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MEMORANDUM FOR DISTRIBUTION C
MAJCOMs/FOAs/DRUs

FROM: HQ USAF/SG
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Air Force Guidance Memorandum to Air Force Instruction (AFI) 41-210, *TRICARE Operations and Patient Administration Functions*

By Order of the Secretary of the Air Force, this Air Force Guidance Memorandum immediately implements changes to AFI 41-210, *TRICARE Operations and Patient Administration Functions*. Compliance with this Memorandum is mandatory. To the extent its directions are inconsistent with other Air Force publications; the information herein prevails, in accordance with AFI 33-360, *Publications and Forms Management*.

The changes set forth in the Guidance Memorandum are effective immediately. A summary of affected areas are outlined below. Health Insurance Portability and Accountability Act (HIPAA) privacy provisions updated to incorporate examples of inappropriate access to PHI; removing US-CERT requirement for reporting, except for when a Federal Government information system has been compromised and confirmed; and Air Reserve Components (ARC) access to AHLTA as a disclosure of Protected Health Information (PHI) to a Command Authority including accounting of disclosures procedures. The Medical Retention Standards Branch (AFPC/DPANM) is the sole authority to direct assignment into the Airman Medical Transition Units (formerly Patient Squadrons). The AF Form 745 is only required to be used in the active volume of outpatient medical records for members on PRP. Use of the AF Form 745 in closed/inactive volumes is optional. In Section 5.7, Medical and Dental Treatment Record Disposition/Retirement Procedures, most notably the AFPC Central Cell business process, has been re-aligned under the Air Force Surgeon General (AF/SG), under the purview of Air Force Medical Operations Agency (AFMOA). As such, a new mailing address and contact information has been provided. The Service Treatment Record (STR) on-time submission goals to meet the Under Secretary of Defense Personnel and Readiness expectations have been included. Additionally, with the wide-spread implementation of AHLTA Web Print and the Health Artifact and Imaging Management Solution (HAIMS), Medical Treatment Facilities (MTFs) are no longer required to print AHLTA notes prior to sending to the AF STR Processing Center (AFSTRPC). Bulk scanning of the entire original paper health records is permissible (following coordination/approval from AFMOA/SGAT).

4.6.2.1. (Replace) Secure messaging between a provider and patient generally requires the patient to access a government sponsored internet website where once a patient's identity has been validated, the patient then has access to an internal website messaging account to use when corresponding with his or her healthcare team. MiCare secure messaging and any other AFMS approved secure messaging programs are authorized. Refer to Section 6I, Use of e-Mail to communicate PHI for additional information regarding this subject.

4.11.1.1. (Replace) Section 11 shall indicate, "Military Treatment Facility – TRICARE Operations and Patient Administration (TOPA) function and/or Airman Medical Transition Unit."

4.14.4. (DELETED)

4.27.1.6. (Replace) Within the CONUS, patients may be administratively assigned or attached to the closest Air Force MTF Airman Medical Transition Unit nearest to the Army or Navy MTF providing medical care. See 4.71.1. for Airman Medical Transition Unit assignments.

4.31.3. (Replace) The patient may be assigned or attached to the Airman Medical Transition Unit.

4.36.2. (Replace) The attending healthcare provider may recommend up to 84 days of postpartum convalescent leave upon discharge, unless the mother's medical condition warrants a longer period.

4.53. (Replace) **HQ AFPC/DPANM Medical Retention Standards Branch.** The AFPC Medical Retention Standards Branch (DPANM) is the reviewing body for all active duty RILO reviews, the sole approval authority for Airman Medical Transition Unit assignments, active duty ALC-C, Medical Hold, and non-emergent surgery during a SM's final six months of service (defined as surgery, which may or may not be necessary, but which is not required urgently or emergently to save life, limb, or eyesight). DPANM is the office of primary responsibility for implementing HQ USAF/SG policy on medical standards for continued military service, and may provide interpretations of gray areas within this AFI consistent with current HQ USAF/SG intent.

4.71. (Replace) **Airman Medical Transition Unit (AMTU) Assignment**.

4.71.1. (Replace) This section contains the authority for administratively assigning patients to an Air Force medical unit for the purpose of obtaining medical care and/or for MEB processing.

4.71.1.2. (Added) Immediate and/or urgent medical care or evaluation can be accomplished quickly by placing SMs in TDY status. Care should not be delayed for the purposes of completing paperwork for an AMTU assignment, even when that is a likely outcome. While in a medical TDY status, the SM's home MTF should notify the PEBLO at the gaining MTF of the SM's status, and anticipated length of treatment. Until PCS action occurs, the SM remains assigned and accountable to their home unit and the associated MTF PEBLO.

4.71.2. (Replace) An AMTU can be established at any Air Force MTF regardless of size. When AFPC/DPANM assigns/directs an SM to an AMTU, he/she is relocated via official orders in either PCS or PCA capacity. The MTF Commander shall assume assignment and command

authority over officers and enlisted members assigned to this unique unit. The MTF Commander may appoint an officer under his/her command to serve as the AMTU commander.

4.71.2.1. (Replace) Typically, patients assigned/attached to an AMTU are assigned to the Medical Support Squadron (MDSS); thus, the MTF Commander appoints the MDSS Commander as the AMTU Commander. The MDSS Commander assumes administrative oversight and UCMJ authority for patients assigned (PCS). UCMJ authority for attached patients (TDY) remains with the home unit. Once an AMTU has been established, it can be designated as a Flight or an Element of the TOPA Flight.

4.71.2.2. (DELETED)

4.71.2.3. (DELETED)

4.71.2.4. (DELETED)

4.71.2.5. (DELETED)

4.71.2.6. (DELETED)

4.71.3. (Replace) AFPC/DPANM is the sole approving authority for Active Duty AMTU PCS assignments and will base assignments on current AF/SG and AFPC policy. Generally, AMTU PCS assignments will be limited to the following situations:

4.71.3.1. (Added) Required medical care is not available at CONUS/OCONUS MTFs or reasonably available in the local or regional areas.

4.71.3.2. (Added) There is overwhelming medical evidence which suggests the SM is not likely expected to return to Active Duty.

4.71.3.3. (Added) When hospitalization beyond the SM's Date of Separation is expected, contact AFPC/DPANM to request a Medical Hold.

4.71.3.4. (Added) For overseas SMs; when hospitalization beyond the member's DEROS is expected.

4.71.3.5. (Added) When a SM undergoes prolonged and/or intensive treatment, and requires proximity to a family support network.

4.71.4. (Replace) Permanent Assignment Process: The requesting MTF SGH initiates an AMTU PCS assignment by completing an AFPC/DPANM - approved AMTU PCS worksheet and submitting it to AFPC/DPANM. A sample (template) is available on the AFMOA Health Benefits KX page at https://kx2.afms.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx.

4.71.4.1. (Replace) MTF Commanders may publish TDY orders to move patients between MTFs. The patient may be temporarily attached to an MTF AMTU while in a medical TDY status, but remain assigned to their home unit. Following TDY medical treatment, the AMTU commander will return the Airman to his or her home unit commander. Attaching patients to an

AMTU does not require AFPC/DPANM approval; however, AFPC/DPANM can be consulted for lengthy TDYs or if TDY turns into a PCS.

4.71.4.2. (DELETED)

4.71.5. (Replace) Special Circumstances.

4.71.5.1. (Replace) Officers pending judicial or adverse administrative action may not be assigned to an AMTU unless approved by the court-martial convening authority or discharge authority.

4.71.5.2. (Replace) Enlisted members pending judicial or adverse administrative actions are attached TDY or assigned PCS without PCA to the AMTU unless PCA is approved by the court-martial convening authority or discharge authority.

4.71.5.2.1. (Added) The AMTU commander in each case above is required to continue the administrative or discharge action.

4.71.5.3. (Replace) PCS action does not apply to ARC Airmen who may travel to an MTF to receive LOD-related, pre-MEB diagnostic treatment, and/or MEB case processing. While at the MTF, RCSMs are considered attached to the MTF.

4.71.5.4. (Replace) SM's in a non-Air Force MTF who meet requirements for assignment to an AMTU are administratively attached to the nearest Air Force MTF AMTU. For guidance, contact AFPC/DPANM.

4.71.5.5. (DELETED)

4.71.6. (Replace) Re-assignment from AMTU to Duty. Members assigned to the AMTU should receive DAWG and AFPC/DPANM or ARC/SGP screening IAW this instruction. If, following treatment, a member is found to have recovered from his/her injuries or illnesses and has been medically cleared or deemed fully capable of returning to full duty, send a RILO to AFPC/DPANM.

4.71.6.1. (Added) When AFPC/DPANM dispositions the case of a member currently assigned to an AMTU, and the member is found to meet medical retention standards, AFPC/DPANM will notify the appropriate officer or enlisted assignment department at AFPC to send a message to the local MPS with assignment instructions. Note: SMs must meet minimum PCS retainability requirements.

4.71.7. (Replace) SMs are not retained as hospital patients for rehabilitation in order to gain retention on active duty.

4.71.8. (Replace) SMs are not placed in an AMTU in order to preserve terminal leave or otherwise to retain a member beyond his or her date of separation or retirement without specific guidance from AFPC/DPANM. Once an SM is placed on terminal leave, he or she is not permitted to change duty status without prior approval for Medical Hold or admission to a hospital for an emergency.

4.71.9. (Replace) A SM is not placed in the AMTU when a Line of Duty determination (formal or informal) is pending.

4.71.9.1. (DELETED)

4.71.9.2. (DELETED)

4.71.9.3. (DELETED)

4.71.9.4. (DELETED)

4.71.9.5. (DELETED)

4.71.9.5.1. (DELETED)

4.71.9.6. (DELETED)

4.71.9.7. (DELETED)

4.71.10. (Added) AMTU Responsibilities.

4.71.10.1. (Added) Verify the TDY/PCS orders of each patient to ensure proper assignment and attachment, and assist the patient in correcting errors.

4.71.10.2. (Added) Notify the First Sergeant of newly assigned personnel.

4.71.10.3. (Added) Assist the patient with unit, group, and wing in-processing requirements.

4.71.10.4. (Added) Refer the patient to case management and other departments as appropriate.

4.71.10.5. (Added) Ensure the patient is briefed on entitlements by responsible base support agencies.

4.71.10.6. (Added) Give regular updates on the patient's status to the AMTU Commander and SGH. If the patient is attached (TDY status), keep the home unit updated on the patient's status.

4.71.10.7. (Added) Maintain daily accountability and tracking of patients assigned and attached.

4.71.10.8. (Added) Assist, as necessary, with lodging and resolving related issues.

4.71.10.9. (Added) Assist, as necessary, with pay/finance issues.

4.71.10.10. (Added) Assist, as necessary, with career milestones activities such as promotion and retirements ceremonies.

4.71.10.11. (Added) Ensure patient goes to their medical appointments and if necessary, assist patient in getting to their appointments.

4.71.10.12. (Added) Provide patient with the name and telephone number of someone or of a department they can reach 24/7.

4.71.10.13. (Added) Mentor/counsel member as needed.

4.71.10.14. (Added) In coordination/approval by the AMTU Commander, place both assigned and attached outpatient SMs in an MTF or external line unit work center provided:

4.71.10.14.1. (Added) the SM is physically and/or mentally capable of completing reasonable normal daily activities, and,

4.71.10.14.2. (Added) the temporary placement of a SM within a work center can be safely accomplished without interfering with his or her treatment, MEB evaluation, or clinical or non-clinical case processing, and,

4.71.10.14.3. (Added) the SM's attending provider supports the decision, and,

4.71.10.14.4. (Added) the SM is able to wear his/her uniform (shoe waiver may be used), and,

4.71.10.14.5. (Added) the AMTU commander is able to secure placement approval or permission to place the SM within the work center.

4.72.4. (Replace) Patient Status. Active Component SMs who must be treated at a VA Hospital before retirement are ordered PCS without PCA. The servicing MPS retains responsibility. If prolonged disability processing ensues, the member may PCA to the VA hospital, but will be assigned to the AMTU of the nearest Air Force MTF.

4.75.1.8.4. (Replace) Reserve Component personnel with significant medical conditions that require persistent clinical care may be attached, never assigned, to an MTF AMTU during MEB processing.

5.4.5. (Replace) EHR Use and Documentation for Members Assigned to Sensitive Duties Programs: Service Members assigned to Sensitive Duties Programs, like the PRP, Presidential Support Duty (PSD) or other sensitive duty National Security program(s), may be suspended or removed from their duty position(s) based on their medical, dental, or mental health status. The current DoD EHR cannot automatically provide for the mandatory notification and receipt confirmation documentation (between the MTF competent medical authority and individual unit commanders or installation operational assurance officials) of a Service Member's health status, operational capabilities/limitations, or his/her fitness for duty following each patient encounter. Following proper notification and documentation (either electronic or written), any forms not already uploaded into the EHR will be uploaded into the Service Member's outpatient medical EHR or filed in the dental treatment record. Note: Newly assessed members who originally did not have hardcopy medical records created IAW para 5.4.10.2.3. should not have new hard copy medical records created regardless of special duty status. These members will still hand-carry their hardcopy dental treatment record.

5.4.9.10.1. (Replace) The practice of scanning entire original paper health records for permanent storage, importing, or uploading into the Health Artifact and Image Management Solution (HAIMS) or similar DoD approved document management system is permissible and applicable

to the AF STR Processing Center (AFSTRPC). Additionally, MTFs/units that want to bulk scan will coordinate with and obtain approval from AFMOA/SGAT prior to bulk scanning.

5.4.9.10.1.1. (Added) In support of the Personnel Reliability Program (PRP) Administrative Qualification (AQ) Central Cell process, all paper health treatment records will be requested from the losing MTF. Paper medical and dental records must be scanned into HAIMS within 7 calendar days. Refer to PRP ADMIN CERT HAIMS SCAN GUIDE, located at: https://kx2.afms.mil/kj/kx2/AFMOAHealthBenefits/Documents/Forms/ShowFolders.aspx?RootFolder=%2Fkj%2Fkx2%2FAFMOAHealthBenefits%2FDocuments%2FMedical%20Records%2FHAIMS&FolderCTID=0x0120000459EFB11C132E479D3C03001C859239&View=%7BDB7164E0%2DEF02%2D4CE4%2DAD97%2DF6B6ED3D1D7B%7D. Note: The PRP AQ process applies to Active Duty. (See Personnel Services Delivery Guide: Personnel Reliability Program (PRP) Administrative Qualification Central Cell, located at https://www.my.af.mil/gcss-af/USAF/ep/globalTab.do?channelPageId=sF575FC8E23D21F6E0123FD054D26070B&command=org for additional information.)

5.4.10. (Replace) HAIMS is a Military Health System (MHS) strategic project that enhances medical informatics through seamless integration of medical digital images into the EHR. The objective of HAIMS is to give healthcare providers global awareness and access to essential healthcare artifacts and images (A&I) throughout the continuum of care from Theater to the Sustaining Base to the Department of Veterans Affairs (VA). HAIMS provides a single enterprise-wide image sharing capability for all types of A&I, including radiographs, photographs, wave forms, audio files, video files and scanned documents.

5.4.10.1. (Added) Using HAIMS in the MTF. ALL Air Force MTFs have received HAIMS implementation and training. MTFs are required to use this capability.

5.4.10.1.1. (Added) All Reserve Medical Units (RMU) will be trained on HAIMS. Units that have received HAIMS implementation training are required to use this capability.

5.4.10.2. (Added) HAIMS Administration. Once HAIMS has been implemented at the site and all users have undergone training, an MTF (outpatient Records, referral management centers, clinical departments, etc.) will use HAIMS exclusively to scan loose paperwork.

5.4.10.2.1. (Added) MTF Staff will cease filing loose paperwork in the hard-copy medical record (to include PRP/PSD/FLY) and instead scan/upload them into HAIMS.

5.4.10.2.2. (Added) Once a loose document has been scanned, validated and uploaded into HAIMS, the document (to include PRP/PSD/FLY) shall be destroyed.

5.4.10.2.3. (Added) Lackland AFB, Maxwell AFB, and USAF Academy will bulk scan entry paperwork. New paper records will not be created. Members will not hand-carry medical records.

5.4.10.2.4. (Added) New paper records will not be created for new dependents.

5.4.10.3. (Added) HAIMS Training. Initial HAIMS implementation training was funded to 50%, MTF clinical systems trainers and super users were responsible for training any remaining users. Note: Active Duty MTF host will provide HAIMS training to tenant RMUs/Guard Medical Units

(GMUs). RMUs not collocated will coordinate training with HQ AFRC/SG and GMUs with HQ NGB/SG.

5.4.10.4. (Added) HAIMS Guidance. DoDI 6040.45, DoD Health Record Life Cycle Management provides guidance and procedure for using HAIMS. Additional guidance on how to use HAIMS can be located on the KX at https://kx2.afm.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx.

5.4.10.4.2. (Added) Guidance for Making the Service Treatment Record (STR) Available for Access by the Department Of Veterans Affairs (VA)

5.4.10.4.2.1. (Added) AF STR Processing Center: The Air Force Medical Service has opted to centralize the STR digitization, for retiring/separating members, into HAIMS for access by the DVA. The STR disposition process can be found in this instruction at chapter and paragraph 5.7.

5.4.10.4.2.2. (Added) The Home MTF/Dental Treatment Facility (DTF) is responsible for securing the service member's paper STR, collecting all unfiled, loose and late flowing documents (LLFDs) and artifacts at the MTF and filing them properly in the STR. This does not include electronic encounter information maintained in AHLTA. Any late and loose flowing documents will be scanned and uploaded into HAIMS by the MTF.

5.7. (Replace) Service Treatment Records (STR) Disposition Instructions for Airman Retiring, Separating and Transitioning to the Reserve Component (RC). There are two categories of Health Records: 1) Service Treatment Records (STR) - the outpatient medical record and dental treatment record for a member of the U.S. Military. It is made up of the patient's medical and dental encounters incurred throughout the course of their military career. The STR ends upon discharge, retirement, separation or death (if death occurred while on AD). 2) Non-Service Treatment Records (NSTR) – outpatient medical records for patients in ALL other categories (dependents, civilians, foreign military, retirees, etc.). The following sections contain guidance regarding the proper procedures to transfer, disposition, and retire all types of heath records to the appropriate location. STR Disposition is discussed in further detail in 5.7.1. Dependent, Non-NATO Foreign military, and Retiree NSTRs are retired to the National Personnel Records Center (NPRC) using the MRT application in CHCS. This process, the Annual NSTR Retirement, is discussed in further detail in para. 5.7.6 and para. 5.7.7. Federal Civilian Employee NSTRs are provided to the local Civilian Personnel Office (CPO) or retired to NPRC, which will be discussed in further detail in para. 5.7.9.

5.7.1. (Replace) In March 2007, the Principal Deputy Under Secretary of Defense for Personnel and Readiness (PDUSD(P&R)) directed the Military Services to institute management systems to ensure timely and accurate disposition of Service Treatment Records (STRs) to the Department of Veteran's Affairs (VA). On 1 Jan 09, the Air Force Medical Service (AFMS) stood up an STR centralized processing contract cell located at the Air Force Personnel Center (AFPC) on Randolph AFB. Previously, all AF STRs were dispositioned to the Department of Veterans Affairs (DVA) via the Air Force Personnel Center (AFPC) Central Records Disposition Center, at the end of a Service Member's military Active Duty career. However, the Department of Defense (DoD) Recovering Warrior Task Force voiced concerns to the Joint Executive Council (JEC) regarding new and emerging recovering warrior issues, directly related to the availability of DoD Service Treatment Records (STRs) to the VA needed for disability claims processing. As a result, the Departments created a Wounded, Ill, and Injured Committee under

the JEC to oversee these matters. The VA/DoD Joint Strategic Plan (JSP) (currently aligned under the JEC) has identified the goal of ending paper STR transmittal from DoD to VA, effective January 1, 2014 (JSP Objective 3.2.A). To meet this requirement, the DoD will utilize HAIMS, in conjunction with AHLTA (the current electronic health record). The AFMS to JSP Objective 3.2.A re-aligned the AFPC Central Cell workload and processes under the Air Force Surgeon General (AF/SG), and shifted program oversight and execution to the Air Force Medical Operations Agency (AFMOA). The STR on-time submission goals to meet the Under Secretary of Defense Personnel and Readiness expectations are 95% on-time submission of Active Component STRs and 75% on-time submission of Reserve Component STRs.

5.7.1.3.1. (Added) In late 2013, officials from AFMOA modified the original STR Disposition process and created/modified the new process to include the use of HAIMS. Beginning 1 Jan 2014, STRs were sent to the new AF STR Processing Center instead of AFPC. Similar to the previous process, the new cell will continue to receive bulk shipments of paper STRs for retiring and separating AF service members. Upon receipt, the new cell will digitize the paper records into HAIMS. The original paper STR will then be dispositioned according to DoD and National Archives and Records Administration (NARA) guidance. This solution not only ensures the AFMS meets the JEC mandate to be entirely paperless by January 1, 2014, but will also vastly improve continuity of care for shared patients, while simultaneously solving the urgent need to reduce the VA claims backlog.

5.7.1.4. (Replace) Total Force Applicability: This STR disposition policy applies equally to the AD MTFs and the Reserve Component Medical Units (RCMUs). Although the following language specifically mentions MTF responsibilities and expectations, the guidance also applies to Air Force Reserve (AFR), Air National Guard (ANG) medical units, and organizations responsible for the day-to-day maintenance and storage of Reserve Component STRs. The AF STR Processing Center (AFSTRPC) is the only Air Force agency authorized to forward AD and RC STRs to the DVA. MTFs and RCMUs are not authorized to mail records directly to the DVA.

5.7.1.5. (Replace) All MTF and DTF records management personnel are expected to apply the following directions to their STR disposition plan. MTF records managers and supervisors must work closely with their DTF counterparts and local MPS, Military Personnel Element (MPE), Military Personnel Section (MPS), or Force Support Squadron (FSS) officials to make this transition as smooth as possible.

5.7.1.7.1. (Replace) In order to streamline the process and standardize acquisition procedures for LOSS Rosters, a Medical Records Management (MRM) SharePoint website was created so MTF, DTF, and RCMU records managers could easily obtain this time sensitive information.

5.7.1.7.2. (Replace) Personnel LOSS rosters include a listing of all projected retiring, separating, transitioning, and discharging AF service members (AD and RC), to include those assigned to GSUs. The rosters also identify Airmen who retired or separated in previous months which the AFSTRPC has not received a complete STR. Column “Q” of each roster indicates the original component(s) which have still not been received by the AFSTRPC. Note: These records will continue to remain on the roster until the AFSTRPC receives the records.

5.7.1.7.3. (Replace) Identified MTF, DTF, and RCMU personnel must obtain the LOSS roster from the MRM SharePoint each month. The local MPS will continue to provide support for

short-notice changes and any other questions which might arise. As the LOSS rosters contain protected personnel information and the SharePoint contains all rosters for all facilities, access to the page is restricted to only those individuals who require access to perform STR disposition duties.

5.7.1.7.4. (Replace) Each MTF or RCMU is authorized one primary and four alternate points of contact (POCs), for a total of five (5). It is recommended that the primary POC be the individual with direct oversight of the records process (NCOIC, in most cases). Alternates should be a dental rep, flight commander or superintendent. Each member must be designated in writing (appointment letter) by the unit commander. A sample (template) is available on the MRM SharePoint and the AFMOA Health Benefits KX page at https://cs3.eis.af.mil/sites/OO-SG-AF-90/default.aspx or https://kx2.afms.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx. As the rosters are in Excel format, they can be downloaded, saved and distributed locally as your facility deems necessary. However, given the Personally Identifiable Information (PII) included on the spreadsheet, access must be limited to only those with a need to know. E-mail messages containing PII must be digitally signed and encrypted. All appointment letters must be updated at least annually.

5.7.1.7.6. (Replace) Use the following guidance to select and identify the responsible MTF, DTF, and RCMU personnel:
a. POCs must be appointed in writing (appointment letter).
b. The appointment letter must include the reason for the request and must be signed by the MTF/MDG/RMU commander. Appointment letters can be updated/resubmitted at any time; letters will be updated at least annually.
c. Address appointment letters to AFMOA/SGAT and scan/e-mail the document to afmoa.sgat@us.af.mil.
d. Once the appointment letter has been submitted and approved, the POCs must request access to the MRM SharePoint at https://cs3.eis.af.mil/sites/OO-SG-AF-90/default.aspx.

5.7.1.7.7. (Replace) The LOSS rosters are located in the main folder "Medical Record Rosters", and then in the sub-folder for the applicable month. The folders correspond with the month the roster was run. For example, the September 2010 roster is located in the "Sep 10" folder which reflects the September 2010 losses, even though the majority are not “actionable” until October (30calendar days post- DOS)

5.7.1.7.8. (Replace) Each roster on the SharePoint is listed separately by Personnell Accounting Symbol (PAS) Code. A number of installations have Guard and/or Reserve units assigned/co-located with the AD MTF, therefore these bases will appear to be listed more than once. The first 2 digits of the PAS Codes determine the applicability of the roster. Generally, AD PAS Codes are two ALPHA characters, whereas Guard and Reserve PAS Codes are identified by an ALPHA Numeric code. For instance, McConnell AFB could appear three times: McConnell (D6); McConnell (MK); and McConnell (R2). The AD MTF roster is identified by (MK), the Guard roster is identified by (D6) and the Reserve unit is identified by (R2).

5.7.1.7.9. (Replace) Some larger MTFs have more than one MPS providing services at their installation, therefore, MTFs and RCMUs will also need to know the two-digit PAS Code for each of those MPS/GSUs for which they provide care/maintain records. A Memorandum of Understanding/Memorandum of Agreement (MOU/MOA) is required for each MTF or RCMU if

co-located with another MTF/RCMU (regardless of Service affiliation) to ensure correct Records Management procedures/policies are followed and addressed.

5.7.1.7.9.1. (Replace) PAS Codes can be obtained from the AFPC secure web site at: https://w20.afpc.randolph.af.mil/AFPCSecureNet20/PKI/MainMenu1.aspx. After accessing the site, click "OK", then "PASS CODES". The PAS Codes are also located on the MRM SharePoint in the Departure Rosters folder.

5.7.1.7.10. (Replace) Facilities have a window of opportunity when records should be mailed to arrive at the AF STR Processing Center. The LOSS roster contains two columns for shipment dates for the STR to arrive at the AFSTRPC, "No Earlier Than" (NET) and "No Later Than" (NLT). The NET date is the member's date of retirement (DOR)/separation (DOS); the NLT date is 30 days after the member's date of retirement/separation. Medical records personnel at all Air Force MTFs and RCMUs must mail a retiring/separating member's STR to arrive at the AF STR Processing Center NET the DOR/DOS and NLT 30 days past the DOR/DOS.

5.7.1.7.12. (Replace) GSUs: When the GSU member separates/retires, his/her name will appear on the LOSS roster of the MTF serviced by the MPS to which the member is assigned. However, STRs for retiring and separating AF service members assigned to remote units or GSUs are frequently maintained at the installation MTF located nearest to the GSU site. If the Airman is enrolled to a TRICARE network Primary Care Manager (PCM), his/her civilian medical documents are maintained at the network PCM office. If the individual appears on the MTFs/RCMUs roster, that specific MTF/RCMU is responsible and will be held accountable for its disposition.

5.7.1.7.13. (Replace) OCONUS Based Member Retiring/Separating: Based on AFPC guidance, retiring/separating members assigned OCONUS are directly retired/separated by the OCONUS MPS; members are no longer PCS'd to CONUS for retirement/separation processing. However, even if a retiring/separating member based at an OCONUS MTF returns stateside just for the purpose of retiring/separating, the OCONUS MTF STR Loss roster will normally reflect the member as retiring/separating and it is the OCONUS MTF's responsibility to ensure the STR is appropriately dispositioned to the AF STR Processing Center.

5.7.1.7.14. (Replace) AFR Rosters: Reserve medical units will download the AFPC retirement/discharge roster (LOSS Roster) from the MRM SharePoint.

5.7.1.7.15. (Replace) ANG Rosters: Guard medical units will download the AFPC retirement/discharge roster (LOSS Roster) from the MRM SharePoint.

5.7.1.8.1.2. (Replace) MTF/DTF Responsibilities:
a. The MTF and DTF will each place one copy of the orders in the member's outpatient medical and dental treatment records. In the outpatient medical record, the member's orders will be placed in Section II. In the dental treatment record, the member's orders will be placed on the inside right-side folder section.
b. The second copy of the orders will be placed into a plastic AF Form 885-887 series, Medical Record Charge-Out Guide and filed in place of the record. It is also recommended to include a reference to where the record is located (transitory file) until the record is mailed.
c. Missing Orders: MTFs and RCMUs should not delay processing STRs for transfer to the AF STR Processing Center due to missing Service Member orders. If, after contacting the MPS or

accessing the Virtual MPS, a copy of the orders cannot be obtained, the STR may be sent without the orders. A memo stating the reason for missing orders should be included. Verifying or checking with the MPS is also required prior to shipment to ensure the Service Member did not re-enlist or extend his or her enlistment.

d. RegAF Active Duty Virtual MPS Checklist Confirmation. Historically, only the MTF Force Health Management (FHM) staff had access to the Virtual MPS. In May 2010, AFPC directed all MPSs to authorize MTF and DTF Records Rooms access. MTF health records offices have been added as mandatory out-processing checklist destinations for each outbound Service Member. Although the FHM may have additional medical out-processing checklist approval authority or obligations, they should not sign off or approve any outpatient medical or dental treatment record out-processing tasks on a Service Member's Virtual MPS out-processing checklist. Outpatient medical and dental records managers and FHM officials will work together to ensure each outbound Airmen has fulfilled all of his or her MTF out-processing responsibilities. RCMU personnel should be included on local out-processing checklist similar to those noted above.

e. Checklist Operation: Multiple (at least two) staff members assigned to MTF and DTF records departments will be granted Virtual MPS Checklist access to ensure each departing Service Member is informed of the requirement to provide the MTF and DTF with copies of his/her orders at the time of MTF/DTF out-processing. Access will also allow MTF records managers to obtain and print individual retirement/separation orders when necessary. Once added to the process or granted access to the Virtual MPS system, records managers can forecast the timeframe when separating and/or retiring Airmen will visit the MTF and DTF to out-process. MTF and DTF records managers may also be able to add special notes to the Virtual out-processing checklists to inform out-processing Airmen to obtain a copy of their STR no earlier than 179 calendar days and no later than 30 days prior to the date of their final separation or retirement date.

5.7.1.8.2. (Replace) AFR Personnel. Each month, the servicing Reserve MPS will provide the servicing RMU a copy of the retirement/discharge/transition orders or AF Form 1288, Request for Ready Reserve for all assigned Airmen serviced by the installation MPS, including GSU personnel with a 60-day projected retirement, discharge, or transition to inactive status date.

5.7.1.8.3. (Replace) ANG Personnel. Guard members receive their retirement/discharge orders from the Retirements/Separations department of the MPS located at their ANG Wing. These retirement/separation orders should be received at the monthly Unit Training Assembly (UTA) immediately preceding the final service obligation date.

5.7.1.10.1. (Replace) For the Active Component Service Member (ACSM):

5.7.1.10.1.1. (Replace) Separating and retiring Airmen may request one complete copy of their STR no earlier than 179 calendar days and no later than 30 calendar days prior to the date of their final out-processing appointment. Only one copy is authorized. The goal is to have one complete STR copy ready for the separating or retiring Airman by the time of his final MTF/DTF out-processing appointment. The copy can be provided as a hard-copy record or in electronic or digital media format, whichever the member requests.

5.7.1.10.1.2. (Replace) Copy requests should be fulfilled no later than 30 calendar days from the date of copy request receipt. Records managers must use all available resources within their means to ensure separating and retiring Airmen understand the importance of submitting their

STR copy requests as early as possible. The volume of electronic patient encounter documents generated from MTF or DTF visits that fall within the 30-day cut-off copy request date through the Airman's MTF/DTF out-processing date are usually not that significant. These few documents should be reasonably easy to identify and print from AHLTA or CHCS on the spot, copy from the paper outpatient medical or dental records and added to the copy package, or provided to the member at the time of out-processing.

5.7.1.10.1.3. (Replace) MTF records manager are expected to notify the Transition Assistance Program (TAP) of the member's right to one copy of their record upon separation or retirement. MTF records personnel will ensure local installation TAP officials are aware each AD Airman enrolled in TAP class may receive a copy of their STR no earlier than 179 calendar days, but not later than 30 calendar days prior to their final retirement or separation date.

5.7.1.10.2. (Replace) For the Reserve Component Service Member (RCSM):

5.7.1.10.2.2. (Replace) Separating and retiring RCSM may request one complete copy of their STR. Copy requests from MTFs should be fulfilled no later than 30 calendar days from the date of copy request receipt. Requests for copies from Reserve Component Medical Units should be fulfilled by the RCMU no later than 90 calendar days from the date of the copy request receipt. Typically, RCMUs are not regularly staffed as well as full-time AD MTFs. Consequently, opportunities to make copies for retiring or discharging members may be diminished, sometimes limited to only drill weekends. Records managers must use all available resources within their means to ensure RC retiring and discharging Airmen understand to submit their STR copy requests as early as possible. The volume of electronic patient encounter documents generated from MTF, DTF or RCMU visits that fall within the period from the 90-day cut-off copy request date through the Airman's MTF, DTF or RCMU out-processing date should not be that significant. These few documents should be reasonably easy to identify and print from AHLTA or CHCS on the spot, copy from the paper outpatient medical or dental records and added to the copy package, or provided to the member at the time of out-processing.

5.7.1.10.2.3. (Replace) Some RCMUs do not have access to HAIMS. For those RCMUs without HAIMS access, records managers are required to contact the AD USAF Support MTF to obtain copies of all AHLTA/CHCS encounters, ancillary laboratory and radiology results. Provide a copy of the Service Member's pharmacy prescription medication history only upon specific request.

5.7.1.11. (Replace) STR Composition. The STR includes traditional paper outpatient medical and dental documents stored in the outpatient medical and dental records as well as ancillary laboratory, radiology reports stored and printed from CHCS, outpatient patient encounter notes and any other PHI reports, data, or information stored and printed from AHLTA. Copies of clinical narrative summaries and operation reports from previous inpatient, ambulatory procedure visits (APV), and/or Medical Evaluation Board (MEB) actions should already be filed in Part I or III of the member's outpatient record. However, MTF records managers or Release of Information (ROI) staff will verify that any narrative summaries and/or operation reports generated from past inpatient, APV or MEB actions completed at the same MTF responsible for the STR disposition, are included in the paper outpatient medical record.

5.7.1.11.1. (Replace) AHLTA Web Print (AWP). AWP is a new feature in AHLTA that allows a user to print or generate a .pdf file of a patient's entire electronic health record (EHR), or specific

sections thereof, with one command. The AWP menu will appear as a link in the AHLTA folder tree. The user interface screen permits configuration and setting of desired report options. These options allow the user to customize the printed report by limiting the report to a specified date range or clinical domains to be included in the report, and to even generate a mailing page.

5.7.1.11.2. (Replace) Given that AWP file comes complete with a Table of Contents which specifies page numbers for each item, it is no longer logical to file it in each applicable section of the record (i.e., SF600's in Section 2, labs/rads in Section 4, etc.). As such, the entire printed copy of the EHR should be kept together as one file to reduce confusion on where an encounter identified in the Table of Contents is located. In the event a patient's entire EHR must be printed/filed, MTFs/RCMUs (utilizing AWP) should file the AWP.pdf as a complete packet in one of the following ways:
a. If the patient's original paper record is small enough, the entire packet can be filed as the top documents in Section 2.
b. If the patient's original paper record is too large, the AWP packet should be placed in its own jacket (another volume), filed in Section 2.

5.7.1.11.3. (Added) AWP and STR Disposition. The availability of AWP in the AFMS has provided significant benefits to reducing the workload associated with printing EHR documentation. As such, patient encounter notes, printable clinical notes, radiology procedures, and laboratory test results electronically stored in AHLTA are no longer required to be printed and filed in the outpatient medical record prior forwarding to the AF STR Processing Center. The STR Processing Center will utilize AWP to generate all AHLTA EHR documents into the AWP.pdf and upload it into HAIMS during STR digitization, thereby making the complete STR available to the VA in one process.

5.7.1.11.4. (Added) AWP and NSTR Retirement. NSTR - outpatient medical records for patients in ALL other categories (dependents, civilians, foreign military, retirees, etc.), are retired to NPRC using the MRT application in CHCS. This process, the Annual NSTR Retirement, is outlined in detail in para 5.7.7 and the MRTR2 Guide. Until necessary data communication links are permanently established between both the MHS and NPRC electronic health record systems, MTF records personnel must continue to print and file (into the patient's paper record) any and all available ancillary, diagnostic or clinical information electronically stored in standardized MHS or local MTF electronic health record systems prior to final records retirement processing and shipment. If designated MTF records personnel do not have access to necessary (sensitive/sequestered, etc.) AHLTA or CHCS systems to identify and print patient encounters, radiology reports, and laboratory reports, then the patient's PCM support staff is expected to complete this requirement and forward the documents to the MTF outpatient medical and/or dental departments for inclusion into the NSTR.

5.7.1.11.5. (Added) To ensure reasonable continuity of care and/or DVA disability evaluation/consideration, documents generated from civilian healthcare providers, stored in any MTF health record, are included in the STR. Examples include:
a. Reports and documents received from civilian referral healthcare providers.
b. Reports and documents from TRICARE Prime and TRICARE Prime Remote civilian network providers. When a service member assigned to a remote unit or GSU is enrolled to a TRICARE network PCM, his civilian documents are owned and maintained at the network civilian PCM office. At the time of the separating or retiring Airman's MTF, DTF or RCMU records department out-processing appointment, each Airman enrolled to a TRICARE civilian PCM

should complete an authorization to obtain healthcare information from the civilian PCM and/or any civilian healthcare provider. These documents should be forwarded to the MTF where the STR is maintained so that ROI staff can make the patient a copy and then include these civilian documents into the STR. MTF records managers are expected to communicate this process to separating and retiring Airmen attending TAP class so last minute civilian PCM requests do not delay STR disposition.

5.7.1.12.1. (Replace) The BDD Program is a joint initiative between the DVA and the DoD. This program enables DVA representatives to help transitioning Airmen assemble and prepare their disability claim packages for DVA disability compensation and benefits review prior to their service separation or retirement. The original STR is not provided to the BDD office. Instead, the MTF will provide the member with a paper copy and/or electronic copy (CD/DVD) of the STR at the member's request. Note: This copy is counted as the member's one complete copy free of charge.

5.7.1.13. (Replace) Collecting and Preparing STRs for Shipment:

5.7.1.13.1. (Replace) Once the LOSS rosters are obtained, retrieve the applicable outpatient medical records and place them in a staging area separate from the main file located within a secure, limited access room. File the STRs in chronological order according to the Loss Roster shipment date. This will help ensure the STRs are mailed to arrive at the AF STR Processing Center by the deadline (i.e., no earlier than DOR/DOS and no later than 30 days after the member's final date of separation).

5.7.1.13.2. (Replace) No later than 1 business day after the Airman's date of separation, MTF and DTF records personnel will ensure the dental treatment records for each separating and retiring Airman are forwarded to a central MTF location where they will be bundled with the outpatient medical record and staged until ready for mailing to the AF STR Processing Center. Note: The outpatient medical and dental records for each Airman must be "bundled" together before shipping to the AF STR Processing Center. DO NOT MAIL THE OUTPATIENT AND DENTAL RECORDS SEPARATELY. Exception: Separate shipment may be necessary, for those medical or dental records or other Volume that may be at another installation. Do not hold medical or dental records after the member's DOS to include documentation or encounters generated for any care they may receive after DOS.

5.7.1.13.3. (Replace) Missing Records: With the DoD-wide implementation of AHLTA, almost all Service Members have patient medical encounters documented electronically. However, the availability of complete STRs (all volumes of a patient's medical and dental records) has the highest level of visibility. As such, it is unacceptable for an MTF/RCMU to be unable to locate the complete STR for a patient. MTFs/RCMUs must have and implement thorough in and out-processing procedures to ensure all records for a patient are available as soon as possible.

5.7.1.13.3.1. (Added) Each Service has developed their own process to provide STRs to the VA. The VA provides metrics for each Service (similar to the STR metrics) to Office of the Secretary of Defense (OSD), the White House and Congress. Each Service is held 100% accountable for missing records/components. In order to facilitate locating these missing items, the records not sent to the AF STR Processing Center will remain on the unit's LOSS roster until found or an acceptable Non-Availability Letter (NAL) and completed MTF STR Manager Search Verification Checklist (Verification Checklist) are received by the AF STR Processing

Center. When an acceptable NAL and completed verification checklist are received, the records will be removed from the Loss Roster. Until the records are located and sent, the AF is still legally required to continue to search for them. Regardless of who maintains the records, if the individual appears on the MTFs/RCMUs roster, that specific MTF/RCMU is responsible and will be held accountable for its acquisition and disposition.

5.7.1.13.4.1.2. (Added) If an STR cannot be located upon notification of a member separating or retiring, the verification checklist must be completed NLT the member's DOS/DOR plus 90 calendar days (DOS/DOR + 90) and the STR being located/shipped to the AFSTRPC, or declared unavailable by the signed NAL.

