STATEMENT OF PERSONAL INJURY - POSSIBLE THIRD PARTY LIABILITY
TRICARE MANAGEMENT ACTIVITY

Please fill out this form to permit the United States to recover medical expenses from whoever caused your injury. Processing of your TRICARE claim will be suspended until you complete and return this form in the attached self-addressed envelope. Address questions to any Judge Advocate office or call toll free telephone number 1-800- ____ - _____.

SECTION I - GENERAL INFORMATION

1. SPONSOR'S SOCIAL SECURITY NUMBER:	☐ ARMY	☐ NAVY	☐ AIR FORCE
	☐ COAST GUARD	☐ USPHS	☐ NOAA

2.a. INJURED PATIENT'S NAME:

b. INJURED PATIENT'S ADDRESS:	c. TELEPHONE NUMBER:

3. DATE INJURY OCCURRED *(YYYYMMDD)*:	APPROXIMATE TIME OF INJURY:

4. LOCALITY AND STATE WHERE INJURY OCCURRED:

SECTION II - TYPE AND CAUSE OF INJURY

☐ 5. TRAFFIC ACCIDENT. *(Give name of at-fault driver and insurance company name. If you were a passenger in the accident vehicle, give name of driver and driver's insurance company.)*

☐ 6. SLIP/FALL, DOG BITE, MISHAP. *(Give name of employer, business, municipality, or homeowner where injury occurred.)*

☐ 7. EXPLOSION. *(Specify type of explosive, name and address of place where injury occurred.)*

☐ 8. ASSAULT. *(Give name(s) of person(s) who assaulted you, and responding police department.)*

☐ 9. TOXIC SUBSTANCE. *(Specify substance or drug name, and place where the incident occurred.)*

☐ 10. ON-THE-JOB INJURY. *(Give name and address of employer, and cause of injury.)*

☐ 11. PRODUCT MALFUNCTION. *(Give product name and place where the injury occurred.)*

☐ 12. MEDICAL MALPRACTICE. *(Give date you first knew of the malpractice, doctor's name, and place where the malpractice occurred.)*

☐ 13. OTHER TYPE AND CAUSE OF INJURY. *(Specify.)*

SECTION III - MISCELLANEOUS

14. LIST OF MILITARY MEDICAL FACILITIES THAT PROVIDED CARE FOR THIS INJURY, AND DATES OF TREATMENT:

15. HAVE YOU HIRED A LAWYER TO REPRESENT YOU REGARDING THIS INJURY?	☐ YES	☐ NO
a. LAWYER'S NAME AND ADDRESS:	b. LAWYER'S TELEPHONE NUMBER:	

16. DO YOU HAVE INSURANCE?	☐ YES	☐ NO
a. NAME OF INSURANCE PROVIDER(S):	b. INSURANCE TELEPHONE NUMBER(S):	

17. YOUR SIGNATURE	18. DATE SIGNED *(YYYYMMDD)*