFHP):** Available in six locations. Submit the completed Enrollment Application to the USFHP address listed on Page 1. For the service area descriptions and telephone numbers for questions, please visit the TRICARE website at www.tricare.mil/usfhp.

SECTION I - SPONSOR INFORMATION

1. **SPONSOR'S NAME** *(Last, First, Middle Initial) (Must match DEERS)*

2. **SPONSOR'S SOCIAL SECURITY NUMBER (SSN)** *(XXX-XX-XXXX)* **or DoD BENEFITS NUMBER (DBN)** *(XXXXXXXXX-XX)*

3. **SPONSOR IS:** *(X one)* ☐ Active Duty ☐ Retired ☐ Deceased *(Go to Section II.)* ☐ Unremarried Former Spouse

4. **SPONSOR'S TELEPHONE NUMBER** *(Include Area Code)*
   a. WORK: c. CELL:
   b. HOME:

5. **SPONSOR'S E-MAIL ADDRESS**

6. **SPONSOR'S DATE OF BIRTH** *(YYYYMMDD)*

7. **SPONSOR'S RESIDENCE ADDRESS** *(Street, Apartment No., City, State, ZIP Code, Country)* ☐ New

8. **SPONSOR'S MAILING ADDRESS** *(Provide APO or FPO if stationed overseas)* ☐ Same as residence ☐ New

9. **SPONSOR'S MILITARY ASSIGNMENT**
   a. UNIT
   b. UNIT IDENTIFICATION CODE (UIC) *(If known)*
   c. STATE, ZIP CODE AND COUNTRY OF WORK ADDRESS

10. **SPONSOR'S REQUESTED ACTION** *(X one)*
    ☐ None *(go to Section II)* ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll (Non-AD only)
    Effective Date Requested: _____

11. **SPONSOR'S PCM PREFERENCE** *(Please list your first and second choices below. PCM assignment depends upon availability and your uniformed service guidelines. Review PCM options online or call your Regional Contractor, preferred MTF, or USFHP member services (non-active duty only) for availability of PCMs.)*

a. 1st CHOICE ☐ MTF ☐ PRP (ADSM) ☐ Civilian	FULL NAME or MTF/CLINIC
b. 2nd CHOICE ☐ MTF ☐ Civilian	FULL NAME or MTF/CLINIC

c. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Flight Medicine

d. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

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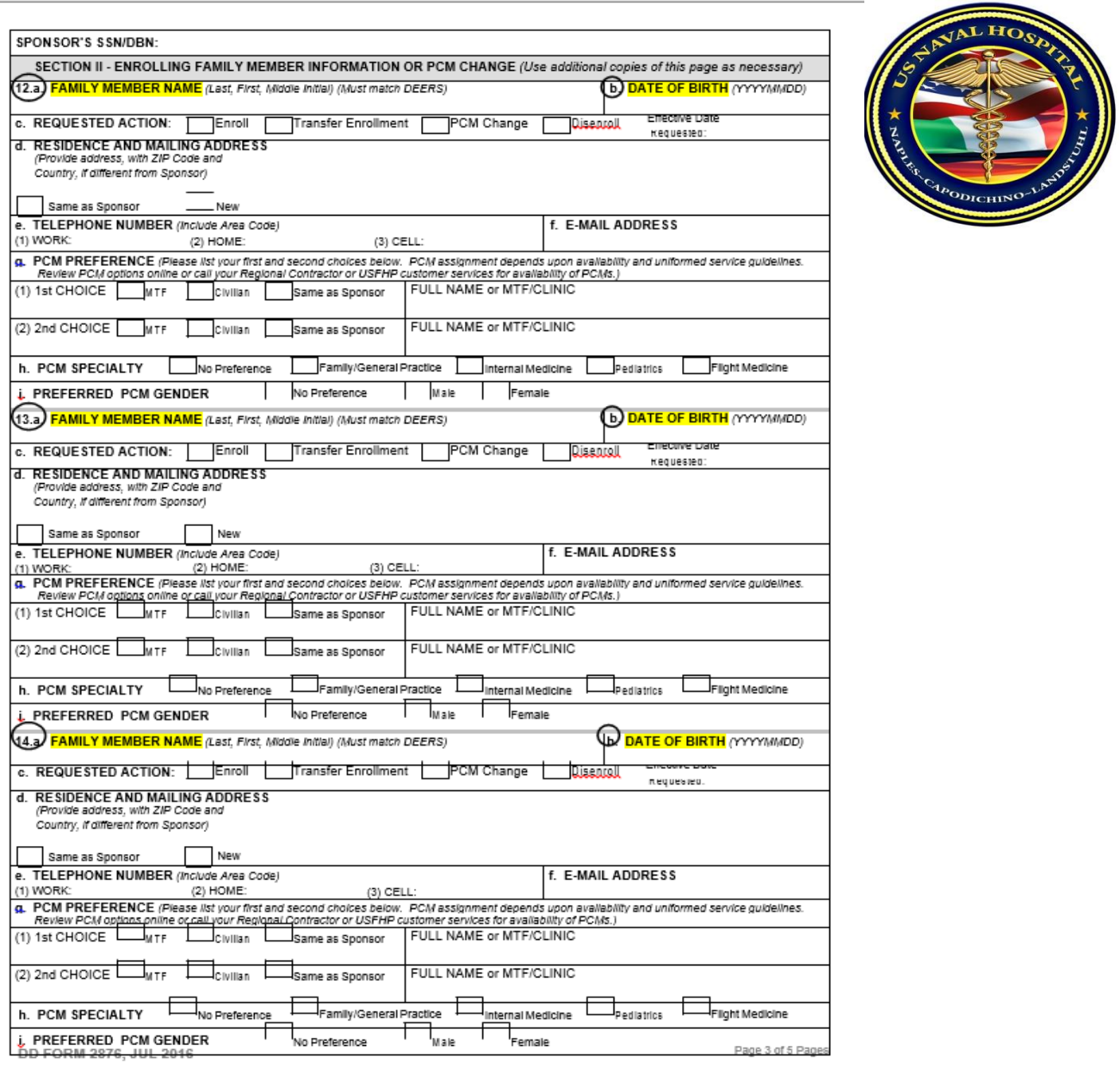
Command Sponsored Dependents Currently in Italy

- Name
- Date of Birth

* For dependents who are arriving on station later: Please visit the Tricare office upon arrival to enroll.



SPONSOR'S SSN/DBN:

SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE *(Use additional copies of this page as necessary)*

12.a FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date requested:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)* (1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

13.a FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date requested:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)* (1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

14.a FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date requested:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)* (1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