5.7.1.13.4. (Replace) Letter of Non-Availability, Verification Checklist, for Missing Original Paper Records:

5.7.1.13.4.1. (Replace) Only after due diligence, to include contacting the patient and the patient's previous MTFs, if either the original paper dental or original paper outpatient medical record(s) are missing and absolutely cannot be located, then include in the bundled package, a Letter of Non-Availability (NAL) and completed verification checklist indicating which original record is missing. A sample (template) is available on the MRM SharePoint and the AFMOA Health Benefits Kx page. See Attachments 10 and 12 of this AFI for the authorized format. Note: If both the original paper dental and original paper outpatient medical record(s) are missing, include two NALs and completed verification checklist.

5.7.1.13.4.2. (Replace) For the MTF/GMU: The Group or MTF Commander responsible for the operational day-to-day maintenance and storage of the missing record identified in the letter must wet or digitally CAC sign the Letter of Non-Availability. (The signature block must reflect the job title of the person signing.) Signature delegation is not authorized. This will mitigate negative impacts on timeliness requirements for mailing STR packages to the AF STR Processing Center.

5.7.1.13.4.2.1. (Added) For the RMU: The RMU Commander responsible for the operational day-to-day maintenance and storage of the missing record identified in the letter is authorized to wet or digitally CAC sign the Letter of Non-Availability. (The signature block must reflect the job title of the person signing.) Signature delegation is not authorized. This will mitigate negative impacts on timeliness requirements for mailing STR packages to the AF STR Processing Center.

5.7.1.13.4.3. (DELETED)

5.7.1.13.5. (Replace) AF Members Empanelled to Other-Service MTFs: STRs for ADSMs are normally maintained at the MTF where the member receives his primary care, regardless of service affiliation. The health record management officials at the AF MTF located nearest to the member's Other-Service PCM/MTF location must establish a local STR Support Agreement (MOU/MOA) (see Attachment 33 for example) with the Other-Service MTF. As this is DoD Policy, MOU verbiage should include both service processes. The agreement should identify how the STRs will be transferred from the Other-Service MTF. How this is accomplished is jointly decided by the MTFs, but acceptable methods include:

5.7.1.13.5.1. (Replace) The Other-Service MTF may mail the STR to the nearest AF MTF for subsequent mailing to the AF STR Processing Center.

5.7.1.13.5.2. (Replace) The Other-Service MTF may forward the STR directly to the AF STR Processing Center if they do so using the instructions outlined in this document. Include a copy of the STR disposition instructions with the agreement if this method is chosen.

5.7.1.13.5.3. (Replace) There may be instances when the member is assigned to a GSU and the responsible AF MTF is not the nearest MTF to the member's Other-Service PCM/MTF location. In these cases, see rules for managing GSU records in the passages that follow.

5.7.1.13.6.1. (Replace) STRs for non-AF service members are normally maintained at the AF MTF when the member is empanelled to the AF MTF. Unless there is a local STR Support Agreement stating otherwise, STRs for Other-Service members should be mailed to the applicable address included in Attachment 34, with the appropriate documentation (i.e., orders, Letter of Non-Availability, etc.). If a local STR Support Agreement is established with another Service, the agreement should identify how the STR will be transferred to the applicable Service.

5.7.1.13.7. (Replace) Personnel Assigned to GSUs:

5.7.1.13.7.1. (Replace) If the MTF identified on the LOSS Roster is not the MTF that maintains the retiring/separating member's STR, the LOSS-Roster-named MTF must coordinate with the MTF where the record is regularly maintained in order to ensure the STRs are mailed to the AF STR Processing Center or RCMU by the deadline. (Note: Names and numbers of POCs at each AF MTF and RCMU are located on the MRM SharePoint.)

5.7.1.13.7.2. (Replace) Once contacted, the MTF maintaining the STR must mail the STR to the AF STR Processing Center in accordance with this guidance.

5.7.1.14.2. (Replace) Outpatient medical record or Letter of Non-Availability, verification checklist.

5.7.1.14.3. (Replace) Dental record or Letter of Non-Availability, verification checklist.

5.7.1.14.4. (Replace) Include a copy of the retirement/separation or discharge order in each record. In the outpatient medical record, the member's orders will be placed in Section II. In the dental treatment record, the member's orders will be placed on the inside right-side folder section, on top of all other pages.

5.7.1.14.5. (DELETED)

5.7.1.14.5.1. (DELETED)

5.7.1.14.6. (DELETED)

5.7.1.15.1. (Replace) Place the STR bundles in order as identified on the copy of the LOSS Roster included with the shipment (as an inventory sheet). Specific order is not relevant provided it matches what is on the inventory sheet.

5.7.1.15.2. (Replace) AF Form 330, Records Transmittal Request (see example in AFI, 41-210, Attachment 24) in each shipped box/package. This form is used to inform the recipients of the type of records being mailed and the purpose of the shipment. In the "Name" box of the AF Form 330 type "SEE ATTACHED ROSTER" and staple the roster (inventory sheet) to the AF Form 330.

5.7.1.15.3. (Replace) Include a copy of the LOSS roster (as the inventory sheet) - The downloaded LOSS roster has 3 additional columns on the right-hand side titled, "Date Record Mailed", "Remarks", and "NCOIC Signature". The NCOIC or records department supervisor must sign off the roster stating they have quality checked or "QC'd" the shipment, annotate the mailing date, and annotate any remarks needed. This is a communication tool for the MTF to AF STR Processing Center. Do NOT type a separate inventory.

5.7.1.15.4. (Replace) Note: MTF records management personnel are required to keep a copy (electronic or paper) of the AF Form 330 and LOSS roster IAW the STR disposition rule in the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule. Place together with the postage tracking/arrival confirmation notice in a central location within the Outpatient Records department.

5.7.1.16.1. (Replace) Boxes - Records personnel are required to use standard white record retirement boxes or other same-sized box, purchased specifically for shipping. The maximum weight per shipping box is 50 pounds. Do not bundle standard shipping boxes within larger containers for shipment as the AF STR Processing Center mailroom will not accept large or heavy packages or containers. MTF records personnel are responsible for ensuring boxes are thoroughly and securely packed, labeled, and taped for shipping so as to prevent inadvertent opening during shipment and subsequent loss of STRs or delays in arriving at destination.

5.7.1.16.2. (Replace) Envelopes – If the STR bundle will easily fit into an envelope, one may be used. Envelopes must be tear resistant (i.e. fiber/cloth-like construction, such as TYVEK), securely packed, labeled, and taped for shipping so as to prevent inadvertent opening during shipment and subsequent loss of STRs or delays in arriving at destination.

5.7.1.17.1. (Replace) STRs will be mailed to arrive at the AF STR Processing Center no earlier than the member's DOR/DOS and no later than 30 calendar days after the member's date of retirement/separation/discharge or transition to inactive status. All OCONUS MTFs will use commercially available global delivery services to mail the STR to arrive at the AFSTRPC on the No Earlier Than Date to prevent the STR from arriving late at AF STR Processing Center.

5.7.1.17.2. (Replace) DO NOT MAIL A MEMBER'S OUTPATIENT AND DENTAL RECORDS SEPARATELY; they must be mailed together as a bundle. Note: See 5.7.1.13.2. for exception.

5.7.1.17.3. (Replace) STR bundles of outpatient and dental records for more than one individual may be combined into one shipment box provided the destination is to the same location.

5.7.1.18.1. (Replace) Forward STR boxes/envelopes to the AF STR Processing Center using standard First Class U.S. mail with immediate delivery confirmation/acknowledgment, certified mail, or other commercially available option, e.g., FedEx, that offers package tracking and delivery/arrival confirmation.

5.7.1.18.2. (Replace) If standard first class United States Postal Service (USPS) is used, package tracking and delivery/arrival confirmation or shipment via Certified Mail is required. These services are typically available via the Base Information Transfer System (BITS) or the Base Information Transfer Center (BITC) at each major installation.

5.7.1.18.5. (Added) Use of standard First Class U.S. Postal Service mailing method alone, without package tracking and immediate delivery confirmation/acknowledgment or certified mail receipt, is prohibited. Return receipt confirmation must not be dependent upon the timeliness or willingness of the destination MTF to complete a DD Form 2825, Internal Receipt, or other manual delivery confirmation receipt option.

5.7.1.19. (Replace) Mailing Location: MTFs/RCMUs are prohibited from mailing STRs or any medical or dental documents directly to the DVA. For AD and RCSMs who are retiring, separating, discharging, or transitioning to inactive status, mail STRs to the AF STR Processing Center at:
AF STR Processing Center
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

5.7.1.19.1. (DELETED)

5.7.1.19.2. (Replace) For Airman Transitioning from the AD to RC, mail the STR to the AF STR Processing Center. RMUs will access all transfer STR records through HAIMS. Exception; AD transferring to RC who are PRP/PSD/FLY will hand carry their medical/dental records to gaining unit.

5.7.1.19.3. (DELETED)

5.7.1.19.3.1. (DELETED)

5.7.1.19.3.2. (DELETED)

5.7.1.19.3. (Added) Airmen transitioning from AD to the RC without a break in service are considered to be a transition rather than a separation. As such, any Service Member or Airman currently assigned or who will be assigned upon arrival at their next installation or organization, to a sensitive duties or active flight status position, including but not limited to: Personnel Reliability Program, Presidential Support Duty, air traffic controllers, any Airmen on active Flight Status (FLY), a Service Member assigned to a Flight position, or those who maintain an active aeronautical rating are no longer required to hand-carry their outpatient medical treatment records (in a sealed envelope or package) from the losing or departure MTF to the arrival or gaining RCMU. These members are still encouraged to hand-carry their dental treatment records since these records are not yet electronic. See para 5.28.2 for additional instructions.

5.7.1.19.4. (Added) MTF records personnel are required to place a copy of the service transition orders, AF Form 1288, or AF Form 300 in the outpatient medical and dental records when mailing to another MTF or RCMU. This will ensure the gaining location knows why they are receiving it.

5.7.1.19.4.2. (Added) Records personnel are required to annotate the LOSS roster stating where the STR was mailed and why.

5.7.1.20. (Replace) MRT Transition in CHCS. Each time a record is mailed to the AF STR Processing Center, RCMU, or the RMG, the action must be documented in the CHCS MRT function. Health records personnel will TRANSFER the record in the CHCS MRT menu to the appropriate location (i.e., AF STRC for AF STR Processing Center). Note: If this location is not available, contact your system administrator to have it created.

5.7.1.21. (Replace) Handling Clarification Queries/Single Point of Entry (SPOE)/ Veterans Lifetime Electronic Record (VLER) Requests from the AF STR Processing Center: Queries/SPOE/VLER requests for clarification on STRs (e.g., requests for missing records) must receive immediate MTF/RCMU record management action as the AF STR Processing Center only has a 5-day window from time of STR receipt to ensure it is digitized appropriately in HAIMS.

5.7.1.21.1. (Replace) Track AF STR Processing Center queries/SPOE/VLER requests and their outcome in a local database. The method is left up to the MTF/RCMU and could include an electronic spreadsheet, simple ledger, or other method.

5.7.1.21.2. (Replace) MTF/DTF/RCMU records managers have only two (2) duty days from receipt of the inquiry to investigate and provide a response. DELAYED RESPONSES WILL REQUIRE IMMEDIATE EXPLANATION TO BE SENT TO: AF STR Processing Center afmoa.sgat.afstrprocessingcenter@us.af.mil.

5.7.1.21.3. (Replace) The MTF/DTF/RCMU may be contacted by phone or e-mail. MTF/DTF/RCMU records managers may contact officials at the AF STR Processing Center via telephone or return e-mail with the results of the inquiry, whether or not the record or missing item was found and when it will be sent to the AF STR Processing Center. Annotate the results in the computer spreadsheet or ledger book.

5.7.1.22. (Replace) Managing Loose and/or Late-Flowing Medical Documents Following STR Shipment. Loose and/or late-flowing medical documents are those medical or dental documents discovered in the MTF or DTF after the STR has already been mailed to the AF STR Processing Center or the departing member's gaining guard or reserve medical unit.

5.7.1.22.1. (DELETED)

5.7.1.22.1. (Added) Loose and/or Late-Flowing Medical Documents must be digitized into HAIMS IAW the HAIMS scanning policy. In the event an RCMU does not have access to HAIMS, the documentation will be forwarded to the nearest MTF with HAIMS access for digitization. Loose paperwork may be digitized at any facility with HAIMS access; it does not need to be mailed or forwarded in hard copy to the patient's MTF of enrollment. Note: Active Duty host will provide HAIMs training to tenant RMUs/GMUs and assign access to HAIMS for digitization of late and loose flowing documents. Non-collocated RMU's will obtain training and access through HQ AFRC/SGSI and GMUs through HQ NGB/SG.

5.7.1.22.2. (DELETED)

5.7.1.22.3. (DELETED)

5.7.1.22.4. (DELETED)

5.7.1.22.4.1. (DELETED)

5.7.1.22.4.2. (DELETED)

5.7.1.22.4.3. (DELETED)

5.7.1.22.4.4. (DELETED)

5.7.1.22.4.5. (DELETED)

5.7.1.22.4.6. (DELETED)

5.7.1.23.1. (Replace) The following guidance applies only to records collected for Airmen who separated/retired before 1 Jan 09. Previously, this was a temporary program for AFPC based on available Air Force Reservist man-days. However, with the implementation of HAIMS and the re-alignment of the STR Cell under AFMOA, the contract requirements have changed. Due to limited space and storage capabilities at the AF STR Processing Center, large shipments (greater than 2 boxes) of Pre-Jan 09 STRs must be coordinated and approved prior to sending. All unauthorized shipments and loose documentation in jackets will be returned at MTF/RCMU expense.

5.7.1.23.3. (Replace) If the information on hand is only loose documentation, digitize it in HAIMS.

5.7.1.23.4. (DELETED)

5.7.1.23.9. (Replace) AF STR Processing Center queries for clarification on STRs (e.g., requests for missing documents) must receive immediate record management action.

5.7.1.23.10. (Replace) Maintain the records in the central records storage location until directed by AFMOA/SGAT to mail them to the AF STR Processing Center. DO NOT MAIL THESE RECORDS UNTIL DIRECTED TO DO SO BY AFMOA. The AF STR Processing Center provides the Shipment Authorization Numbers.

5.7.1.23.11. (Replace) Large pre-coordinated shipments of pre 1 Jan 09 STRs will be mailed to the AF STR Processing Center at the following address:
AF STR Processing Center
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

5.7.2. (Replace) Sequestered/Deceased Member's Records. In the event an STR is sequestered for legal reasons or has already been provided to the installation Casualty or Mortuary Affairs office in the event of an Active Duty or RCSM's death, MTF records managers must annotate "SEQUESTERED" in the COMMENTS column next to the Airman's name on the LOSS roster.

Records managers will include the LOSS roster in the next-outbound shipment to AF STR Processing Center.

5.7.2.3. (Replace) Home Station MTF STR Disposition Responsibility: If notified by an official agency or unit (e.g., unit commander or chain of command representative, installation Command Post, Mortuary or Casualty Affairs) that an ADSM was killed in action while deployed, remove the deceased Service Member's outpatient medical and dental records from the main file and contact the installation Casualty or Mortuary Affairs office. Notify the Casualty or Mortuary Affairs office upon request. Forward the STR to the AF STR Processing Center according to processes identified earlier within this section, no later than 30 calendar days following notification of the service member's death. The AF STR Processing Center will digitize the STR in HAIMS, thus making it available to the DVA. Surviving family members may be eligible for Service or DVA death benefits or compensation. The deceased Airman's STR may be required as part of the DVA death benefits or compensation evaluation. If, at any time, while preparing to ship the STR to the AF STR Processing Center, the installation Mortuary or Casualty Affairs unit or Air Force Institute of Pathology specifically requests the outpatient medical or dental records for official purposes, provide a certified copy of the STR.

5.7.3.2. (Replace) Service members subject to appellate review may relocate and reside anywhere within the Continental United States, to meet unique administrative and personnel accountability requirements. Service Members placed on appellate review leave are assigned to the HQ Air Force Security Forces Center (AFSFC), Joint Base San Antonio (JBSA) Lackland, TX.

5.7.3.3. (Replace) While on appellate leave, the service member must remain enrolled in TRICARE Prime and be enrolled to an MTF. If the service member relocates to another area, the servicing MTF must brief the member on the processes required for obtaining health care for themselves and any dependents prior to departure. Service members on appellate leave cannot enroll into TRICARE Prime Remote or choose a civilian PCM. See para 2.40.7 for additional information on enrollment.

5.7.3.4. (Replace) Following the conclusion of all punitive discharge processing, punitive legal proceedings, or general court-martial trial, unless otherwise required by law, court order, or urgent medical necessity, the service member's STR will be forwarded (in a sealed envelope) to the Wilford Hall Ambulatory Surgical Center (WHASC) at JBSA Lackland, TX where it [STR] will be maintained until the appellate review period has completed.

5.7.3.8. (DELETED)

5.7.3.14. (Replace) No later than three days following the start of the appellate review period, mail the complete STR and AF Form 330 to the address identified below following the steps outlined in para. 5.29.5.5.

Wilford Hall Ambulatory Surgical Center
ATTENTION: Lackland STR Manager
2200 Bergquist Drive, Suite 1
JBSA Lackland, TX 78236-9908

5.7.3.15. (Replace) Upon completion of the appellate review, if the Service Member is officially and permanently discharged from the Service, his/her name will appear on the installation personnel LOSS roster for JBSA Lackland, TX. The records department at WHASC is responsible for forwarding the original STR to the AF STR Processing Center. If the case is overturned during the appeal process and the Service Member is returned to AD status, WHASC will transfer the original STR to the Service Member's previous assignment support MTF or to another MTF upon MTF request. Medical records personnel will not release or forward the STR to anyone, any place, or any agency without obtaining written direction or orders.

5.7.3.17. (Replace) During the appellate review period, even if a Service Member is immediately transported to a correctional facility, the MTF where the Service Member's STR is normally maintained is responsible for forwarding the original STR to WHASC in accordance with the instructions (associated with appellate review record disposition) previously identified in this section.

5.7.3.18. (Replace) Records personnel at the Service Member's support MTF and/or the WHASC are prohibited from providing or forwarding the original STR to any prisoner escort detail or correctional facility. Instead, provide the escort detail or confinement facility with a complete STR copy. If a copy cannot be immediately provided, a copy will be mailed to the destination military correctional facility within five duty days. Copies of STRs may be mailed to state and federal prisons upon proper request. If available, obtain a copy of the Service Member's orders or court confinement order from the prisoner escort detail.

5.7.4. (Replace) USAF Academy Cadets and Airmen with Less than 180 days of Continued Service: Applies to members of the US Air Force Academy and all other Air Force recruits separated or discharged prior to accruing 179 days or less days of Military Service. Forward STRs for these two beneficiary categories to the AF STR Processing Center. Follow the same STR disposition instructions as identified for AD and RCSMs identified earlier in this instruction. Place a copy of the separation or retirement order or personnel document ordering the separation, discharge, or retirement inside the STR.

5.10.8. (Replace) Maintain civilian employee medical records in manila folders or SF 66D. Place the record in SF 66D when the employee transfers to another Federal agency or is separated from Federal Service. Send the record to the civilian personnel office (CPO). Civilian employees [including Air Reserve Technicians (ART)] who are also members of an RC will have one medical record maintained as indicated in para. 5.14. The only exception will be if the individual is not employed as a civilian at the same base where his/her RC unit is assigned. In these cases, a civilian medical record will be maintained as described in the beginning of this paragraph. Civilian employees who are also assigned to a PRP/PSD or Sensitive Duties Program position or job will have one medical record maintained as indicated in para. 5.11.6 until such time as they are removed from the program or are transferred to another federal agency or separated from federal service.

5.11.6.2. (Added) An AF Form 745 will be affixed to Section 2 of the active Volume of the outpatient medical record. NOTE: Use of the AF Form 745 in closed/inactive volumes is authorized, but not required. This only applies to existing records.

5.12.5.9. (Replace) For Service Members assigned to Sensitive Duties Programs (e.g., PRP and PSD), MTF records personnel will attach an AF Form 745, Sensitive Duties Program Record

Identifier inside the DD Form 2766 cardstock record at the time of deployment. Additionally, stamp “PRP” or “PSD” in approximately 2-inch letters on the cover of the DD Form 2766 prior to a Service Member’s deployment. NOTE: This only applies to existing records.

5.13.4. (Replace) Annual Active Duty Inventory. Establish local procedures to perform an annual inventory for all Active Duty Air Force records by 31 March. Medical records personnel will contact the local MPS and obtain a roster of all assigned and/or attached active duty personnel. Sort the roster by terminal digit order. If missing record(s) and/or volume(s) are discovered during the initial audit, records personnel will perform monthly follow-up audits until the missing record(s) and/or volume(s) are retrieved or located.

Para 5.16.8.1.1. (Replace) Exception #1. Applies to Service Members assigned to sensitive duties programs, including but not limited to: Personnel Reliability Program, Presidential Support Program (Duty), air traffic controllers, overseas U.S. embassy support, or any Airmen assigned to a current flight status (FLY) position or possessing an active aeronautical rating. Service Members who meet the aforementioned requirements or Service Members who [will be] assigned to a sensitive duties or active flight status position upon arrival to their next installation, are no longer required to hand-carry their outpatient medical treatment records (in a sealed envelope or package) from one MTF to another or from one official duty assignment location to another during a Permanent Change of Station, re-assignment, or extended Temporary Duty assignment. PRP will no longer hand-carry their medical records. These members are still encouraged to hand-carry their dental records since these records are not yet electronic. See paragraph 5.28. for additional PRP records transfer instructions.

.20.3.1. (Replace) The following procedures are required after discovering a record is missing: Check to identify possible borrower charge-out locations in the automated MRT module; check for record misfiles in each record storage room; search provider offices and exam rooms; ensure the record has not been forwarded to a peer review or clinical review committee, meeting, or function; verify the record has not been sequestered from main file; verify the record has not been temporarily separated from the main file for any other official review function; if known, contact the previous MTF responsible for maintaining the beneficiary’s health records; contact the service member/beneficiary to see if he/she is in possession of the record. If the record still has not been located following the preceding minimum search requirements, begin processing the non-availability letter (NAL) for STRs and breach notifications.

5.20.4. (DELETED)

5.20.4.1. (DELETED)

5.20.4.2. (DELETED)

5.20.4.2.1. (DELETED)

5.20.4.2.2. (DELETED)

5.20.4.2.3. (DELETED)

5.20.4.2.4. (DELETED)

5.20.4.2.5. (DELETED)

5.20.4.2.6. (DELETED)

5.20.4.2.7. (DELETED)

5.20.4.2.8. (DELETED)

5.20.4.2.9. (DELETED)

5.20.5.1. (Replace) After all efforts to find the lost health record(s) are exhausted the MTF Commander may deem the missing health record as “lost”. Once the MTF Commander has deemed a record “lost”, MTF HIPAA Privacy Officer (HPO) must follow the guidelines and procedures identified in DoD 5400.11-R in consultation with the installation Public Affairs Officer and available installation legal staff and/or the MLC.

5.28.1. (Replace) Medical Notification Process: The Service Treatment Record (medical and dental records) for Service Members assigned to the Presidential Support Program (Duties), active flying programs/status, or other highly sensitive, national security operations, require special handling to maintain program reliability and integrity. Overall PRP program requirements are located in DoDM 5210.42, Nuclear Weapons Personnel Reliability Program, January 13, 2015 and AFMAN 13-501, same title (29 May 2015). MTF records managers are no longer required to print the Electronic Health Record (EHR) patient encounter document(s) for every episode of care for each Service Member assigned to a sensitive duties (e.g., PSD, etc.) position. Record encounters occurring outside the EHR should be scanned and uploaded into HAIMS for appropriate review by the provider team. Printing of every encounter is not required for Service Members on FLY status. Aeromedical dispositions on FLY status may be performed electronically, with unit notifications for changes in status being managed via the ASIMS program.

5.28.2.1. (Replace) This section applies to any Service Member or Airman currently assigned or who will be assigned upon arrival at their next installation or organization, to a sensitive duties or active flight status position, including but not limited to: PRP, Presidential Support Program (Duty), air traffic controllers, overseas U.S. embassy support, or any Airmen on active Flight Status (FLY) or a Service Member assigned to a Flight position or those who maintain an active aeronautical rating. Airmen meeting these requirements, or any other Service Member authorized by the MTF Commander, are no longer required to hand-carry their outpatient medical treatment records (in a sealed envelope or package) from the losing or departure MTF to the arrival or gaining MTF; from the departure RCMU to the arrival or gaining RCMU; or from any official location responsible for maintaining health records to the arrival or gaining MTF, RCMU, or official duty assignment during a Permanent Change of Station, Permanent Change of Assignment, duty location re-assignment or extended Temporary Duty (TDY) assignment (excluding deployment). These members are still encouraged to hand-carry their dental records since these records are not yet electronic.

5.36.6.5. (Replace) File FMS for stillborn infants, as defined by the Center for Disease Control and Prevention (CDC) and/or State guidelines as appropriate, under the register number of the mother.

6.6.2. (Added) When a patient requests an accounting of disclosures, the MTF will provide a report of the disclosures made during the time period requested by the patient, for up to 6 years preceding the request. In addition, the following statement must be included with each report provided by the MTF:

6.6.2.1. (Added) "Recurring Disclosure to ARC Command Authority. If you are a member of a Reserve or National Guard unit (ARC) your Guard or Reserve medical unit has had access to your medical information beginning on or around the date you in-processed into the unit, and thereafter on an ongoing basis, until such time as you are no longer assigned to the particular unit. Such access was for purposes of: determining your fitness for duty and fitness to perform any particular mission, assignment, order, or duty; health surveillance; reporting on casualties; or carrying out any other activity necessary to the proper execution of the mission."

6.7.4. (Added) ARC access is understood to be multiple disclosures of PHI to the command authority for a single purpose.

6.7.4.1. (Added) The host MTF or NGB/SG Office for ANG will provide access to health records systems (AHLTA, CHCS, HAIMS, etc.), and where applicable, SG approved access mechanisms (AVHE/successor system(s), Citrix, etc.) to ARC medical personnel. Such ARC SG provider's access to PHI in a health records system is subject to the terms and conditions of access applicable to the system for which access is required. Access to the patient's medical information will be accounted for IAW para. 6.6.2.

6.7.4.2. (Added) The ARC Medical Unit Commander must designate in writing and maintain such designation of ARC members (ARC Access List) who are medical personnel to access, receive, use or disclose PHI of an individual under an ARC Commander's authority for the purposes outlined in the Chapter 7 of the DoD 6025.18-R (or superseding publication).

6.7.4.2.1. (Added) Once information is in the possession of the ARC Medical Unit, the information is no longer subject to HIPAA because the ARC Medical Unit is not a HIPAA covered entity and is not acting as a business associate. However, the information does remain subject to the Privacy Act.

6.7.4.3. (Added) Completion of AHLTA system training at any MTF is valid for ARC medical personnel regardless of assigned location.

6.7.5. (Added) The ability to access PHI must be consistent with the individual's authority to access the record for treatment, payment, or health care operations. Accessing PHI outside the scope of an individual's job function is not permissible.

6.7.5.1. (Added) Impermissibility may include, but is not limited to, the following examples. Each situation should be evaluated on a case-by-case basis in order to determine if the individual had a valid reason for obtaining the PHI:

6.7.5.1.1. (Added) The gaining command accessing PHI of a potential staff member prior to assignment;

6.7.5.1.2. (Added) Supervisors checking the appointment history of a staff member;

6.7.5.1.3. (Added) MTF Commanders, who also have provider-level access, looking up information in the medical record of an individual that would not normally be provided to them in their role as a Commander accessing ASIMS;

6.7.5.1.4. (Added) Looking up information on self, co-workers, or their family members, friends, political figures, or celebrities;

6.7.5.1.5. (Added) Looking up demographic information of a patient in order to contact them outside the work or treatment environment when not in the course of a performing one's job function (e.g., looking up a new staff member that has not yet PCS'd to the MTF, calling a patient for a date); or

6.7.5.1.6. (Added) Opening a document in HAIMS that has a sensitive or mental health indicator when you are not treating the patient, just to see what is wrong with them.

(Ad6.7.6. (Added) Use, disclosure, or access is limited to the minimum amount of information necessary to accomplish the task.

6.7.6.1. (Added) This would also include ensuring any recipients of the information are authorized to receive the information under the Privacy Act, HIPAA, and any other applicable law or regulation.

6.9.1. (Replace) Delivery. Joint Knowledge Online (JKO) is the required Air Force method of delivering initial and annual core HIPAA training. MTFs may request use of alternative delivery methods in instances where JKO is determined to be unusable due to connectivity issues which cannot be resolved. Use of alternative delivery methods must be coordinated through the AFMOA HIPAA team and approved by the Air Force HIPAA Privacy Officer at AFMSA, prior to implementation to ensure compliance with core training content and documentation requirements. AFMSA/SG3SA will provide standardized training content for use in delivering core training content to those facilities that are approved for alternative delivery methods. Use of commercially available or locally produced training content is not authorized to meet core HIPAA training requirements. Organizations approved for use of alternative delivery methods must maintain current and accurate records of initial and annual training of all workforce members and provide training statistics to AFMOA/SGAT as requested. MTFs requesting waiver consideration must submit the following information to AFMOA/SGAT in letter format, endorsed by the MTF Administrator (SGA) or medical support squadron commander:

6.9.1.1. (Replace) Identify the nature of the technical difficulties that prevent the MTF from using JKO.

6.9.1.2. (Replace) Identify the specific actions that have been taken to correct problem (e.g., contacting Base Communications or the JKO Help Desk, and/or user computer configuration attempts).

6.9.1.3. (DELETED)

6.15.1. (Added) The risk assessment will be conducted using the HIPAA Privacy Incident Report (PIR).

6.16. (Replace) Use of Electronic Mail. All communications of PII, which includes identifiable health information, must be properly safeguarded in accordance with HIPAA and Air Force Messaging guidelines. Use of electronic communications to transmit PHI is authorized For Official Use Only (FOUO) purposes and clinical consultation and must comply with encryption and digital signature requirements of AFI 33-119, Air Force Messaging and permissible uses/disclosures as described in AFI 33-332 and the HIPAA privacy rule.

6.16.1. (Replace) Patient communications. The Corporate Dental Application (CDA), MiCare secure messaging, and other AFMS approved secure messaging programs are the only authorized methods for clinical consultation and advice (collectively "clinical consultation"). All medical encounters done through secure messaging must be fully documented in the patient medical record. Non-clinical communications with patients is permissible, but must comply with the limitations outlined in paragraph 6.16.1.2.

6.16.1.1. (Replace) The use of e-mail between MTF personnel and a patient for clinical consultation is not authorized. Common examples of clinical consultation include, but are not limited to:

6.16.1.1.1. (Added) Providing healthcare consultation or advice.

6.16.1.1.2. (Added) Discussion of services and treatment options.

6.16.1.1.3. (Added) Communications of sensitive medical conditions or situations that require more rigorous protections of privacy, such as HIV status, STI, mental illness, or chemical dependency.

6.16.1.2. (Replace) One-way communications to a patient's personal e-mail or cell phone via text messaging is permissible under limited circumstances (non-clinical communications) and is subject to the minimum amount of information necessary to carry out the task. Non-clinical communications should contain a footer advising the patient not to respond to the message and that replies will not be monitored. Common examples of non-clinical e-mails include, but are not limited to:

6.16.1.2.1. (Added) Prescription pick-up reminders.

6.16.1.2.2. (Added) Appointment reminders.

6.16.1.2.3. (Added) Sending non-clinical administrative blank forms (e.g., DD 2870, DD 2871, VLER opt-out).

6.16.1.2.4. (Added) Distributing general education materials (not patient specific health education materials).

6.16.1.3. (DELETED)

6.16.1.4. (DELETED)

6.16.1.5. (DELETED)

Attachment 14 (Replace) SAMPLE MEMO FOR MISSING ORDERS

A20.1.1. (Replace) Requirement. DoD 5400.11-R, Department of Defense Privacy Program, AFI 33-332, Air Force Privacy Program, DoD 6025.18-R DoD Health Information Privacy Regulation, and the Health Insurance Portability and Accountability Act of 1996, require our facilities to properly safeguard the confidentiality of PII and PHI within our control. Organizational leadership must ensure a prompt and coordinated response is initiated when PII or PHI is lost, stolen or compromised within an AFMS organization. Response procedures must limit or prevent further damage, assess the probability of compromise to the individuals involved, mitigate to the extent possible, and ensure all mandatory reporting and notification requirements are accomplished to Air Force, DoD, Defense Health Agency (DHA) Privacy and Civil Liberties Office (PCLO) (f/k/a TRICARE Management Activity (TMA) Privacy Officer), and Department of Health and Human Services (HHS) offices as appropriate. These procedures, to include breaches, specifically apply to contractors under DoD 5400-11R and the contracting officer should be engaged ASAP for contract compliance issues.

A20.2.5.2. (Replace) Ensures a copy of the initial Breach of Personally Identifiable Information (PII) Report (DD 2959) and completed MTF STR Manager Search Verification Checklist (for lost or missing service treatment records) are transmitted to AFMSA/SG3SA within 24 hours of the time the breach was identified.

A20.2.7. (Replace) AFMSA/SG3SA. The AFMS HIPAA Privacy Officer develops, updates, and interprets policy as necessary to ensure AFMS compliance with Air Force, DoD, HHS and other Federal requirements associated with the safeguarding of PII/PHI and responding to breaches of the same.

A20.3.1.2.2. (Replace) Submit US-CERT ONLY if a Federal Government information system has been compromised and confirmation is required in order to establish if a US-CERT should be initiated, pursuant to AFI 33-332, para. 1.1.2.4.5.2. US-CERT filings are required within one hour of the PII breach becoming known.

A20.3.2.5. (Replace) Contact the Installation Privacy Act Official upon learning of a breach to provide them with preliminary facts surrounding the incident, when applicable. In cases where US-CERT reporting is not required, fully document the decision and maintain the documentation with the case file. In cases where reporting is required, initiate a US-CERT notification at https://forms.us-cert.gov/report. Print a copy of the completed US-CERT notification and document the US-CERT confirmation number. Maintain a copy of the US-CERT notification with the events log. Notification must be completed within one hour of receiving notification of lost, stolen or compromised information.

A20.3.3.5. (Replace) Notify the AFMOA/SGAT HIPAA team at AFMOAHIPAATRAINING@US.AF.MIL or respective AFMOA HIPAA representative in an unencrypted e-mail message, marked FOUO, that an incident has occurred. Place “FOUO” in the subject line. Include the following information and attachments with the message:

A20.3.3.5.2. (Replace) A completed copy of the DD 2959.

A20.3.3.5.3. (Added) A completed copy of the MTF STR Manager Search Verification Checklist (for lost or missing service treatment records).

A20.3.3.5.3.1. (Added) Before submitting the MTF STR Manager Search Verification Checklist, remove or redact any and all elements of the Social Security Number (SSN).

A20.3.4.2. (Replace) With the facts of the incident known, the Breach Response Coordinator will assess the level of compromise to affected individuals as a result of the breach and make a recommendation to organizational leadership regarding the need to notify affected individuals of the compromise. The risk assessment will be conducted using the most current HIPAA Privacy Incident Report (HIPAA PIR) located on the AFMOA Health Information Compliance KX website. The Breach Response Coordinator will consult with the Installation Privacy Act Official, AFMOA/SGAT HIPAA team, and legal counsel as necessary for questions pertaining to the risk assessment and recommended findings.

A20.3.4.2.1. (Replace) Organizational leadership will assess the results of the risk assessment and recommendations of the Installation Privacy Act Official in determining whether affected individuals should be notified of the breach. Leadership should bear in mind that notification when there is a low level of compromise might create unnecessary concern or confusion. The Breach Response Coordinator must thoroughly document the circumstances of all breaches and the decisions made relative to each of the factors; the documentation must clearly demonstrate the rationale behind the notification determination.

A20.3.4.2.2. (Added) The HIPAA PIR must be completed for each HIPAA privacy incident and submitted to AFMOA HIPAA. The report is located on the AFMOA Health Information Compliance Team KX website.

A20.3.4.2.3. (Added) The MTF STR Manager Search Verification Checklist involving lost or missing service treatment records under the AF control, must be completed for each HIPAA privacy incident and submitted to AFMOA/SGAT HIPAA.

A20.6.1. (Replace) Timeline. The time requirements for breach reporting and mitigation begin at the time the breach is discovered or becomes known. Although it is possible various processes and follow-on reporting actions will extend beyond ten (10) days, most breaches are concluded within the ten (10) day notification requirement established by DoD 5400.11-R. The most current Breach Timeline & Notification flow chart can be viewed on the AFMOA Health Information Compliance KX website.

A20.6.1.1. (DELETED)

A20.6.1.2. (DELETED)

A20.6.1.3. (DELETED)

A20.6.1.4. (DELETED)

Table A20.1. (DELETED)

Table A20.2. (DELETED)

Figure A20.1. (DELETED)

Figure A20.2. (DELETED)

Figure A20.3. (DELETED)

Figure A20.4. (DELETED)

Attachment 32 (Replace) SAMPLE LETTER OF NON-AVAILABILITY

Attachment 37(Added) MTF STR MANGER VERIFICATION CHECKLIST

Attachment 38(Added) SAMPLE LETTER OF NON-AVAILABILITY (INCOMPLETE TRAINING)

This Memorandum becomes void after one year has elapsed from the date of this Memorandum, or upon incorporation by interim change to, or rewrite of AFI 41-210, *TRICARE Operations and Patient Administration Functions*, whichever is earlier.

MARK A. EDIGER
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachments:
1. Sample Letter of Non-Availability
2. Sample Letter of Non-Availability (Incomplete Training)
3. MTF STR Manager Verification Checklist
4. Sample Memo for Missing Orders

Attachment 1

Sample Letter of Non-Availability

DEPARTMENT OF THE AIR FORCE
(Unit Name)

DATE:

MEMORANDUM FOR AF SERVICE TREATMENT RECORDS (STR) PROCESSING CENTER (AFSTRPC)

SUBJECT: Incomplete STR and Completed Verification Checklist

The Service Treatment Record for the member identified below is incomplete. The **(circle one)** Dental or Outpatient Medical Record is missing:

Member Full Name and Rank:

SSAN / Date of Birth:

Final Service Obligation Date: **REQUIRED**

The service member's record (volume) identified is considered missing as described in AFI 41-210. All search requirements outlined in AFI 41-210 have been accomplished (see attached verification checklist).

We will continue to search for the missing record and if located, it will be mailed to the AFSTRPC, 3370 Nacogdoches Rd., Ste 116, San Antonio, TX 78217.

If you have any questions, contact the XX MDG STR manager SSgt John D. Doe at DSN 543-0123 or via email at john.doe@us.af.mil.

FIRST A. LAST NAME, Colonel, USAF
Commander, XXX Medical Group

Attachment
MDG STR Manager Search Verification Checklist

The information herein is For Official Use Only (FOUO) which must be protected under the Freedom of Information Act of 1966 and Privacy Act of 1974, as amended. Unauthorized disclosure or misuse of this PERSONAL INFORMATION may result in criminal and/or civil penalties.

Attachment 2

Sample Letter of Non-Availability (Incomplete Training)

DEPARTMENT OF THE AIR FORCE
(Unit Name)

DATE:

MEMORANDUM FOR AF SERVICE TREATMENT RECORD PROCESSING CENTER

SUBJECT: Missing Service Treatment Record Information (Incomplete Training)

The Service Treatment Record for the member identified below is incomplete. The (**circle one**) Dental or Outpatient Medical Record was not established:

Member Full Name and Rank:

SSAN / Date of Birth:

Final Service Obligation Date: **REQUIRED**

The member did not complete all aspects of initial training, therefore the record was never created. We utilized and reviewed all automated patient tracking and registration mechanisms available. Please consider the member's Service Treatment Record complete.

Please contact TSgt First Last name at DSN 555-1111 or commercial (555) 111-1111 with any questions or concerns.

FIRST A. LAST NAME, Lt Col, USAF
Commander, XXXX Dental Support Squadron

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Attachment 3

MTF STR MANAGER SEARCH VERIFICATION CHECKLIST DATE ACTION COMPLETED:

Table 3.1. MTF STR Manager Search Verification Checklist.

