Defense Health Agency - Great Lakes
DHA-GL Worksheet-01
Rev. 3/15/2024

MEDICAL ELIGIBILITY VERIFICATION:
RESERVE COMPONENT

Instructions: Member or unit representative completes Sections I and II. **ONLY** Unit representative or Commanding officer completes and validates Section III; then email, mail, or fax this form & supporting documentation to DHA-GL.

Complete ALL Blocks

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by the Defense Health Agency Great Lakes and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE Program and, E.O. 9397 (SSN), as amended.

PURPOSE: To collect information from Military Health System beneficiaries in order to determine their eligibility for coverage under the TRICARE Program.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a (b) of the Privacy Act of 1974, as amended, which incorporates the DOD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of coverage.

REFERENCES: Governing Law- 10 U.S. Code § 1074a; and DODI 1241.01 - Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements

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COMPLETE ALL BLOCKS

Section I Member Data

1. Branch of Service: ○ USAR ○ USNR ◉ USMCR ○ USAFR ○ ARNG ○ ANG ○ USCGR

2. Name (Last, First, MI):	3. Rank or Grade:	4. SSN (full) / DOD ID:
5a. Address (street, apt #, city, state, & zip):		6. DOB (YYMMDD):
5b. Member Email Address:		7. Phone # (include area code):

Section II Illness/Injury Information

8. Date of injury/illness (YYMMDD):	9. Treated on (YYMMDD):	10. Duty Dates (YYMMDD): 10a. From: 10b.To:

11. Diagnosis or description of injury/illness: (include ICD-10 Code):

Section III Current Unit Certification of Eligibility

12. Type of ORDERS: ◉ Weekend Drill ○ Annual Training ○ Other

13. Name of the nearest Military Treatment Facility:_____which is_____miles from the member's **residence.**

14a. Unit Assignment (unit name, staff symbol, code, etc.):	14b. Unit UIC/OPFAC:
14c. Unit Address (street, bldg #, city, state, & zip):	14d. Unit Phone # (include area code):
15a. Unit POC - Medical Rep/Unit Administrator (name, rank and title):	15b. POC Phone # (include area code):
15c. Unit POC Department of Defense email address (.mil):	

16. **Certification**: I certify that this individual is eligible for care at government expense (CO or Unit Rep. Digital CAC signature ONLY):

Signature Printed Name: Date:

STOP Include all required documents!

You must include the following:

- **Drill Attendance Sheet or Certified Orders** (for initial date of medical care)
- **ER/Urgent Care Provider's Notes**

Documents must match or cover the dates in blocks 8-10 above.

Army Reserve and Army National Guard must submit eligibility through eMMPS/MedChart.

EMAIL, MAIL, or FAX INFORMATION

EMAIL this form/documents to: **(preferred)**
dha.great-lakes.j-10.mbx.mmso-lod-misc@health.mil
Note: this box can only accept emails from .mil addresses

MAIL this form/documents to:
Defense Health Agency Great Lakes (DHA- GL)
2834 Green Bay Road Ste 304
Great Lakes, IL 60088

FAX this form/documents to: **224-447-0152**