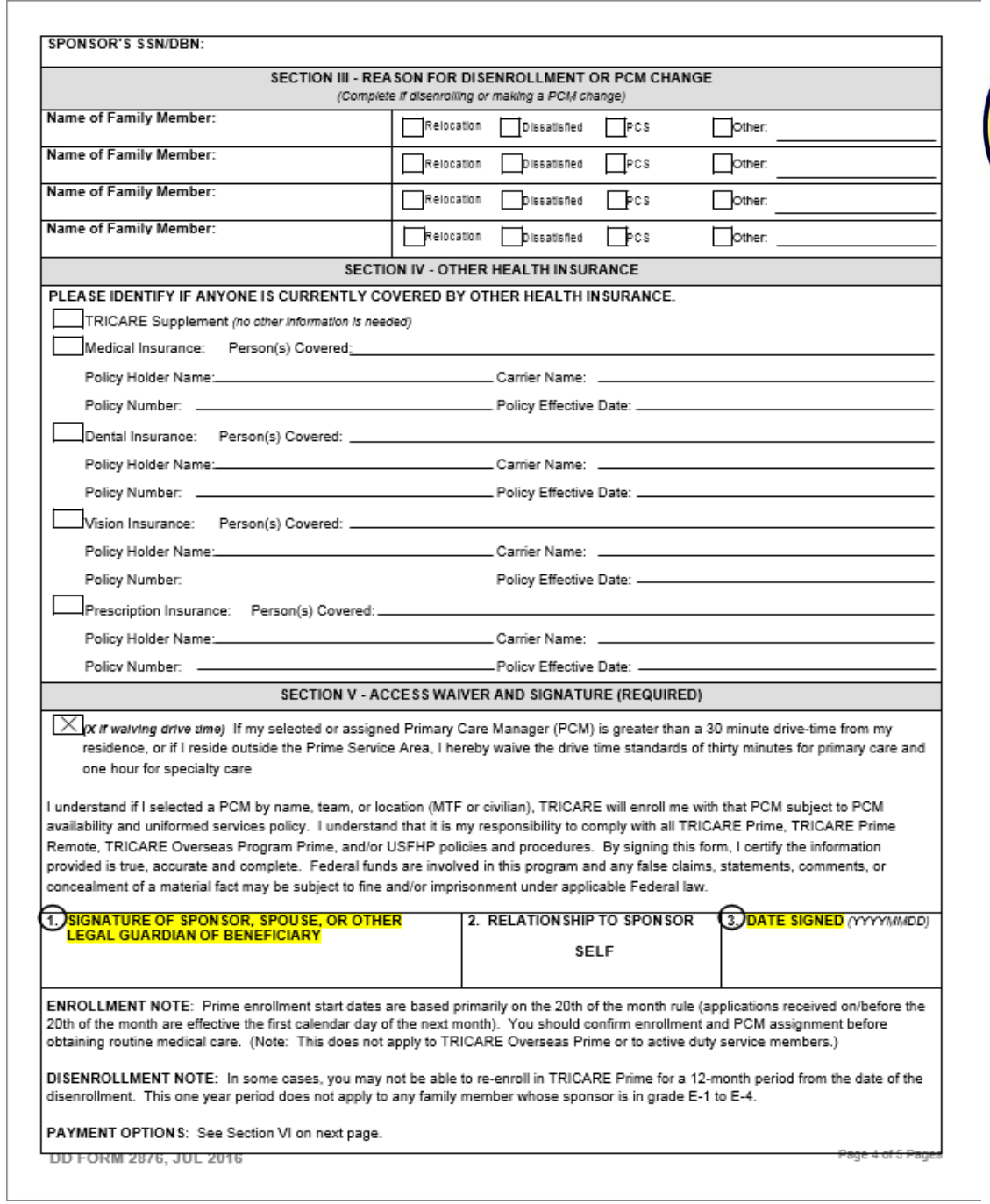
h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

DD FORM 2876, JUL 2016 Page 3 of 5 Pages

"We Keep Warfighters in the Fight"

- Sign and Date Your Enrollment
- Make Sure Your Orders are in the Folder
- “Last Name, First Name” is on your folder tab.



SPONSOR'S SSN/DBN:

SECTION III - REASON FOR DISENROLLMENT OR PCM CHANGE
(Complete if disenrolling or making a PCM change)

Name of Family Member:	☐ Relocation	☐ Dissatisfied	☐ PCS	☐ Other:	
Name of Family Member:	☐ Relocation	☐ Dissatisfied	☐ PCS	☐ Other:	
Name of Family Member:	☐ Relocation	☐ Dissatisfied	☐ PCS	☐ Other:	
Name of Family Member:	☐ Relocation	☐ Dissatisfied	☐ PCS	☐ Other:	

SECTION IV - OTHER HEALTH INSURANCE

PLEASE IDENTIFY IF ANYONE IS CURRENTLY COVERED BY OTHER HEALTH INSURANCE.

☐ TRICARE Supplement *(no other information is needed)*

☐ Medical Insurance: Person(s) Covered:
Policy Holder Name: Carrier Name:
Policy Number: Policy Effective Date:

☐ Dental Insurance: Person(s) Covered:
Policy Holder Name: Carrier Name:
Policy Number: Policy Effective Date:

☐ Vision Insurance: Person(s) Covered:
Policy Holder Name: Carrier Name:
Policy Number: Policy Effective Date:

☐ Prescription Insurance: Person(s) Covered:
Policy Holder Name: Carrier Name:
Policy Number: Policy Effective Date:

SECTION V - ACCESS WAIVER AND SIGNATURE (REQUIRED)

☒ *(X if waiving drive time)* If my selected or assigned Primary Care Manager (PCM) is greater than a 30 minute drive-time from my residence, or if I reside outside the Prime Service Area, I hereby waive the drive time standards of thirty minutes for primary care and one hour for specialty care