Patient Rank/Name/Status:			**Last 4 SSN:**
	Action	**Description/Instruction**	**MTF Response**
1.	Describe reason for STR search and which portion is missing.	Provide reason/brief description of issue.	☐Medical Record missing ☐Dental Record missing Brief Explanation: *Example: "Mbr is on Loss Roster, CHCS/CDA reveals medical & dental record not received at in-processing. Initial search did not result in locating record."*
2.	a. Provide service member's Separation/Retirement date, status info, assignment, and enrollment information. b. Provide explanation of coordination with other units/MTFs/DTFs if applicable.	Status info examples: RegAF, Guard, Reserve, IMA, etc. For dual status members (those who were previously a dependent, Guard, Reserve, etc.) check for STR under previous sponsor SSN.	a. Sep/Ret Date: Status info prior to Sep/Ret: ☐Flying Status ☐PRP/PSP Did mbr have dual status prior to Sep/Ret?: ☐Yes (submit separate checklist if dual status record is also missing) ☐No Unit assigned: Enrolled MTF: b. *Example: "TOPA/Dental contacted xxx location on (date). They searched for missing STR and were unable to find this STR."*
3.	Describe available tracking information of STR (medical and dental as applicable).	Provide CHCS Trace Movement. For Dental, include CDA Records Tracker) and local tracking log information.	*Example: "CHCS indicates medical record has been charged to xxx for xxxx days", etc. CDA states that record should be in the file but cannot be found ."*
4.	Check sequestered records.	*If sequestered, send original STR to AFSTRPC and make a copy for MTF. **Do not**	☐Yes,* STR is sequestered; cannot release ☐No, STR is not sequestered

		complete this checklist, do not send NAL. If unable to send original, include this checklist with roster (no NAL needed as STR must remain overdue). Attach Dental so full STR will be sent together.	TOPA Flt/CC or NCOIC Initials_____ Reason original STR cannot be sent: *Example: "Medical STR is currently sequestered due to ongoing investigation; original cannot be released until approximately (insert date). Dental record is available and has been consolidated with the sequestered medical record. POC info: xxxx, DSN xxx-xxxx."*
5.	Conduct physical search & check for misfiled records.	Search all records room areas. Include any closed volume rooms and warehouses. Search should be throughout the member's terminal digit # (all of the 6s if last four is xx6x). Search office areas/exam rooms as applicable.	List office/exam and record rooms searched and results *Example: "XX MDG/DTF has x record rooms as identified below. A misfile check was conducted with the following results:"* - *OPR* - # of misfiles - *FLT MED* - # of misfiles - *INTERNAL MED* - # of misfiles - *PEDIATRICS* - # of misfiles - *DENTAL* - # of misfiles TOPA Flt/CC or NCOIC Initials _____ Dental Support OIC or NCOIC Initials_____
6.	Check AHLTA History for record location if accessible, otherwise state N/A	AHLTA may provide an additional record location. Provide explanation of search.	
7.	Check last available Active Duty Record Inventory list of last MTF/DTF where STR was located.	Inventory documents may provide verification on STR location. If member was at a different location during the inventory, contact the last MTF that member was assigned. Provide comments.	☐Yes, record was documented as available on last inventory. Date of inventory: _____ Location of inventory:_____ ☐No, record was not available on last inventory. ☐No, member hand carried *Example: "Although record was available on last inventory, STR is missing; most likely due to misfiling of record/member hand-carried."*
8.	Contact service member to request complete STR	Document date member was contacted and	Svc mbr's printed name/signature

		obtain member's signature	
9.	List any additional actions taken.	Provide additional details of any other search actions completed.	
10.	Certify actions 1-9 were taken	Provide signature block/signature	XXXXXXXX, XSgt, USAF NCOIC, Outpatient Records XXXXX, XSgt, USAF NCOIC, Dental Support Flt/Element XXXXX, Xxxx, USAF Flight Commander, TOPA
11.	Obtain AFSTRPC coordination (this will include the AFSTRPC completing a virtual search in the Enterprise Health Data Optimization System (eHDOS) and coordination with the MTF if needed.)	Prior to deeming record "lost", obtain AF STR Processing Center coordination.	XXXXX, Xxxx, USAF AF Medical Records Consultant or designated AF STRPC representative
12.	MTF Commander deems record "lost."	Per AFI 41-210, 5.20.5. Provide signature block/signature	*Example: "STR in question was unable to be located after extensive search as documented above. MTF Commander has deemed paper STR "lost," per AFI 41-210, para 5.20.5. Record was flagged missing in CHCS on (insert date)."* XXXXX, Xxxx, USAF Commander
13.	Contact member with HIPAA Privacy Officer to complete HIPAA Breach Actions.	Provide summary of findings. If member is in possession of STR, instruct them to return it, per AFI 41-210, DoDI 6040.43, DoDI 6040.45. The VA will not accept paper records provided by the member. The MTF/CC may engage the member's leadership since it is government property.	*Example:* "Missing STR reported via DD Form 2959 on (insert date). IAW AFI 41-210, following actions occurred: Documented actions per requirements in AFI 41-210, Atch 20, A20.3."
14.	Obtain HIPAA Privacy Officer acknowledgement	Provide signature block/signature	XXXXXXXX, GS-XX, USAF HIPAA Privacy Officer

Note 1: Reference AFI 41-210, *TRICARE Operations and Patient Administration Functions*, Chapter 5.
Note 2: Attach specific correspondence or documents as required supporting the above information.

The information herein is For Official Use Only (FOUO) which must be protected under the Freedom of Information Act of 1966 and Privacy Act of 1974, as amended. Unauthorized disclosure or misuse of this PERSONAL INFORMATION may result in criminal and/or civil penalties.

Attachment 4

Memo for Missing Orders
DEPARTMENT OF THE AIR FORCE
(Unit Name)

DATE:

AF STR PROCESSING CENTER
3370 NACOGDOCHES ROAD, SUITE 116
SAN ANTONIO, TX 78217
MEDICAL RECORDS DISPOSITIONS

SUBJECT: Memo for Missing Orders

MTF NAME:

Outpatient Records Staff could not obtain orders for the following member:

Full Name:

Rank:

SSAN:

Date of Birth:

Final Service Obligation Date:

We utilized and reviewed all mechanisms available within our means, but could not locate the orders for one or more of the following reasons (check all that apply):

____ Member did not out-process with the MTF
____ MPF Staff (**identify POC**) could not provide due to (**provide reason**)
____ Other (**provide detailed reason and POC**) _____
_____

Please contact TSgt First Last name at DSN 555-1111 or commercial (555) 111-1111.

FIRST A. LAST NAME, Lt Col, USAF
Commander, XXX Medical Support Squadron

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BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 41-210

6 JUNE 2012

Health Services

TRICARE OPERATIONS AND PATIENT ADMINISTRATION FUNCTIONS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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AFI41-115, 28 December 2001
AFI41-101, 1 April 1996
AFH41-114, 1 March 1997

This Instruction implements AFPD 41-2, Medical Support. This Instruction identifies and defines the requirements, policies, procedures, activities, and minimum expectations necessary to ensure a successful Air Force MTF TRICARE Operations and Patient Administration mission. It describes how to manage TRICARE Operations and Patient Administration functions including determining eligibility for care, protecting medical information, managing health records, the preparation and disposition of medical documentation and managing other administrative activities to support patients. Organizational alignment of these functions may vary among Medical Treatment Facilities. This Instruction directs the collection and maintenance of information subject to The Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This Instruction applies to all Air Force medical units and Air National Guard or Air Force Reserve Components where TRICARE Operations and Patient Administration functions are performed. OASD/HA Memorandum titled Armed Forces Reserve Component Medical Activities under the DoD Health Information Privacy Regulation, 2 Dec 2003 clarifies the status of the Armed Forces Reserve Component medical activities as it relates to compliance with privacy rules. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**.

All field publications that either implement or supplement this publication must be submitted to AFMSA/SG3SA for coordination prior to approval. Comments or suggested improvements to this AFI must be submitted on an AF Form 847, Recommendation for Change of Publication, to AFMSA/SG3SA.

SUMMARY OF CHANGES

This document has been substantially revised, incorporates AFI 41-115, AFI 41-101 and AFH 41-114 and must be completely reviewed.

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Chapter 1

ROLES AND RESPONSIBILITIES

Section 1A—TRICARE Operations Roles and Responsibilities

1.1. TRICARE Overview. TRICARE is the name of the Department of Defense's managed healthcare program for active duty military and their families, Reserve Component members and their families, retirees and their families, and other beneficiaries. The TRICARE Program offers options for healthcare coverage including: TRICARE Prime, TRICARE Extra, and TRICARE Standard (formerly called CHAMPUS), TRICARE Prime Remote, TRICARE for Life, TRICARE PLUS, TRICARE Young Adult, and several other programs. For detailed information on the various TRICARE health plans and to access the TRICARE Manuals go to the TRICARE website at **http://manuals.tricare.osd.mil**/.

1.2. TRICARE Operations Overview.

1.2.1. Managed Care Support Contract Liaison Officer. Acts as the liaison between the MTF and the Managed Care Support Contractor.

1.2.2. Beneficiary Counseling and Assistance Coordinator (BCAC). For further information related to this position, see Section 3B-Beneficiary Counseling and Assistance Coordinator (BCAC).

1.2.3. Debt Collection Assistance Officer (DCAO). For further information related to this position, see Section 3C-Debt Collection Assistance Officer (DCAO).

1.2.4. Medical in/out-processing. For further information related to these requirements, see Section 3F-Medical In/Out-Processing Program.

1.2.5. TRICARE On-Line (TOL). For further information related to this function, see Section 3G-TRICARE On-Line.

1.2.6. TRICARE Marketing and Education.

1.2.7. Health Plan Analysis.

1.2.8. MOU Support.

1.2.9. Enrollment Management.

1.2.10. Resource Sharing Agreements.

1.2.11. Clinical Support Agreements.

1.2.12. Referral management center. For further information related to this function, see Section 3E-Referral Management Program.

Section 1B—Patient Administration Roles and Responsibilities

1.3. Patient Administration Overview. Patient Administration provides healthcare support services as part of the delivery of basic and comprehensive medical treatment to eligible beneficiaries and manages or provides appropriate guidance and oversight of all aspects of medical records functions within the Medical Treatment Facility (MTF).

1.3.1. The following activities are functions of Patient Administration: Admissions and Dispositions, Birth Registration, Death Processing, Casualty Reporting, Inpatient Records Management, HIPAA Privacy Compliance, non-clinical Aeromedical Evacuation (AE) duties, Line of Duty Determinations (LOD) coordination, Outpatient Records Management, Medical Evaluation Boards administration, Organ Donor Program, Patient Registration, Release of Information, Secretary of the Air Force Designee Program, Sensitive Duties Program records management, and the Tumor Registry Program.

1.3.2. Patient administration performs the following tasks:

1.3.2.1. Ensures that adequate health records are created and maintained.

1.3.2.2. Manages/provides oversight of outpatient records.

1.3.2.3. Manages/provides oversight of inpatient records.

1.3.2.4. Manages/provides oversight of medical transcription services.

1.3.2.5. Reviews and processes inpatient (clinical) records to ensure all required documentation, reports, narrative summaries, and provider signatures are present. Refers incomplete or inadequate records to the responsible provider of care or department chief for review and completion.

1.3.2.6. Performs duties associated with the Medical Records Review Function.

1.3.2.7. Supervises the administrative functions of admission and disposition of patients.

1.3.2.8. Assigns patients to inpatient nursing units (based on clinical management direction at time of admission).

1.3.2.9. Arranges the collection and safeguarding of patient valuables and baggage when required. Coordinates with Resource Management Office (RMO) personnel to ensure valuables are secured, inventoried, and returned to the patient when necessary.

1.3.2.10. Initiates preparation of individual inpatient and related administrative records.

1.3.2.11. Advises Military Personnel Section (MPS) of service member hospitalization when appropriate, (e.g., assignment to Patient Squadron).

1.3.2.12. Ensures the proper reporting and recording of births and deaths to the local department of vital statistics/registrar.

1.3.2.13. Performs patient movement requests and coordinates Aeromedical Evacuation of patients.

1.3.2.14. Coordinates healthcare management of personnel participating in the sensitive duties program as outlined in DoD 5210.42-R_AFMAN 10-3902, Nuclear Weapons Personnel Reliability Program (PRP).

1.3.2.15. Provides administrative support for the Disability Evaluation System (DES) to include Medical Evaluation Boards (MEB), Physical Evaluation Boards (PEB) and examination of members on the Temporary Disability Retired List (TDRL).

1.3.2.16. Manages the tumor registry when histopathology is not authorized in the MTF or ensures another MTF (via written agreement or memorandum of agreement) assumes this responsibility.

1.3.2.17. Provides administrative support for LOD determination processing.

1.3.2.18. Provides administrative support to inpatient units through ward clerks when authorized.

1.3.2.19. Performs casualty reporting and procedures relating to death notifications.

1.3.2.20. Manages the release of information program and the safeguarding of Protected Health Information (PHI).

1.3.2.21. Supervises 4A0X1 staff assigned to Patient Centered Medical Home (PCMH) clinics at the option of the MTF Commander.

1.4. Patient Administration Officer/Director/Noncommissioned Officer (NCO).

1.4.1. The MTF Commander will appoint a Patient Administration Officer, Director, or Senior NCO/NCO, depending on the size of the MTF, to manage and/or provide oversight of all patient administration functions performed throughout the MTF.

1.4.1.1. Based on MTF organizational structure, operational control of some patient administration functions may be distributed throughout the MTF crossing squadron lines of authority. The individual appointed by the MTF Commander has primary authority to facilitate and/or enforce the policies, on behalf of the commander, identified in this instruction.

1.4.2. Responsibilities:

1.4.2.1. The Patient Administration Officer (PAO), Director, or SNCO/NCO will manage functions listed in paragraph 1.3.1. regardless of Patient Administration or TRICARE Operations & Patient Administration (TOPA) Flight organizational structure.

1.5. HIPAA Privacy Officer. The duties and responsibilities of the MTF HIPAA Privacy Officer are discussed in Chapter 6 of this instruction.

1.6. RHIA. Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT), or Air Force member with equivalent education and experience.

1.6.1. The RHIA or RHIT is credentialed by the American Health Information Management Association and is a civilian rated eligible by the Office of Personnel Management Qualification Standard for the GS 669 or GS 675 series.

1.6.2. Responsibilities:

1.6.2.1. Management of the inpatient records department, coding of inpatient records, inpatient professional service encounters (rounds), Ambulatory Procedure Visits (APVs), medical transcription, and provision of oversight regarding outpatient record documentation and coding.

1.6.2.2. The RHIA or RHIT works closely with the Information System Security Office (ISSO) and HIPAA Privacy Officer (HPO) to ensure security of and controlled access to both the paper-based and automated medical records, and to ensure release of information procedures conform to all legal requirements.

Chapter 2

HEALTHCARE ENTITLEMENTS AND ELIGIBILITY REQUIREMENTS

Section 2A—Healthcare for Current and Former Uniformed Services Personnel

2.1. Administering Healthcare Benefits. The military services administer the TRICARE Managed Care Health Plan according to Title 10, United States Code, Chapter 55, Sections 1071 through 1088, 1090, 1093, 1095, and 1097. Additionally, the military services are directed to administer healthcare benefits under DoDD 6010.04, Healthcare for Uniformed Services Members and Beneficiaries.

2.2. Provision of Services. Healthcare personnel provide services under this program regardless of the sponsor's service affiliation and in accordance with the patient rights and responsibilities outlined in DoDI 6000.14, DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS). Military Healthcare System coverage extends to the following members of the Uniformed Services and other fully or partially authorized beneficiary categories (Department of Defense [DoD] healthcare may be reduced or limited depending on patient category) and the authority to provide care are as follows:

2.3. Uniformed Services Active Duty Personnel. Authority is 10 U.S.C. § 1074; 31 U.S.C. § 1535. Active Duty personnel will be provided all care that is medically necessary.

2.4. Medal of Honor Recipients. Authority is 10 U.S.C. § 1074h. Also reference National Defense Authorization Act (NDAA) 2001.

2.4.1. Medal of Honor recipient means a person who has been awarded a medal of honor under § 3741, § 6241, or § 8741 of 10 U.S.C. or § 491 of 14 U.S.C.

2.4.2. A former member of the armed forces who is a Medal of Honor recipient and who is not otherwise entitled to medical and dental benefits as a retiree will be given medical and dental care as if entitled to retired pay.

2.5. Former US Military Personnel Held as Prisoners of War (POW) or Detainees by Foreign Governments. Authority is Secretary of Defense Designee Status. See Section 4F for specific Secretarial Designee information.

2.5.1. Repatriated US military personnel who were POWs or detainees who have left the military service for reasons other than retirement.

2.5.2. Former POWs are eligible for care for 5 years after separation from military service. The Assistant Secretary of Defense (Health Affairs) provides a statement of eligibility.

2.5.3. For purposes of aeromedical evacuation, consider the individual in the same category as active duty.

2.5.4. For other than aeromedical evacuation, consider the individual a retiree.

2.6. Academy Cadets and Midshipmen. Cadets enrolled at the Air Force Academy, the US Military Academy at West Point, the USCG Academy, and midshipmen enrolled at the US Naval Academy. Authority is 10 U.S.C. § 1074, § 6201-6203; 31 U.S.C. § 1535. See paragraph 2.31. for additional information regarding authorized MTF care for U.S. Service Academy applicants.

2.6.1. Healthcare for Service Academy cadets and Midshipmen is generally limited to MTF direct care. Enrollment into TRICARE is not authorized. Required healthcare that exceeds an MTF's capabilities is usually authorized and arranged by the MTF Referral Management Center similarly to the process used for Reserve Component members with In-Line-of-Duty injuries and/or illnesses. Referral to another MTF or a civilian network or non-network provider may be authorized.

2.7. Former Active Duty Female Service Members – Obstetrical/Maternity Healthcare.

2.7.1. Female Uniformed Service Members discharged or separated from Military Service under Honorable conditions or in association with a General Discharge, occurring Under Honorable Conditions, and who are or have been determined to be pregnant prior to Service separation or discharge, may be authorized OB/maternity-related direct care (if available) at an Air Force MTF only after obtaining the MTF Commander's permission. Service Members separating or receiving a discharge under other circumstances (e.g., involuntary separation under Honorable conditions not already covered by TAMP), who seek MTF direct healthcare, may be eligible for specific MTF care under the Secretary of the Air Force Designee Program (10 U.S.C. § 8013).

2.7.2. Former female Service Members seeking continued MTF direct care under this provision must not be eligible for MHS or direct MTF care under another higher priority beneficiary category. For example, in the case of a dual military, opposite sex, married couple; following military service separation or discharge, a former ADSM female is not authorized healthcare under this provision if she is already authorized healthcare benefits under her spouse's (sponsor's) healthcare entitlement.

2.7.3. Former female ADSMs discharged under Other-Than-Honorable conditions may be eligible for direct MTF care when authorized by a General Court-Martial Authority and only when approved by an Air Force MTF Commander.

2.7.4. MTF direct care is generally not extended to former female ADSMs who receive uncharacterized, entry-level, administrative separations or discharges when determined (by a military provider) the female ADSM is or was immediately pregnant prior to Service enlistment or appointment. MTF direct care is generally not authorized for former female ADSMs who become pregnant during the entry-level Service period when Service separation or discharge characterization is not typically granted or provided.

2.7.5. Individuals who are married to an ADSM should not apply for benefits under this paragraph since they are authorized care as a family member.

2.7.6. Individuals must present a DD Form 214, Discharge Certificate, or other official discharge documents that reflect the Service characterization, to apply for care under this section.

2.7.7. Obstetrical/maternity care described under this section is authorized for former female ADSMs and RCSMs who became pregnant prior to being discharged or relieved from Extended Active Duty (EAD).

2.7.7.1. Obstetrical/maternity care is unauthorized after the female Service Member is released from Inactive Duty Training (IDT), Active Duty for Training (ADT), Annual Tour (AT), or Temporary Tour of Active Duty (TTAD). Former female ADSMs who

become pregnant while entitled to Transitional Assistance Management Program (TAMP) are not eligible for care under this program. See paragraph 2.47. for definitive TAMP eligibility information.

2.7.8. Medical care is limited to obstetrical (OB) care only at MTFs with OB capabilities. Obstetrical/maternity care shall not be extended to individuals who are already covered under another insurance plan where OB care is offered. This benefit does not apply to MTFs with external resource sharing agreements.

2.7.9. Healthcare benefits approved by the MTF Commander and provided under this section, do not extend to the TRICARE program. Healthcare is limited to available MTF prenatal OB care and infant delivery, as well as required medically necessary follow-up care, not to exceed six weeks post-partum. In cases where complications arise and the patient requires definitive MTF inpatient care following delivery, provide the required healthcare. Discontinue care or transfer the patient to an appropriate civilian MTF after the six-week post-partum period or when the patient is stable enough to transfer. If complications were the result of MTF intervention during treatment of the patient, continued care may be considered under the Secretary of the Air Force Designee program. Designee status may be applied in accordance with Chapter 4, Section 4E, under the provisions of "Best Interest of the Air Force." The MTF Commander is responsible for ensuring this extended care provision is not abused. Obtaining approved Secretarial Designee status is not guaranteed.

2.7.10. Individuals must request care by applying to the servicing MTF Commander. Request must include a copy of the individual's DD Form 214 or other official discharge or separation papers. If approved, inform the individual that any maternity care in a civilian medical facility is at her own expense. Further, if at any time during the management of her maternity care it becomes necessary to transfer the patient to a civilian healthcare facility because care required is beyond the capability of the MTF, all costs, to include aeromedical evacuation, are charged to the individual. Before providing care, the individual must acknowledge receipt and understanding of these provisions by signing a statement that explains these facts and includes the following:

2.7.10.1. "I understand that if at any time during the management of my healthcare it becomes necessary for the Air Force MTF to transfer me to a civilian medical facility for healthcare beyond the Air Force hospital's capability or capacity, I am responsible for the costs of all civilian medical care provided, including transportation cost to the civilian facility." File a copy of the signed statement in the individual's inpatient health record.

2.7.11. As soon as possible and/or well in advance of the former ADSM’s infant delivery at the MTF, advise the patient she should apply for Secretarial Designee status for her newborn infant, otherwise the newborn becomes a pay patient at the Full Reimbursement Rate after the six-week post-partum/post-delivery check-up.

2.7.12. Use of Supplemental Care is limited to diagnostic treatment associated with inpatient maternity care when not available in the MTF.

2.7.13. Post partum sterilization is authorized when performed during the obstetrical admission.

2.7.14. Healthcare includes medically necessary induced abortion within the policies established by AFI 44-102 and includes one outpatient examination no later than six weeks

after the procedure. See paragraph 2.54. for more definitive information regarding when an abortion may be performed in an MTF.

2.7.15. Reserve Component members who apply for maternity care upon release from an EAD period who do not meet the requirements of paragraph 2.7.7., are advised that continuing maternity care is not authorized at government expense and that they must seek healthcare from a civilian provider of their choice.

2.7.16. Former female ADSMs separated or discharged under Other Than Honorable Conditions (OTHC) may be extended healthcare under this section when the following conditions are met:

2.7.16.1. When healthcare is authorized under limited approval authority granted by the Secretary of the Air Force (SECAF) to the General Court-Martial Convening Authority (whether the person was discharged IAW court-martialed order(s) or administratively separated) and only when supported by the MTF Commander where healthcare is desired. This limited approval authority is provided to help discharge authorities separate individuals from Active Duty who might normally be maintained on Active duty solely because of pregnancy and/or in the face of evidence that would otherwise not result in separation. The MTF Commander should provide supporting information to the convening authority to assist in deliberations, e.g., does the MTF (where care is sought or desired by the Service Member) have the capacity or capability to provide OB care. Individuals extended benefits under this provision must be reported as Secretary of the Air Force Designees annually in the log outlined in Attachment 6, by the medical facility providing treatment. The following guidelines are used in determining whether to extend this benefit:

2.7.16.2. The care is granted only as an exception, not as a general rule.

2.7.16.3. Consideration is given as to whether medical continuity of care is an issue (e.g., the same facility providing prenatal care will also perform delivery).

2.7.16.4. Consideration is given as to whether the individual has alternate resources for providing the care (e.g., child's father, court order for payment of maternity care, major medical coverage, other government benefits program, other family members, and the general health of the mother).

2.7.16.5. Other factors which might be considered reasonable.

2.7.17. Authority for care of newborn children of women veterans receiving maternity care at Department of Veteran Affairs (DVA) facilities, or another facility pursuant to a DVA contract, is the Caregivers and Veterans Omnibus Act of 2010, Section 206.

2.7.18. Newborn children of women veterans receiving maternity care furnished by the Department of Veterans Affairs (DVA) or another facility pursuant to a DVA contract for services relating to delivery are eligible to receive up to 7 days post-delivery care, including routine care that a newborn would generally require. This impacts those Air Force MTFs that have DoD/VA Resource Sharing Agreements for OB care.

2.8. Retired members of the Uniformed Services. Authority is 10 U.S.C. Chapter 55, 31 U.S.C. § 1535, Executive Order (EO) 11733. Provide healthcare as directed per statutory requirement.

Section 2B—Healthcare Benefits for the Reserve Component

2.9. Reserve Component Authority. Reference 10 U.S.C. § 175, § 1209, § 1074, 31 U.S.C. § 1535; 32 U.S.C. § 502, 29 U.S.C. § 1002. Reserve Component (RC) members on orders or participating on an active duty tour are entitled to the same quality of care that members of the active component are entitled to. However, there are restrictions to the type and amount of available Military Health System (MHS) benefits authorized to Reserve Component Service Members (RCSM) based upon, a) the duration of the member's active duty commitment (indicated on his/her orders), b) the purpose or category (e.g., AT, UTA-drill weekend, IDT, man-days, TDY, etc.) of the active duty period, and, c) the nature in which the RCSM was activated or "mobilized" to active duty may influence the level of healthcare that the member may expect or is authorized to receive during the covered period.

2.9.1. Definitions:

2.9.1.1. Reserve Component (RC) Personnel: Members of the Air National Guard, Army National Guard and Reserves of the Air Force, Army, Navy, Marine Corps, Coast Guard, Public Health Service or National Oceanographic and Atmospheric Administration.

2.9.1.2. Drill Status Member: Member of a RC not on Extended Active Duty (EAD) or Active Guard/Reserve (AGR) status required to perform one drill weekend, a.k.a. Unit Training Assembly (UTA), per month in Inactive Duty Training (IDT) status and one Annual Tour (AT), which shall consist of at least two weeks of Active Duty (AD) time per year. Reserve Component Service Members are placed on, and removed from, active duty periods of varying lengths according to their orders throughout their military career.

2.9.1.3. Air Reserve Technician (ART): Full-time civilian employee who is also a member of the Reserve Component unit in which they are employed. In addition to their civilian employment, they are assigned in the Reserve Component organization with a military rank.

2.9.1.4. Annual Tour (AT): Period of active duty performed annually by RCSMs.

2.9.1.5. Active Duty for Support: Reserve Component Service Members not in EAD, AGR, IDT, or AT status called to active duty to provide support to reserve or active duty organizations for an established period of time (length may be for one or more days; published orders required).

2.9.1.6. Extended Active Duty (EAD) and Active Guard/Reserve (AGR): Reserve Component Service Members on voluntary active duty providing full-time support to Reserve Component or Active Component organizations for the purpose of organizing, administering, recruiting, instructing, or training the Reserve Components.

2.9.1.7. Inactive Duty Training (IDT) status definition: Duty normally performed during Unit Training Assembly (UTA).

2.9.1.8. Healthcare: For the purposes of this instruction, the term "healthcare" includes treatment for any medical or dental condition.

2.9.1.9. Medical Condition: For the purposes of this instruction, the term "medical condition" includes both medical and dental injuries, illnesses, or diseases.

2.10. General Healthcare Entitlements. Authority DoDD 1241.01, Reserve Component Medical Care and Incapacitation Pay for Line of Duty Conditions and DoDI 1241.2, Reserve Component Incapacitation System Management.

2.10.1. When not in an Extended Active Duty (EAD) military status (orders for greater than 30 days), TRICARE Early mobilization or TAMP status; Reserve Component members' military healthcare is limited. Refer to DoDD 1241.01 for entitlements. Generally, RCSMs on AD orders for 30 days or less will not appear as eligible for healthcare in the Defense Enrollment Eligibility Reporting System (DEERS). Direct Care (for specialized or follow-up care for a RCSM's medical condition resulting from an In Line of Duty determination-related injury or illness) shall not be denied based solely on a RCSM's DEERS ineligibility status. Government sponsored healthcare eligibility for RCSMs may be further verified by:

2.10.1.1. Reviewing the Service Member's duty status orders.

2.10.1.2. Reviewing the Service Member's AF Form 348, Line of Duty Determination, or Air Force Reserve Component (AFRC) Form 348, Informal Line of Duty Determination (with In Line of Duty findings), and all required signatures, (e.g., unit commander and legal). See Section E, paragraph 4.28 for additional information regarding RCSM LOD determination processing. Do Not Deny Direct Care or TRICARE network healthcare to a RCSM until a "Not in Line of Duty" finding is confirmed.

2.10.1.3. Contacting the MTF LOD representative.

2.10.1.4. Contacting the Service Member's unit.

2.10.1.5. Contacting the Service Member's MPS.

2.10.1.6. Contacting the Military Medical Support Office (MMSO).

2.10.2. RCSMs placed on orders for more than 30 days for non-contingency related operations are authorized TRICARE benefits equal to the active duty component. Additionally, TRICARE benefits are also extended to the RCSM's authorized family members during this same period. Refer to Attachment 25, Reserve Healthcare Eligibility Matrix, Non-Contingency Operations for additional eligibility information.

2.10.3. RCSMs ordered to Federal Active Duty for more than 30 days in support of contingency operations are also authorized full TRICARE benefits. Healthcare coverage is also extended to each of the RCSM's authorized family members. Additionally, if the RCSM is issued delayed-effective-date active duty orders for more than 30 days in support of a contingency operation, the member and his family members are eligible for "early" TRICARE medical and dental benefits beginning on the latter of either: (a) the date their orders were issued or (b) 180 days before the member reports for duty or is "activated" to active duty. Refer to Attachment 26, Reserve Healthcare Eligibility Matrix, Contingency Operations for additional eligibility information.

2.10.4. Outpatient appointments must be scheduled and completed within the time period specified on the RCSM's current active duty orders. However, if the Service Member is seeking healthcare for duty related medical conditions and holds an approved or pending LOD, or the MTF is able to verify eligibility for care regarding the member's service-connected injury or illness, then healthcare, necessary to treat the Service Member's service-

connected injury or illness, is authorized. RCSMs may make medical appointments for duty-related medical conditions regardless of their duty status at the time the appointment is requested. RCSMs who live in TRICARE Prime Remote (TPR) areas should obtain their initial and/or completed LOD (if available) from their unit medical representative and produce this document when seeking care at an MTF.

2.10.5. Healthcare for non-duty related medical conditions is not authorized beyond the expiration date of a RCSM's orders. Medications dispensed for non-duty related medical conditions should be dispensed in a quantity sufficient to last the duration of the RCSM's orders or until civilian healthcare can reasonably be obtained after termination of orders.

2.10.6. RCSMs on AD orders (except EAD or AGR) with non-duty related medical conditions listed below should be referred to their immediate commander for possible termination of AF orders.

2.10.6.1. Frequent or prolonged treatment.

2.10.6.2. Results in excessive absences from duty or training.

2.10.6.3. Prevents the satisfactory performance of duty or training.

2.10.7. RCSMs in IDT status are not entitled to routine military healthcare. Treatment for acute exacerbations of pre-existing or non-duty related medical conditions not aggravated by military service is only authorized to prevent pain or undue suffering until the member can reasonably be referred to a civilian healthcare provider.

2.10.8. RCSMs who incur or aggravate a medical condition while performing military duty or traveling directly to/from such duty require a Line of Duty determination IAW AFI 36-2910, Line of Duty (Misconduct) Determination, to determine entitlement to military healthcare while not on active duty orders.

2.10.9. RCSMs not on active duty orders and pending completion of a Line of Duty investigation (informal or formal) are entitled to military healthcare only for the medical condition under investigation. The completed 1st page of AF Form 348 or completed blocks 1-5 on the AFRC Form 348 (both forms must be include provider signatures and dates) are enough to justify treatment at government expense until the Service Member's unit commander is able to render a LOD decision. Continued entitlement exists only if the medical condition is determined to be In Line of Duty.

2.10.10. RCSMs without published orders are entitled to healthcare in military MTFs to include referrals to civilian medical facilities as appropriate under the following conditions:

2.10.10.1. The RCSM's service-connected medical condition is currently under LOD investigation. Entitlement exists only for the healthcare condition under LOD investigation. Eligibility and/or LOD verification may be obtained from the, a) MTF patient administration LOD representative, b) the Service Member's unit, c) the Service Member's MPS, d) or by contacting the Military Medical Support Office (MMSO).

2.10.10.2. The RCSM's medical condition has been determined to be In Line of Duty. Entitlement exists only for the medical condition determined to be In Line of Duty. An AF Form 348, AFRC Form 348, or DD Form 261, Report of Investigation Line of Duty and Misconduct Status, or Provisional LOD with all signature blocks complete, is

required to establish eligibility. LOD is valid for care only until being found fit and returned to duty or separated by the DES system for the documented medical condition.

2.10.11. Civilian Healthcare: Healthcare expenses (to include supplemental care charges) from civilian healthcare sources are authorized for RCSMs. RCSMs may be authorized initial or emergency civilian healthcare (related to an In-Line-of-Duty injury or illness) at government expense without pre-approval. However, follow-up civilian healthcare must be pre-approved prior to receiving said care at government expense. Pre-authorization must be obtained from the military MTF referring the RCSM for civilian treatment or from the MMSO. Requests for civilian healthcare will be submitted to the MMSO prior to the RCSM receiving said care when not requested through an active duty MTF IAW appropriate RC and MMSO guidance.

2.10.12. Medical Devices and/or Aids: RCSMs are authorized prosthetic devices, hearing aids, or orthopedic footwear for those medical conditions incurred or aggravated by military duty. Spectacles are authorized for certain personnel under AFJI 44-117, Ophthalmic Services. Military orthopedic footwear may be authorized for RCSMs if required for the performance of military duty and the individual is fit for military duty.

2.10.13. Pregnancy: Unless otherwise eligible, pregnant RCSMs are not provided delivery services or maternity care past the period of their active duty orders. Pregnant RCSMs ending an EAD or AGR tour receive care IAW paragraphs 2.7.7. and 2.7.7.1.

2.10.13.1. If a RCSM begins childbirth while on active duty orders (does not include Service Members on EAD/AGR tours) and her orders terminate while in the MTF, she and her newborn are charged the Full Reimbursement Rate (FRR) for each day past the expiration of orders. Transfer the member to a civilian medical facility as soon as possible. See AFRC 41-104, Pregnancy of Air Force Reserve Personnel.

2.10.13.2. If a Service Member is hospitalized for delivery during IDT, charge the mother and newborn the FRR for the entire period and transfer the mother and child to a civilian medical facility as soon as possible.

2.10.13.3. Reserve Component Service Members are not authorized issuance or extension of orders for the purpose of obtaining maternity care at government expense (including members on active duty orders over 30 days).

2.10.14. Reserve Component Service Members deployed or stationed at OCONUS assignments for 30 days or less, and who have received civilian medical care while deployed or are expected to obtain additional TRICARE Prime Remote (TPR) healthcare, related to an LOD service-connected medical condition upon return to CONUS, must obtain the appropriate eligibility documents (AD orders) before leaving OCONUS. The member must submit these documents to MMSO to ensure continuity of care and ensure claims are processed.

2.10.15. Transitional Assistance Management Program (TAMP): Refer to paragraph 2.47. for definitive information regarding this benefit.

2.11. Physical Examinations & Specialty Consultations.

2.11.1. General Eligibility Rule (as applied to this section only): Reserve Component Service Members must possess valid published orders at the time of the examination and/or consultation.

2.11.2. Physical Exam: Reserve Component Service Members may receive a required periodic physical examination in an active duty MTF at the request of a Reserve Component Medical Unit (RCMU) or RCSM (when the Service Member has no supporting RCMU). The request must be submitted to the appropriate MTF Aerospace Medicine or Force Health Management element in the active duty MTF. See paragraph 2.51., Authorization for Physical Examinations Other than Flying (including periodic examinations) for additional information.

2.11.3. Specialty Consults: Upon recommendation from a RCSM's military medical evaluating provider or military medical evaluating authority, RCSMs are authorized care at active duty MTFs to obtain specialty consultation and/or diagnostic laboratory testing to evaluate abnormal findings found during annual physical examination in order to determine the member's medical qualification for continued military duty or continued special operational duty. If the active duty MTF does not possess the required specialty service or cannot perform the required laboratory testing, the RCSM will be referred to civilian healthcare network providers in the same manner as active duty members.

2.11.4. Referrals: Reserve Component Service Members who require follow-up healthcare outside of the area where initial treatment was rendered are referred by the military MTF responsible for the Service Member's healthcare. The referring military MTF contacts the receiving military/civilian MTF to ensure care is delivered. The referring MTF must notify the RCSM's supporting RCMU or the installation Individual Mobility Augmentee (IMA) point of contact also referred to as the Base IMA Administrator (BIMAA) for issues related to an IMA.

2.11.5. Reserve Component Preventive Health Assessments: Preventive Health Assessments are generally not considered comprehensive physical exams, however, these assessments are critical to identifying potential illnesses or injuries that would otherwise be overlooked and potentially lead to serious future medical issues or result in the member's inability to meet deployment requirements. Members of the RC are entitled to an annual PHA. However, RCSMs not placed on active duty orders for 30 days or more are only authorized MTF diagnostic testing to evaluate abnormal findings found during the PHA as long as the necessary testing/care can be provided before the member's temporary duty tour period expires. Any necessary follow-up diagnostic testing that cannot be provided within the RCSM's temporary duty period must be obtained from the member's own personal healthcare provider. RCSMs may be placed on invitational travel orders for evaluations required for suitability for continued service. See AFI 36-2254V1, Reserve Personnel Participation for additional information.

2.12. Special Eligibility Considerations.

2.12.1. Aircrew: Reserve Component aircrew members are not normally entitled to aerospace clinical services unless on AD orders. Reserve Component aircrew members not

on AD orders may be seen by an AD flight surgeon (FS) for placement on or removal from "Duty Not Involving Flying" (DNIF) status.

2.12.2. Dental: Complete elective dental care may not be available during periods of active duty for the correction of all pre-existing dental defects. A dental officer may elect to provide treatment, but may also defer such treatment. Each case is evaluated on individual merit. The criteria for elective care in one instance may not be valid in another, even though the required clinical procedures are similar. Prosthodontic or orthodontic services may be provided according to AFI 47-101, Managing Air Force Dental Services. Members accepted for initiation of prosthodontic or orthodontic treatment must have sufficient active duty retainability or reasonable expectation that the prescribed treatment can be completed before the end of the active duty order. Continuation of treatment or necessary follow-up for non-duty related conditions are not authorized after expiration of active duty orders.

2.12.3. Surgery: Surgical correction of non-duty related defects while on active duty orders (except EAD or AGR) are not authorized except under conditions where it is required to save life, limb, sight, or prevent undue suffering. If the healthcare condition is likely to be aggravated by or interfere with the performance of military service, the Service Member should be referred back to their RC unit commander for appropriate action and possible termination of active duty orders.

2.12.4. Hospitalization: Reserve Component Service Members may require hospitalization when not on active duty orders. At some point during the hospitalization, an LOD Determination for Healthcare (1st page of AF Form 348) must be initiated and forwarded to the Service Member's supporting RCMU for appropriate processing through the Reserve Component LOD processing system. Reserve Component Service Members hospitalized beyond the termination date of their AD orders, or while in IDT status are entitled to continued military healthcare only for duty related medical conditions, or medical conditions currently undergoing LOD investigation.

2.12.4.1. Notify the RCSM's unit commander and supporting RCMU when a RCSM is hospitalized. Contact RMG/IRMS for IMAs hospitalized at DoD MTFs. Provide the following information: name, rank, SSN, diagnosis, if injured the nature of the injury, and whether or not the individual is attached to a school for training.

2.12.5. Newly Commissioned Reserve Officers - Initial Active Duty TRICARE Program (RC-IAD). Authority is 10 U.S.C. § 1074(a)(2)(B)(i). Also reference DoDI 7730.54 encl 17(draft) and National Defense Authorization Act (NDAA) 2004/2006.

2.12.5.1. This section applies to RCSMs of a Uniformed Service who have been newly commissioned as Reserve officers and who also have an approved request for initial Active Duty orders. Reserve Component members in this category must have either, a) orders that are to be issued but have not been issued, or b) have been issued but the member has not entered Active Duty yet. Additionally, healthcare eligibility is only granted if the RCSM is not already covered by another healthcare coverage insurer or health benefits plan.

2.12.5.2. Eligibility is determined by the RCSM's servicing personnel component.

2.12.5.3. If eligible, members are entitled to full medical/dental benefit as Active Duty.

2.12.5.4. Further details may be found at the TRICARE Management Activity website at **http://www.tricare.mil**.

2.12.6. IMA Healthcare: IMAs attached to Active Duty units receive primary medical support (while on orders) from the AD MTF that supports the Service Member's unit of attachment.

2.12.6.1. Contact the Base IMA Administrator or BIMAA for information related to IMA personnel management, or questions related to an IMA's unit of attachment, or when seeking assistance when routing important information regarding an IMA's LOD determination status.

Section 2C—Healthcare for Current and Former Uniform Service Family Members

2.13. Family Members (dependents) of Active Duty and Reserve Component Personnel of the Uniformed Services. Authority is 10 U.S.C. § 1076, § 1077, § 1078; 31 U.S.C. § 1535.

2.13.1. The following categories of family members are entitled to healthcare benefits within the MHS.

2.13.1.1. A family member (dependent, as defined in AFI 36-3026V1_IP, Identification Cards for Members of the Uniformed Services, Their Eligible Family Members, and Other Eligible Personnel, 17 June 2009) and surviving family members of a former reserve component member if the member was eligible for retired pay and died before age 60;

2.13.1.2. Dependents of a commissioned officer, warrant officer, or enlisted member of the Air Force, Army, Navy or Marine Corps, whose sponsor is/was:

2.13.1.2.1. An active duty member.

2.13.1.2.2. A member who died while on active duty.

2.13.1.2.3. A retired uniformed service member.

2.13.1.2.4. A member who died while in retired status.

2.13.1.2.5. A member on the Temporary Disability Retired List.

2.13.1.2.6. A member of a Reserve Component called to active duty or Federal service for more than 30 days.

2.13.1.2.7. Under sentence to a punitive discharge until the discharge is executed.

2.13.1.2.8. A member of a Reserve Component called into Federal service who died from an injury or illness incurred or aggravated while performing duty or while traveling to or from the place of duty (according to Public Law (PL) 99-145 Department of Defense Authorization Act, 1986, this applies to those individuals whose sponsor died after 30 September 1985).