I understand if I selected a PCM by name, team, or location (MTF or civilian), TRICARE will enroll me with that PCM subject to PCM availability and uniformed services policy. I understand that it is my responsibility to comply with all TRICARE Prime, TRICARE Prime Remote, TRICARE Overseas Program Prime, and/or USFHP policies and procedures. By signing this form, I certify the information provided is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments, or concealment of a material fact may be subject to fine and/or imprisonment under applicable Federal law.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*
	SELF	

ENROLLMENT NOTE: Prime enrollment start dates are based primarily on the 20th of the month rule (applications received on/before the 20th of the month are effective the first calendar day of the next month). You should confirm enrollment and PCM assignment before obtaining routine medical care. (Note: This does not apply to TRICARE Overseas Prime or to active duty service members.)

DISENROLLMENT NOTE: In some cases, you may not be able to re-enroll in TRICARE Prime for a 12-month period from the date of the disenrollment. This one year period does not apply to any family member whose sponsor is in grade E-1 to E-4.

PAYMENT OPTIONS: See Section VI on next page.

DD FORM 2876, JUL 2016

Page 4 of 5 Pages

“We Keep Warfighters in the Fight”

- 1 form per beneficiary
- Beneficiaries 18 and older must complete and sign their own
- Forms for minor children must be completed and signed by sponsor
- If you need more than one form, please ask Tricare rep.

TRICARE® OVERSEAS PROGRAM (TOP)

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM

THIS FORM IS FOR INTERNAL USE BY THE INTERNATIONAL SOS GROUP OF COMPANIES

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079 and 1086, 32 U.S.C. Chapter 17; 32 CFR 199.17; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.
PRINCIPAL PURPOSE(S): To obtain information necessary for the processing of requirements and benefits related to the TRICARE Overseas Program (TOP), including but not limited to medical management, your medical related claims, and proper updates of your medical record.
ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and to other Federal, State, local, or foreign government agencies, and to private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.
DISCLOSURE: Voluntary; however, failure to provide consent may result in the inability of International SOS to provide the full range of services and benefits under the TOP.

BENEFICIARY DETAILS:

Beneficiary First Name:	**Beneficiary Last Name:**
Beneficiary Date of Birth:	**DoD Benefits Number (DBN):**
Beneficiary Phone Number:	**Beneficiary Email Address:**

Section is to be signed by TRICARE Beneficiaries ONLY

RELEASE OF MEDICAL INFORMATION

International SOS Government Services, Inc. and its affiliated entities (International SOS) is a data processor on behalf of the Defense Health Agency (DHA) of your personal data. You may contact International SOS at any of its locations or methods as identified on http://www.tricare-overseas.com or in the footer below. Your personal data will be used for the following purposes:

1. *Collection of medical record to load into the United States (U.S.) Government system of record for TRICARE beneficiaries.*
2. *Translation of medical records to support your continued health care and maintenance of your medical record in the U.S. system of record.*
3. *Case Management, utilization management, and other medical management activities required under the TRICARE benefit.*
4. *Claims inquiries and processing in accordance with the TRICARE benefit.*

The categories of personal data you are being asked to consent to International SOS' collection and use are your name, address, email address, telephone number, DoD Benefits Number (DBN), Social Security Number, and Personal Health Information. International SOS will share this information on an as needed and required basis with the DHA, the cognizant Military Treatment Facility, third-party medical translation vendors and/or Wisconsin Physician Services Insurance Corporation.

Your personal data will be transferred out of the European Union or other locality you are in and sent to the entities referenced above which are in the U.S. or on U.S. soil. Your personal data will be processed and stored in accordance with U.S., EU, and other applicable laws and record retention requirements applicable to International SOS.

Under our processes and these laws, you have the right to request access to, rectify, erase and restrict the processing of your personal data. You also have the right to revoke this consent to use your personal data. If you feel International SOS has violated your rights under a cognizant privacy regulation, you have the right to file a complaint with the appropriate supervisory authority.
I consent to International SOS using my personal data for the purposes described in this notice and understand that I can withdraw my consent at any time. This consent authorization shall be in force and effect until two (2) years from the date of execution at which time this authorization expires.