2.13.2. Parents and parents-in-law lose their eligibility only when the sponsor fails to establish dependency when the ID card is renewed or when the sponsor takes action to eliminate their eligibility. A former spouse is not entitled to care under this paragraph.

2.13.3. Parents and parents-in-law are not entitled to TRICARE benefits.

2.13.4. Children do not lose their entitlement due to the divorce of their parents as long as the sponsor remains entitled to care and the children do not otherwise lose their eligibility.

2.13.5. Children under 21 years (or up to 23 years of age if enrolled full time in college) who marry an individual who is not entitled to privileges under the Military Health System (MHS), lose their entitlement to care. However, if the marriage is terminated, the child is once again entitled to medical privileges. Adult children of sponsors eligible for benefits who are unmarried, have reached age 21, or 23 if in school, but not reached age 26 and not eligible for an employer sponsored health plan can purchase TRICARE Young Adult (TYA) coverage. Reserve Component members must be enrolled in TRICARE Retired Reserve or TRICARE Reserve Select for their dependent to be eligible for, and purchase, TYA coverage.

2.13.6. Military Health System benefit entitlements are extensively defined in TRICARE Policy Manuals located at the **http://www.tricare.mil**/ TRICARE Management Activity (TMA) Internet website.

2.13.7. Aeromedical Evacuation is authorized IAW AFI 41-301, Worldwide Aeromedical Evacuation System.

2.13.8. Dental Care (on a space available basis only).

2.13.8.1. TRICARE Family Member Dental Plan enrollees receive emergency dental care not to exceed care provided by the program.

2.13.8.2. Non TRICARE Family Member Dental Plan enrollees are not authorized care unless for determining fitness for overseas clearance.

2.13.8.3. Dental care not authorized at Uniform Service Family Health Plan facilities.

2.13.9. Emergency Care (outpatient & inpatient) is authorized.

2.13.10. Immunizations are authorized.

2.13.11. Under 10 U.S.C. § 1077, the following types of care are not provided, or provided with exceptions, to family members:

2.13.11.1. Domiciliary or Custodial Care. (Not Authorized).

2.13.11.2. Generally, prosthetic devices, hearing aids, orthopedic footwear, and spectacles are not authorized. However, prosthetic devices, hearing aids, orthopedic footwear, and spectacles for family members located outside of the United States and at stations inside the United States where adequate civilian facilities are unavailable may be sold to family members at cost to the United States.

2.13.11.3. The elective correction of minor dermatological blemishes, marks or minor anatomical anomalies. (Not Authorized).

2.14. Immediate Family Members (Dependents) of Medal of Honor Recipients. Authority is 10 U.S.C. § 1074h.

2.14.1. The term immediate family member means the spouse; un-remarried widow; un-remarried widower; a child who has not attained the age of 21, or has not attained the age of 23 and is enrolled in a full-time course of study at an institution of higher learning, or a child who is incapable of self-support because of a mental or physical incapacity.

2.14.2. The immediate family members of a Medal of Honor recipient who is not otherwise entitled to medical and dental benefits as a retiree will be given medical and dental care as if the member was retired from active duty.

2.15. Family Members (Dependents) of US Military Personnel Held as Prisoners of War or Detainees by Foreign Governments. Authority is Secretary of Defense Designee Status.

2.15.1. Family members (dependents) of repatriated US military personnel who were prisoners of war or detainees whose sponsor left military service for reasons other than retirement.

2.15.2. Individual is eligible for care for 5 years after separation from military service and will have a statement of eligibility provided by the Assistant Secretary of Defense (Health Affairs).

2.15.3. For purposes of aeromedical evacuation, consider the individual in the same category as a family member of an active duty member.

2.15.4. For other than aeromedical evacuation, consider the individual a family member of a retiree.

2.15.5. Family members enrolled in the TRICARE Active Duty Family Member Dental Program are provided emergency dental care not to exceed that care provided by the program.

2.16. Un-remarried Former Spouses. Authority is 10 U.S.C. § 1408, § 1447, § 1448, § 1449, § 1450, § 1072, § 1086a, and 32 CFR 199.3.

2.16.1. Certain former spouses of active duty or retired service members may be eligible for medical care (including TRICARE) if a DEERS-Uniformed Services issuing ID card office has certified the un-remarried, former spouse's eligibility. The basic requirements for a former spouse's eligibility are:

2.16.1.1. Must not have remarried. (If the former spouse remarries, the loss of benefits remains applicable even if remarriage ends in death or divorce).

2.16.1.2. Must not be covered by an employer-sponsored health plan.

2.16.1.3. Must not be the former spouse of a North Atlantic Treaty Organization (NATO) or "Partners for Peace" (PFP) nation member.

2.16.1.4. Must meet certain requirements about length of marriage (depending upon the situation, 20 years or 15 years) and length of former sponsor's service (number of years that are creditable in determining the member's eligibility for retirement pay).

2.16.2. The preceding elements represent only the basic requirements that may authorize DoD healthcare for certain types of former spouses. Accurate DEERS information is the key to TRICARE eligibility. DEERS enrollment and/or updates are only authorized at Uniformed Services personnel offices, not the local TRICARE service center, local TRICARE Flight, or local Patient Administration Flight. For more definitive eligibility answers, please refer AFI 36-3026V1_IP, Identification Cards for Members of the Uniformed Services, Their Family Members and Other Eligible Personnel.

2.16.3. Additional un-remarried former spouse guidance, frequently asked questions and case scenarios may be found at TRICARE Internet website at **http://www.tricare.osd.mil/Factsheets/viewfactsheet.cfm?id=174**.

2.16.4. Effective October 1, 2003, un-remarried former spouses are registered in DEERS under their own Social Security numbers (SSNs), not their former sponsors' SSNs. Healthcare information is filed under the un-remarried former spouse's own SSN and name. Un-remarried Former Spouses can now use their own name and SSN to schedule medical appointments and to file TRICARE claims.

2.16.5. All un-remarried former spouses are eligible to purchase Continued Healthcare Benefit Program (CHCBP).

2.17. Family Members of Reserve Component Members – HIV Discovery.

2.17.1. The spouse of a RCSM, who is not otherwise eligible for care, may apply for Secretary of the Air Force Designee status (SECDES) for preventive medicine counseling and serologic testing when their sponsor tests positive for HIV. Submit IAW DoDI 6025.23, Health Care Eligibility Under the Secretarial Designee Program and Related Special Authorities.

2.18. Newborns Not Automatically Eligible for Healthcare Without Pre-Approval.

2.18.1. Newborns of Former Active Duty Females. Newborns of former Service Members are not DoD healthcare beneficiaries. Direct MTF healthcare will be at the Full Reimbursement Rate (FRR) unless Secretary of the Air Force Designee status (SECDES) has been requested for the infant prior to birth. Authorization for care under this program applies only to newborns of former active duty females when the mother is/was receiving care in the MTF as described in paragraph 2.7. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.18.1.1. Care for newborn infants of former Active Duty female service members is only authorized in MTFs in conjunction with delivery, from time of birth to initial discharge. Coverage includes one post-partum visit (for the mother), one well-baby examination and necessary infant immunizations (provided no later than six weeks following delivery). MTF Commanders have the authority to approve MTF medical treatment for newborn infants of former Active Duty female service members. If the SECDES application is approved by the MTF Commander, charges will be at the Family Member Rate (FMR).

2.18.1.2. Aeromedical evacuation is unauthorized. Government or MTF sponsored transfer to another MTF is not authorized. Government or MTF sponsored healthcare coverage for civilian healthcare (TRICARE network or non-network care included) is unauthorized.

2.18.2. Newborns of Dependent Daughters.

2.18.2.1. Newborns of family member daughters are not DoD healthcare beneficiaries. Direct MTF healthcare will be at the FRR (charged to the sponsor) unless SECDES has been approved for the infant prior to birth. Care for newborn infants of unmarried dependant daughters is only authorized in MTFs in conjunction with delivery, from time of birth to initial discharge. Coverage includes one well-baby examination and necessary

infant immunizations (provided no later than six weeks following delivery). MTF Commanders have the authority to approve MTF direct care for newborn infants of unmarried dependent daughters. If SECDES application is approved by the MTF Commander, charges will be at the Family Member Rate (FMR). There is no sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement for newborns of dependent daughters, unless, the sponsor qualifies the newborn as legal custody ward (with an approved financial dependency determination) or adoption per AFI 36-3026V1_IP.

2.18.2.2. Aeromedical evacuation is unauthorized. Government or MTF sponsored transfer to another MTF is not authorized. Government or MTF sponsored healthcare coverage for civilian healthcare (TRICARE network or non-network care included) is unauthorized.

2.18.2.3. Charge the FMR if sponsor provides proof of intent to adopt the newborn within 30 days of delivery.

2.18.2.4. The infant's mother and her sponsor must be informed that any newborn healthcare received in a civilian medical facility will be at the expense of the sponsor or the family and not the government. Ensure that the mother (if older than 18 years of age) and sponsor sign a memorandum acknowledging the possibility of associated costs for civilian care. The infant's mother's care will be provided under TRICARE.

2.18.2.5. If, through the normal course of MTF inpatient treatment, medical complications arise that require advanced life support or specialized medical care (for the infant) not previously authorized on the original SECDES approval letter, or if said medical care is not reasonably available from local civilian healthcare providers, or if the required healthcare falls outside of the capabilities of local civilian healthcare providers and, if the MTF does have the medical capability to treat the infant to save life, limb, or eyesight, the MTF is authorized to provide treatment. The MTF is required to immediately contact AFMOA/SGAT and submit another healthcare request to the Secretary of the Air Force, Administrative Assistant (SAF/AA). MTF direct care is expected to last only long enough to stabilize the infant and transfer the child to an accepting civilian medical facility. TRICARE benefits may be extended to the infant if the sponsor adopts the child.

2.18.2.6. Upon birth, register the infant child into Composite Healthcare System (CHCS) using the PAT CAT "F29" and FMP "60." The use of this PATCAT and FMP will generate a bill for services. The bill will be waived if Secretarial Designee status has previously been granted.

2.19. Abused Family Members/Dependents. (Authority Title 10 U.S.C. § 1076; § 1408(h), § 1059, and DoDI 1342.24, Transitional Compensation for Abused Dependents).

2.19.1. When a sponsor is discharged or separated from Military Service for dependent abuse, the abused individual(s) or those affected by the knowledge of the abuse may receive DoD-sponsored healthcare (including MTF direct care and TRICARE network benefits). Eligible family members or dependents who claim associated physical or psychological problems may apply for transitional compensation benefits through the installation Military Personnel Section (MPS) and/or Accounting and Finance office. When an individual meets

the criteria specified in this paragraph and requirements identified in DoDI 1342.24, AFI 36-3024, and AFI 36-3026V1_IP, the individual may be issued an identification card for the approved eligible transition period. Benefits may include TRICARE or MTF direct medical care only, financial compensation, installation exchange, and commissary privileges as well as other benefits. Special circumstances may dictate additional transitional compensation benefits not identified in this instruction. An MTF Commander may be called upon to provide a medical sufficiency statement if required from the installation MPS or Finance section, from the Air Force Personnel or Financial Authority, or from the Defense Finance and Accounting Service (DFAS). Although eligible beneficiaries under this category may be entitled to transitional benefits approved by the appropriate Air Force Personnel or Financial Authority in coordination with the DFAS, approval of DoD healthcare may first require clinical case review by a qualified military or civilian physician employed by the Federal Government. Said clinical review may be required to establish medical sufficiency and to identify specific medical, dental, or psychological issues that may exist as a direct result of abuse received from the sponsor/Service Member.

2.19.2. Eligible dependent family members of a Service Member who received a dishonorable or bad-conduct discharge, was dismissed as a result of a court-martial, or was administratively separated from a Uniformed Service as a result of dependent abuse, may be entitled to medical or dental care for problems associated with the documented abuse. A medical sufficiency statement from the nearest Air Force MTF Commander may be required.

2.19.3. If a medical sufficiency statement is required, a qualified military or civilian physician employed by the Federal Government should meet with each affected family member to assess their injuries or illnesses (including psychological problems) and review available supporting clinical documents. From the interview(s) and clinical case review, the provider should draft a brief medical narrative summary (for each identified family member) that identifies:

2.19.3.1. Each family member's symptoms and diagnosis. Identify the injuries and/or illnesses (if any) affecting each of the abused family members.

2.19.3.2. Family history.

2.19.3.3. Assessment and Analysis. Include a brief description as to how the injury or illness has affected the individual. Include physical and emotional limitations, complications, and necessary rehabilitative requirements. Include information regarding each family member's ability to cope with everyday challenges or their ability to perform routine life activities (working, attending school, social interaction, driving a car, etc.).

2.19.3.4. Prognosis.

2.19.4. The medical narrative summary should be forwarded to the TOPA function. The TOPA function is required to draft a separate standard medical sufficiency statement for the MTF Commander or his/her authorized delegate's signature. The medical sufficiency package should include available copies of any applicable medical documents or recommendations and analysis from civilian providers. A separate medical narrative summary (including supporting medical documents and medical sufficiency statement) will be created for each family member. Identify each document with the patient's name, family

member prefix, sponsor Social Security Number, date of birth, and family member relationship to the sponsor.

2.19.5. Submit the package(s) to the MTF Commander or his authorized delegate. The MTF Commander may choose an authorized designee if he/she [commander] is not a physician or provider. Often, this responsibility is delegated to the Chief of the Medical Staff (SGH). The authorized designee is required to review the package for clinical adequacy and medical sufficiency. The delegate is then required to select one of the sufficiency statement recommendations below:

2.19.5.1. "In my opinion there is adequate clinical evidence to indicate a significant injury and/or illness (including psychological injury or illness) has occurred as a result of verifiable abuse at the hands of this family member's sponsor. This patient will likely require extensive medical treatment and/or rehabilitative care for the next ____ year(s) before his/her medical problem(s) may be resolved.

2.19.5.2. "In my opinion there is adequate clinical evidence to indicate a modest injury and/or illness (including psychological injury or illness) has occurred as a result of verifiable abuse at the hands of this family member's sponsor. This patient will likely require a reasonable amount of medical treatment and/or rehabilitative care for the next ____ year(s) before his/her medical problems may be resolved."

2.19.5.3. "In my opinion, I find no obvious medical condition, injury, or illness (including psychological injury or illness) which has occurred as a result of verifiable abuse at the hands of this family member's sponsor. However, I cannot overlook the possibility of an injury or illness that may be discovered in the future that could be directly related to the documented abuse this family member has received at the hands of his/her sponsor."

2.19.6. The MTF shall provide the requesting agency (MPS, Finance office, or DFAS) with only the original medical sufficiency letter(s) and not the clinical narrative summary or any other medical-related documents.

2.19.7. File a copy of the medical sufficiency letter along with the clinical narrative summary and all related medical documents in the patient's medical record.

2.19.8. If the Air Force Personnel or Finance Authority, and/or the DFAS approve healthcare benefits, the eligibility period should match the period approved for the abused family member's transitional compensation benefits.

2.19.9. If all or some transitional benefits are denied, the discharged or separated Service Member's family member dependents may apply for consideration of limited (MTF direct care only) medical benefits to the Secretary of the Air Force (SAF/AA). If approved, healthcare is specifically limited to medical services necessary to treat injuries or illnesses suffered as a direct result of the sponsor's abuse. See the Secretarial Designee (SECDES) application section, identified in further detail in Chapter 4, for definitive SECDES program management instructions.

2.19.10. If requested, by one or more family members of the discharged Service Member, the MTF is required to submit a SECDES application to the SAF/AA (via AFMOA/SGAT intermediary). Confirmation of this action must be coordinated with the abused family

member dependent(s) or his/her legal guardian(s). Upon formal notification or receipt of approval of transitional compensation benefits (from the installation MPS or Finance Office), the MTF shall submit a SECDES application to the SAF/AA (via AFMOA/SGAT intermediary) on behalf of the affected family member(s). The MTF location responsible for assembling the SECDES package should include the standard application package documentation identified in Chapter 4 and Attachment 6, to include the application letter signed by the MTF Commander and the medical summary or statement that clearly identifies the medical illness, injury or condition (related to, or as a consequence of abuse) for which military healthcare is requested.

Section 2D—Healthcare for Foreign Forces Members

2.20. SOFA (SOFA/PFP) Military Personnel. Authority is 32 CFR 108, DoDI 6025.23, Health Care Eligibility Under the Secretarial Designee Program and Related Special Authorities, DoDI 6015.23, Delivery of Healthcare at Military Treatment Facilities: Foreign Service Care; Third-Party Collection; Beneficiary Counseling and Assistance Coordinators (BCACs), DoDI 1000.13, Identification (ID) Cards for Members of the Uniformed Services, their Dependents, and other Eligible Individuals. Generally, Air Force MTFs will provide healthcare to foreign forces IAW existing healthcare agreements that the United States, Department of Defense, or the US Air Force may have with the foreign member's country. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.20.1. Category Definition. Military members of SOFA countries, including those under the Foreign Military Sales (FMS) or International Military Student (IMS) Programs who are in the United States, [IMS assigned, SOFA assigned or on a temporary duty (TDY)] at the official invitation of a Federal Department or Agency.

2.20.2. If there is a DoD Reciprocal Health Care Agreement (RHCA) that establishes different benefits and/or charges, the RHCA takes precedence. RHCA care is limited to the capabilities/capacity of DoD MTFs only in the 50 States; no civilian health care.

2.20.3. Claims for SOFA military personnel residing in TPR locations must be submitted to the MMSO for payment determination and/or payment methodology review based on DEERS eligibility. (SOFA AD members require a referral from MMSO prior to non-emergent and following emergent outpatient civilian care. Civilian inpatient care is not covered by DoD.) Supplemental healthcare should only be used for SOFA military personnel assigned to locations within in the United States.

2.20.4. Billing procedures for SOFA personnel, who are participating in FMS or IMS programs, are identified in the individual's invitational travel order (IMS charged IMS rate, FMS charged FRR).

2.20.5. Overseas MAJCOM Command Surgeons and/or the Air Force Medical Operations Agency, Health Benefits function are expected to supplement this paragraph with guidance, if needed, on how to treat and bill SOFA personnel assigned within the United States and treated in MTFs overseas while on official DoD TDY orders.

2.20.6. Reimbursement is required for aeromedical evacuation unless exempt under a DoD international health care agreement. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to

support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.20.7. To obtain a current listing of reciprocal healthcare agreements between the United States Department of Defense and other foreign countries, please visit the TRICARE/TMA website at **https://private.fhp.osd.mil/portal/rhas.jsp**. If your browser is unable to open the website from this hyperlink, please copy the URL and paste into the URL address line on your browser. Additional information regarding international training agreements, including healthcare provisions, can be found at **http:/www.disam.dsca.mil/itm/intl_tng_mgt.htm**.

2.21. Non-SOFA Military Personnel. Authority is 32 CFR 108, DoDI 6025.23, DoDI 6015.23, and DoDI 1000.13. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.21.1. Category Definition. Military members of non-SOFA countries who are in the United States (assigned or TDY) at the official invitation of a federal department or agency and not funded under the Foreign Military Sales (FMS) or IMS programs. This includes individuals on the Diplomatic List or the List of Employees of Diplomatic Missions published by the State Department, individuals assigned or attached to a United States military unit for training, individuals working on official duty in the United States at the invitation of DoD, and individuals assigned to a joint US defense board or commission. Non-SOFA military members under the FMS or IMS programs on official business (assigned or TDY) who are funded through the Air Force Security Assistance Training (AFSAT) Squadron are covered in paragraphs 2.22. and 2.23.

2.21.2. If there is a RHCA that establishes different benefits and/or charges, the agreement takes precedence.

2.21.3. To determine eligibility for Partnership for Peace Non-SOFA countries refer to **https://private.fhp.osd.mil/portal/rhas/ADmatrix.jsp**.

2.21.4. Prosthetic devices, excluding dental prostheses, are billed at the current AFMS price. Dental prostheses are billed at the current rate publicized by AFMOA/SGYR.

2.21.5. Reimbursement is required for aeromedical evacuation unless exempt under a DoD international health care agreement. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.22. Foreign Military Sales (FMS) Personnel (Non-SOFA). Authority is DoDI 1000.13, Identification (ID) Cards for Members of the Uniformed Services, their Dependents, and other Eligible Individuals. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.22.1. Category Definition. Non-SOFA personnel in the United States or overseas who are participating in an FMS program (part of the Security Assistance Training Program). SOFA FMS participants are covered under paragraph 2.20.

2.22.2. If there is a RHCA that establishes different benefits and/or charges, the agreement takes precedence.

2.22.3. Billing procedures are identified in the individual's invitational travel order (ITO). If the ITO states payment is to be made under the FMS case, then send the bill to the military department sponsoring the individual. For the Air Force, this is Air Force Security Assistance Training (AFSAT); the address is 315 J Street West, Randolph AFB, TX 78150.

2.22.4. If the MTF Commander determines an FMS trainee requires medical treatment that results in the discontinuance of the individual's training program for more than 30 days, notify the commander of the training facility.

2.22.5. If an FMS trainee is physically or mentally disqualified for further training, the MTF Commander sends an e-mail message to: AFSAT, Randolph AFB, TX with an information copy to Office of the Secretary of the Air Force (OSAF/IAX) Washington, DC. Include the individuals name, grade, service number, home country, diagnosis, prognosis, expected time and type of disposition, and recommendation on whether return to home country is indicated. If the patient is subsequently transferred to his or her home country, provide a complete set of medical records and ensure the patient's personal effects accompany the individual. Movement is requested by AFSAT to HQ USAF, Defense Communications Services Agency (DCSA).

2.22.6. Unless there is a DoD International Health Care Agreement in place, dental care is limited to emergency care or that care required to keep individuals progressing in their training program. The decision as to what care is necessary rests with the Dental Squadron Commander or equivalent.

2.22.7. FMS funds will not be used to provide elective medical care. The patient or his country must reimburse charges for elective medical care unless there is a DoD International Health Care Agreement in place.

2.22.8. Reimbursement is required for aeromedical evacuation unless exempt under a DoD international health care agreement. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.22.9. To obtain a current listing of reciprocal healthcare agreements between the United States Department of Defense and other foreign countries, please visit the TRICARE/TMA website at **https://private.fhp.osd.mil/portal/rhas.jsp**. If your browser is unable to open the website from this hyperlink, please copy the URL and paste into the URL address line on your browser. This secure Internet website may only be accessed from official DoD computer systems.

2.23. International Military Student (IMS) Program Personnel. Authority is 32 CFR 108, DoDI 6025.23, DoDI 1000.13, AFI 16–105 Joint Security Cooperation Education and Training and Defense Security Cooperation Agency Policy Memorandum 11-32. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.23.1. Category Definition. Personnel in the United States, on a US installation under the IMS program. IMS active duty personnel from countries with SOFAs and/or RHCAs, unless specifically excluded in the agreement(s), are covered by the agreement(s). The agreement(s) are secondary payers to the IMS Program.

2.23.2. Billing procedures are identified in the individual's ITO. Send the bill to the military department sponsoring the individual. For the Air Force, this is Air Force Security Assistance Training (AFSAT); the address is 315 J Street West, Randolph AFB, TX 78150.

2.23.3. If the MTF Commander determines an IMS trainee requires medical treatment that forces discontinuance of the individual's training program for more than 30 days, notify the Commander of the training facility.

2.23.4. If an IMS trainee is physically or mentally disqualified for further training, the MTF Commander sends a message to AFSAT, Randolph AFB TX with an information copy to OSAF/IAX, Washington, DC. Include the individual's name, grade, service number, home country, diagnosis, prognosis, expected time and type of disposition, and recommendation on whether return to home country is indicated. If the patient is subsequently transferred to his or her home country, provide a complete set of medical records and ensure the patient's personal effects accompany the individual. Movement is requested by AFSAT to HQ USAF/DCSA.

2.23.5. Unless there is a DoD International Health Care Agreement in place, dental care is limited to emergency care and care required to keep an individual progressing in their training program. The decision as to what care is necessary rests with the dental squadron commander or equivalent.

2.23.6. IMS funds will not be used to provide elective medical care. The patient or his country must reimburse charges for elective medical care unless there is a DoD International Health Care Agreement in place.

2.23.7. Reimbursement is required for aeromedical evacuation. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.24. Aviation Leadership Program (ALP) Participants. Authority is 10 U.S.C. Chapter 905. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.24.1. Category Definition. Personnel in the United States who are participating in the Aviation Leadership Program (ALP), an AF Undergraduate Pilot Training (UPT) Scholarship program (part of the Security Assistance Training Program). While in the U.S. they will also

participate in other training such as the English Language Program at the Defense Language Institute and UPT and necessary related training.

2.24.2. Program participants are provided medical/dental care without charge. If family members accompany the ALP student, the student or his government must defray all associated costs; charge the family member the full reimbursement rate for direct and emergency care. Billing procedures are identified in the individual's invitational travel order (ITO).

2.24.3. If the MTF Commander determines an ALP student requires medical treatment that precludes start or successful completion of the program, contact OSAF/IAX, 1080 Air Force Pentagon, Washington, DC 20330-1080, for further instructions.

2.24.4. Dental care is limited to that care required to keep individuals progressing in their training program. Family members are limited to emergency treatment only at the full reimbursement rate.

2.24.5. Elective medical care will not be provided to ALP participants or their family members.

2.24.6. Reimbursement is not required for aeromedical evacuation. Prior to travel, enter patient/traveler pertinent information into TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.24.7. Program students who have not obtained the required medical exams prior to arriving in the United States will be examined by a US military flight surgeon. Reimbursement for this exam is required.

2.25. Foreign Military Personnel Overseas. Authority is 32 CFR 108, DoDI 6025.23, and DoDI 1000.13. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.25.1. Category Definition. Non-US military personnel and their family members outside the 50 states including the District of Columbia. This does not include FMS or IMS active duty members.

2.25.2. In-theater agreements take precedence over this paragraph.

2.25.3. Healthcare/transportation will not be provided if these services are available from the parent country.

2.25.4. Reimbursement is required for aeromedical evacuation. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

Section 2E—Healthcare for Foreign Forces Family Members

2.26. Family Members (Dependents) of SOFA Personnel. Authority is 32 CFR 108, DoDI 6025.23, and DoDI 1000.13. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.26.1. Category Definition. Family members (dependents) of military members of SOFA countries who are in the United States (assigned or TDY) at the invitation of DoD. This includes family members of FMS and IMS participants.

2.26.2. Individuals must possess a valid DD 1173, Uniformed Services Identification and Privilege Card (Accountable).

2.26.3. Under 10 U.S.C. § 1077, the following types of care are not provided, or provided with exceptions, to SOFA family members:

2.26.3.1. Domiciliary or custodial care is not authorized.

2.26.3.2. Generally, prosthetic devices, hearing aids, orthopedic footwear, and spectacles are not authorized. However, prosthetic devices, hearing aids, orthopedic footwear, and spectacles for SOFA family members located inside the United States at stations where adequate civilian facilities are unavailable, may be sold to family members at government cost.

2.26.3.3. The elective correction of minor dermatological blemishes and marks or minor anatomical anomalies are not authorized.

2.26.4. If there is an international DoD agreement that establishes different benefits and/or charges, the agreement takes precedence over this section.

2.26.5. Parents and parents-in-law are not entitled to TRICARE.

2.26.6. Outpatient TRICARE Standard care is also authorized.

2.26.7. Space available and emergency dental care is authorized.

2.26.8. Billing procedures for SOFA family members whose sponsor is an FMS or IMS student will have billing procedures outlined in the sponsor's ITO.

2.26.9. Reimbursement is required for aeromedical evacuation unless exempt under a DoD international health care agreement. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.27. Family Members (Dependents) of Non-SOFA Military Personnel. Authority is 32 CFR 108, DoDI 6025.23, DoDI 6015.23 and DoDI 1000.13. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.27.1. Category Definition. Family Members (dependents) residing with a military member who is not a member of a SOFA country and is in the United States on official business

(assigned permanently or TDY) with DoD. This category includes FMS and IMS family members.

2.27.2. If there is a RHCA that establishes different benefits and/or charges, the agreement takes precedence.

2.27.3. Non-SOFA countries who have signed up to the Partnership for Peace SOFA will receive the same medical care as SOFA countries. If the country currently has an SOFA and an RHCA, the more generous agreement takes precedence.

2.27.4. Under 10 U.S.C. § 1077, the following types of care are not provided to family members: See paragraphs 2.26.3.1. – 2.26.3.3.

2.27.5. Billing information contained in the sponsor's orders takes precedence over this paragraph.

2.27.6. Emergency dental care to relieve pain or undue suffering is authorized.

2.27.7. Reimbursement is required for aeromedical evacuation unless exempt under a DoD international health care agreement. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.27.8. No charge for outpatient care for family members of individuals in the Military Personnel Exchange Program.

2.28. Family Members (Dependents) of Foreign Military Sales (FMS) Personnel (Non-SOFA). Authority is 32 CFR 108, DoDI 6025.23, and DoDI 1000.13. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.28.1. Category Definition. Family Members (dependents) residing with a non-SOFA member who is in the United States participating in an FMS program (part of the Security Assistance Training Program).

2.28.2. If there is a RHCA that establishes different benefits and/or charges, the agreement takes precedence.

2.28.3. Billing information is contained in the sponsor's invitational travel orders (ITOs). If the ITO states payment is to be made under the FMS case, then send the bill to the military department sponsoring the individual. For the Air Force, this is AF Security Assistance Training (AFSAT); the address is SA DAO DE, San Antonio/IB, 2021 1st Drive West, Randolph AFB, TX 78150-4302.

2.28.4. Under 10 U.S.C. § 1077, the following types of care are not provided to family members: See paragraphs 2.26.3.1. – 2.26.3.3.

2.28.5. See also paragraphs 2.27.6. – 2.27.8. for additional guidance.

2.29. Family Members (Dependents) of International Military Student (IMS) Personnel (Non-SOFA). Authority is 32 CFR 108, DoDI 6025.23, DoDI 1000.13, AFI 16–105 Joint

Security Cooperation Education and Training and Defense Security Cooperation Agency Policy Memorandum 11-32. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.29.1. Category Definition. Family Members (dependents) residing with a non-SOFA member who is in the United States or overseas participating in an IMS program (part of the Security Assistance Training Program).

2.29.2. Billing information is contained in the sponsor's ITO. If the ITO states payment is to be made under the IMS case, then send the bill to the military department sponsoring the individual. For the Air Force, this is SA DAO DE, San Antonio/IG, 2021 1st Drive West, Randolph AFB, TX 78150-4301.

2.29.3. Under 10 U.S.C. § 1077b, the following types of care are not provided to family members: See paragraphs 2.26.3.1. – 2.26.3.3. See also paragraphs 2.27.6 – 2.27.8. for additional guidance.

Section 2F—Healthcare for Eligible Civilians and Special Categories of Beneficiaries and Their Family Members

2.30. Senior College or University ROTC Cadets; ROTC Membership Applicants; Uniformed Service Applicants; and Service Academy Applicants. Authority is 10 U.S.C. § 2103-2107, § 2109, § 2110; 5 U.S.C. § 8140, 37 U.S.C. § 101. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP. TRICARE coverage is not authorized for ROTC participants and/or ROTC participant applicants.

2.30.1. College year senior ROTC cadets are members of the Reserve Officer Training Corps (ROTC) of any branch of the Uniformed Services, or Applicants for Membership. Applicants for membership include students enrolled in a course that is part of ROTC instruction at an educational institution.

2.30.2. Cadets may be provided MTF medical care for any injury or illness incurred while traveling to and from, and participating in, any summer field training or other practical military training. Practical military training includes military drill instruction, ROTC organized physical fitness activities, and training designed to orient cadets to military equipment, missions, or installations. To determine if the training falls under the definition of practical military training, contact HQ AFROTC/DOTF at Maxwell AFB AL 36112-6106, DSN 493-4979.

2.30.3. Only emergency dental care is authorized. Cadets are provided MTF dental care for any injury or illness incurred while traveling to and from, and participating in, any summer field training or other practical military training. Practical military training includes military drill instruction, ROTC organized physical fitness activities, and training designed to orient cadets to military equipment, missions, or installations. To determine if the training falls under the definition of practical military training, contact HQ AFROTC/DOTF at Maxwell AFB AL 36112-6106, DSN 493-4979.

2.30.4. ROTC Pre-Commissioning, Uniformed Service, and Service Academy Applicant Examinations: (See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP). Generally, the DoD Medical Examination

Review Board (DoDMERB) provides rules for determining medical acceptability of applicants for appointment to a U.S. Military Service Academy, Uniformed Services University of Health Sciences, and the ROTC scholarship programs of the U.S. Armed Forces. However, not withstanding any other provision of the DoDMERB process, an Air Force MTF may provide limited examinations under the following circumstances:

2.30.4.1. If a ROTC cadet's college, university, or institution does not have the ability to perform a physical exam, the cadet may be provided an examination(s) at an MTF, including admission if required to satisfy clinical diagnostic requirements. Uniformed Service or Service Academy applicants may receive initial service eligibility examination(s) at an MTF. For remedial ROTC commissioning, Uniformed Service, or Service Academy entrance examinations that require additional diagnostic care beyond an MTF's capabilities, refer the cadet or applicant to the closest MTF (with the required capabilities) for required medical testing.

2.30.5. If a cadet is admitted, contact HQ AFROTC/DOTF at Maxwell AFB, AL 36112-6106, DSN 493-6958.

2.30.6. Cadets who are admitted for any reason must meet a board of medical officers for final disposition. The board is composed of Medical Corps officers familiar with the individual's case. The board should consider the individual's diagnosis, required care, etc., and other factors as directed by HQ AFROTC. Cadets are not entitled to service disability processing under AFI 36-3212, Physical Evaluation for Retention, Retirement and Separation, 2 Feb 2006, but the results of the medical board may be provided to the cadet so a claim can be filed with the Department of Labor, Federal Employees Compensation Act (FECA), or the Veterans Affairs, as appropriate. Provide a copy of the board results to HQ AFROTC; they will provide final disposition instructions for the patient.

2.30.6.1. Board proceedings must indicate the diagnosis, patient's line of duty status, physical condition upon discharge, a statement that further hospitalization is or is not required, and a concise medical history. If the individual requires additional treatment beyond the hospitalization, the reason and probable duration of the treatment must be included.

2.30.6.2. Two copies of the proceedings are prepared and attached to a completed SF 88, Report of Medical Examination, which indicates the date of discharge. Send the report to HQ AFROTC/DO for Air Force cadets. For Army Cadets, send the report to Headquarters US Army ROTC, Cadet Command, ATTN: ATCC-PC, Fort Monroe VA 23651-5237, DSN 680-4534. For Navy Cadets send the report to Commander, Naval Medical Command, Department of the Navy, Washington DC 20372-5120.

2.30.7. Under the Federal Employees Compensation Act (FECA), cadets may choose their source of care if they meet FECA reimbursement criteria. For example, the criteria include a provision that the injury or illness be incurred in the line of duty, and the training period meets certain criteria of the law. Cadets cannot be forced to remain in an Air Force MTF if the cadet or legal guardian chooses another source of care. In cases where the cadet or guardian chooses a non-DoD source of care, the cadet or guardian should sign:

2.30.7.1. An "against medical advice" or AMA discharge letter if a serious medical condition exists and the cadet is, in fact, leaving AMA.

2.30.7.2. A letter explaining the Air Force (DoD) is not responsible for any financial obligation incurred as a result of the choice. If a cadet chooses to obtain care at a non-DoD site, contact HQ AFROTC/DOT, DSN 493-6958, and AFMSA/SG3SA, 1500 Wilson Blvd, Suite 120, Arlington VA 22209 via e-mail; **AFMSAHealth.workflow@pentagon.af.mil.**

2.30.8. Cadets requiring additional follow-up medical care after hospitalization and/or after completing summer training, military exercise training, practical military training, etc., are authorized DoD MTF care only. Geographic isolation should not necessarily excuse any ROTC cadet or membership applicant from traveling to a DoD MTF to receive follow-up care.

2.30.9. The Department of Labor (DOL), Workers' Compensation Fund, reimburses DoD for medical expenses at the Inter-Agency Rate (IAR) and/or Inter-Agency Outpatient Rate (IAOPR) for individuals who incur an injury or illness traveling to or from, and participating in, practical military training, summer training sessions, practice cruises, flight training, or on a flight.

2.30.9.1. A member of the Reserve Officers' Training Corps is entitled to receive disability benefits through the Dept of Labor when the individual suffers an injury in the line of duty during the period of the member's attendance at training. Expenses incurred by a military department in providing hospitalization, medical and surgical care, necessary transportation incident to that hospitalization or medical and surgical care are also reimbursed by the Secretary of Labor from the Employees' Compensation Fund. "However, reimbursement may not be made for hospitalization or medical or surgical care provided an individual by a military department in a facility of a military department." (5 U.S.C. § 8140(f)).

2.30.10. All civilian medical care claims for ROTC cadets, regarding "In-Line-of Duty" injuries or illnesses, must be submitted or filed with Department of Labor, Office of Workers' Compensation Program (OWCP) IAW provisions mandated in Public Law 103-3, Section 8140 of the Federal Employees' Compensation Act 5 U.S.C. § 8140. Refer ROTC claims to the US Department of Labor (OWCP), 800 North Carolina Street, NW, Room 800, Washington DC 200211 or visit the Department of Labor Internet website at **http://www.dol.gov/dol/compliance/comp-feca.htm** for more information.

2.31. Members of Uniformed Services Auxiliaries (Official Government Business). Authority is 5 U.S.C. § 8103, 42 U.S.C. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.31.1. Category Definition. Members of the Civil Air Patrol (USAF Auxiliary) either senior members or cadets, age 18 or older, incurring an injury or illness while on official government business for which a specific Air Force mission number is assigned. Mission numbers can be verified by contacting HQ CAP-USAF/DO, Maxwell AFB AL 36112-5000.

2.31.2. Adult members of the USCG Auxiliary incurring an injury or illness while performing official duty for the US Government.

2.31.3. Individuals under this paragraph are covered by Federal Employees Compensation Act (FECA), Office of Workers' Compensation Programs (OWCP).

2.31.4. Inpatient care is normally provided only until the individual can be transferred to a civilian medical facility.

2.31.5. Dental care is authorized only as an adjunct to medical care.

2.32. Members of Uniformed Services Auxiliaries (Official Organizational Business). Authority is 10 U.S.C. § 9441. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.32.1. Category Definition. Individuals from the following organizations participating in an official function on a military installation:

2.32.1.1. Senior (adult) and cadet members of the Civil Air Patrol (USAF Auxiliary) with military travel authorization or military support authorization signed by an Air Force liaison official who is assigned to CAP. CAP members attending other CAP functions on base which are not covered by these authorizations are provided care under Paragraph 2.35.

2.32.1.1.1. Adult members of the Coast Guard Auxiliary.

2.32.1.1.2. Adult leaders and cadets of the Naval Sea Cadet (US Navy).

2.32.1.1.3. Adult leaders and cadets in the Young Marines (US Marine Corps).

2.32.2. Outpatient care for minor illness or injury such as the common cold, flu, cuts, abrasions, etc., that inhibit the individual's ability to perform duties, may be provided.

2.32.3. Inpatient care is provided until the individual is stabilized and can be moved to a civilian medical facility.

2.33. Federal Civilian Employees. Authority is 5 U.S.C. § 7901, § 8101 and § 8103; 29 U.S.C. § 668; 24 U.S.C. § 34 and § 35; DoDD 1404.10, DoD Civilian Expeditionary Workforce, January 23, 2009; DoDI 1400.32, DoD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures, April 24, 1995. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.33.1. Category Definition. US citizens or individuals who normally live in the United States and are hired (excluding contract employees) directly or indirectly to work for the DoD, paid from appropriated or non-appropriated funds, including Army & Air Force Exchange Service (AAFES) employees, under permanent or temporary appointment. This also includes certain seamen and air reserve technicians while performing duties as civil servants.

2.33.2. Workers' Compensation Eligibility for Medical Services or Supplies. Under the FECA Law, 5 U.S.C. Sub Section 8101, the United States shall furnish to an employee with a federal job-related illness or injury the services, appliances, and supplies prescribed or recommended by a qualified physician, to cure, give relief, reduce the disability, or aid in lessening the amount of the monthly compensation. Said services, appliances, and/or supplies may be furnished by military MTFs, VA, or, U.S. Public Health facilities. However, this instruction does not guarantee that the required service(s) or supplies will be available at any one particular military MTF, VA, or, U.S. Public Health facility. When the local MTF has the capacity to provide this care and supplies, the employee must choose to either seek care through the MTF or the civilian sector. Once the worker has chosen a care provider, he

or she must stay with that provider in order to ensure coverage by OWCP until he or she either obtains permission to change from the District OWCP office or is referred by the designated provider to a new provider. The employee may obtain guidance from Civilian Personnel Services on how to apply for coverage through the appropriate compensation system. A Compensation Act, form CA-16, Authorization for Examination C/S and/or Treatment, authorizes an injured employee to obtain examination and/or treatment for up to 60 days. The Office of Workers' Compensation Program defines an "injury" as a medical condition that evolves over a period of time less than a complete work shift (an "illness" is defined as a medical condition evolving over more than a single work shift). The CA-16 is used to authorize payment for medical care of injuries only and cannot be used for illnesses. The form is necessary for MTF care and prior to referring the patient outside of the MTF for a consult or special study. If the patient is referred out to a specialist for assumption of control of the case, the worker's supervisor completes the CA-16 to authorize payment to the specialist (again, only for the first 60 days following injury). The form is prepared by the individual's supervisor and must be presented prior to treatment outside the MTF unless it is a medical emergency. In an emergency, the supervisor prepares the form within 48 hours after treatment is rendered. If a CA-16 is created, a copy is filed in the individual's AF medical record. The MTF Patient Administration function does not provide advice to employees or supervisors regarding form completion.

2.33.2.1. Direct MTF medical care for job related injuries or illnesses requires: a) Presentation of a completed CA-16. A separate CA-16 is not required for each episode of follow-up care if a CA-16 was provided on the initial visit. If follow-up care is required beyond 60 days of the initial issuance of the CA-16, the supervisor contacts the DOL for authorization to issue another CA-16; b) the care being provided is for the same illness or injury as on the initial visit; and c) the MTF has the capability to provide the care.

2.33.2.2. Associated costs for supplies and services listed above should be addressed by Resource Management.

2.33.3. Aeromedical evacuation is authorized IAW JTR Chapter 7, Part K, "Medical Tvl" , 1 March 12. OCONUS Aeromedical evacuation patients who have been validated by their respective Patient Movement Requirements Center (PMRC) as not requiring direct patient care in flight may travel as "medical passengers" and as such will not be charged the ambulatory reimbursement rate for Aeromedical evacuation services (as identified in the Office of the Secretary of Defense (Comptroller) DoD Reimbursable Rates, Tab I).

2.33.4. Individuals will have a DD Form 1173, Uniformed Services Identification and Privilege Card (Accountable) or appropriate TDY orders overseas.

2.33.5. Wage Marine personnel and Civil Service Mariners are billed directly to the USPHS at the interagency rate by the MTF. Do not collect subsistence for inpatient care from the individual. Forward a SF 1080 along with the DD 7/7A to: US Public Health Service (USPHS) Division of Commissioned Personnel, Medical Affairs Branch, Room 4C-06, 5600 Fishers Lane, Rockville MD 20857.

2.33.6. Conditional Employment/Annual Occupational Exam Requirements. According to 5 CFR, Part 339.301, Authority to Require an Examination, an agency may require an individual to meet the physical or medical requirements of his or her position (fitness for duty) when the individual has applied for or occupies a position for which specific medical

standards or physical requirements exist, or where federal employees are subject to an established medical evaluation program that requires the employee to report for a medical examination whenever there is a direct question about the employee's continued capacity. When requested in writing from Civilian Personnel Services (CPS), the MTF provides occupational exams through the Occupational Medicine Services Clinic (if present), Flight Medicine Clinic or if neither of the other two clinics exists on the base or limited resources require its participation, Family Medicine Clinic.

2.33.6.1. The Office of Personnel Management (OPM) provides medical standards for many federal civilian jobs. It authorizes agencies (e.g., the Air Force) to develop their own standards as well. It is the responsibility of the worker's supervisor to accurately identify functional requirements and environmental factors for a job. IAW 5 CFR 339, the Air Force must not charge workers for occupational examinations required by the Air Force.

2.33.6.2. When the local MTF does not have the capability to provide an employer (AF) required medical examination (or a portion of the exam) that the AF is responsible for providing free of charge to the employee, the AF may arrange to have the examination (lab tests, etc.) completed in the civilian sector (non-DoD) healthcare community after receiving authorization from the employee's unit commander.

2.33.6.2.1. The employee's unit commander must also authorize payment for the examination. Payment is made from the same appropriation that funds the employee's salary. The Defense Health Program (DHP) appropriation may not be used for the examinations, unless the employee's salary is DHP-funded (e.g., an MTF employee).

2.33.6.2.2. The Installation Occupational and Environmental Medicine Consultant (IOEMC) will provide clinical oversight of referrals/consults to ensure they are appropriate and justified.

2.33.6.2.3. The MTF provider's support staff notifies the MTF Resource Management Office (RMO) that a private sector exam is needed for a civil service employee (the clinic must include the estimated cost of the exam/test).

2.33.6.2.4. The RMO will send a Request for Commander's Authorization of Payment for Civilian Medical Exam packet to the employee's Unit Commander. The packet contains two attachments: (1) Commander's Authorization of Payment for Civilian Medical Exam, and (2) Instructions for the Unit Resource Advisor.

2.33.6.2.5. Commander's Authorization of Payment for Civilian Medical Exam: This letter serves as the MTF's authorization to process the employee's referral. It also expresses the Commander's acknowledgement that his/her unit funds will be used for payment of the exam.

2.33.6.2.6. Instructions to Unit Resource Advisor: This information sheet explains to the employee's Unit Resource Advisor the steps he/she must take in order for payment to be made to the civilian healthcare provider. Payment will not be made until exam results are received by the MTF.

2.33.6.2.7. Once the RMO receives the Commander's Authorization of Payment for a Civilian Medical Exam from the employee's unit, a copy is provided to the MTF clinic. The clinic will then schedule the employee's exam.

2.33.6.2.8. The MTF clinic that schedules the employee's exam must emphasize to the civilian sector provider's office that results of the exam and the associated invoice for full and final payment must be sent to the MTF's Referral Management Center (RMC). **Note:** Be sure to provide the address, FAX, point of contact information. This is required in order to avert HIPAA and PHI violations as well as to ensure the provider receives payment.

2.33.6.2.9. The RMC will (1) Forward the exam results to the MTF provider that requested the exam, and (2) Forward the invoice for the exam to RMO.

2.33.6.2.10. The RMO will: (1) Verify that the invoice contains "Full" or "Final" payment on the invoice. If the invoice does not state that it is for full/final payment, then RMO must contact the civilian provider's billing office in order to receive a revised bill; (2) Process payment according to the option indicated by the employee's unit commander on the bottom of the Commander's Authorization of Payment for Civilian Medical Exam, and per the Instructions to the Unit Resource Advisor. **Note:** RMO will not proceed with payment until exam results are received by the MTF.

2.33.7. State Department employees who must be aeromedically evacuated to CONUS are reported to the nearest Department of State principal or administrative officer who authorizes the move.

2.33.8. Except as noted in above paragraph regarding State Department employees, federal civilian employees of the US Government who are covered under the State Department's medical program do not have any special entitlement based on their enrollment in that program. The State Department's medical program is in effect an insurance program like Blue Cross and Blue Shield. As a result, healthcare may be billed to this program if the individual wishes. If the claim is denied, the individual pays for his or her care. Agencies involved in this program are:

2.33.8.1. ACTION/Peace Corps staff.

2.33.8.2. Department of State: Agency for International Development, US Arms Control and Disarmament Agency, US Information Agency.

2.33.8.3. Department of Agriculture; Agricultural Research Service, Animal/Plant Health Inspection, Foreign Agriculture Service, OICD, SCS.

2.33.8.4. Department of Commerce: Export Development, Foreign Commercial Service.

2.33.8.5. Environmental Protection Agency.

2.33.8.6. Department of Health and Human Services: Centers for Disease Control.

2.33.8.7. Inter-American Foundation.

2.33.8.8. Department of Interior: Bureau of Reclamation, Office of the Inspector General, US Geological Survey.

2.33.8.9. Department of Justice: Drug Enforcement Agency, Immigration and Naturalization Service, US Marshall's Service.

2.33.8.10. Library of Congress.

2.33.8.11. National Aeronautics and Space Administration.

2.33.8.12. Office of the US Trade Representative (Executive Office of the President).

2.33.8.13. Department of Transportation: Federal Aviation Administration, Federal Highway Administration, US Maritime Commission.

2.33.8.14. Department of Treasury: Internal Revenue Service, Office of International Affairs, US Customs, US Secret Service, US Saudi-Arabian Joint Commission for Economic Cooperation.

2.33.8.15. United States Postal Service.

2.33.9. Participants in the State Department Medical Program are only authorized reimbursement for emergency dental care. This is not a limitation on the entitlement, but on the coverage. Those covered under the State Department Medical Program must pay the dental rate.

2.33.10. Immunizations may be provided at no cost to civilian federal employees living in the CONUS who are preparing for a overseas assignment transfer, TDY or PCS, or who are CONUS-based and immunizations are required by the destination country or government component to meet occupational health requirements. For individuals participating in the State Department Medical Program, a request for immunizations will be provided on a DSL-820 in two copies. This request will state the type of inoculation or vaccination needed and that it is at the expense of the State Department Medical Program. Report the results of the immunization as requested on the DSL-820. This form may be obtained from Department of State, 2401 E St, NW, Room 209, Washington, DC 20552. Hepatitis B vaccine is provided upon request to DoD civilian emergency medical technicians, paramedics, and rescue personnel. Hepatitis B immune globulin may also be provided in cases of exposure. There is no charge for Hepatitis vaccinations.

2.33.10.1. Chemoprophylaxis (e.g., anti-malarial medication) is provided to a Civilian Federal Employee free of charge when the assessing healthcare provider determines this is needed to protect the employee from health hazards during an official deployment or TDY.

2.33.11. Deployed DoD Employees. DoD Civil Service employees designated as emergency essential in response to a national crisis or emergency as described by the National Command Authority, and who participate in direct support to combat operations, participate in support of humanitarian missions, disaster relief, restoring order in civilian disorders, drug interdiction, operations, contingencies, and/or emergencies, shall receive the following healthcare services (excludes DoD contractor employees):

2.33.11.1. Required pre-deployment immunizations shall be provided to deploying DoD federal employees in the same manner as provided to and for military personnel prior to deployment departure and while assigned to the contingency location or combat theater of operations.

2.33.11.2. Health professional analysis of completed pre-deployment and post-deployment healthcare assessment questionnaire(s).

2.33.11.3. Forward deployed federal civilian employees will be provided the same type and level of healthcare in the deployed theater of operations as any Active Duty Service Member would receive. If required, federal civilian employees shall be HIV-tested before deployment. All DoD-sponsored, non-military personnel who are assigned (PCS), deploy, or leave TDY outside the U.S. or assigned to any U.S. territory shall have orthopantograms (also known as dental panoramic radiographs) taken of their teeth and jaw, or Deoxyribonucleic Acid (DNA) samples taken for identification purposes. Dental panoramic radiographs may be substituted when the ability to obtain DNA samples is not available. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.33.11.3.1. Medical and dental examinations and, if warranted, psychological evaluations to ensure fitness for duty (applicable to the duty at the deployed location) or to support mission requirements.

2.33.11.4. Post Deployment MTF Medical Care: Upon returning from a deployment in support of contingency operations, federal civilian employees should report to the MTF Force Health Management (FHM) or Public Health Office (PHO) for PDHA/PDHRA review. After clinical review by the Installation Occupational and Environmental Medicine Consultant (IOEMC) or his or her alternate, if the employee's injury(s) or illness(s) is determined to be deployment connected or related, the FHM or PHO will refer the employee to the MTF TOPA function. The TOPA function verifies healthcare eligibility based on the IOEMC's recommendation and facilitates appointments for eligible employees. Eligible civilian employees will receive medical care at the same level and scope as that provided to active duty military service members.

2.33.11.4.1. The worker is referred to CPS for guidance on completing an application for a compensation claim. The worker is asked to declare in writing his or her choice to receive medical care either within the MTF or from a civilian source. The MTF works with CPS to facilitate release of all relevant medical information to the Installation Compensation Program Administrator once the employee has completed an application for workers' compensation (which authorizes that release of relevant medical records). Employees with acute medical needs may require immediate care within the MTF prior to applying for and obtaining compensation program coverage. Care must be taken to avoid a gap in coverage between care provided by the MTF and the determination of work "relatedness" by OWCP (or the applicable insuring agency). If OWCP determines a case is not work related, the Installation Occupational and Environmental Medical Consultant or his or her appointee/alternate reviews the case to see if an appeal should be written to the District OWCP (for appropriated employees). If an appeal is appropriate, the reviewing provider writes it and coordinates with the ICPA to send it to the district OWCP office. If no appeal is indicated or after an appeal, the decision of the OWCP district office is final. If the final OWCP determination is that the case is not work related, the employee is responsible for paying for his or her medical care and the MTF will cease to provide care. The MTF then assists the employee in transferring all relevant medical information to his or her private healthcare provider (once the employee has signed

an appropriate release). When the healthcare needs of an employee's deployment related injury or illness exceed the capabilities of the local MTF and the case is accepted by OWCP (or the appropriate insurer) the employee should be assisted in choosing and transferring to appropriate care that will accept compensation coverage.

2.33.12. Non-Deployment, non-work related illness/injury MTF Healthcare: Civil Service or federal civilian employees may be provided limited MTF medical treatment of non-work related conditions on an outpatient basis at no charge to prevent excessive loss of time from duty, or when immediate occupational requirements dictate. These cases should only be seen at the request of the employee's supervisor or work leader. A physician must validate the need for care and must limit treatment to what is needed to complete the work shift. Surgical procedures, intravenous fluids and prolonged course of care should not be provided. Controlled substances must not be administered. Outpatient MTF medical care provided to Civil Service employees for the urgent relief of minor illnesses (e.g., sunburn, insect bite/stings, etc.) during the duty period, must be approved by the MTF Commander. If the MTF Commander authorizes treatment, the MTF outpatient care may only be administered to alleviate pain or when minor urgent treatment, during the duty period, from a private medical provider, would require a disproportionate amount of time lost from the job. If simple outpatient medical care is approved by the MTF Commander and care is provided, the MTF and/or the Government are not obligated and do not assume responsibility for continued treatment for any condition that could not be reasonably resolved during the initial episode of treatment. The MTF Commander has authority to approve/authorize care when medically necessary, when said care is in the best interest of the government, and only if MTF capabilities exist. The Supplemental Care program may not be used to pay for referred civilian medical care and is not authorized under the provisions of this paragraph.

2.33.12.1. Federal Civil Service employees employed outside the United States who require treatment for conditions not covered by the OWCP who are not beneficiaries of any other federal agency listed in this chapter and dependents of such employees may receive space available care in Air Force MTFs outside the United States. Charges will be collected locally IAW DoD 6010.15-M, Military Treatment Facility Uniformed Business Office (UBO) Manual, from the individual at the interagency rate except that no charge will be made for immunizations authorized by AR 40-562/AFJI 48-110/BUMEDINST 6230.15A/CG COMDTINST M6230.4F, Immunizations and Chemoprophylaxis, or for occupational health services as authorized elsewhere in this chapter.

2.33.13. Non-Appropriated Fund (NAF) employees, while generally not considered to be US Government employees for most benefits, are entitled to treatment as described below.

2.33.14. Non-Appropriated Fund (NAF) employees' medical expenses are covered under a NAF self-insurance program. This program covers NAF employees with on-the-job injuries and illnesses. A Form LS-1, Request for Examination and/or CS Treatment, or a Form LS-204, Attending Physician's Supplementary Report (Longshore and Harbor Workers' Compensation Act, as extended), is required before treating the patient in the same manner as a CA-16, Authorization for Examination CS and/or Treatment, is required for appropriated fund employees. Employees of the Army and Air Force Exchange Service use an LA-202, Employer's First Report of Injury or Occupational Illness.

2.33.15. Non-Appropriated Fund (NAF) employees may be given pre-employment and periodic physicals at no charge to the individual when requested in writing from CPS or deemed necessary for medical surveillance by the Occupational Environmental Health Working Group. The MTF must also have the capability as determined by the MTF Commander.

2.33.16. According to 5 US Code, section 7901, health promotion programs may be provided at no charge to civilian employees when space is available in the program. Space availability is determined by the MTF Commander using guidance in Section 2G. Medicine required for participation (e.g., nicotine patches) is furnished by the employee.

2.33.17. Hearing aids are authorized for civilians stationed overseas on a reimbursable basis at US government cost when the hearing loss is not job related.

2.34. Family Members (Dependents) of Civil Service Personnel. Authority is 24 U.S.C. § 34. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.34.1. Family members (dependents) who reside overseas and where their civil service sponsor is stationed overseas are entitled to routine healthcare benefits at the Inter-Agency Outpatient Rate (IAOPR) or Interagency Rate (IAR). Family members of civilians stationed in the United States are not entitled to any routine healthcare benefits. For the purposes of this paragraph, civilian personnel are defined as US Government employees, paid from appropriated or non-appropriated funds, and who are US citizens.

2.34.2. Family member (dependents) who reside overseas and where their civil service sponsor is stationed overseas may be provided routine dental care on a space-available basis at the installation DTF and only if the DTF possesses the required capability to address the family member's requested dental needs. The DTF commander determines whether or not adequate capabilities exist. When capabilities do not exist, care is limited to that required to relieve pain or undue suffering.

2.34.3. Aeromedical evacuation is authorized overseas (intra-theater/region) and from overseas MTF locations to CONUS MTF destinations and back again to originating overseas location. Other moves within CONUS for civilian family members are not authorized under this instruction. See AFI 41-301, Worldwide Aeromedical Evacuation System and DoDI 6000.11, Patient Movement for instruction on AE operations.

2.34.4. Under 10 U.S.C. § 1077, the following types of care are not provided, or provided with exceptions, to family members of Civil Service Personnel:

2.34.4.1. Domiciliary or custodial care is not authorized.

2.34.4.2. Generally, prosthetic devices, hearing aids, orthopedic footwear, and spectacles are not authorized. However, prosthetic devices, hearing aids, orthopedic footwear, and spectacles for dependents of US Government employees located outside of the United States and at stations inside the United States where adequate civilian facilities are unavailable, may be sold to family members at cost from the United States.

2.34.4.3. The elective correction of minor dermatological blemishes and marks or minor anatomical anomalies are not authorized.

2.34.5. Individuals may be provided immunizations at no cost in CONUS when preparing for a transfer overseas either PCS or TDY.

2.34.6. Reimbursement is required for aeromedical evacuation unless exempted under an international military reciprocal healthcare agreement. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.35. Civilian Emergencies. (Reference: Title 42 U.S.C. 1395dd., Examination and Treatment for Emergency Medical Conditions and Women in Labor (EMTALA), 1985.)

2.35.1. Category Definition. Individuals who are not authorized care under any other provision of this instruction and require emergency medical or dental care.

2.35.2. Medical and dental care is authorized to the extent necessary to save life or limb and prevent undue suffering. Patients are transferred to a civilian medical facility as soon as they are stabilized. Collect the full-reimbursement rate from the individual or the individual's insurance company.

2.35.3. Civilians treated in a natural disaster are not charged individually for outpatient care and charged only subsistence if they are provided inpatient care.

2.35.4. Aeromedical evacuation of US citizens overseas is requested through the Department of State. The United States embassy in the foreign country requests this assistance direct to the Department of State who in turn notifies the Patient Airlift Center. Charges apply and the patient is responsible for payment. When charges apply, the MTF reporting the patient for movement obtains a fund cite and billing address from the patient's sponsoring agency and provides that information when reporting the patient for movement. If there is no sponsoring agency, provide a billing address for the patient. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC). The Patient Airlift Center can approximate these charges when requested by the Department of State.

2.36. Contractors. (Authority is DoDI 3020.41, Operational Contract Support, 20 Dec 2011). See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP. Because these are general rules, always check the contract terms and governing directives and consult the contracting officer first as there are many variations in care provided to contractors, depending on the contractors' support role.

2.36.1. Category Definition. Defense contractors and employees of defense contractors and associated subcontractors, including U.S. citizens, U.S. legal aliens, Third Country Nationals (TCNs), and citizens of Host Nations (HNs) who are authorized to accompany U.S. military forces in contingency operations or other military operations, or exercises designated by the geographic Combatant Commander. This includes employees of external support, systems

support, and theater support contractors. Such personnel are provided with an appropriate identification card under the Geneva Conventions.

2.36.2. Authorized Care. Contractors employed in CONUS are authorized MTF emergency care associated with employment related accidents, or injuries. Additionally, exams and evaluations to determine fitness for employment or compliance with occupational requirements are authorized at an MTF, unless exam(s) are already authorized under an agreement between the employee and contractor/employer as a medical requirement and/or stipulation of pre-employment or other employer-employee provisions not related to the MHS.

2.36.2.1. Deploying contractors shall receive a human immunodeficiency virus (HIV) test before deployment if the country of deployment requires it. Additionally, all DoD-sponsored non-military personnel assigned (PCS) or deployed in a TDY status outside the United States of America or its Territories shall have orthopantograms, also known as dental panoramic radiographs, taken of their teeth and jaw, or Deoxyribonucleic acid (DNA) samples taken for identification purposes. Dental panoramic radiographs may be substituted when the ability to obtain DNA samples is not available. Contractors may also be issued "dog tags" for identification purposes. Components shall establish procedures to store and access such identification data that are the same as or parallel to those for the military.

2.36.2.2. Deploying contractors shall also receive all appropriate immunizations, the same as active duty military, in compliance with the destination country's requirement and/or military public health policy.

2.36.2.3. Deploying contractors shall receive medical and dental examinations and, if warranted, psychological evaluations, to ensure fitness for duty in the theater of operations to support the military mission. During a contingency or emergency crisis, IAW DoDI 3020.41, Enclosure 3, civilian contractors returning to the United States, from a theater of operations, may receive cost-free post-deployment physical examinations and screening at an MTF.

2.36.3. Contractor personnel shall deploy with a minimum 180 day supply of any required medication, obtained at their own expense.

2.36.4. Elective care is not authorized, and in many instances, routine care is not authorized. Always check the contract for specific terms.

2.36.5. Contractors not in a contingency or emergency situation may request approval from the local overseas MTF Commander for medical care beyond emergency treatment. Agreements reached under this paragraph are reported as a special narrative section in the annual report outlined in Attachment 6.

2.36.6. A patient whose disability prevents his or her return to work or who needs a long-term treatment for a chronic medical condition(s) is reported to the contractor for disposition. The patient may be returned to CONUS as soon as his/her condition permits via aeromedical evacuation at cost to the contractor. If care in CONUS is required, the patient or contractor arranges for the care prior to transfer. Care in CONUS MTFs is not authorized except while in transient status in the aeromedical evacuation system.

2.36.6.1. No charge for transportation if the sponsor is a DoD employee stationed overseas; reimbursement is required for in-flight medical care.

2.37. Family Members (Dependents) of Contractors. Authority DoDI 1000.13. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.37.1. Category Definition. Overseas, a family member (dependent) of an individual who normally lives in the United States, under contract to the US Government, and whose sponsor is traveling on orders while accompanying a uniformed service in the field. This includes US citizen scientific consultants, US citizen technical representatives, and contract technicians.

2.37.2. Individuals are provided routine care when the overseas MAJCOM Command Surgeon determines that local civilian facilities are not available or adequate and the individual has been granted Secretarial Designee status.

2.37.3. Elective care is not authorized.

2.37.4. Contractors may request approval from the overseas MAJCOM Commander for medical care for their family members beyond emergency care. Agreements reached under this paragraph are reported as a special narrative section in the annual report outlined in Attachment 6, for Secretarial Designees.

2.37.5. Patients with medical conditions that require long periods of care or extensive treatment, as determined by the MTF leadership, will be transitioned to civilian care when possible. A patient, for which a long-term period of care or which extensive treatment is expected, as determined by MTF leadership, may be transferred (via aeromedical evacuation) to CONUS as soon as his/her condition permits. If healthcare in CONUS is required, the patient or contractor arranges for the care prior to transfer. Healthcare at CONUS MTFs is not authorized except while the patient is in transient status in the aeromedical evacuation system.

2.37.6. Aeromedical evacuation costs may be charged to the patient instead of the contractor depending on contract language, healthcare related exceptions, and/or limitations (including aeromedical evacuation). Military aeromedical evacuation should not be utilized if adequate commercial aircraft options are available. Specific contract provisions may take precedence over this paragraph.

2.37.7. The FRR is required for aeromedical evacuation. Prior to travel, enter patient/traveler pertinent information into TRAC2ES. After travel is complete, obtain information necessary to support the billing process from TRAC2ES or contact GPMRC, HQ TRANSCOM, 505 D Street, Room 100, Scott AFB, IL 62225-5049, Commercial (618) 229-4200, DSN 779-4200, or (800) 303-9301, FAX DSN 779-4786 or the appropriate Patient Movement Requirements Center (PMRC).

2.38. Additional Beneficiary Categories.

2.38.1. Department of Veterans Affairs (DVA) and Other Government Agencies. Except for Secretarial Designees covered in Chapter 4, Section 4F outlines descriptions of beneficiaries, their eligibility for services, and special considerations in providing their care. Treat all persons requiring emergency medical care, that are not otherwise authorized or eligible for DoD healthcare according to any of the provisions listed in this instruction, as civilian

emergency patients. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.38.1.1. The DVA provides care for active duty and other DoD beneficiaries on a space-available basis, in accordance with Title 38 United States Code, Section 8111, Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act, via resource sharing agreements.

2.38.1.2. Title 31 United States Code, Section 1535, The Economy Act, provides authority for federal agencies to order goods and services from other federal agencies (including other Military Departments and Defense Agencies) and to pay the actual costs of those goods and services. In accordance with the provisions of DoD Financial Management Regulation Volume 11A Chapter 3, the MTF Commander may provide such services under the limitations of this paragraph. Unless this instruction specifies otherwise, this paragraph applies when non-DoD Federal agencies request healthcare for their beneficiaries in an Air Force MTF. The appropriate agency official must request MTF services in writing. This authority also applies to occupational health services. The MTF shall provide a copy of occupational health exams results and other medical services when requested upon receipt of patient authorization.

2.38.2. Dependent Parents and Parents-In-Law. When MTF direct care eligibility is approved by the Defense Finance and Accounting Service (DFAS), authorized dependent parents and parents-in-law may be treated in an MTF on a space available basis. Family members in this category are not eligible for TRICARE and cannot be referred for civilian care at Government expense. Prior to providing space-available treatment, ensure the sponsor and patient understand that when MTF personnel cannot provide the necessary care, on a space-available basis, or if the required healthcare can no longer be provided due to limited MTF capacity or capability, the parent(s) or parent-in-law(s) will likely be discharged to a civilian medical facility. Continued healthcare costs at civilian medical facilities are paid by the parent(s) or parent(s)-in-law. MTF personnel may authorize supplemental care funds for diagnostic tests and ancillary services for parents and parents-in-law, only when the patient remains in an inpatient status. Both the patient and sponsor will be informed of their financial responsibility when discharged/transferred to civilian care.

2.38.3. Expanded Medical Care for Caregivers of Members of the Armed Forces Recovering from Serious Injuries or Illnesses. This paragraph includes Identification, Tracking, and Reporting Requirements.

2.38.3.1. In appreciation of the selfless service that caregivers provide to seriously injured or ill Service Members, the National Defense Authorization Act for FY 2008, Section 1672 and authority contained in Title 10, United States Code, Section 1074, authorizes individuals designated as caregivers by Service Members, to receive space available inpatient and outpatient medical care at any MTF. To qualify, seriously ill/very seriously ill caregivers must meet the specific requirements. MTF Commanders must ensure their providers and medical support personnel are aware of the requirements of this expanded benefit.

2.38.3.2. MTFs are required to inform all Service Members who are identified as seriously injured or seriously ill of this benefit. This also includes Service Members at local civilian or Veterans Affairs (VA) medical institutions.

2.38.3.3. For the designated caregiver to qualify, the Service Member's injury or illness must be incurred In the Line of Duty while on Active Duty in the Armed Forces and be of such severity that the Service Member may be rendered medically unfit to perform the duties of his or her office, grade, rank, rating as contained in the National Defense Act for Fiscal year 2008, section 1602.

2.38.3.4. The designated caregiver must be:

2.38.3.4.1. On invitational travel orders while caring for the Service Member.

2.38.3.4.2. A non-medical attendant caring for the Service Member.

2.38.3.4.3. Receiving per diem payments from DoD while caring for the Service Member.

2.38.3.5. When the qualifications above are fulfilled, space-available inpatient/outpatient medical care is authorized for the qualified caregiver at any MTF. Title 10, United States Code, Section 1076 specifies that the commanding officer or the officer-in-charge at the designated MTF will determine what care is available based on space, facilities, and capabilities. Care authorized by this instruction may not be permitted to interfere with the primary mission of the MTF. Authorization for care terminates for the caregiver when the qualifications specified above cease to be met.

2.38.3.6. Each MTF Resource Management Office will seek reimbursement for MTF healthcare provided to caregivers who possess third-party payer insurance in the same manner as costs are collected for the provision of care for trauma care and other medical care provided to civilians. The MTF TRICARE Operations and Patient Administration function will serve as the central data collection, tracking, and reporting office. All Air Force MTFs are responsible for identifying, tracking and reporting each of their seriously injured or ill Service Members, their caregivers, and associated caregiver healthcare costs according to the instructions identified below.

2.38.3.7. Current Limiting Factors. CHCS provides basic SI/VSI identification capabilities. This function is generally only activated in conjunction with an inpatient admission. When tracking SI/VSI Service Members admitted to civilian or VA medical facilities, non-bedded MTFs, who do not employ qualified inpatient coding or supplemental inpatient coding compliance software, may experience un-intended automated inpatient records management, coding, and SIDR errors if this mechanism is activated.

2.38.3.8. Interim Solution (Overview). To offset this limited functionality and to streamline the data collection and analysis process, the TRICARE Operations and Patient Administration function has been identified as the central data collection, tracking, and reporting office to minimize confusion and focus overall program efforts; however their mission cannot be met without the support from several internal and external customers.

2.38.3.9. MTF Responsibilities (Identification, Tracking, and Information Management).

2.38.3.9.1. Each MTF TOPA function will establish rapport with multiple information offices/sources to collect this information. These potential sources include, but are not limited to:

2.38.3.9.1.1. Internal Customers/Sources: MTF providers, case managers, the

Resource Management Office, and the MTF Executive Committee.

2.38.3.9.1.2. External Customers/Sources: Civilian and VA medical facilities; installation Casualty Affairs, and Airman and Family Readiness Centers.

2.38.3.9.2. Each office within the MTF responsible for completing non-medical attendant orders, if not the TOPA function, shall provide TOPA with information to help identify each seriously injured or ill Service Member and their caregiver.

2.38.3.9.3. Collecting and Safeguarding PHI.

2.38.3.9.3.1. Collect the following information for each seriously injured or ill Service Member:

a. Full name and Social Security Number.

b. If not a patient at the MTF, identify and document the name of the civilian or VA medical facility where the seriously injured or ill Service Member is being treated.

c. Full name of patient's caregiver.

d. Inclusive dates of caregiver treatment.

e. ICD and/or CPT code(s) and applicable costs for each caregiver visit.

2.38.3.9.3.2. Ensure the Caregiver is entered into CHCS using PAT CAT K91-1 (Civilian Humanitarian). This is per TMA guidance as they work to identify a permanent caregiver specific patient category. Caregiver healthcare will be tracked in CHCS and other health insurance will be billed appropriately.

a. The TOPA function and/or the specific MTF patient care clinic or office, must ensure caregivers acknowledge both the Military Health System Notice of Privacy Practices, and the Privacy Act if a caregiver receives MTF direct care.

b. Caregivers are required to fill out a DD Form 2569, Third Party Collection Program - Other Health Insurance form upon first receiving care in the MTF.

2.38.3.9.3.3. The process of collecting and tracking seriously injured Service Members, their caregivers, and the associated caregiver healthcare costs have the potential to become problematic if not properly maintained.

2.38.3.9.3.4. If there is an established system of records where PHI information can be stored, MTFs are required to use those system(s).

2.38.3.9.3.5. Data must be properly safeguarded and accounted for at all times.

2.38.3.9.3.6. Limit access to authorized users via role-based access procedures.

2.38.3.9.3.7. PHI data shall not be stored on a desktop or laptop computer, or other portable media unless properly encrypted and inventoried.

2.38.3.9.3.8. If the data is stored on a facility-shared computer drive, the drive or data folder must be locked so unauthorized users are prevented from gaining access to the information.

2.38.3.9.3.9. The data collected should be regularly verified through a validation process to verify the status of the caregiver can be confirmed and is accurate.

2.38.3.9.3.10. Officials with the nearest Casualty Affairs office should be regularly included in this verification process.

2.38.3.10. MTF Case Reporting Instructions.

2.38.3.10.1. MTF TOPA officials will report the collected information to AFMOA/SGAT, Health Benefits Office semi-annually.

2.38.3.10.2. Data transfers may be completed via official e-mail message, using standardized Public Key Infrastructure (PKI) e-mail security message encryption and digital signature verification protocols.

2.38.4. Hospital Volunteers. Authority is 10 U.S.C. § 1588.

2.38.4.1. Category Definition. Volunteers working in an MTF who incur an injury or illness associated with their volunteer work. This includes students under affiliation agreements.

2.38.4.2. General Entitlements. If a hospital volunteer, regardless of volunteer organization affiliation, e.g., Red Cross, military retiree activities office, etc., is normally entitled to MTF Direct Care or TRICARE benefits, then provide the necessary healthcare coverage without delay. Otherwise, hospital or MTF volunteers may be authorized outpatient and inpatient direct MTF healthcare for volunteer-related injury or illness for stabilization. If extensive medical care appears to be required to treat a volunteer who has incurred an injury or illness related to their MTF volunteer duties, consider submitting a Secretarial Designee request according to the applicable Secretarial Designee Program section identified in this instruction.

2.38.5. Native American Indians and Alaska Natives. Authority: 31 U.S.C. § 1535; 42 U.S.C., Compact of Free Association Amendments Act of 2003, Public Law 108-188, December 17, 2003.

2.38.5.1. Category Definition. Individuals within this category are Native American Indian and Alaska Natives who are receiving care under the USPHS or Indian Health Service, Micronesian Citizens, and Citizens of Samoa.

2.38.5.2. Special Requirements.

2.38.5.2.1. Native American Indians seeking care in MTFs must be referred by competent authority and must present a properly executed pre-authorization for payment signed by either the Director of an Indian Health Service Area office or Contract Health Service. Pre-Authorizations include: Any standard inter-agency purchase, authorization, or financial reimbursement form, NAF Purchase Order/Contract/PR Register (LRA), AF Form 1735, NAF Interfund Purchase Order, SF 44, Purchase Order/Invoice/Voucher.

2.38.5.2.2. Purchase Orders will include extent of authorized care. If the patient requires care which exceeds the extent of the purchase order, the MTF will contact the Contract Health Service Director to obtain additional authorization(s).

2.38.5.2.3. Aeromedical evacuation is authorized when care cannot be provided locally at the MTF and is not available through local civilian hospitals at the expense

of the Indian Health Service of USPHS. Reimbursement from referring agency is required.

2.38.5.3. General Entitlements.

2.38.5.3.1. When payment is pre-authorized, MTF direct care (outpatient and inpatient care) is authorized. If the general benefit is identified and pre-authorized, then bill according to the IAOPR or IAR. Collect charges centrally from HQ AFMSA/SG8Y. Submit request for reimbursement using DD Form 7, Treatment Furnished Pay Patients, Report of - Hospitalization Furnished (Part A) and/or DD Form 7A, Treatment Furnished Pay Patients, Report of - Outpatient (Part B).

2.38.5.3.2. MTF emergency care (outpatient and inpatient care) is authorized. Bill according to the Inter-Agency Outpatient Rate (IAOPR) or Interagency Rate (IAR). Collect charges centrally from HQ AFMSA/SG8Y. Submit request for reimbursement using DD Form 7, Treatment Furnished Pay Patients, Report of - Hospitalization Furnished (Part A) and/or DD Form 7A, Treatment Furnished Pay Patients, Report of - Outpatient (Part B).

2.38.5.3.3. Healthcare from TRICARE network providers is not authorized.

2.38.5.3.4. Supplemental Care may be used to pay for required diagnostic care (obtained from a civilian provider) when the required diagnostic care is not available at the MTF. Submit request for reimbursement using DD Form 7, Treatment Furnished Pay Patients, Report of - Hospitalization Furnished (Part A) and/or DD Form 7A, Treatment Furnished Pay Patients, Report of - Outpatient (Part B).

2.38.5.3.5. Charge the standard Dental Rate for dental care authorized according to the external agency's pre-authorized payment order/agreement.

2.38.5.3.6. Transfer, deferment, or referral to Uniformed Services Family Health Plans or providers is not authorized.

2.38.5.3.7. Immunizations may be provided at the standard Immunization Rate.

2.38.5.3.8. Prosthetic devices may be provided only in accordance with a properly executed pre-authorization for payment received from the referring agency. Reimbursement will be at the Government cost of the device(s).

Section 2G—Eligibility Priority and Verification Procedures

2.39. Eligibility Priority and Limiting Services in the Direct Care System. MTFs provide care without regard to the sponsor's Service affiliation, rank or grade, according to 10 U.S.C. § 1071-1110b. Enrollment to TRICARE Prime is mandatory for all ADSMs. Refer to Health Affairs (HA) Policy 11-005, TRICARE Policy for Access to Care for priority of access to MTF care by beneficiary status.

2.39.1. When individuals fall into several beneficiary categories provide care at their highest priority level. If unable to determine a beneficiary's eligibility for healthcare, contact the AFMOA Health Benefits office for assistance.

2.40. Eligibility Verification. MTFs do not establish healthcare eligibility. Each Uniformed Service personnel authority establishes healthcare eligibility through a credentialing

confirmation process that ensures authorized beneficiaries are identified in DEERS. MTFs are responsible for verifying healthcare eligibility for each beneficiary seeking healthcare in the Military Health System (MHS) by referencing DEERS. The installation MPS or Element is generally responsible for validating a beneficiary's eligibility for DoD benefits (including healthcare). For additional information regarding the requirements to establish healthcare eligibility refer to AFI 36-3026V1_IP. Designated MTF personnel confirm the patient's identity and verify entitlement by performing a DEERS and identification (ID) card "check." DEERS eligibility may be verified by accessing the Composite Health Care System (CHCS)-DEERS eligibility menu option or by referring to the General Inquiry of DEERS Internet website (user ID and password is required). MTF personnel must contact their information site security manager to obtain access to this website. Eligibility questions should be directed to the TRICARE Operations and Patient Administration Flight Commander or other MTF authorized official(s).

2.40.1. Individuals requesting care must provide satisfactory evidence of their beneficiary status (e.g., a valid ID card and a DEERS eligibility check). Children under age 10 must be enrolled in DEERS, but generally do not require their own ID card to prove healthcare eligibility. The exception to this rule is for children who are eligible beneficiaries, but whose guardians are not MHS beneficiaries. MTF personnel should not provide routine care to patients with questionable eligibility until they make a final determination on a patient's eligibility. Eligible beneficiaries enrolled in a Uniformed Services Family Health Plan (USFHP) are not eligible for routine care at MTFs. In an emergency, always provide care first, and determine eligibility after treatment.

2.40.2. Eligibility verification is a two-step process. First, the patient must present a valid ID card. Designated MTF personnel shall ensure all patients seeking direct MTF care, including Service Members in uniform, present a valid ID before MTF healthcare is provided. RCSMs and their family members who have presented a valid ID card and passed a DEERS check will not be asked for a copy of active duty orders.

2.40.3. The second step in verifying a person's eligibility status can be performing a "DEERS check." MTFs will perform DEERS checks on all beneficiaries presenting for care.

2.40.3.1. Not all beneficiaries are enrolled in DEERS. When the DEERS verification process fails to confirm eligibility, a competent medical officer is required to perform a brief assessment to identify whether the patient would be at risk without the requested treatment or care. If there is a possibility of risk to either the patient or the Air Force, treat the patient. Patients who cannot establish their eligibility for healthcare must first sign a locally created statement (or standardized AFMS statement if available) that indicates their willingness to provide documentation of eligibility within 30 days or be held responsible for the costs associated with the requested treatment or care. After the 30th day, if the individual has not produced evidence that establishes eligibility, the TRICARE Operations and Patient Administration Flight shall forward the patient information to Resource Management Flight to initiate the billing process. This procedure applies to outpatient direct care, inpatient care, and ancillary care.

2.40.3.2. If the patient fails a DEERS eligibility check, provide routine care in the direct care system to these categories of patients when/for:

2.40.3.2.1. The patient is a member of the Reserve Component on active or inactive duty for less than 30 days and presents with a copy of their orders or administrative documentation.

2.40.3.2.2. The patient is a member of the Reserve Component on active or inactive duty status, and is seeking healthcare related to an "In Line of Duty" medical/dental condition or a condition which is currently under line of duty investigation IAW AFI 36-2910, Line of Duty (Misconduct) Determination. Medical care may be provided to an RCSM of another US Military Service, provided the Service Member produces an appropriate service "In Line of Duty" determination approval document signed by the member's command authority.

2.40.3.3. RCSMs on active duty for greater than 30 days and their family members must present a valid ID card and pass a DEERS check per para 2.40.1.1 above. If, and only if, the DEERS check does not pass, the RCSM or the family member must present a copy of the member's active duty orders. If the RCSM is issued "delayed-effective-date" active duty orders for more than 30 days in support of a contingency operation, the member and the member's family are eligible for "early" TRICARE medical and dental benefits beginning on the later of either: (a) the date their orders were issued or (b) 90 days before the Service Member reports for duty or is "activated" to active duty. Refer to Attachment 25 and Attachment 26, Reserve Healthcare Eligibility Matrix, Contingency Operations for additional eligibility information for RCSMs and their families.