☐ I consent ☐ I do **not** consent

Signature of Beneficiary or Legally Authorized Representative_____ **Date**_____

Name and Relationship of Legally Authorized Representative to Patient_____

Address of the Beneficiary or Legally Authorized Representative_____

***Note**: If the beneficiary is considered a minor, their legal or authorized representative [the parent/s entitled to custody or guardian, and for adults the person in charge or designee] must sign on behalf of the beneficiary.*

August 2021

TRICARE Latin America & Canada
Tel: +1-215-942-8393 | **Fax:** +1-215-773-2701
Email: tricarephl@internationalsos.com

TRICARE Eurasia-Africa
Tel: +44-20-8762-8384 | **Fax:** +44-20-8762-8255
Email: tricaretln.top@internationalsos.com

TRICARE Pacific
Tel: +65-6339-2676 | **Fax:** +65-6336-0921
Email: sin.tricare@internationalsos.com

"We Keep Warfighters in the Fight"

CONTROLLED

TRICARE® OVERSEAS PROGRAM (TOP)

INTERNATIONAL SOS

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM

THIS FORM IS FOR INTERNAL USE BY THE INTERNATIONAL SOS GROUP OF COMPANIES

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079 and 1086, 32 U.S.C. Chapter 17; 32 CFR 199.17; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain information necessary for the processing of requirements and benefits related to the TRICARE Overseas Program (TOP), including but not limited to medical management, your medical related claims, and proper updates of your medical record.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and to other Federal, State, local, or foreign government agencies, and to private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.

DISCLOSURE: Voluntary; however, failure to provide consent may result in the inability of International SOS to provide the full range of services and benefits under the TOP.

BENEFICIARY DETAILS:

Last Name:		**First Name:**	
Date of Birth:		**DoD ID Number:**	
Italian Phone Number:		**Personal Email Address:**	

Section is to be signed by TRICARE Beneficiaries ONLY

RELEASE OF MEDICAL INFORMATION

International SOS Government Services, Inc. and its affiliated entities (International SOS) is a data processor on behalf of the Defense Health Agency (DHA) of your personal data. You may contact International SOS at any of its locations or methods as identified on http://www.tricare-overseas.com or in the footer below. Your personal data will be used for the following purposes:

1. *Collection of medical record to load into the United States (U.S.) Government system of record for TRICARE beneficiaries.*
2. *Translation of medical records to support your continued health care and maintenance of your medical record in the U.S. system of record.*
3. *Case Management, utilization management, and other medical management activities required under the TRICARE benefit.*
4. *Claims inquiries and processing in accordance with the TRICARE benefit.*

The categories of personal data you are being asked to consent to International SOS' collection and use are your name, address, email address, telephone number, DoD Benefits Number (DBN), Social Security Number, and Personal Health Information. International SOS will share this information on an as needed and required basis with the DHA, the cognizant Military Treatment Facility, third-party medical translation vendors and/or Wisconsin Physician Services Insurance Corporation.

Your personal data will be transferred out of the European Union or other locality you are in and sent to the entities referenced above which are in the U.S. or on U.S. soil. Your personal data will be processed and stored in accordance with U.S., EU, and other applicable laws and record retention requirements applicable to International SOS.

Under our processes and these laws, you have the right to request access to, rectify, erase and restrict the processing of your personal data. You also have the right to revoke this consent to use your personal data. If you feel International SOS has violated your rights under a cognizant privacy regulation, you have the right to file a complaint with the appropriate supervisory authority.

I consent to International SOS using my personal data for the purposes described in this notice and understand that I can withdraw my consent at any time. This consent authorization shall be in force and effect until two (2) years from the date of execution at which time this authorization expires.

☐ I consent ☐ I do not consent

Signature of Beneficiary or Legally Authorized Representative _____ **Date** _____

Printed Name and Relationship of Legally Authorized Representative to Patient _____ SELF SPONSOR

Address of the Beneficiary or Legally Authorized Representative CMR _____ BOX _____ APO, AE _____

Note: *If the beneficiary (command sponsored dependent) is considered a minor, their legal or authorized representative [the parent/s entitled to custody or guardian, and for adults the person in charge or designee] must sign on behalf of the beneficiary.*

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