2.40.3.4. TRICARE Prime/TRICARE Prime Remote coverage is automatic following birth or adoption and for 60 days thereafter or 90 days for OCONUS. The family must; however, submit a completed TRICARE Prime enrollment application in enough time for the application to be processed by the 60th day of life/custody. After 60 days, additional claims will be processed as TRICARE Standard (higher costs) until 365 days after the child's birth or adoption. On day 366, DEERS will indicate "loss of eligibility," and the child will no longer be eligible to receive any TRICARE benefits. MTF personnel are encouraged to remind new parents to visit the local DEERS office to update their family member DEERS status as soon as possible.

2.40.3.5. The patient is a Secretarial Designee (Use the designee letter to verify eligibility and benefits). Ensure the patient only receives care limited to the specific dates and diagnosis annotated in the approval letter.

2.40.3.6. The patient is a foreign military sponsor or family member. **Note:** Foreign military active and reserve members (and their family member dependents) are generally issued ID cards and entered into DEERS in accordance with AFI 36-3026V1_IP. If no ID card is provided, ask for a copy of the Foreign Service Member's orders. Refer to Section 2D, Healthcare for Foreign Forces Members, for further direction on potential billing issues.

2.40.3.7. The sponsor is stationed overseas, afloat, or has an Army or Air Force Post Office (APO) or Fleet Post Office (FPO) address. The patient should present some documentation to indicate the sponsor's status, e.g., TDY or PCS orders.

2.40.4. Reserve Component Eligibility Verification. The failure of a DEERS check will not be the sole basis for denying healthcare to RCSMs. There may be circumstances when a

RCSM may be eligible for healthcare (including pharmacy benefits) and a DEERS verification check fails. In this situation, the member should present one of the following:

2.40.4.1. A completed and approved "In Line of Duty" AF Form 348 or AFRC 348 (for Air Force Reserve Service Members).

2.40.4.2. An AF Form 348 (with the first side completed and signed by a provider).

2.40.4.3. A copy of their active duty orders.

2.40.5. If the documents referenced above are not produced, do not simply deny medical care. If the RCSM seeking healthcare claims the injury or illness is service-connected or first presented while he or she was on Active Duty or in IDT status, the injury or illness is presumed to have occurred in the line of duty. The MTF TOPA function is, however, responsible for contacting the RCSM's unit to verify the LOD process has been initiated.

2.40.6. Reserve Component Service Members residing in TPR areas with prescriptions to treat symptoms resulting from service-connected "In-Line-of Duty" injuries or illnesses, may obtain civilian prescriptions from participating network pharmacies. Reserve Component Service Members are required to purchase or pay for the prescription(s), then file a reimbursement request through Express Scripts following guidance on the MMSO web site at **http://www.tricare.mil/tma/MMSO**/.

2.40.7. Appellate Leave Eligibility/Enrollment for Active Duty Service Members: Enrollment to TRICARE Prime is mandatory for all ADSMs. This requirement does not end when the ADSM enters appellate leave status. ADSMs on appellate leave are not eligible for TRICARE Prime Remote (TPR) because they lack a permanent assignment to a TPR location. ADSMs in appellate leave status shall remain enrolled in TRICARE Prime, at an MTF, until their separation, discharge, or retirement date. **Note:** See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP. ADSMs in appellate leave status may transfer their enrollment to another MTF. Upon notification or discovery of an ADSM in appellate leave status, the local MTF TOPA function shall brief the ADSM about how he or she may access MHS healthcare while in appellate leave status. Except in an emergency, at no time is a Service Member in appellate leave status authorized to seek care outside an MTF without prior approval.

2.41. Dependency Determinations for Incapacitated Children. AFI 36-3026V1_IP outlines the initial eligibility criteria and procedures to apply for continued benefits for a child who becomes incapacitated before losing eligibility at age 21, or 23 if enrolled as a full-time student. Children enrolled in TRICARE Young Adult do not fall under the provisions of this paragraph.

2.41.1. The Defense Finance and Accounting Service-Indianapolis Center (DFAS-IN) is the final approving authority for dependency determinations. The Manpower, Personnel, and Services (MPSs) and Base Finance Office review DD 137-5 and other documentation to determine if the initial eligibility criteria warrant further processing and forwarding to the Defense Finance and Accounting Service-Indianapolis Center (DFAS-IN).

2.41.2. A medical statement in narrative format from the attending physician, or primary care manager, including a medical sufficiency statement (MSS) (endorsement for or against dependency status) must be included in the dependency determination application package

from the MTF. The MTF Commander is responsible for completing the MSS. However, the Commander may delegate the responsibility.

2.41.3. The patient and/or their sponsor is responsible for obtaining and providing any supporting medical documentation required for the application package. The TOPA Office will coordinate all requests for dependency determinations with the Chief of Medical Staff (SGH), or equivalent senior MTF physician if no SGH position exists. Final medical dependency review rests with the MTF Commander or his designee. If the MTF Commander has delegated endorsement authority to the MTF/SGH, the application package does not need the MTF Commander's signature before forwarding to officials at the installation personnel/finance office. The completed application package is provided to the sponsor regardless of medical sufficiency endorsement (approval) or non-endorsement (disapproval).

2.41.4. If the patient's care is rendered outside of the MTF and it would be a burden on the patient or sponsor to travel to the MTF solely to process the MSS, the MSS may be completed by a civilian provider. The civilian provider will complete the recommendation in paragraph two of the form (Attachment 4), sign, and submit the MSS directly to DFAS. In these cases, a medical statement as required in 2.41.2 is not required if the provider completing the MSS maintains medical records that support the MSS determination in 2.41.6. In order to establish medical incapacity, the patient's illness must be substantial and truly disabling. In addition, the medical incapacity must occur before the individual's 21st birthday (or 23rd birthday if enrolled as a full-time student when incapacitation occurred). The Air Force does not consider a diagnosis of alcoholism/or drug abuse as an incapacitating illness for the purposes of dependency determinations. The likelihood of future medical expenditures and/or the existence of a medical condition that will worsen over time, do not justify a determination of medical incapacity if no incapacitation currently exists.

2.41.5. The civilian or MTF provider will include the following information in the medical statement:

2.41.5.1. Diagnosis (use medical and layperson's terms).

2.41.5.2. Summary of the individual's incapacitation, including the nature and extent of the illness or disease. Non-medical personnel must be able to understand this summary.

2.41.5.3. Explain how the incapacity affects the individual's ability to perform routine life activities, such as self-care.

2.41.5.4. Age when the incapacitation began (might not be the same as when medical personnel diagnosed the illness or disease).

2.41.5.5. Probable duration of the incapacitation. Indicate if the incapacity predated the individual's (21st) or (23rd) birthday and has been continuous since diagnosis.

2.41.5.6. Based on the healthcare provider's professional opinion, indicate if the incapacity makes the individual incapable of self-support.

2.41.6. Depending on the circumstances involved in the dependency determination, the MTF Commander or civilian provider recommends one of the following endorsements (approved, disapproved, or no determination made) in the MSS (see Attachment 4):

2.41.6.1. Approved: If incapacity existed before age (21) or (23 years for dependent children attending college or university as a full-time student) and continues to exist, then

indicate: "Medical sufficiency is established based on the patient's medical condition. This individual is incapable of self-support because of a mental or physical incapacity that has existed on a continuous basis and originated before the individual's [choose one of the following ages based on the child's school status]: (21st) or (23rd) birthday and may be resolved within (estimate of years) years." If incapacity will not be resolved, then conclude prior sentence with, "...and will not be resolved in the foreseeable future."

2.41.6.2. Disapproved: If there is no incapacitating illness or/disease then indicate, "The patient's condition is such that it does not establish medical sufficiency."

2.41.6.3. Disapproved: If an incapacitation did not exist before age (21) or (23 years for dependent children attending college or university as a full-time student) and continues to exist, then indicate, "This individual is incapable of self-support because of a mental or physical incapacity that exists at this time. It is my opinion (based upon SGH review if the MTF COMMANDER is not a physician) that this incapacity did not exist before the individual's [choose one of the following ages based on the child's school status] (21st) or (23rd) birthday."

2.41.6.4. No Determination Made: Medical sufficiency of patient's medical condition or supporting documentation is lacking; therefore, no determination of incapacity can be made at this time.

2.41.7. The MTF or civilian provider completing the MSS shall provide the sponsor with the completed request package. However, only an approved MSS must be submitted to DFAS. The sponsor is responsible for coordinating with the appropriate finance and MPS officials. However, if circumstances exist where the sponsor is unable to transfer the request package to the appropriate finance and/or MPS officials, and procedures listed in para 2.41.4. are not possible, send the completed package to the following:

2.41.7.1. Installation finance office if the Commander's endorsement supports the request.

2.41.7.2. To the MPS if the Commander's endorsement does not support the request.

2.41.8. A copy of the medical sufficiency statement and any other supporting medical documentation should be filed in the appropriate section of the patient's medical record.

2.41.9. The applicant may submit a request for reconsideration to the MTF Commander or patient's civilian provider if there is new or compelling information. The MTF Commander or patient's civilian provider can review and, if the commander determines a change from original recommendation to the Military Finance Office is warranted, will so notify that office. DFAS-IN remains the ultimate decision authority for granting dependency status based on the MSS and financial support (over 50%) from the sponsor.

Section 2H—Other Services and Authorizations

2.42. TRICARE Extended Care Health Option (ECHO). The TRICARE ECHO is a supplement to the TRICARE Basic Program. The purpose of the TRICARE ECHO is to provide an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the beneficiary's qualifying condition. It does not provide acute care or benefits through the TRICARE Basic Program. Services include those

necessary to maintain, minimize or prevent deterioration of function of a TRICARE ECHO - eligible beneficiary. Only Active Duty Family Members (ADFMs) are authorized to participate. **Note:** See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP. Services covered under the basic TRICARE benefit cannot be authorized under the TRICARE ECHO program-those services must be authorized under the TRICARE program option the beneficiary is using (TRICARE Prime, TRICARE Prime Remote, TRICARE Standard, TRICARE Extra). If a beneficiary's family member has a condition that may qualify for services under TRICARE ECHO, they should contact their regional contractor for assistance. This instruction provides only the fundamental aspects of the program. For more definitive information regarding the TRICARE ECHO refer to the TRICARE Benefits Internet Website at **http://www.tricare.osd.mil/echo/default.cfm**.

2.42.1. Eligibility. Benefits under this program may be extended to authorized beneficiaries when they have a qualifying condition. Authorized beneficiaries include:

2.42.1.1. Eligible active duty family members (including members of the Reserve Component activated for more than 30 days).

2.42.1.2. Family members eligible for benefits under the Transitional Assistance Management Program (TAMP).

2.42.1.3. A victim of physical or emotional abuse, who is a spouse or child of a former member of a Uniformed Service of the United States. Benefits are limited to the period that the abused dependent is in receipt of transitional compensation.

2.42.1.4. Eligible surviving family members whose sponsor died while on active duty for a period of more than 30 days (to include those who die while on delayed-effective-date active duty orders) may continue their TRICARE ECHO eligibility. Their status is reflected as either Transitional Survivor or Survivor status. Spouse: Transitional Survivor status is retained for three years from the date of death of the sponsor. Incapacitated Children and Incapacitated Unmarried Persons are eligible until:

2.42.1.4.1. The date on which such dependent attains 21 years of age.

2.42.1.4.2. The date on which the dependent attains 23 years of age if enrolled in a fulltime course of study in a secondary school or in a full-time course of study in an institution of higher education.

2.42.1.5. Family members of a deceased sponsor who were receiving TRICARE ECHO benefits at the time the sponsor died and the sponsor was eligible at the time of death for receipt of hostile-fire pay, or died as a result of a disease or injury incurred while eligible for such pay, remain eligible for TRICARE ECHO benefits until midnight of the beneficiary's 21st birthday.

2.42.1.6. Participation in the TRICARE ECHO program requires all eligible beneficiaries to do the following:

2.42.1.6.1. Enroll in the Exceptional Family Member Program (EFMP) that is available through their service branch.

2.42.1.6.2. Register with their regional contractor to obtain TRICARE ECHO benefit authorization.

2.42.2. The following are TRICARE ECHO qualifying conditions:

2.42.2.1. Mental retardation. A diagnosis of moderate or severe mental retardation made in accordance with the criteria of the current edition of the "Diagnostic and Statistical Manual of Mental Disorders" published by the American Psychiatric Association.

2.42.2.2. Serious physical disability. A serious physical disability as defined in 32 CFR 199.2.

2.42.2.3. Extraordinary physical or psychological condition. An extraordinary physical or psychological condition as defined in 32 CFR 199.2.

2.42.2.4. Infant/toddler. Beneficiaries under the age of three years, who are diagnosed with a neuromuscular developmental condition or other condition that is expected to precede a diagnosis of moderate or severe mental retardation or a serious physical disability, shall be deemed to have a qualifying condition for the TRICARE ECHO. The Director, TRICARE Management Activity or designee shall establish criteria for TRICARE ECHO eligibility in lieu of the requirements of paragraph 2.42.1.

2.42.2.5. Multiple disabilities. The cumulative effect of multiple disabilities, as determined by the Director, TRICARE Management Activity or designee shall be used in lieu of the requirements of paragraphs 2.42.2.1. through 2.42.2.3. to determine a qualifying condition when the beneficiary has two or more disabilities involving separate body systems.

2.42.3. Loss of TRICARE ECHO Eligibility. Eligibility for TRICARE ECHO benefits ceases as of 12:01 a.m. of the day following the day that:

2.42.3.1. The sponsor ceases to be an active duty member for any reason other than death.

2.42.3.2. Eligibility, based upon the abused dependent provisions referenced in paragraph 2.42.1.3. expires or ends.

2.42.3.3. Eligibility, based upon the provisions of paragraph 2.41.1. expires or ends.

2.42.3.4. Eligibility based upon a beneficiary's participation in the Transitional Assistance Management Program and/or the Exceptional Family Member Program expires or ends.

2.42.3.5. The Director, TRICARE Management Activity or designee determines that the beneficiary no longer has a qualifying condition.

2.42.4. Continuity of Eligibility. A TRICARE beneficiary who has an outstanding Program for Persons with Disabilities (PFPWD) benefit authorization on the date of implementation of the TRICARE ECHO program shall continue receiving such services for the duration of that authorization period provided the beneficiary remains eligible for the PFPWD. Upon termination of an existing PFPWD authorization, or if the beneficiary seeks benefits under this section before such termination, the beneficiary shall establish eligibility for the TRICARE ECHO in accordance with this section.

2.42.4.1. Current PFPWD participants may be eligible to enroll in the EFMP. Refer beneficiaries to the Internet Website **www.militaryhomefront.dod.mil/efm** for further information regarding this program.

2.42.5. TRICARE ECHO benefit. Items and services that the Director, TRICARE Management Activity or designee has determined are capable of confirming, arresting, or reducing the severity of the disabling effects of a qualifying condition, include but are not limited to:

2.42.5.1. Diagnostic procedures to establish a qualifying condition or to measure the extent of functional loss resulting from a qualifying condition. Diagnostic services available under the TRICARE Basic Program are not eligible to be cost-shared under the TRICARE ECHO.

2.42.5.2. Medical, habilitative, or rehabilitative methods, techniques, therapies, equipment, prosthetic devices, orthopedic braces and appliances. Treatment and or services available under the TRICARE Basic Program are not eligible to be cost-shared under the TRICARE ECHO. Benefits may be provided by an authorized institutional or individual professional provider on an inpatient or outpatient basis and rendered in the beneficiary's natural environment. This includes at home, at school, or other location that is suitable for the type of services being rendered.

2.42.5.3. Training that teaches the use of assistive technology devices or to acquire skills that are necessary for the management of the qualifying condition. Said training is also authorized for the beneficiary's immediate family. Vocational training, in the beneficiary's home or a facility providing same, is also allowed. Training services available under the TRICARE Basic Program are not eligible to be cost shared under the TRICARE ECHO.

2.42.5.3.1. Training for parents (or guardians) and siblings of an TRICARE ECHO beneficiary, when required as an integral part of the management of the qualifying condition, may be cost shared as a TRICARE ECHO benefit subject to all applicable TRICARE ECHO requirements.

2.42.5.4. Special education as provided by the Individuals with Disabilities Education Act and defined at 34 CFR 300.26 and that is specifically designed to accommodate the disabling effects of the qualifying condition. Other public programs and facilities must be used to the extent available and adequate. The local educational agency with responsibility for the beneficiary is the sole agency to provide public facility use certification for special education services.

2.42.5.5. Institutional care within a state, as defined in 32 CFR 199.2, in private nonprofit, public, and state institutions and facilities, when the severity of the qualifying condition requires protective custody or training in a residential environment. For the purpose of this section protective custody means residential care that is necessary when the severity of the qualifying condition is such that the safety and wellbeing of the beneficiary or those who come into contact with the beneficiary may be in jeopardy without such care.

2.42.5.6. Transportation of a TRICARE ECHO beneficiary, and a medical attendant when necessary to assure the beneficiary's safety, to or from a facility or institution to receive authorized TRICARE ECHO services or items.

2.42.5.7. Respite care. TRICARE ECHO beneficiaries are eligible for 16 hours of respite care per month in any month during which the beneficiary otherwise receives a

TRICARE ECHO benefit(s). Respite care is defined in 32 CFR 199.2. Respite care services will be provided by a TRICARE-authorized (Medicare or Medicaid certified home health agencies only) home health agency and will not be provided in areas where Medicare or Medicaid certified HHAs are not available. TRICARE ECHO respite care will be designed to provide healthcare services for only the covered beneficiary, and not baby-sitting or child-care services for other members of the family. The benefit is not cumulative. That is, any respite care not used in one month will not be carried over or banked for use on another occasion.

2.42.5.7.1. Currently the TRICARE ECHO respite benefit is limited to the 50 United States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

2.42.5.7.2. TRICARE ECHO respite care will not be provided to those beneficiaries who are receiving the TRICARE ECHO Home Health Care (EHHC) benefit or the EHHC-Respite Care benefit. TRICARE ECHO respite care will not be provided to cover absences of the primary caregiver(s) due to deployment, training, employment, seeking employment, or pursuing education.

2.42.5.7.3. The Government's cost-share incurred for these services accrue to the maximum monthly benefits of $2,500.

2.42.5.8. Other services.

2.42.5.8.1. Assistive services. Services of qualified personal assistants, such as an interpreter or translator for TRICARE ECHO beneficiaries who are deaf or mute and readers for TRICARE ECHO beneficiaries who are blind, when such services are necessary in order for the TRICARE ECHO beneficiary to receive authorized TRICARE ECHO benefits.

2.42.5.8.2. Equipment adaptation. The allowable equipment purchase shall include such services and modifications to the equipment as necessary to make the equipment useable for a particular TRICARE ECHO beneficiary.

2.42.5.8.3. Equipment maintenance. Reasonable repairs and maintenance of beneficiary owned or rented durable equipment provided by this section shall be allowed while a beneficiary is registered in the TRICARE ECHO.

2.42.6. TRICARE ECHO Exclusions.

2.42.6.1. Basic Program. Services or items allowed under the TRICARE Basic Program will not be provided through the TRICARE ECHO.

2.42.6.2. Inpatient care. Inpatient acute care for medical or surgical treatment of an acute illness, or of an acute exacerbation of the qualifying condition, is excluded.

2.42.6.3. Structural alterations. Alterations to living space and permanent fixtures attached thereto, including alterations necessary to accommodate installation of equipment or to facilitate entrance or exit, are excluded.

2.42.6.4. Homemaker services. Services that predominantly provide assistance with household chores are excluded.

2.42.6.5. Dental care or orthodontic treatment.

2.42.6.6. Deluxe travel or accommodations. The difference between the price for travel or accommodations that provide services or features that exceed the requirements of the beneficiary's condition and the price for travel or accommodations without those services or features is excluded.

2.42.6.7. Equipment: Purchase or rental of durable equipment that is otherwise allowed by this section is excluded when:

2.42.6.7.1. The beneficiary is a patient in an institution or facility that ordinarily provides the same type of equipment to its patients at no additional charge in the usual course of providing services.

2.42.6.7.2. The item is available to the beneficiary from a Uniformed Services MTF.

2.42.6.7.3. The item has deluxe, luxury, immaterial or nonessential features that increase the cost relative to a similar item without those features.

2.42.6.7.4. The item is duplicate equipment as defined in 32 CFR 199.2.

2.42.6.8. Maintenance agreements. Maintenance agreements for beneficiary owned or rented equipment are excluded.

2.42.6.9. No obligation to pay. Services or items for which the beneficiary or sponsor has no legal obligation to pay are excluded.

2.42.6.10. Public facility or Federal Government. Services or items paid for, or eligible for payment, directly or indirectly by a public facility, as defined in 32 CFR 199.2, or by the Federal government, other than the Department of Defense, are excluded for training, rehabilitation, special education, assistive technology devices, institutional care in private nonprofit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilities, except when such services or items are eligible for payment under a state plan for medical assistance under Title XIX of the Social Security Act (Medicaid). Rehabilitation and assistive technology services or supplies may be available under the TRICARE Basic Program.

2.42.6.11. Study, grant, or research programs. Services and items provided as a part of a scientific clinical study, grant, or research program are excluded.

2.42.6.12. Unproven status. Drugs, devices, medical treatments, diagnostic, and therapeutic procedures for which the safety and efficacy have not been established in accordance with 32 CFR 199.4 are excluded.

2.42.6.13. Immediate family or household. Services or items provided or prescribed by a member of the beneficiary's immediate family, or a person living in the beneficiary's or sponsor's household, are excluded.

2.42.6.14. Court or agency ordered care. Services or items ordered by a court or other government agency, which are not otherwise an allowable TRICARE ECHO benefit, are excluded.

2.42.6.15. Excursions. Excursions are excluded regardless of whether or not they are part of a program offered by a TRICARE-authorized provider. The transportation benefit available under TRICARE ECHO is addressed elsewhere in this section.

2.42.6.16. Drugs and medicines. Drugs and medicines that do not meet the requirements of 32 CFR 199.4 or 32 CFR 199.21 are excluded.

2.42.6.17. Therapeutic absences. Therapeutic absences from an inpatient facility or from home for a homebound beneficiary are excluded.

2.42.6.18. Custodial care. Custodial care, as defined in 32 CFR 199.2 is not a stand-alone benefit. Services generally rendered as custodial care may be provided only as specifically identified in this section.

2.42.6.19. Domiciliary care. Domiciliary care, as defined in 32 CFR 199.2, is excluded.

2.42.6.20. Respite care. Respite care for the purpose of covering primary caregiver (as defined in 32 CFR 199.2) absences due to deployment, employment, seeking of employment or to pursue education is excluded. Authorized respite care covers only the TRICARE ECHO beneficiary, not siblings or others who may reside in or be visiting in the beneficiary's residence.

2.43. TRICARE ECHO Home Healthcare (EHHC). The EHHC benefit provides coverage of home healthcare services and respite care services specified in this section.

2.43.1. Home healthcare. Covered TRICARE ECHO home healthcare services are the same as, and provided under the same conditions as, services described in 32 CFR 199.4(e)(21)(i), except that they are not limited to part-time or intermittent services. Custodial care services, as defined in 32 CFR 199.2, may be provided to the extent such services are provided in conjunction with authorized TRICARE ECHO home healthcare services, including the EHHC respite care benefit specified in this section. Beneficiaries who are authorized EHHC will receive all home healthcare services under EHHC and no portion will be provided under the TRICARE Basic Program. TRICARE-authorized home health agencies are not required to use the Outcome and Assessment Information Set (OASIS) to assess beneficiaries who are authorized EHHC.

2.43.2. Respite care. EHHC beneficiaries whose plan of care includes frequent interventions by the primary caregiver(s) are eligible for respite care services in lieu of the TRICARE ECHO general respite care benefit. For the purpose of this section, the term "frequent" means "more than two interventions during the eight-hour period per day that the primary caregiver would normally be sleeping." The services performed by the primary caregiver are those that can be performed safely and effectively by the average non-medical person without direct supervision of a healthcare provider after the primary caregiver has been trained by appropriate medical personnel. EHHC beneficiaries in this situation are eligible for a maximum of eight hours per day, 5 days per week, of respite care by a TRICARE-authorized home health agency. The home health agency will provide the healthcare interventions or services for the covered beneficiary so that the primary caregiver is relieved of the responsibility to provide such interventions or services for the duration of that period of respite care. The home health agency will not provide baby-sitting or childcare services for other members of the family. The benefit is not cumulative. That is, any respite care hours not used in a given day may not be carried over or banked for use on another occasion. Additionally, the eight-hour respite care periods will not be provided consecutively, that is, a respite care period on one calendar day will not be immediately followed by a respite care

period the next calendar day. The Government's cost-share incurred for these services accrue to the maximum yearly TRICARE ECHO Home Healthcare benefit.

2.43.3. EHHC eligibility. The EHHC is authorized for beneficiaries who meet all applicable TRICARE ECHO eligibility requirements and who:

2.43.3.1. Physically reside within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam; and,

2.43.3.2. Are homebound, as defined in 32 CFR 199.2; and,

2.43.3.3. Require medically necessary skilled services that exceed the level of coverage provided under the Basic Program's home healthcare benefit; and/or,

2.43.3.4. Require frequent interventions by the primary caregiver(s) such that respite care services are necessary to allow primary caregiver(s) the opportunity to rest; and,

2.43.3.5. Are case managed to include a reassessment at least every 90 days, and receive services as outlined in a written plan of care; and,

2.43.3.6. Receive all home healthcare services from a TRICARE-authorized home health agency, as described in 32 CFR 199.6(b)(4)(xv), in the beneficiary's primary residence.

2.43.3.7. To avoid delaying receipt of EHHC services while completing the TRICARE ECHO registration process, in particular awaiting completion of enrollment in the Exceptional Family Member Program (EFMP) of the sponsor's service, otherwise TRICARE ECHO -eligible beneficiaries may be granted provisional eligibility for a period of not more than 90 days. Upon completion of the TRICARE ECHO registration process, the provisional status will be converted to permanent and subject to all other applicable requirements and made retroactive to the date of the request for EHHC or respite care services. If it is determined that the beneficiary is not eligible for the TRICARE ECHO, the provisional status will be terminated; authorization and government liability for TRICARE ECHO benefits will also terminate at that time. The government will not recoup claims paid for TRICARE ECHO benefits provided during the provisional period.

2.43.4. EHHC plan of care. A written plan of care is required prior to authorizing TRICARE ECHO home healthcare. The plan must include the type, frequency, scope and duration of the care to be provided and support the professional level of provider. Reimbursement will not be authorized for a level of provider not identified in the plan of care. The plan of care will be reviewed for appropriateness whenever the MCSC is informed that the condition of the beneficiary has changed or there is otherwise a need to update the plan. In all cases the beneficiary will be reassessed and the plan reviewed and updated at least every 90 days.

2.43.5. EHHC exclusions.

2.43.5.1. General. TRICARE ECHO Home Healthcare services and supplies are excluded from those who are being provided continuing coverage of home healthcare as participants of the former Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) or previous case management demonstrations.

2.43.5.2. Respite care. Respite care for the purpose of covering primary caregiver absences due to deployment, employment, seeking of employment or to pursue education

is excluded. Authorized respite care covers only the TRICARE ECHO beneficiary, not siblings or others who may reside in or be visiting in the beneficiary's residence.

2.44. TRICARE ECHO Cost-Share Liability.

2.44.1. No deductible. TRICARE ECHO benefits are not subject to a deductible amount.

2.44.2. Sponsor cost-share liability. Regardless of the number of family members receiving TRICARE ECHO benefits or TRICARE ECHO Home Healthcare in a given month, the sponsor's cost-share is listed on the TRICARE Internet Website.

2.44.2.1. The Sponsor's cost-share will be applied to the first allowed TRICARE ECHO charges in any given month. The Government's share will be paid, up to the maximum amount specified in paragraph 2.45.3., for allowed charges after the sponsor's cost-share has been applied.

2.44.2.2. The provisions of 32 CFR 199.18(d)(1) and (e)(1) regarding elimination of co-payments for active duty family members enrolled in TRICARE Prime do not eliminate, reduce, or otherwise affect the sponsor's cost-share obligation.

2.44.2.3. The sponsor's cost-share payment amounts do not accrue to the Basic Program's Catastrophic Loss Protection under 10 U.S.C. § 1079(b)(5) as listed in 32 CFR 199.4(f)(10) and 199.18(f).

2.44.3. Government cost-share liability.

2.44.3.1. TRICARE ECHO. The total Government share of the cost of all TRICARE ECHO benefits, except TRICARE ECHO home healthcare EHHC respite care, provided in a given month to a beneficiary may not exceed $2,500 after application of the allowable payment methodology.

2.44.3.2. TRICARE ECHO home healthcare.

2.44.3.2.1. The maximum annual fiscal year Government cost share per EHHC-eligible beneficiary for TRICARE ECHO home healthcare, including EHHC respite care may not exceed the local wage-adjusted highest Medicare Resource Utilization Group (RUG-III) category cost for care in a TRICARE-authorized skilled nursing facility.

2.44.3.2.2. When a beneficiary moves to a different locality within the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, or Guam, the annual fiscal year cap will be recalculated to reflect the maximum established under paragraph 2.44.3.2.1. for the beneficiary's new location and will apply to the EHHC benefit for the remaining portion of that fiscal year.

2.45. TRICARE ECHO Benefit Payment.

2.45.1. Transportation. The allowable amount for transportation of an TRICARE ECHO beneficiary is limited to the cost of the standard published fare plus any standard surcharge made to accommodate any person with a similar disability or to the cost of specialized medical transportation when non-specialized transport cannot accommodate the beneficiary's qualifying condition related needs, or when specialized transport is more economical than non-specialized transport. When transport is by private vehicle, the allowable amount is

limited to the Federal government employee mileage reimbursement rate in effect on the date the transportation is provided.

2.45.2. Equipment.

2.45.2.1. The TRICARE allowable amount for durable equipment shall be calculated in the same manner as durable medical equipment allowable through 32 CFR 199.4.

2.45.2.2. Allocating equipment expense. The TRICARE ECHO beneficiary (or sponsor or guardian acting on the beneficiary's behalf) may, only at the time of the request for authorization of equipment, specify how the allowable cost of the equipment is to be allocated as a TRICARE ECHO benefit. The entire allowable cost of the authorized equipment may be allocated in the month of purchase provided the allowable cost does not exceed the TRICARE ECHO maximum monthly benefit of $2,500 or it may be prorated regardless of the allowable cost. Prorating permits the allowable cost of TRICARE ECHO -authorized equipment to be allocated such that the amount allocated each month does not exceed the maximum monthly benefit. The accrued amount from these sections must also be applied against the government's annual fiscal year maximum of $36,000.00.

2.45.2.2.1. Maximum period. The maximum number of consecutive months during which the allowable cost may be prorated is the lesser of:

2.45.2.2.1.1. The number of months calculated by dividing the allowable cost for the item by 2,500, then doubling the resulting quotient, round off to the nearest whole number; or,

2.45.2.2.1.2. The number of months of expected useful life of the equipment for the requesting beneficiary, as determined by the Director, TRICARE Management Activity or designee.

2.45.2.2.2. Alternative allocation period. The allowable equipment cost may be allocated monthly in any amount so that the $2,500 maximum allowable monthly ECHO benefit or the maximum period under paragraph 2.45.2.2.1. is not exceeded.

2.45.2.2.3. Authorization.

2.45.2.2.3.1. The amount allocated each month, as determined in accordance with paragraph 2.45.2.1. will be separately authorized as a TRICARE ECHO benefit.

2.45.2.2.3.2. An item of durable equipment shall not be authorized when such authorization would allow cost-sharing of duplicate equipment, as defined in 32 CFR 199.2, for the same beneficiary.

2.45.2.2.4. Cost-share. A cost-share, as provided by paragraph 2.44.2., is required for each month in which a prorated amount is authorized.

2.45.2.2.5. Termination. The sponsor's monthly cost-share and the prorated equipment expense provisions provided by paragraphs 2.43. and 2.44. shall be terminated as of the first day of the month following the death of a beneficiary or as of the effective date of a beneficiary's loss of TRICARE ECHO eligibility for any other reason.

2.45.3. For-profit institutional care provider. Institutional care provided by a for-profit entity may be allowed only when the care for a specific TRICARE ECHO beneficiary:

2.45.3.1. Is contracted by a public facility as a part of a publicly funded long-term inpatient care program; and,

2.45.3.2. Is provided based upon the TRICARE ECHO beneficiary's being eligible for the publicly funded program which has contracted for the care; and,

2.45.3.3. Is authorized by the public facility as a part of a publicly funded program; and,

2.45.3.4. Is a cost-share liability in the absence of TRICARE eligibility; and,

2.45.3.5. Produces a TRICARE ECHO beneficiary cost-share liability that does not exceed the maximum charge by the provider to the public facility for the contracted level of care.

2.45.4. TRICARE ECHO home healthcare and EHHC respite care.

2.45.4.1. TRICARE-authorized home health agencies must provide and bill for all authorized home healthcare services through established TRICARE claims mechanisms. No special billing arrangements will be authorized in conjunction with coverage that may be provided by Medicaid or other federal, state, community or private programs.

2.45.4.2. For authorized TRICARE ECHO home healthcare and respite care, TRICARE will reimburse the allowable charges or negotiated rates.

2.45.4.3. The maximum monthly Government reimbursement for EHHC, including EHHC respite care, will be based on the number of hours of EHHC services rendered in the month, but in no case will it exceed one-twelfth of the annual maximum Government cost share as determined in this section.

2.45.5. Other Requirements. Active duty sponsors must register potential TRICARE ECHO eligible beneficiaries through the Director, TRICARE Management Activity or designee prior to receiving TRICARE ECHO benefits. The Director, TRICARE Management Activity or designee will determine TRICARE ECHO eligibility and update DEERS accordingly. Sponsors must provide evidence of enrollment in the Exceptional Family Member Program provided by their branch of Service at the time they register their family member(s) for the TRICARE ECHO.

2.46. TRICARE ECHO Benefit Authorization. All TRICARE ECHO benefits require authorization by the Director, TRICARE Management Activity or designee prior to receipt of such benefits.

2.46.1. Documentation. The sponsor shall provide such documentation as the Director, TRICARE Management Activity or designee requires as a prerequisite to authorizing TRICARE ECHO benefits. Such documentation shall describe how the requested benefit will contribute to confirming, arresting, or reducing the disabling effects of the qualifying condition, including maintenance of function or prevention of further deterioration of function, of the beneficiary.

2.46.2. Format. An authorization issued by the Director, TRICARE Management Activity or designee shall specify such description, dates, amounts, requirements, limitations or

information as necessary for exact identification of approved benefits and efficient adjudication of resulting claims.

2.46.3. Valid period. An authorization for TRICARE ECHO benefits shall be valid until such time as the Director, TRICARE Management Activity or designee determines that the authorized services are no longer appropriate or required or the beneficiary is no longer eligible under paragraph 2.42.1.

2.46.4. Authorization waiver. The Director, TRICARE Management Activity or designee may waive the requirement for a written authorization for rendered TRICARE ECHO benefits that, except for the absence of the written authorization, would be allowable as a TRICARE ECHO benefit.

2.46.5. Public facility use.

2.46.5.1. An TRICARE ECHO beneficiary must demonstrate that a public facility is not available and adequate to meet the needs of the beneficiary's qualifying condition(s) in the beneficiary's state of residency. Such requirement shall apply to beneficiaries who request authorization for training, rehabilitation, special education, assistive technology, and institutional care in private nonprofit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilities. The maximum Government cost share for services that require demonstration of public facility non-availability or inadequacy is limited to $2,500 per month per beneficiary. State-administered plans for medical assistance under Title XIX of the Social Security Act (Medicaid) are not considered available and adequate facilities for the purpose of this section.

2.46.5.2. The domicile of the beneficiary shall be the basis for the determination of public facility availability when the sponsor and beneficiary are separately domiciled due to the sponsor's move to a new permanent duty station or due to legal custody requirements.

2.46.5.3. Written certification, in accordance with information requirements, formats, and procedures established by the director, TRICARE Management Activity or designee that requested TRICARE ECHO services or items cannot be obtained from public facilities because the services or items are not available and adequate, is a prerequisite for TRICARE ECHO benefit payment for training, rehabilitation, special education, assistive technology, and institutional care in private nonprofit, public, and state institutions and facilities, and if appropriate, transportation to and from such institutions and facilities.

2.46.5.3.1. An administrator or designee of a public facility may make such certification for a beneficiary residing within the service area of that public facility.

2.46.5.3.2. The Director, TRICARE Management Activity or designee may determine, on a case-by-case basis, that apparent public facility availability or adequacy for a requested type of service or item cannot be substantiated for a specific beneficiary's request for TRICARE ECHO benefits and therefore is not available.

2.46.5.3.2.1. A case-specific determination shall be based upon a written statement by the beneficiary (or sponsor or guardian acting on behalf of the beneficiary) which details the circumstances wherein a specific individual

representing a specific public facility refused to provide a public facility use certification, and such other information as the Director, TRICARE Management Activity or designee determines to be material to the determination.

2.46.5.3.2.2. A case-specific determination of public facility availability by the Director, TRICARE Management Activity or designee is conclusive and is not subject to appeal under 32 CFR 199.10.

2.46.5.3.3. Repair or maintenance of beneficiary owned durable equipment is exempt from the public facility use certification requirements.

2.46.5.3.4. The requirements of this paragraph notwithstanding, no public facility use certification is required for services and items that are provided under Part C of the Individuals with Disabilities Education Act in accordance with the Individual Family Services Plan and that are otherwise allowable under the TRICARE ECHO.

2.47. Transitional Assistance Management Program (TAMP). See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

2.47.1. The Transitional Assistance Management Program (TAMP) offers transitional TRICARE coverage to certain separating Active Duty Service Members (ADSM) and their eligible family members. TAMP coverage by default is TRICARE Standard, however, certain TAMP eligibles may enroll or re-enroll in TRICARE Prime. During TAMP, beneficiaries are still eligible for active duty programs (e.g., TRICARE ECHO).

2.47.2. In accordance with the National Defense Authorization Act for Fiscal Year 2005, effective Oct. 28, 2004, TRICARE eligibility under the TAMP has been permanently extended from 60 or 120 days to 180 days.

2.47.3. Covered TAMP groups are:

2.47.3.1. Members involuntarily separated from active duty and their eligible family members.

2.47.3.2. Reserve and National Guard members, collectively known as the Reserve Component (RC), separated from active duty after being called up or ordered in support of a contingency operation for an active duty period of more than 30 days and their family members.

2.47.3.3. Members separated from active duty after being involuntarily retained in support of a contingency operation and their family members.

2.47.3.4. Members separated from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency mission and their family members.

2.47.3.5. A Service Member who receives a sole survivorship discharge as defined in 10, U.S.C. § 1074.

2.47.3.6. A Service Member who is separated from active duty who agrees to become a member of the Selected Reserve of the Ready Reserve of a Reserve Component.

2.47.4. Active duty sponsors and family members enrolled in TRICARE Prime who desire to continue their enrollment upon the sponsor's separation from active duty status are

required to reenroll. To re-enroll in TRICARE Prime, the sponsor or family member must complete and submit a TRICARE Prime enrollment application. Under TAMP, former active duty sponsors, former activated reservists, and family members of both are not eligible to enroll or reenroll in TRICARE Prime Remote (TPR) or in TRICARE Prime Remote for Active Duty Family Members (TPRADFM) because both programs require the sponsor to be on active duty. Under the TAMP, the sponsor is no longer on active duty and is treated as an active duty family member for benefits and cost sharing purposes. The effective date shall be the date the sponsor separated from active duty as the intent is to ensure that Prime coverage is seamless.

2.47.5. TPR and TPRADFM are not available during the transitional health benefit under TAMP. However, Members and Family Members who were enrolled in TPR or TPRADFM while on active duty and are eligible for TAMP benefits, may enroll in TRICARE Prime if they live in a TRICARE Prime coverage area. Prime coverage under TAMP still requires enrollment and is subject to the "twentieth of the month" rule. If an application for an initial enrollment is received after the twentieth day of the month, Prime enrollment benefits will begin on the first day of the second month after the month in which the application was received by the regional contractor.

2.47.6. Dental Coverage.

2.47.6.1. TAMP does not provide dental coverage for former ADSMs or ADFMs. Former ADSMs may use a military Dental Treatment Facility (DTF) on a space-available basis or enroll in the premium-based TRICARE Dental Program (TDP). Former ADFMs may purchase TDP coverage.

2.47.6.2. The TDP is a voluntary dental insurance program that is available to ADFMs, non-active duty National Guard and Reserve Members, and family members of non-active duty National Guard and Reserve Members, including the Individual Ready Reserve.

2.47.6.3. Transitional dental benefits for Reserve Component Service Members (RCSM) on active duty for more than 30 days in support of a contingency operation have been expanded to include dental care in DTFs; DTF referred care to the private sector; and authorized remote dental care in the private sector during the 180 day transitional health care period. Both DTF referred care and remote care will be administered by TRICARE's Active Duty Dental Program (ADDP). TDP eligibility will begin after the transitional health care period ends.

2.47.7. Eligibility for the TAMP for sponsors and family members is determined by the sponsor's Service branch and information in DEERS. Sponsors may verify eligibility for themselves and their family members by visiting or contacting the nearest military identification card issuing facility or contacting the Defense Manpower Data Center Support Office toll free at (800) 538-9552. For additional TRICARE benefit information, visit the TRICARE Internet Web site at **www.tricare.osd.mil** or contact the MMSO or regional managed care support contractor.

2.48. Reciprocal Healthcare Agreements. Foreign military and diplomatic personnel pay for MTF inpatient medical care, unless the foreign country and the United States have entered into a reciprocal healthcare agreement indicating alternative arrangements. Reciprocal healthcare

agreements require that both countries provide a comparable level of healthcare to a comparable number of personnel.

2.48.1. To obtain a current listing of reciprocal healthcare agreements between the United States Department of Defense and foreign countries, please visit the Force Health Protection and Readiness Policy and Programs Office website at [**https://private.fhp.osd.mil/portal/rhas.jsp**]. If your browser is unable to open the website from this hyperlink, please copy the URL and paste into the URL address line on your browser. Additionally, this secure Internet website may only be accessed from official DoD computer systems.

2.48.2. As additional agreements are completed, AFMSA/SG3SA will send the necessary information via message to MAJCOM Command Surgeons and/or AFMOA.

2.49. Medically Related Services. Sections 9271 and 1401 of Title 20, U.S.C. entitles handicapped DoD Dependents Schools (DoDDS) students to a free public education. Federal Law also entitles handicapped DoDDS students who require medically related services and are in a "tuition free" status under DoD Directive 1342.13 Eligibility Requirements for Education of Minor Dependents in Overseas Areas July 8, 1982, with Changes 1 and 2, to receive those medical services free of charge, regardless of their beneficiary category, or the location of the service.

2.49.1. Under DoD Instruction 1010.13, Provision of Medically Related Services to Children Receiving or Eligible to Receive Special Education in DoD Dependent Schools Outside the United States August 28, 1986, with Change 1, and DoD Instruction 1342.12, Provision of Early Intervention and Special Education Services to Eligible DoD Dependents in Overseas Areas, 12 March 1996, the DoD provides medical care and related services in-theater in overseas locations according to MTF capabilities. When a handicapped student who is entitled to government medical care needs an evaluation or services outside the theater, aeromedical evacuation of that student and an accompanying adult to and from CONUS is free. The Air Force may also authorize commercial transportation of the handicapped student and accompanying adult.

2.49.2. Providing medically related services under Sections 9271 and 1401 of 20 US Code must not disrupt the individual's special education. For evaluations performed in CONUS, consider the scope of the law. For example, ongoing care or physical therapy, in CONUS based facilities, is likely disruptive and, as such, inconsistent with the law and DoD directives. As a result, in the extremely rare case of a handicapped DoD student who cannot obtain required ongoing services in-theater, command must consider reassigning the individual's sponsor to another accompanied area where the necessary medical services are available that do not disrupt the child's special education.

2.50. Authorization for Physical Examinations Other than Flying. This paragraph does not cover the physical examinations (flying, non-flying and occupational health) addressed in AFI 48-123, Medical Examination and Standards.

2.50.1. The MTF Force Health Management or Medical Standards Management Element (MSME) functions schedule employment physicals when the MTF Commander determines that MTF personnel are available and an official of the sponsoring agency sends a written request for the physical. School physicals may be scheduled by the appropriate clinical

management function when the MTF Commander determines that MTF personnel are available and an official of the sponsoring agency sends a written request for the physical. There is no charge to the individual for the physical. Individuals who may receive physicals under this paragraph are:

2.50.1.1. Contract food service, housekeeping, and other healthcare employees or healthcare volunteers.

2.50.1.2. Army and Air Force Exchange Service (AAFES) personnel and AAFES concessionaire employees.

2.50.1.3. Employees of Officer, Non-Commissioned Officer (NCO) and Service Clubs.

2.50.1.4. DoD School System teachers working on base or overseas in uniformed service schools that a US military department operates.

2.50.1.5. Civilian contractors working in positions that require exposure to occupational hazards such as laser energy and/or toxic substances.

2.50.1.6. Domestic servants of uniformed services personnel. MTF personnel will provide a physical for these domestic servants when command directives require it as a condition of employment, or the employer overseas requests it.

2.50.1.7. Non-appropriated fund (NAF) employees.

2.50.1.8. Civilian employees may receive (at no charge to the individual) physicals for:

2.50.1.8.1. Required occupational health screening, fitness for duty assessments and follow-up under the AFOSH.

2.50.1.8.2. DoD sponsored overseas assignments, when DoD requires it.

2.50.1.8.3. DoD sponsored courses, when it is a course requirement.

2.50.2. The MTF also provides physicals for any individual on a DoD sponsored orientation flight IAW local and MAJCOM and/or AFMOA directives.

2.50.3. The MTF performs physicals to determine if a person is qualified for duty in the uniformed services according to AFI 48-123. MTF specialty clinics will also perform examinations/physicals as necessary to determine fitness for accession to active duty or to apply to a service academy.

2.50.4. At overseas locations, the MTF may perform premarital physicals for intended spouses (ineligible beneficiaries), IAW AFI 36-2609, Marriage in Overseas Commands.

2.50.5. The MTF Commander may determine that providing the physical or immunization serves the best interest of command health. If necessary, the MTF will provide physicals, health inspections and immunizations to ensure detection of any communicable disease at a uniformed services installation.

2.50.6. Under 31 U.S.C. § 1535, the MTF may provide physicals for applicants for:

2.50.6.1. Foreign Service Posts. The State Department requests physicals for Foreign Service Officers or applicants for the Foreign Service (including family members) on Form DSL-820, Letter of Authorization for Medical Examination (two copies). Return the report of the physical examination as outlined in the DSL-820.

2.50.6.2. Federal employment, when necessary to meet occupational requirements.

2.50.6.3. Job Corps and VISTA. Appropriate agency officials request physicals. The MTF completes the appropriate forms as requested by the agency and returns these reports to the requesting official. The MTF provides five copies of DD Form 7A, Report of Treatment Furnished Pay Patients-Outpatients Treatment Furnished Part B (RCS: HAF-SGH[M]7103), to HQ USAF/SG8Y for reimbursement and includes a copy of the request for physicals.

2.50.6.4. Peace Corps. Peace Corps officials request physicals for volunteers and family members. These are typically pre-selection, separation, or special physicals.

2.50.6.5. Specific FAA physicals/examinations, performed by an MTF FAA-credentialed provider or Flight Surgeon, may be provided at the discretion of the MTF Commander. Requests by FAA Regional office officials should be directed to the MSME section for consideration. Civilian Air Traffic Controllers (ATC) who are contracted to work in military ATC Facilities, would fall under this paragraph. (FAA now requires that providers who perform FAA physicals apply and obtain a certification number).

2.50.6.6. US Secret Service. The Chief, US Secret Service or a designated representative submits a written request for the MTF to perform the same type of periodic physical as for a non-flying officer (AFI 44-170). Send one copy of the appropriate forms to the Chief, US Secret Service, US Treasury Department, Washington DC 20220.

2.50.6.7. Federal Bureau of Investigation (FBI) applicants and investigative personnel and Deputy US Marshals in Alaska. The special agent in charge of an FBI field office for FBI personnel and an official of the Department of Justice requests that the MTF perform physicals using SF 88 and SF 93. Send a copy of the forms to the requesting official.

2.50.7. Reserve Component (RC). Active Duty MTFs perform periodic physical exams IAW reasons identified in AFI 48-123, Medical Examination and Standards for RCSMs. Many RCSMs must travel considerable distances to obtain these services. If the individual lives outside the MTF catchment area or more than 40 miles from the MTF, clinic/ancillary services personnel must complete the physical and/or consultation in one (1) day (this does not include the completion of the paperwork or the administrative requirements necessary to properly document findings and final written evaluation, only the clinical testing, physical evaluation, etc.). A traditional RCSM (not on EAD orders) but one who is obligated to one drill weekend a.k.a. Unit Training Assembly weekend per month) is generally only entitled to healthcare benefits identified in paragraphs 2.9. and 2.10. The RCSM's private-employer-sponsored health insurance provides routine medical care.

2.50.8. MTF personnel may authorize one-time ancillary services, such as drawing blood for individuals who are not beneficiaries, if the service is part of an evaluation or treatment program for an authorized beneficiary (e.g., a non-beneficiary who may be a potential organ or blood donor for an authorized beneficiary).

2.50.9. It is a civilian employee's responsibility to get an eye refraction exam for safety glasses. Employees must present their civilian prescriptions to the MTF to obtain safety glasses. If space is available, the MTF may provide eye refraction or contract for such services locally, if the MTF Commander feels it better serves the Government to do so.

2.50.10. Upon written request from the appropriate government agency, the MTF provides physicals for individuals who have filed claims against the Federal Government. These physicals are to determine the nature and extent of that individual's injuries or disabilities.

2.50.10.1. If the individual is filing a claim against the Army, Navy, Air Force, or Marine Corps or if a Congressman is considering filing for a private relief bill, there is no charge for this examination unless it results in an admission. In that case, collect the subsistence rate from the individual.

2.50.10.2. If the individual is filing a claim against another government agency, the MTF completes a DD Form 7A for the IAR and sends it to AFMSA/SGY.

2.50.11. When the government considers it necessary or desirable and the appropriate Commander files a request, the MTF performs physicals, based on space availability and capability, for civilians who are performing aircrew duties or flying in military aircraft. The following individuals may receive physicals under this provision, IAW the standards and guidelines set forth in AFI 48-123 and the Federal Aviation Regulation (FAR), Part 67, and in the Guide for Aviation Medical Examiners published by the FAA Office of Aviation Medicine.

2.50.11.1. Employees or prospective employees of government contractors whom the government has approved for training in DoD facilities or for performing aircrew duties under the AFI 36 series or other DoD agency directives.

2.50.11.2. Passengers and maintenance personnel flying in high performance aircraft under AFI 11-403, Aerospace Physiological Training Program.

2.50.11.3. Civilian employees of, or under contract to, the DoD or other government departments or agencies who have been approved to perform aircrew duties or receive instructions in such duties, under AFI 48-123.

2.50.11.4. DoD test pilots, representatives of (or persons sponsored by) foreign governments, other non-US citizens, and US citizens not a part of the DoD who have been otherwise approved for flying aircraft under appropriate flying management AFIs or comparable non-DoD directives.

2.51. Care of Minors. MTF personnel may treat minors without parental consent for routine care as allowed by applicable state and local laws or other federal regulations applicable to such care. MTF Commanders overseas must consult the base Staff Judge Advocate (SJA) and have a written policy available before treating minors without parental consent.

2.51.1. MTF providers may treat minors without parental consent, if unable to contact the parent or legal guardian, in a medical emergency when failure to treat would result in potential loss of life, limb, or sight. Two Medical Corps (MC) officers should concur with the need for emergency treatment when possible. Do not delay care for a second opinion when such delay could result in loss of life, limb, or sight. Contact the parent(s) as soon as possible after treatment.

2.51.2. When needed or appropriate, substitute a properly executed limited power of attorney (medical power of attorney) for parental consent.

2.52. Elective Civilian Medical Care for Active Duty Members.

2.52.1. Elective medical and dental care provided at civilian medical facilities or from other civilian sources is not authorized at the government's expense. Service Members who seek medical/dental care outside the Military Health System without prior approval or coordination with the MTF responsible for their primary care, do so at their own risk. Any unfavorable outcome resulting from elective care provided by civilian sources could result in a not-in-line-of duty finding and potentially impact disability benefits. Service Members must arrange for the civilian medical facility to send a summary of treatment to the servicing MTF. All members assigned or attached to a sensitive duty program, e.g., the Personnel Reliability Program (PRP), Presidential Support (PSP) Program, or other national security dependent program, must obtain written permission from their unit Commander and local MTF Commander prior to treatment. If approved, personnel in these uniquely critical programs must have their treatment reviewed by the MTF PRP consultant or designated competent medical authority. Protected Health Information disclosures to command authorities will be tracked in accordance with DoD 6025.18-R.

2.52.2. Prior to any elective treatment from the MHS, a Service Member must consult with a competent military medical authority. A Service Member who elects to have elective care or treatment provided at his or her own expense may not be eligible for compensation for any adverse residuals resulting from the elected treatment. A record of the counseling will be made by the BCAC or other designated individual to document that the member was counseled about the elective treatment and his or her subsequent potential ineligibility for disability compensation for any adverse residuals incurred secondary to the elective treatment.

2.52.3. The MTF Commander, after consultation with the member's PCM and/or specialist, may request a case review by the Deployment Availability Working Group (DAWG) prior to the Service Member's anticipated episode of civilian healthcare if there is concern about the Service Member's current fitness for duty. This action serves to provide documentation of preexisting medical conditions should the future risk of a finding of Not Fit for Duty and the need for a disability evaluation be deemed likely.

2.52.4. If the Service Member suffers complications and presents to the MTF for treatment, the healthcare required to resolve the complication is authorized and the MTF must provide care for the Service Member unless the later care or procedure(s) are elective in nature and not medically necessary. If complications jeopardize the member's fitness for duty, the Service Member's commander may request an MEB. If the member requires further convalescent time because of a complication, the Service Member should be recommended for convalescent leave. If the complication requires hospitalization the Service Member must be placed in hospital inpatient status.

2.52.5. Ordinary leave for lost time may be required in accordance with AFI 36-3003, Military Leave Program. **Note:** If an Airmen elects childbirth from civilian sources at her own expense (hospitalization or home delivery), the mother must take ordinary leave to cover any period of time lost from duty before delivery. The attending provider recommends convalescent leave IAW AFI 36-3003 and AFI 44-102.

2.52.6. For more additional information regarding elective civilian medical care, refer to AFI 44-102, Medical Care Management and AFI 36-3003, Military Leave Program.

2.53. Administration Requirements for Organ Donation Requests.

2.53.1. Active Duty Service Members who wish to donate one or more of their organs, must:

2.53.1.1. Be made aware of the risks and benefits of the procedure, including where complications might limit or prohibit further active duty service. The Service Member must provide a letter requesting to be an organ donor. The request must be coordinated with the unit commander, the local MTF Commander, and the MAJCOM Command Surgeon before forwarding to the AFMOA Commander.

2.53.2. The MTF Commander ensures the member has the permission of his/her commander. The Airman is required to submit a request letter to their unit Commander identifying what organ(s) is to be donated and to whom. The unit commander must approve/disapprove the request.

2.53.3. Unit commander permission is documented on an endorsement or approval letter addressed to the MTF Commander. The unit permission or authorization letter becomes part of the approval package. The unit commander must document that his/her mission will not be significantly impacted because of the requestor's departure during the procedure or afterwards, during the recovery period.

2.53.4. The MTF Commander is also responsible for documenting (e.g., endorsement letter) that the member can be expected to remain deployable or physically qualified for "worldwide duty" after a reasonable recovery period following the donation - assuming no unforeseen complications exist. The letter must be forwarded to the AFMOA Commander, along with the member's request, and the unit commander's approval letter. MTF's will track disclosures in accordance with DoD 6025.18-R.

2.53.5. A Service Member who elects to have such treatment done at his or her own expense will likely not be eligible for compensation from any adverse residual complications resulting from the elected treatment, unless it can be demonstrated that such election was reasonable or resulted from a significant impairment of judgment that can be attributed or is the product of a ratable medical condition. A record of the counseling will be made by the BCAC or other designated individual to document that the member was counseled about the elective treatment and his or her subsequent ineligibility for disability compensation for any adverse residuals incurred secondary to the elective treatment.

2.53.6. The request for organ donation along with the unit commander's approval and documentation of the required counseling identified above must be sent per AFI 44-102 guidance.

2.53.7. Organ donors may have permissive TDY to travel, inpatient status for the surgery, and convalescent leave for the recovery IAW AFI 36-3003. See AFI 44-102, Medical Care Management for further information regarding organ donation.

2.54. Abortions.

2.54.1. The Air Force Medical Service restricts abortions to cases in which the mother's life would be endangered if she carried the fetus to term. If there is a significant chance that the mother's life is in jeopardy, MTFs are authorized to perform the procedure with MTF Commander approval. No pre-payment for inpatient care is required. Services and supplies

related to spontaneous, missed or threatened abortions and abortions related to ectopic pregnancies may be provided. Refer to the TRICARE Policy Manual Chapter 4.

2.54.1.1. Overseas MTFs may perform prepaid abortions only in cases where the pregnancy is a result of rape or incest. Refer to AFI 44-102 for additional information.

2.55. Artificial Insemination. Except in cases meeting the requirements of the Health Affairs Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (category II or III) Active Duty Service members, dated 3 April 2012, the use of supplemental healthcare funds for Artificial Insemination (AI) is not authorized. In limited cases outside the scope of the Heath Affairs policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (category II or III) Active Duty Service members, Air Force teaching facilities may provide AI with husband's semen (AIH). Artificial Insemination using semen from an unknown donor (AID) cannot be performed using military funding. Medical care continues for women who become pregnant as a result of artificial insemination. Availability of care is based on their beneficiary category.

2.56. Sperm Cell or Spermatozoa Frozen Storage. Temporary and/or long-term frozen sperm storage for male beneficiaries undergoing cancer treatment (including Active Duty and Reserve Component) is not authorized. Air Force payment or reimbursement for said storage is not authorized.

2.57. TRICARE Coverage of Surrogate Pregnancies. The Office of the Assistant Secretary of Defense for Health Affairs, by letter published 29 April 2009 and accompanying Information Paper on TRICARE Coverage of Surrogate Pregnancies, established DoD policy regarding TRICARE coverage of surrogate pregnancies.

2.57.1. There is nothing in law, regulation, or policy that prohibits military family members from engaging in surrogate pregnancies.

2.57.2. Policy specifies that surrogate pregnancies resulting from contractual arrangements are subject to statutory limitations on TRICARE being a second payer to all other health plan coverage.

2.57.2.1. TRICARE policy Manual, Chapter 4, Section 8.1., Paragraph III.D.

2.57.2.2. TRICARE Reimbursement Manual, Chapter 4, Section 4, Paragraph XIV.

2.57.3. TRICARE considers a contract for surrogacy to be "other health insurance" (OHI) and cost shares accordingly.

2.57.3.1. Applies when the contract requires the adoptive parents to pay all or part of the medical expenses of the surrogate mother as well as when contractual arrangements for payment do not specifically address reimbursement for the mother's medical care.

2.57.3.2. TRICARE will cost share on the remaining balance of otherwise-covered benefits related to the surrogate mother's medical expenses after the contractually agreed upon arrangement has been exhausted.

2.57.3.2.1. Value of the OHI is considered to be the amount specified in the contract for medical care or, in the absence of a specified amount, the full amount of all undersigned payments.

2.57.4. Identifying a surrogate pregnancy has proven to be problematic.

2.57.4.1. If information gained after the delivery reveals the pregnancy to have been a surrogate one, either the MTF or the managed care support contractor, as appropriate, must undertake recoupment action.

2.58. Intersex Surgery. (Reference TRICARE Policy Manual 6010.54-M, 1 Aug 2002, Chapter 4, Section 16.2., Surgery, Intersex Surgery). Authority: 32 CFR 199.4(e)(7) and (g)(29).

2.58.1. Surgery performed to correct sex gender confusion (e.g., ambiguous genitalia) which has been documented to be present at birth is a covered benefit.

2.58.2. Exclusion. All services and supplies directly and indirectly related to intersex surgery for other than ambiguous genitalia documented to be present at birth are excluded from cost-sharing and are not provided at Air Force MTFs.

Chapter 3

TRICARE OPERATIONS

Section 3A—Access to Care Guidance

3.1. Access to Care (ATC) Standards.

3.1.1. Access to care for our beneficiaries is a top priority for the Military Health System (MHS). All enrolled beneficiaries (including active duty), regardless of their location, should be afforded ATC according to the standards published in 32 CFR 199.17. See AFI 44-176, Access to the Care Continuum for additional information.

3.1.2. The ATC standards are:

3.1.2.1. Acute Care Access: to be provided within 24 continuous hours from the patient's request.

3.1.2.2. Routine Care Access: To be provided within one week (seven calendar days) from the patient's request.

3.1.2.3. Specialty/Wellness Care Access: To be provided within four weeks (28 calendar days) from the patient's request.

3.1.3. MTF and TRICARE authorized providers have the authority to determine what category of care (acute or routine) is required for a given healthcare need, even if it is different from the patient's original request. In other words, if the patient calls in for an acute appointment and a provider determines, based upon his or her own training, experience, and appropriate criteria that a routine appointment is merited, the routine appointment will be offered. The provider should document the logic behind the decision in the patient's medical record.

3.1.4. In most circumstances the beneficiary will speak to an appointing agent. The appointing agent should make every effort to accommodate the patient's access to care request (e.g., if the beneficiary requests an acute appointment and one is available, it should be offered regardless of branch or service affiliation).

3.1.5. Military Health System's (MHS) Guide to Access Success. A MHS Guide to Access Success developed by the AFMS is available for download from the Health Benefits Knowledge Junction at **https://kx.afms.mil/healthbenefits**. This guide provides all the information needed to successfully manage access to care programs in any AFMS MTF and its use is mandatory.

3.2. Specialty Care Access Standards.

3.2.1. 32 CFR 199.17(p)(5)(ii) states that "wait time for an appointment for the initial routine specialty care referral shall not exceed four weeks." To meet the access to care standard, the MTF or the Managed Care Support Contractor (MCSC) would, upon being contacted by either the patient or referring provider, have to offer a specialty care appointment within four weeks of the date of that request.

3.2.2. Wait time begins from the date the TRICARE Service Center/Healthcare Finder, an MTF, or a provider is contacted for an appointment either by the patient or referring provider.

3.2.3. Patients should be strongly encouraged to go to the MTF's Referral Management Center (RMC) to process and get instructions regarding their specialty care referral. The MTF is responsible to track and account for all its referrals.

3.2.4. The MTF need only to offer one MTF appointment within the access to care standards to fulfill its duty to provide care within the access standards. If multiple and convenient appointment choices are available, whenever possible, the patient should be offered more than one option that meets the access to care standard. Moreover, if the patient is unable to accept the initial appointment offered, the patient should be offered the next available appointment thereafter. Appointing staff should be trained to use access to care measurement features of the CHCS to accurately document timeliness of services and patient refusals of appointments within access standards.

3.2.4.1. Once offered an MTF appointment, the Prime patient, except active duty, may choose to exercise their point of service option.

3.2.5. A provider's professional judgment cannot waive the standards. There is no provision for waiving the standards, which are fixed by regulation and incorporated into the MCSC contracts. While the provider cannot relieve any entity of its obligations under the access to care standards, the provider can, exercising his or her professional judgment, advise the patient of his or her opinion that a condition is amenable to a greater than four week wait for an appointment time. If a patient accepts that opinion, the patient would have the option of declining timely offered appointments as discussed above.

3.2.6. A contractor may request exceptions to the requirement to make specialty services available within the network if they are not sufficiently available in the area to make inclusion practical. However, absent such an exception, the contractor is bound by the network adequacy standards. If the network is legally and contractually adequate, but there is still no ability to provide an appointment in the MTF or network within four weeks, the appropriate solution is for the MCSC to refer the patient to an non-network provider within the access to care standards or to give the patient the option, with the referring provider's concurrence, of waiting for a network appointment.

3.3. Non-Availability Statements.

3.3.1. To obtain information regarding Non-availability Statement management, visit the TRICARE.mil website or review DoD Manual 6010.54-M, TRICARE Policy Manual, Chapter 1, Section 6.1. Non-availability Statement (DD Form 1251) for Inpatient Care and Chapter 12, Section 2.1., Benefits and Beneficiary Payments.

Section 3B—Beneficiary Counseling and Assistance Coordinator (BCAC)

3.4. BCAC General Roles and Responsibilities. As developed between the Services and TRICARE Management Activity (TMA), the following are general roles and responsibilities that BCACs are expected to follow when completing their duties.

3.4.1. Serves as a beneficiary advocate and problem solver, providing dedicated service to all Military Health System (MHS) beneficiaries. Ensures health benefit information and assistance to access healthcare services is available to all eligible beneficiaries.

3.4.2. Receives inquiries directly from beneficiaries, DoD Components, other agencies, and various interested parties.

3.4.3. Coordinates with appropriate points of contact throughout the MHS to include TMA, TRICARE Regional Offices (TROs), overseas TRICARE Area offices (TAOs), Managed Care Support Contractors (MCSCs), pharmacy, dental, fiscal intermediaries and MAJCOM Command Surgeon, AFMOA or specific service points of contact to best meet a beneficiary's need for information or assistance.

3.4.4. Facilitates issue resolution through open communication with all involved parties.

3.4.5. Ensure TRICARE information and assistance with accessing healthcare services is available across the TRICARE system for eligible beneficiaries.

3.4.6. Helps beneficiaries address/resolve healthcare benefit concerns.

3.4.7. Counsels beneficiaries regarding their healthcare benefits, consulting with other agencies as needed, to clarify information on various TRICARE basic benefit programs and supplemental programs to include TRICARE for Life, Dental Programs, and other Demonstrations/Projects.

3.4.8. Works with functional experts to provide enrollment, benefit, and claims processing assistance. BCACs will describe or seek clarification on eligibility requirements and benefits based on the category of beneficiary seeking assistance.

3.4.9. As directed, and with appropriate legal authority to disclose PHI, responds to beneficiary, leadership, and congressional inquiries regarding healthcare matters.

3.4.10. Addresses access to healthcare complaints, ensuring that beneficiaries get the appropriate benefits and services to which they are entitled.

3.5. BCAC Operational Activities. As part of their operational responsibilities BCACs shall:

3.5.1. Use current information from TMA Program Offices and the Service on TRICARE instructions, regulations, and policies as needed.

3.5.2. Coordinate with TROs/TAOs who act as the liaisons to resolve TRICARE issues with regional MCSCs, overseas providers/contractors, Fiscal Intermediaries, the Services, and other concerned parties, when such issues cannot be resolved at the MTF level.

3.5.3. Follow-up and troubleshoot claims, enrollment, referral and authorization problems or other system problems that are exceedingly complicated, unduly delayed, or inappropriately handled through primary program managers/systems. Elevate issues concerning network providers to the TRO.

3.5.4. Bring identified systemic problems to the appropriate TRO or MTF point of contact.

3.5.5. Support analysis, research and resolution of inquiries, regardless of method received (e.g., walk-in, written, telephonic, and e-mail).

3.5.6. Provide information and assistance based on inquiries; address care concerns based on direct care and TRICARE program elements.

3.5.7. Maintain statistical data and generate reports for the TRO/TAO and MTF Commander on workload volume and categories of issues encountered.

3.5.8. Input beneficiary associated case work into the Assistance Reporting Tool (ART), developed and maintained by TMA, Communications and Customer Service Division.

3.5.8.1. Track, manage, refer, categorize, and document case workload in the ART. Any cases that need referral to a TRICARE Program Office (TMA, TRO, TAO) must be sent via ART. ART credentials are requested by e-mailing **bcacdcao@tma.osd.mil.**

3.5.8.1.1. In the event of system connectivity issues, MTFs are encouraged to create and utilize a temporary internal tracking mechanism. MTFs shall transport information from internal tracking tool to the ART when the tool is once again operational.

3.5.8.2. Maintain and analyze case data and generate reports for the MTF Commander, Service on workload volume and categories of issues encountered.

3.5.9. Use information gleaned from reports to make suggestions for developing beneficiary and provider education efforts to improve understanding of issues and benefits at local, regional, or Service levels.

3.5.10. Ensure external communications are consistent with the strategies and objectives established by Air Force Medical Service, MTF Commander, TMA and TRO/TAO.

3.6. Key Professional BCAC Relationships and Contacts.

3.6.1. All BCACs are required to establish, facilitate, and maintain ongoing and effective communication with TMA, TRO/TAO, TRICARE Service Center (TSCs), MCSCs, AFMOA, and others for issue coordination and resolution. As needed, they will coordinate with subject matter experts on issues.

3.6.2. Keep the MTF chain of command and TRO/TAO informed of ongoing issues and special cases.

3.6.3. Maintain a continuing cooperative relationship with various agencies to include TRO/TAO, Service Surgeon General Offices, MTFs, TSCs, MCSC regional and corporate offices, TMA, Social Security Administration, Medicare, Department of Veterans Affairs, Dental contractors, Fiscal Intermediaries, and Congressional field offices.

3.7. Claims Assistance.

3.7.1. Provide or direct communication information on healthcare services covered and excluded from TRICARE and convey how these benefits and policies integrate with other healthcare sources. Explain what costs and responsibilities must be borne by the beneficiary when enrolling in TRICARE Prime or Plus, as well as costs when accessing services under the Standard, Extra or other TRICARE options, to include TRICARE ECHO, TRICARE Reserve Select, TRICARE Young Adult and TRICARE For Life (TFL), Demonstration and other healthcare benefit programs.

3.7.2. Explain to and assist beneficiaries in understanding the TRICARE claims process, to include such things as information on filing claims, resolving unpaid healthcare claims, pre-authorization requirements, and third-party liability and effects of having other health insurance on TRICARE benefits.

3.7.3. Assist with eligibility problems in DEERS, which could result in denial of claims (medical or dental).

3.8. Appeals and Grievances. BCACs will explain appeals and grievance procedures. They will refer beneficiaries to points of contact that can provide detailed and specific information on how to access TRICARE services and what steps beneficiaries can take if not satisfied with services received.

3.9. Knowledge and Skills Required.

3.9.1. BCACs are expected to possess an above average to expert knowledge of the MTF, Service and TRICARE statutes, regulations, policies, references, and guidance – related to health benefits and entitlements.

3.9.2. Possess in-depth knowledge, experience, and training to handle and solve complex cases that arise when addressing healthcare benefit issues.

3.9.3. Possess tact, diplomacy, and restraint in counseling and explaining entitlements, benefits, and responsibilities to all customers.

3.9.4. BCACs must have a solid understanding of the military health system and all TRICARE program elements. BCAC duty requires the successful completion of the TRICARE Fundamentals Course via online TRICARE University or attendance in residence.

3.9.5. Master of oral and written communication, customer service principles, methods, practices, techniques, and methods to include using research tools, data analysis and, interpersonal relations practices.

3.9.6. Practical knowledge and understanding of TRICARE contract language, regional healthcare issues and initiatives, and other federal health benefits programs.

3.9.7. Knowledge of basic principles and practices relating to the entire military healthcare delivery system.

3.9.8. Knowledge of TRICARE claims processing, instructions, procedures, and policies to assure payment of legitimate claims.

3.9.9. Knowledge of region-specific TRICARE contracts relating to authorized benefits and requirements needed to obtain healthcare.

3.10. Complexities Associated with the BCAC Position.

3.10.1. Positions require that BCACs remain abreast of continual updates/changes to the variety of health benefits programs available to the beneficiaries at the appropriate Health Affairs (HA), TMA, regional, Service and MTF level.

3.10.2. Positions require the ability to organize, prioritize, complete, and track multiple complaints, issues and projects.

3.10.3. BCACs exercise a great deal of initiative, independence, and considerable judgment in interpreting issues and adapting existing practices and precedents, using these skills as a foundation for developing approaches that integrate all aspects of the Service's and TMA's objective to establish a unified beneficiary services program.

3.10.4. Requires ability to prioritize and reconcile benefit issues, working through different sources/agencies.

3.10.5. Guidelines and regulations, used by BCACs in the conduct of their duties, are often complex and under continuous change, cover many different programs, and may require the use of extensive interpretive judgment.

3.11. Resources Available to Assist the BCAC in Providing Services.

3.11.1. Health Affairs/TRICARE policy and program documents and manuals, MCSC and other healthcare associated contracts, DoD documents, directives, manuals and Service-level instructions are the BCACs most frequently used documents. General policy statements and statutory mandates, such as guidance found in DoD instructions pertaining to correspondence, also guide the BCAC. Applicable TMA Operations, Reimbursement and Policy Manuals are also used, as well as, the appropriate Code of Federal Regulations.

3.11.2. MTF BCAC roles and responsibilities are defined by MTF Commanders, under the guidance of the Air Force Medical Service.

3.11.3. The TMA provides online resources to provide assistance to the BCACs/DCAOs and Customer Service personnel. These links contain operational and policy manuals, fact sheets, TRICARE educational resources, contact information, and a myriad of other resources to assist the BCAC in meeting the needs of the beneficiary. The following are links to these invaluable resources:

3.11.3.1. Main TRICARE Web Page: **http://www.tricare.mil**.

3.11.3.2. TRICARE University: **http://www.tricare.mil/tricareu**/.

3.11.3.3. TRICARE Customer Service Page: **http://www.tricare.mil/customerservicecommunity**/.

3.11.4. Questions can also be forwarded directly to TMA Communications and Customer Service via e-mail at **bcacdcao@tma.osd.mil.**

3.12. Case Resolution Activities.

3.12.1. The BCAC initially contacted assumes responsibility for the beneficiary case and/or inquiry from the time of initial contact until the issue is resolved.

3.12.2. BCACs will assign a case identifier to each beneficiary case, using the ART developed by TMA. BCACs will track cases, categorizing caseload by data elements and timeliness of resolution.

3.12.2.1. After assignment of a case identifier and initial data entry, some cases may need to be referred via ART to the TRO or TMA for resolution. BCACs will use Service-processes when resolving service-related healthcare issues.

3.12.2.2. Follow processes established by MTF Commanders to ensure tracking and timeline requirements of all cases received from the TRO/TMA, higher headquarters/AFMSA, congressional staffers, etc.

3.12.2.3. BCACs will comply with case completion time requirements as follows: Resolve "Priority" cases (i.e., those cases forwarded on behalf of a beneficiary by the Office of the Assistant Secretary of Defense for Health Affairs (OSD/HA), TMA/Service/AFMSA, members of Congress or those otherwise designated as Priority by the TRO/MTF Commander) within 10 calendar days. The timeline for resolution of routine beneficiary cases is 30 calendar days. Complex cases may require additional time for resolution. Case details in ART support case resolution requiring greater than 30 days.

3.12.3. The BCAC is responsible to notify the beneficiary of case closure and determine satisfaction with case outcome via an oral, written or automated process.

3.12.4. Provide required input and ad hoc reports as requested or needed by the MTF. The ART provides both standard and ad hoc reporting capabilities based on data elements input by the BCAC.

3.12.4.1. BCACs will generate MTF-specific ad-hoc reports as required by MTF Commanders to meet specific needs.

Section 3C—Debt Collection Assistance Officer (DCAO)

3.13. DCAO Roles and Responsibilities.

3.13.1. DCAOs are mandated at each MTF and TRICARE Regional Office. Upon notification and presentation of appropriate documentation of a debt collection or adverse credit rating issue due to an unpaid TRICARE bill, DCAOs receiving the case assume responsibility and work it to conclusion. For a case to qualify as a Debt Collection case, one or both of the following must be presented by the beneficiary:

3.13.1.1. A letter from a Collection Agency indicating that the beneficiary has been sent to collection for non-payment, partial payment or denial of claim for services of a TRICARE-associated claim.

3.13.1.2. A negative credit report secondary to the above.

3.13.2. The role of the DCAO includes the following:

3.13.2.1. Assisting the beneficiary to obtain a determination as to whether or not the basis for the underlying alleged debt or collection notice is valid, in whole or part, when the beneficiary presents documentation from a provider or collection agency for services rendered to the beneficiary.

3.13.2.2. Collecting copies of all pertinent documentation available from the beneficiary concerning the case (e.g., provider bills and notices, TRICARE, Medicare, or Other Health Insurance explanations of benefits/notices and letters from providers/credit reporting agencies).

3.13.2.3. Obtaining written permission (via DD Form 2870, Authorization for Disclosure of Medical or Dental Information, or other locally approved form) from the sponsor

and/or patient (if the patient is at least 18 years old), authorizing the DCAO to obtain PHI and/or billing information from civilian medical sources. Before a DCAO can provide any significant assistance to a beneficiary when helping to resolve inaccurate or mistaken debt collection action taken by a civilian medical provider, often the civilian medical providers will not cooperate with the DCAO without first showing proof the beneficiary has granted written permission to the DCAO to obtain or discuss medical and/or billing information.

3.13.2.4. Assigning case number and securely transmitting copies of beneficiary documentation to the MCSC's Priority Collections Unit in the region service or other contractor's POC (dental, pharmacy, TFL) where service was rendered, for investigation. If possible, DCAO case details/documentation shall be forwarded within one working day of receipt from beneficiary.

3.13.2.5. Notifying, by telephone or in writing, provider(s) and collection or credit reporting agencies that the beneficiaries' case is being reviewed by the contractor.

3.13.2.5.1. Requesting a temporary suspension of further collection activities until the review is complete.

3.13.2.6. Tracking the timeframe for case resolution.

3.13.2.7. Preparing and forwarding case completion letter to the beneficiary upon receiving written determination of the investigation outcome. If applicable, the DCAO will confirm, within 30 days of case resolution, that provider/beneficiary has received payment.

3.13.2.8. Providing written guidance on further action available to the beneficiary when appropriate (e.g., contact numbers for local JAG offices, Family Support Centers, Ombudsmen, and financial assistance resources such as Service-specific relief organizations). Additionally, when a DCAO is assisting a beneficiary with financial assistance, the DCAO should provide the beneficiary with a fact sheet explaining the beneficiary's rights under the Fair Debt Collection Practices Act.

3.13.2.9. Submitting "balanced billing" cases to regional MCSC or TMA Office of Program Integrity.

3.13.2.10. Verifying beneficiary understanding of the scope of services to be provided by the DCAO.

3.13.3. DCAOs will enter validated debt collection cases into the ART as cases are presented. (Specific procedures are listed in the DCAO Training Guide located in the reference tab of the ART).

3.13.4. MTF, Service BCACs, DCAOs, and other registered and/or authorized users, may create debt-collection case related ad-hoc reports and/or standardized reports from the ART.

3.13.5. Under NO circumstance must a DCAO tell the beneficiary that they will be able to correct a negative credit report. This can only be accomplished by the beneficiary working directly with the credit reporting agency.

3.13.6. TRICARE Prime Remote members may contact MMSO at 1-(888)-647-6676 DCAO Representative for assistance with debt collection issues related to Line-of-duty determinations; otherwise they should work with the regional MCSC first.

3.13.7. BCAC DCAO Directory: BCACs must ensure that their contact information is accurately reflected in the public BCAC DCAO directory: **http://www.tricare.mil/bcacdcao**/ Changes and updates should be forwarded to the TRO.

Section 3D—Service Change Requests

3.14. Changes in Clinical Services. Congressional reporting is no longer required. Approval authority for changes in clinical services has been delegated by Assistant Secretary of Defense for Health Affairs, OASD(HA), to the Secretaries of the Army, Navy, and Air Force. The Secretary of the Air Force (SECAF) has further delegated approval authority to the Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR). All clinical service change requests packages must be vetted through AFMOA/SGAT and AFMSA/SG3SA (Health Benefits). The AFMSA Health Benefits office is responsible for coordinating the package with AF/SG and the SECAF.

3.14.1. MTFs will first submit their service closure packages to their respective MAJCOM Command Surgeon, then to their TRICARE Regional Office, before forwarding to AFMOA/SGAT. During the entire process the MTF, MAJCOM Command Surgeon, and AFMSA/SG3SA will ensure appropriate Public Affairs and potential Congressional concerns are briefed at each level and elevated as appropriate. After reviewing and analyzing each service closure request, AFMOA/SGAT will forward the packages to AFMSA/SG3SA. Service change requests must be submitted according to the following criteria:

3.14.1.1. Permanent changes in services which significantly affect the current annual volume of care provided to one or more categories of beneficiaries at an MTF for one or multiple specialty or ancillary service(s).

3.14.1.2. Changes that impact users in a way that may stimulate local public or congressional objections.

3.14.1.3. Temporary closures of services that are projected to last 90 days or more, or for an indefinite period.

3.14.2. MAJCOM Command Surgeons, AFMOA/SGAT, and MTF operational and resource planners should include projected changes in services in their strategic planning documents, such as strategic plans, business plans, and/or strategic resourcing portfolios. Notify AFMSA/SG3SA as soon as possible of any projected changes in service, keeping in mind the various planning cycles involved in accommodating changes. The planning cycles is at least three fiscal years prior to facility modifications that involve major construction projects, at least two years prior to the current fiscal year for manpower and financial resources, and at least 12 months in advance for personnel assignments. The content and submission requirements for change in service requests shall vary depending on impact and cause of the proposed change.

3.14.2.1. Change in service requests shall include information as outlined below and must arrive at AFMSA/SG3SA at least six months prior to the proposed effective date when the change involves significant downgrading or upgrading in level of services.

This includes downgrading from hospital to clinic, permanent closure of services, and adding a service which has been previously unavailable at the facility. MTFs should not to assume their request will be approved.

3.14.2.2. Abbreviated requests or notifications may be submitted for any changes in service which result in minor changes in type of services (such as discontinuing a subspecialty service) or for any changes resulting from circumstances beyond the control of the MAJCOM Command Surgeon, AFMOA/SGAT, or the MTF. This includes actions due to Resource Management Decisions (RMDs), economic analyses for Military Construction Projects (MCPs), and for situations described below. Abbreviated requests or notifications should be coordinated through respective MAJCOM Command Surgeons or AFMOA/SGAT, with information copies sent to TROs, and should arrive at AFMSA/SG3SA not later than 90 days prior to the effective date of the change.

3.14.2.3. If a temporary change in services occurs as a result of sudden staffing changes or reassignments, equipment breakdowns, supply shortages, or other unexpected circumstance, immediately notify the TRO, Command Surgeon, AFMOA/SGAT, and AFMSA/SG3SA, and prepare an abbreviated package as soon as possible but arriving at AFMSA/SG3SA no later than 30 days following the change. If the change eventually results in a permanent closure of services, a more detailed package is required within 90 days of the original closure.

3.14.3. MTFs will submit written request packages, already coordinated with their TROs, MAJCOM Command Surgeon, AFMOA/SGAT, to AFMSA/SG3SA, who will then prepare requests for SAF/MR approval. The following information will be included or addressed:

3.14.3.1. Name and location of the facility.

3.14.3.2. Type of change in service and, if applicable, the Medical Expense and Performance Reporting System (MEPRS) specialty area.

3.14.3.3. Proposed effective date of the change and/or the estimated duration of the change.

3.14.3.4. Reason/Justification for the change.

3.14.3.5. Summary of the impact on beneficiaries, including access and quality of alternatives and difference in cost, if any (e.g., estimated increase or decrease in out-of-pocket expenses).

3.14.3.6. Evidence of briefing and feedback to Wing Commanders and/or line Commanders and beneficiary groups supported by MTF (such as retiree and veterans associations and staff of congressional field offices), and concerns resolved or addressed by MTF; may include beneficiary marketing and education plan in package.

3.14.3.7. Impact on readiness capability, including how training needs will be affected and/or addressed to maintain technical and clinical skills and currency, knowledge, and tasks required for wartime, enhancement of a fit force, and improvements in force protection.

3.14.3.8. Description of how the change(s) is/are consistent with the overall health services mission and strategy for the medical facility, MAJCOM Command Surgeon, and AFMOA, Department of Defense Health Services Region, Air Force, MHS, etc.,

including implementation of new and innovative ways for promoting better health among beneficiaries and the military community.

3.14.3.9. Estimated workload changes, by MEPRS specialty area and beneficiary category, including number of non-availability statements (NAS), beneficiary visits, admissions, bed days, and/or ancillary service work units. Beneficiary categories should include active duty (AD), non-TRICARE eligible, and TRICARE-eligible, with the latter broken down into active duty dependents (ADD), and non-active duty dependents (NADD).

3.14.3.10. Projected savings (or cost) to the government, by fiscal year, resulting from the change, including operations and maintenance funds (including civilian staffing), military personnel (MILPERS), impact from estimated bid price adjustment, and MILCON costs, if applicable. Submit all calculations used in determining final estimates, including methodology for both full and marginal cost estimates.

3.14.3.11. Net manpower, equipment, and facilities resources resulting from the proposed change, and projected methodology for redistributing resources, if applicable; include how surplus resources will be used in other functions or eliminated.

3.14.3.12. Analysis of alternative ways to provide care to the beneficiaries affected, including projected increases in cost or each alternative, as well as, the financial implications to the beneficiary. The analysis should include the following:

3.14.3.12.1. Quality and Utilization of Services: Provider qualifications, accreditation, preventive measures, health outcomes, beneficiary satisfaction, and projected volume and level of care based on beneficiary needs and/or referrals.

3.14.3.12.2. Cost: Government as well as beneficiary savings or costs.

3.14.3.12.3. Access: Availability of civilian or other federal healthcare providers in community, including options such as DoD/VA sharing, contracting, TRICARE resource sharing or resource support agreements.

3.14.3.12.4. Other: Local market factors which may influence the use of alternatives such as quality, cost, access and other unique factors specific to the MTF, local community, or region that could potentially generate future benefits or problems resulting from the requested service change.

3.14.3.13. Projected impact in terms of increased reliance on TRICARE managed care support contract and/or Medicare providers in the service area in which the MTF is located.

3.14.3.14. Long-term costs/savings in infrastructure such as information systems requirements, contracts, and facilities (including minor construction, major repair or military construction projects) currently underway, recently completed, and/or planned.

3.14.3.15. Explanation of how the change is/is not consistent with the MTF strategic resourcing portfolio (SRP), business plan, goals and objectives, etc.

3.14.4. MTFs shall coordinate requests through their respective TRO. TRO input may include, but is not limited to:

3.14.4.1. How the change is/is not consistent with the TRO business plan/strategic plan/regional health plan, including comparison with any regional alternatives or initiatives, particularly those involving the TRICARE MCSC.

3.14.4.2. Impact on the MCSC, and if available, the net negative or positive cost impact to the region and/or another DoD MTF, particularly in overlapping catchment areas.

3.14.4.3. Coordination/feedback from other Services, MAJCOM Command Surgeons, and/or AFMOA/SGAT, particularly if impacting GME programs.

3.14.4.4. Recommendations, including estimated timeline.

3.14.5. MAJCOM Command Surgeons must submit evidence of coordination with MAJCOM Commanders (through MAJCOM Plans and Programs offices) and shall include in their evaluation:

3.14.5.1. Impact on readiness baseline and how MAJCOM Command Surgeon or AFMOA/SGAT proposes to make any necessary changes to operational mission within the command to accommodate change.

3.14.5.2. Validation of MILPERS disposition (e.g., if MILPERS savings are expected and, if applicable, how MAJCOM Command Surgeon or AFMOA/SGAP proposes to redistribute resources in accordance with projected limits to downsizing force IAW AFMS rightsizing efforts, Base Realignment and Closure (BRAC) plans, and other factors).

3.14.5.3. Explanation of how the change is/is not consistent with the MAJCOM Command Surgeon's business plan, strategic plan, or strategic resourcing portfolio.

3.14.6. Changes in services which are made under the following circumstances do not require prior notification to HQ USAF/SG and SAF/MR approval, but shall be promptly reported along the chain of command. If the facility is closing, information listed below shall be included in the basic operating plan for the closure or realignment of the facility:

3.14.6.1. A facility rendered structurally unsound by a natural disaster.

3.14.6.2. A change in a Status of Forces Agreement.

3.14.6.3. An initial response to an emergency deployment of healthcare personnel.

3.14.6.4. A change in local Force Protection Condition.

Section 3E—Referral Management Program

3.15. Referral Management Program.

3.15.1. Information regarding referral management guidelines can be obtained by accessing the MTF Referral Management Center Users Guide located on the AFMS KX Health Benefits website.

3.15.2. Support to Geographically Separated Units (GSU)/TRICARE Prime Remote (TPR) enrollees.

3.15.2.1. GSU members are usually enrolled to a civilian PCM through the TPR program. When a TPR member's medical condition warrants referral to an MTF for

either administrative reasons (e.g., LOD, MEB, etc…) or specialty care, the MTF becomes clinically responsible for that patient. If the MTF subsequently refers the patient to the local network, while maintaining clinical oversight of the patient's care, the approval/authorization process rests with the referring MTF. Under no circumstance will the Service Point of Contact (SPOC) at the Military Medical Support Office (MMSO) be asked to place an authorization into the system for a TPR enrolled patient when an MTF initiated the referral. If the patient's clinical needs exceed the MTFs oversight capability, care management is returned to the civilian PCM through the SPOC. These same guidelines apply to RC personnel referred to our MTFs for medical and administrative support.

3.15.2.2. The supporting MTF Commander has direct control of patient travel funding for GSU members as outlined in the Joint Federal Travel Regulation.

3.15.3. Access to Care and Referral Times:

3.15.3.1. Refer to 3.1. for Access to Care standards and 3.2. for Specialty Care Access Standards.

Section 3F—Medical In/Out-Processing Program

3.16. Overview.

3.16.1. The DoD has established policy that all military service members will be apprised of their healthcare benefits as they move from one assignment to another. Specifically, members must be informed of the scope of their benefits; how to access healthcare in their local community; how to access healthcare while away from home or enroute to a new duty station; and how to get problems resolved during this transitional period should they arise. Furthermore, medical in/out-processing appointments, briefings, and meetings offer MTF providers and preventative healthcare specialists with an opportunity to collect, review, and assess a Service Member and his/her family members' health status to identify significant medical or dental conditions or complications that may have otherwise gone unnoticed or untreated if the medical in/out-processing review had not been completed.

3.16.2. MTF Commanders will establish medical in/out-processing programs designed to ensure enrolled beneficiaries have a basic understanding of their individual health benefits, the MTF's capabilities, and a basic overview of preventative health programs available to patients. MTF Commanders will also ensure MTF staff members are familiar with the typical subject issues and topics discussed at in/out-processing briefings. Staff members should have a basic understanding of TRICARE benefit options and be able to clearly communicate these options to beneficiaries when required – or at least know to refer patients who have TRICARE enrollment or general health benefits questions to the appropriate office to obtain further information. Health benefits briefings may be combined with other installation information briefings normally provided to arriving and departing service members. A good example of an in-processing briefing opportunity is the "base newcomer's" briefing or Right Start Program briefing. These types of briefings are normally held at installation theaters, officer and enlisted clubs, or any other suitable locations of opportunity that assure maximum participation and/or compliment existing installation in/out-processing policies. Although not specifically limited as an exclusive TOPA

obligation, generally, MTF staff members assigned to the TOPA function are responsible for providing the healthcare benefits portion of each in/out-processing function. Individual medical health status questionnaires or personal assessments obtained by TOPA personnel at any in/out-processing briefing are to be forwarded to locally identified MTF providers and preventative healthcare specialists so appropriate continuity of care health assessments can be accomplished. The MTF TOPA function is specifically responsible for providing a minimum one-hour healthcare benefits briefing to all First Term Airman Center (FTAC) students at the local FTAC facility.

3.17. In-processing Requirements. At a minimum, the following information or procedures must be accomplished with or briefed to each sponsor during the in-processing appointment(s).

3.17.1. TRICARE enrollment options.

3.17.2. Choosing a new PCM and how to contact their provider or clinical team support.

3.17.3. How to change their PCM at the new location.

3.17.4. Benefits of enrolling in TRICARE Prime, including Point of Service.

3.17.5. Local polices on TRICARE Prime enrollment and CHCS registration data collection.

3.17.6. How to enroll family members in the dental plan.

3.17.7. MTF/TRO/Managed Care Support Contract/TRICARE Service Center points of contact.

3.17.8. Exceptional Family Member Program (EFMP) with a brief description of each of the MTF partner programs that support EFMP, EFMP-Medical (EFMP-M) and the Family Member Relocation Clearance (FMRC) processes.

3.17.9. Family Advocacy Program (FAP).

3.17.10. Procedures required to obtain a TRICARE card.

3.17.11. How to schedule/cancel appointments.

3.17.12. Out of area care procedures.

3.17.13. Services available at local MTF(s).

3.17.14. How to access services not available at the local MTF and after hours.

3.17.15. Services available in the network.

3.17.16. Air Force Medical Service health record custody policy.

3.17.17. Mental Health.

3.17.18. Local prescription services.

3.17.19. Recommended preventive services for Prime enrollees.

3.17.20. Immunizations review and update.

3.17.21. PRP, PSP, and other sensitive duties program overview.

3.17.22. How to file a civilian medical/dental claim.

3.17.23. Contact information for the Beneficiary Counseling and Assistance Coordinator/Debt Collection Assistance Officer (BCAC/DCAO).

3.17.24. Co-payments and cost-share/deductible fees for care outside the direct care system.

3.17.25. How to enroll or update TRICARE On-Line member profiles to gaining MTF.

3.17.26. Collect any medical or dental records from the sponsor that he or she may be carrying and return to the MTF records room or primary care management team for which the beneficiary is or will be assigned.

3.17.27. Obtain documented personal health status information from the sponsor and family members to ensure Continuity of Care.

3.17.28. Procedures for participation in Secure Messaging, if available at the MTF.

3.18. Out-processing Requirements. At a minimum, the following information or procedures must be accomplished with or be briefed to each sponsor during the out-processing appointment(s).

3.18.1. Ensure all laboratory and radiology results are printed and filed in the individual's health record NLT 10 days prior to final out-processing appointment for PCS, separation or retirement. For individuals enrolled in, or traversing the Family Member Relocation Program/Process, print and file results in their health records prior to the screening required in paragraph 4.35.

3.18.2. The DoD and Air Force Medical Service health records custody and control policies.

3.18.3. The process required to file medical claims for care while in transit.

3.18.4. The process required to schedule appointments in transit.

3.18.5. The process required to locate a TRICARE Service Center (TSC) or MTF at his/her next assignment.

3.18.6. The process required to obtain prescription services while in transit.

3.18.7. The process required to transfer/change your PCM to a new MTF.

3.18.8. The process required to avoid point of service charges while in transit.

3.18.9. Although not a specific TOPA function, each MTF is required to determine a local process used to identify critical health conditions and communicate required follow-up recommendations to gaining MTFs. At a minimum, the MTF out-processing clinical review mechanism must identify, detail, and communicate (to the gaining MTF) any:

3.18.9.1. Recent identification and/or clinical management efforts to achieve control of chronic disease condition (OM, CAD, Cancer, mental health condition, etc.).

3.18.9.2. Poorly controlled chronic disease conditions requiring regular uninterrupted follow-up (physical and mental health conditions).

3.18.9.3. Current pregnancy or medical diagnoses requiring obstetric follow-up as well as newborns with follow-up requirements.

3.18.9.4. Pending radiographic, laboratory and pathologic specimens (surgical biopsies, mammography, etc.).

3.18.9.5. Pending/incomplete referrals, or referrals where a result has not been obtained.

3.18.10. Designated MTF healthcare providers are required to conduct a PIMR review to ensure personnel complete any outstanding deployment health requirement, e.g., PDHA, PDHRA. These reviews are a critical requirement for AD members who are separating or retiring and shall be completed prior to any MTF out-processing checklist "sign-off" or approval.

3.18.11. The losing MTF will document Continuum of Care elements in AHLTA (utilizing an AFMS standardized COMPASS CORE Automated Information Management form) for any beneficiary with a critical finding or condition. The Assessment/Plan portion of the Electronic Health Record (EHR) patient encounter note will contain the diagnosed conditions, patient care plan and follow-up recommendations for the gaining facility. Designated healthcare providers at the losing MTF must contact appropriate healthcare providers at the gaining MTF to transfer case information and secure pre-arranged initial medical appointments for high-risk patients. Both MTF clinical review authorities shall be identified by each MTF/SGH. A copy of the EHR encounter note(s) will be provided to the patient during the transition from the losing MTF to the gaining MTF in the event of urgent/emergent care enroute.

3.18.12. Procedures for participation in Secure Messaging, if available at the MTF.

Section 3G—TRICARE Online

3.19. TRICARE Online Background.

3.19.1. TRICARE Online (TOL) is the enterprise-wide, secure, Internet portal for use by all DoD beneficiaries, providers, managers, manage care support contractors, and worldwide medical support staff to access available healthcare services, benefits, and information. TOL is a scalable, open standards platform upon which other applications can be integrated.

3.19.2. MTF leadership and commitment are vital to the success of TOL implementation/sustainment and adoption. MTF Commanders must appoint experienced, empowered, and motivated personnel, with appropriate rank/position, to serve in key TOL implementation/sustainment team leadership positions.

3.20. TRICARE Online Roles and Responsibilities.

3.20.1. Air Force TOL Program Manager. The Air Force TOL program manager is located at AFMSA/SG3SA. The USAF TOL program manager provides the MAJCOM Command Surgeons and/or AFMSA TOL execution office with program policy direction and implementation and sustainment support. Additionally, the Air Force TOL Program Manager works with TRICARE Management Activity/Information Management offices regarding system changes and recommended fixes. Responsibilities include:

3.20.1.1. Provide support to TOL Program Management as Service Program Manager/Champion.

3.20.1.2. Support/coordinate maintenance efforts in accordance with service guidelines.

3.20.1.3. Coordinate process to receive, develop and approve systems change requests/new requirements received from AFMSA, AFMOA, MAJCOM and/or MTF level functional personnel.

3.20.1.4. Coordinate the final development of necessary measures/metrics of performance of system operations with applicable AF and TMA organizations.

3.20.1.5. Submit AFMS system change requests/requirements to applicable AF and TMA level organizations.

3.20.1.6. Coordinate and approve new requirements in conjunction with other services.

3.20.1.7. Attend TOL related meetings (e.g., Program Management meeting, sustainment meeting, and various joint-service configuration management working groups).

3.20.1.8. Provide guidance to Air Force Inspection Agency, MAJCOM Command Surgeons, AFMOA, and/or MTFs as needed.

3.20.1.9. Review marketing, training, and support materials for release to Major Commands, AFMOA, and MTFs.

3.20.1.10. Coordinate training with Major Commands, AFMOA and/or MTFs as needed.

3.20.1.11. Coordinate implementation of new TOL capabilities with TMA TOL Program Office, Major Commands, AFMOA, and MTFs as needed.

3.20.1.12. Coordinate applicable system security, information assurance certifications with TMA, AF, AFMSA and/or necessary AFMOA offices as needed to ensure that applicable documents to include Authority to Connect, Authority to Operate and other system security certifications are approved to support secure TOL system operations.

3.20.2. AFMSA and AFMOA TOL Responsibilities. The AFMSA Health Benefits Branch will identify functional points of contacts (POC) for the coordination and facilitation of the overall TOL implementation/sustainment processes at all MTFs under their control. The AFMOA, Health Benefits Branch, acting on behalf of the MAJCOM Command Surgeons, will coordinate with the AFMSA/SG3SA TOL program management office regarding program and system implementation requirements. Responsibilities include:

3.20.2.1. Coordinate with AFMSA/SG3SA as required.

3.20.2.2. Serve as MTF POC for TOL program implementation and sustainment for their respective MAJCOM or area of geographic responsibility.

3.20.2.3. Ensure all MTFs identify a TOL Project Officer and maintain an MTF POC list that is updated as often as necessary. AFMOA/SGAT will forward the list to AFMSA/SG3SA.

3.20.2.4. Guide the MTFs on functional preparation for receiving new applications or updating software in conjunction with AFMSA/SG3SA and TOL Program Office.

3.20.2.5. Advise MTFs on business practice changes related to TOL appointing capability.

3.20.2.6. Participate in TOL meetings, as needed, to provide reports on implementation/sustainment/performance progress and issues that need resolution.

3.20.2.7. Communicate regularly with each MTF TOL program representatives at AFMOA and AFMSA.

3.20.2.8. Resolve issues that cannot be resolved at the MTF level.

3.20.2.9. Report status of TOL problems as necessary to AFMSA/SG3SA.

3.20.2.10. Facilitate TOL implementation/sustainment processes at their MTFs.

3.20.2.11. Assist AFMSA/SG3SA and TOL Program Office with educating and training MTF personnel about new TOL features, capabilities, changes, and procedures.

3.20.2.12. Facilitate communication between AFMSA/SG3SA, TOL Program Office and MTFs on matters related to TOL.

3.20.2.13. Develop, provide written system change requests to AFMSA/SG3SA for any recommended TOL system changes from MTFs.

3.20.3. MTF Responsibilities. MTFs will appoint and empower personnel to fill the following TOL implementation and sustainment team positions (MTFs should allocate responsibilities as needed among their staff, e.g., smaller MTFs can assign more than one responsibility to a single person):

3.20.3.1. TOL Project Officer/Champion.

3.20.3.2. TOL System Administrator.

3.20.3.3. TOL Appointing Subject Matter Expert.

3.20.3.4. Provider Champion, Clinic POCs, Marketing POC as needed/able.

3.20.4. MTF TOL Project Officer/Champion. The MTF Commander should designate a Project Officer who is the "champion" for TOL implementation/sustainment. This is a functional, not a technical, position and is often filled by Managed Care Personnel. It is recommended that this individual have an in depth knowledge of clinic operations and should be viewed as the Commander's personal representative for this project, exhibiting sufficient rank, experience, and commitment to interact with the MAJCOM Command Surgeons, and Air Staff (AFMOA & AFMSA) officials to successfully orchestrate myriad tasks at the local level. Responsibilities include:

3.20.4.1. Coordinate/Chair MTF TOL meetings as needed.

3.20.4.2. Attend Medical Group staff meetings as appropriate to disseminate new TOL information.

3.20.4.3. Ensure the maintenance of an MTF TOL web page, including current image of the MTF and current information about the facility within six months.

3.20.4.4. Develop, maintain MTF specific implementation/sustainment plan.

3.20.4.5. Coordinate necessary new TOL capability activation tasks with MTF TOL team members.

3.20.4.6. Brief AFMOA and/or AFMSA TOL program representatives. Participate in MAJCOM, AFMSA, or AFMOA conference calls as required.

3.20.4.7. Oversee activities of MTF TOL team.

3.20.4.8. Coordinate TOL account permissions and facilitate activation of accounts.

3.20.4.9. Establish business practices to incorporate TOL into the orientation process for new MTF/Wing personnel.

3.20.4.10. Recommend at least 80 percent of all CHCS appointment slots in primary care clinics to include Family Health (Practice), Pediatrics, Internal Medicine, Flight Medicine and select specialty clinics schedules are available/viewable for booking in TOL, IAW AFMSA/SG3SA developed measures.

3.20.4.11. Work with clinic POCs and MTF Marketing POC to ensure successful marketing and marketing sustainment within the MTF.

3.20.5. MTF TOL System Administrator. The TOL System Administrator should review and understand the MTF Server Installation and Configuration Guide and basic TOL features that are hosted on the Science Applications International Corporation (SAIC) Field Services Website. Responsibilities include:

3.20.5.1. Coordinate with the MAJCOM Command Surgeon and/or AFMOA TOL Program Office and Defense Health Information Management System (DHIMS) officials to assist with TOL hardware and software installation activities.

3.20.5.2. Resolve TOL system/technical issues at the MTF level as needed.

3.20.5.3. Review TOL Server Installation and Configuration guide hosted on the SAIC Field Services Website.

3.20.5.4. Serve as POC when changes to CHCS or any other network impact the operation of TOL at the MTF.

3.20.5.5. Ensure MTF is ready for new TOL capabilities interfacing with CHCS and/or other systems.

3.20.6. TOL Appointing Subject Matter Expert. This individual is responsible for understanding, preparing, monitoring, and maintaining the MTF for TOL's web-enabled appointing functionality. The Appointing SME will work with the TOL Program Office, TMA/IM, MAJCOM Command Surgeon, AFMSA/SG3SA and AFMOA/SGAT to prepare and standardize CHCS appointing templates to meet the TOL System's appointing requirements for successful online appointing. Responsibilities include:

3.20.6.1. Complete all TOL Web Based Training pertaining to appointing.

3.20.6.2. Know TMA Appointing Standardization Business rules and requirements.

3.20.6.3. Serve as POC when changes to the CHCS appointing templates impact TOL, or when new functionality or appointment reasons are added to TOL.

3.20.6.4. Ensure the MTF TOL implementation/sustainment team understands the appointing business rules.

3.20.6.5. Ensure that at least 80 percent of all CHCS appointment slots in primary care clinics to include Family Health (Practice), Pediatrics, Internal Medicine, Flight Medicine and select specialty clinics schedules are available/viewable for booking in TOL IAW AFMSA/SG3SA developed metric definitions.

3.20.7. Provider Champion, Clinic POCs, Marketing POC. The Marketing POC performs one of the most critical functions for TOL implementation/sustainment. Internal MTF staff/provider knowledge about TOL is crucial to the success of the program and/or any new application releases on TOL. Responsibilities include:

3.20.7.1. Developing and organizing a visible creative marketing strategy that targets the MTF's various patient groups. This strategy should include: having providers and clinic staff act as informal promoters of TOL, utilize available resources (e.g., newsletters, on-hold telephone messages, installation newspapers) to market TOL, coordinate with clinic POCs to develop marketing strategies specific to clinic (e.g., pediatric vs. adult medicine clinic), and/or supply marketing materials to clinics and throughout the MTF.

3.20.7.2. Redefine marketing strategies for specific clinics and MTFs as needed.

3.20.7.3. Take the lead; develop a marketing strategy for new TOL capabilities and changes.

3.20.7.4. Attend Marketing meeting with TOL Program Office, MAJCOM Command Surgeon and/or AFMOA TOL POC, and AFMSA/SG3SA as needed.

3.21. TOL Scheduling and Appointment Management.

3.21.1. The procedures for scheduling and displaying appointments on TOL will be in accordance with TRICARE Management Activity and AF TOL program user's manuals and web based training classes. Manuals can be downloaded at AFMS Kx Health Benefits website.

3.21.2. TOL appointing processes will be overseen by the MTF TOL Project Manager and the TOL Appointing Supervisor, if so designated.

3.21.3. If the MTF uses the Open Access (OPAC) Appointing model, Open access PCMH teams or other primary care clinics using OPAC appointment types on their schedules will set the radio buttons on the TOL MTF administrator screen for display of timeframes of TOL OPAC appointments to menu options (1) "Same Day" which displays all available OPAC appointments until 2400 the same day, or (2) "Next 24 Hours" which displays all OPAC appointments available during the next 24 hours. Option (3) "Today and Tomorrow" is not permitted to be used by AFMS Open Access sites.

3.21.4. Appointment slots that have the $ suffix on the appointment type or the GDBL and/or CB detail codes cannot be displayed to TOL users even though the WEA (web enabled) detail code is also used in another detail code slot.

Chapter 4

PATIENT ADMINISTRATION FUNCTIONS

Section 4A—Legal Aspects of Protected Health Information and Release of Information

4.1. Safeguarding Medical Information and Health Record Custody and Control.

4.1.1. Maintaining custody and control of original medical, dental, and inpatient records. The information contained in outpatient medical, dental and inpatient treatment records is personal to the individual and will be properly safeguarded. Take necessary precautions to avoid compromise of medical information during the movement of the record inside and outside the MTF. Only medical personnel are authorized access to the information except as noted throughout this chapter. Original health records are not to be released to anyone outside the MTF without specific and verifiable operational mission related, legal or medical necessity requirements. See DoDI 6040.43, Custody and Control of Outpatient Medical Records for additional guidance.

4.1.2. Limit access to all open record storage areas and to electronic records to authorized personnel only. Authorized personnel are defined as personnel who, through a verification process, have presented a valid requirement to access medical records. Personnel granted access must be fully aware of the requirements in this instruction regarding safeguarding PHI maintained in the MTF. Furthermore, MTF Commander approval/authorization is required for unescorted access to medical records areas. Written authorization must be posted near each entrance for ready reference. If commander's written authorization is required prior to electronic access ID card "swipe" activation, individuals with ID card swipe access do not need to be identified on the posted listing. This does not apply to keypad access due to the potential for security compromise.

4.1.3. Establish written procedures to ensure highly sensitive records and sensitive medical information are safeguarded. This includes copying electronic records for inclusion into the hard-copy record, safeguarding x-rays and fetal monitoring strips. Drug and alcohol abuse, rape, child or adult abuse and possible claims against the government are examples of highly sensitive records. Information which may affect the patient's morale, character, medical progress or mental health is considered sensitive. To protect the sensitive nature of the information, ensure that sensitive records or documents are only handled directly by medical personnel when advised by the attending physician or MTF Commander.

4.1.3.1. Role-based access procedures. Each MTF will develop policies and procedures for defining levels of access to paper and electronic health information by individuals or groups of individuals (work centers) based on requirements in fulfillment of assigned duties. At a minimum, guidance should address:

4.1.3.1.1. Standardized matrix for evaluating specific roles against access requirements.

4.1.3.1.2. Review and approval process, to include approval authority.

4.1.3.1.3. Procedures for periodically validating access requirements.

4.1.3.1.4. Termination procedures.

4.1.3.2. Protection of PHI. MTFs must evaluate and implement administrative, technical and physical safeguards to reasonably protect health information from unauthorized use or disclosure, and to limit instances of incidental disclosure.

4.1.4. Sequestering Health Records. Sequestering a health record is the storage and securing of a health record separate from other health records for added security or for legal purposes. The MTF may sequester the original medical record or a certified copy when the situation warrants. A notice should be placed on the original record to ensure personnel do not allow the patient to hand-carry the record while there is an active claim or litigation. If a certified copy is made for sequestering, return the original record to the file room and suspense it for periodic updates. Records will be sequestered under the following conditions:

4.1.4.1. When an administrative claim or law suit claim against the government has been filed.

4.1.4.2. When a patient has tried to tamper, alter or illegally remove a record from the facility.

4.1.4.3. When a request is received from an attorney under circumstances indicating claim or law suit is being considered.

4.1.4.4. When an Inspector General (IG) or Congressional Inquiry or Investigation has been initiated.

4.1.4.5. When the record becomes relevant to an Office of Special Investigation (OSI) or Security Forces investigation. Annotate sequestered record form with the OSI/Security Forces agent's name and case number for annual review process. For all other government investigative agency inquiries, refer to paragraph 4.5. and the DoD 6025.18-R, Health Information Privacy Regulation Internet website at **http://www.dtic.mil/whs/directives/corres/pdf/602518r.pdf**. Contact the local SJA, in-house MLC or HIPAA Privacy Officer for questions.

4.1.4.5.1. For purposes of safety or mishap investigations, sequestration of medical records in a manner similar to the previous paragraphs is not automatically required. However, all efforts should be made to secure and provide copies of pre-incident records to all appropriate investigative bodies IAW AFI 91-204.

4.1.5. It is the MTF Commander's responsibility (with advice from the Quality Services Manager, SJA or in-house MLC) to establish local operating instructions regarding sequestered medical records safekeeping policy and procedure. As a minimum, the records will be kept in a separate, locked location, with limited staff and patient access. If the patient is actively being seen at the MTF, copy the original record for the outpatient records room and annotate on the jacket "Clinic Copy." Create the "Clinic Copy" in CHCS as a unique record type for tracking purposes in the Medical Records Tracking (MRT) module.

4.1.6. Place a cover sheet on the original medical record stating the record has been sequestered. Maintain a separate file on why the record has been sequestered, and the date (or occurrence of an event) when the record should be reviewed to determine the need for continued sequestering. Place a charge out in appropriate records room with statement that the record has been sequestered. If a "Clinic Copy" is made, ensure that original documentation is forwarded to the sequestered file and a copy is placed in the "Clinic Copy."

4.1.7. Coordinate an annual review of sequestered records with the base legal office to determine whether the records should continue to be sequestered. In addition, ensure that records are reviewed prior to patient relocation to see if sequestering is still applicable. If sequestering is still required, mail the outpatient records to the gaining MTF. Include a cover letter stating the records are to be sequestered and an explanation of the circumstances. The losing MTF will make a certified true copy of the record before mailing for cases identified earlier in this section. Maintain the copy until the claim or litigation is resolved and the base legal office or AFLA/JACC concurs.

4.2. Laws and Provisions Affecting Disclosure of Medical Information.

4.2.1. Medical personnel must comply with the Privacy Act, Freedom of Information Act, HIPAA, Genetic Information Nondiscrimination Act, law protecting the confidentiality of drug and alcohol abuse and treatment records, and Comprehensive Alcohol Abuse amendments. Each of these laws must be complied with regarding maintenance, access and disclosure of information from health records and related documentation.

4.2.2. Privacy Act of 1974. (PL 93-579 and 5 U.S.C. § 552a).

4.2.2.1. Medical records are maintained within a system of records protected by the Privacy Act. Electronic and hard copy records are covered by the system notice "Medical Record System" (F044 AF SG E), which identifies the records, including secondary files, as inpatient and outpatient records of care received in Air Force MTFs. Automated records of treatment and clinical diagnostic tests provided to Service Members on an inpatient/outpatient basis in MTFs and in civilian medical facilities are covered by Automated Medical/Dental Record System (F044 AF SG D). Disclosure to third parties is prohibited, except pursuant to the written authorization of the individual to whom the record pertains or in specified limited circumstances as outlined in the Privacy Act (as implemented by AFI 33-332), and the HIPAA Privacy Rule (as implemented by DoD 6025.18-R).

4.2.2.2. Refer to AFI 33-332, Air Force Privacy Program, for guidance on the collection, safeguarding, use, maintenance, access, amendment and disclosure of information. This AFI explains policy on access, disclosure, time periods, denial authority, judicial sanctions, and accountability of disclosure. Refer to Chapter 3 for information regarding responding to requests from individuals for copies of their personal health records submitted under the Privacy Act.

4.2.2.3. DD Form 2005, Privacy Act Statement - Healthcare Records, eliminates the need for a separate Privacy Act statement for each medical, dental or related document requiring individual identifying information. The DD Form 2005 is not a consent form. It serves as evidence that, as prescribed by the Privacy Act, the individual was informed of the purpose and uses of the information collected and was advised of his/her rights and obligations with respect to supplying the data. The patient's signature is not mandatory. When the Privacy Act statement is printed on the reverse of AF Form 560, Authorization and Treatment Statement, or on the record folder, do not use the DD Form 2005. The patient does not need to sign the DD Form 2005 even though there is a space for signature.

4.2.3. ADAPT Records. ADAPT Program treatment information collected and maintained as a part of ADAPT treatment or aftercare services are maintained IAW 42 U.S.C. § 290dd-2 and AFI 33-332. These records are protected from public disclosure and only released under the circumstances listed in 42 U.S.C. § 290dd-2(b) and (c).

4.2.4. Freedom of Information Act (FOIA), (PL 93-502 and 5 U.S.C. § 552). Information from health records is not released if such disclosure would result in a clearly unwarranted invasion of privacy. See DOD 5400.7-R_AFMAN 33-302, Freedom of Information Act Program, for specific guidance and procedures related to FOIA.

4.2.5. Patient Self-Determination Act (PL 101-508, Sections 4206 and 4751). The Patient Self-Determination Act (PSDA) mandates that healthcare institutions inform patients of their rights, according to state law, to make decisions regarding their medical care. This includes the right to accept or refuse treatment and the right to prepare advance directives. An "advance directive" is defined as a written instruction by the patient, in the form of what is commonly known as "living will" or a durable power of attorney for healthcare, recognized under State law (some states require both) and related to the provision for such care when the patient is incapacitated.

4.2.5.1. Each MTF will establish and maintain written policies and procedures to implement patient's rights to make decisions concerning their medical care. Ensure compliance with State law (whether statutory or as recognized by the courts of the State) respecting advance directives.

4.2.5.2. Provide to all adult patients written information on their rights under the host State's law to make decisions concerning their medical care, including the right to execute an advance directive.

4.2.5.3. Document whether or not each patient has an advance directive. This information shall be documented on the AF Form 560 for inpatient care or the DD Form 2766, Adult Preventive and Chronic Care Flowsheet for outpatient care, and on the automated cover sheet for ambulatory procedure visit (APV) cases. **Note:** Utilize the DD Form 2766 and/or DD Form 2882, Pediatric and Adolescent Preventative and Chronic Flowsheet for all new records. See Chapter 5, Health Records Management, paragraph 5.12.5. for more information regarding this form. Provider teams are encouraged to ensure adequate free texting occurs within AHLTA or Essentris notes to document whether or not each patient has an advance directive, however, the hard copy documentation shall remain available.

4.2.5.4. Provide for education of the staff and community on issues concerning advance directives.

4.2.5.5. Check with your local SJA and/or Medical Law Consultant (MLC) for further guidelines.

4.2.5.6. Title 10 U.S.C. § 1044c. Advance medical directives of members and family members: Includes an important safeguard for military members and their family members entitled to legal assistance. This law creates "military advance medical directives" that are exempt from any requirements of form, substance, formality or recording required by State law. For example, if an Air Force member has a military "Living Will" prepared in Florida, but then becomes severely injured in California, the

military Living Will is honored in California even though the document may not conform to California Law.

4.2.6. Provisions Regarding the Release of Mental Health Information: Mental health information will be released IAW AFI 33-332, AFI 44-172, Mental Health, AFI 44-109 and DoD 6025.18-R. See these directives for additional information.

4.2.7. Restricted Reporting Guidance for Medical Personnel.

4.2.7.1. Some states require medical providers to report to civilian authorities in situations addressed by the DoD restricted-reporting policies. Mandatory reporting laws for domestic abuse require medical providers to adhere to state reporting requirements for domestic abuse/violence and sexual assault based on the state where they are currently providing care and not their state of licensure. To verify specific reporting requirements in the state where care is being provided, consult your local SJA or in-house MLC. Report incidents of sexual assault to the installation Sexual Assault Response Coordinator (SARC). Report domestic abuse to Family Advocacy Officer (FAO) who will ensure an immediate assessment of the victim's safety, determine eligibility for Domestic Violence Restricted Reporting, and coordinate victim advocacy services through the Family Advocacy Program. Follow restricted reporting guidance provided in DoDI 6495.02 Sexual Assault Prevention and Response Program Procedures and AFI 36-6001, Sexual Assault Prevention and Response (SAPR) Program.

4.2.7.2. Medical record documentation under restricted reporting must contain sufficient information to allow for continuity of care and coding. The following wording in bold type should be placed at the top of each notation in the electronic (AHLTA) or paper record: "Restricted from disclosure unless and until determined to be releasable by the MTF Commander or designee. Do not release without specific patient authorization or as specifically authorized by DoD or AF policy." Electronic records in AHLTA may also be secured via a "break the glass" function with the above notation in place. This highlights those entries as restricted and prompts additional review prior to release or electronic review.

4.3. General Guidelines on Releasing Medical Information.

4.3.1. Information may only be released from health records according to the requirements of this chapter, and as permitted under other applicable laws and DOD 6025.18-R. Information released will be limited to the minimum necessary to accomplish the intended purpose of the disclosure, to an identified requester, and in support a valid requirement for the information.

4.3.2. MTFs must develop policies and procedures for reviewing and responding to requests for access to PHI in accordance with the requirements described in DoD 6025.18-R, C8.2.4.

4.3.3. Original medical documents or records are not released to any person or agency outside the Executive Branch, except in compliance with a valid court order or as otherwise required by law. Always consult the SJA or in-house MLC prior to releasing medical information under these circumstances.

4.3.4. Health records may contain information from non-military sources. A patient can be referred to a non-military source for ancillary and/or diagnostic care, and/or treatment.

Documentation from the non-military source that supports the diagnosis and treatment will be filed in the patient's outpatient medical record. This documentation will then become a part of the patient's medical record and subsequent releases of information from the patient's record will include this information from non-military sources.

4.3.5. When required, obtain written authorization from the patient or his/her legal representative before releasing information from the health record to any person or agency. The DD Form 2870, Authorization for Disclosure of Medical or Dental Information, should be used for this purpose.

4.3.5.1. HIPAA applies to the release of PHI for living and deceased patients. For deceased persons, if there is a need for an authorization before releasing PHI, the decedent's legal personal representative signs written authorization. The status of Personal Representative is normally determined by the laws of the jurisdiction where the records are held. Consult with local SJA or MLC to determine the requirements for personal representatives.

4.3.5.2. Unless state law affords the minor the opportunity to be considered an adult and gives the minor greater privacy protections, for un-emancipated minors, physically or mentally challenged persons, a parent or guardian signs the written authorization and furnishes a copy of the court order appointing guardianship, if applicable, with the request. Consult with the SJA or in-house MLC if there are questions.

4.3.5.2.1. It is important to coordinate with the MLC and/or SJA on all cases where State Law provides unique provisions for emancipated minors. MTFs should coordinate with their MLC to identify specific State requirements and incorporate these requirements into MTF policies and procedures for the treatment of minors. Examples of these issues include birth control, abortion, STD treatment, etc.

4.3.5.3. If litigation is pending or contemplated, send the request for release to the SJA or in-house MLC for advice and appropriate action in accordance with AFI 51-301, Civil Litigation.

4.3.6. General rules and individual state laws specify when a power of attorney is required. Refer any questions about power of attorney to the SJA or in-house MLC.

4.3.7. File all correspondence, e.g., requests for PHI from the patient's health insurance company, state worker's compensation agency, or federal and state disability agencies, with an attached information release statement regarding the release of information in Section III of the health record for permanent safekeeping. Refer to paragraph 4.5.2. for special instructions regarding release to Department of Defense (DoD) Investigative Agencies. The Release of Information Office will keep a copy of all investigative agency requests. **Note:** Do not file federal investigative agency requests in the patient's medical record.

4.3.8. Fees for copying, certifying and searching health records are listed in AFI 33-332. Refer to Chapter 3 of AFI 33-332 for information regarding responding to requests from individuals for copies of their personal health records.

4.3.9. Advance payments for information requests from insurance companies and other agencies may be accepted. If the request is for a large volume or requires extensive research, notify the requester of any additional charges.

4.3.9.1. If the payment is incorrect, inform the requesting agency that the information is being provided even though the required fee (specify amount) has not been paid, to avoid possible adverse effect to the patient. Advise the requester to send payment promptly to the Medical Service Account (MSA) office by check or money order payable to the Treasurer of the United States.

4.3.9.2. Send payment to the MSA office with the completed copy of the transmittal letter (see paragraph 4.4.1.) if correct payment is received with the request. If the information cannot be obtained on the day the request is received, complete only the required items and send the form and payment to the MSA office before the ordinary close of business each day.

4.3.10. Records of Newborns Released for Adoption: Take special care releasing information from the records of newborns who have been released for adoption. Delete all references to the child's natural parents. Stamp or identify the newborn inpatient record with the following statement, "Release of Information Restricted according to AFI 41-210, Chapter 4, section 4.3." Do not forward AF Form 560, AF Form 565, Record of Inpatient Treatment, SF 502, Medical Record - Narrative Summary (Clinical Resume), or SF 535, Medical Record - Newborn included in the outpatient record.

4.3.11. Restrictions on Information: According to HIPAA and the MHS Notice of Privacy Practices (NoPP), a patient has the right to request restrictions of uses and disclosures of their medical or dental information. The MTF is not required to agree to the restriction. The restriction should be denied if the MTF could not reasonably accommodate the request, or if the request conflicts with this instruction or any other applicable DoD or Air Force directive. See DoD 6025.18-R for more information.

4.3.11.1. Requests for restrictions must be made in writing using DD Form 2871, Request to Restrict Medical and Dental Information. The MTF Commander, or designee, must respond to information restriction requests as soon as practicable.

4.3.11.2. If granted, the patient should be informed that the restriction is not permanent, and only applies to the individual or MTF that grants the request. The restriction can later be rescinded (upon written notice to the patient) if complying with the restriction becomes too cumbersome. The restriction may be waived in emergency situations to save life or limb.

4.4. Releasing Information and Patient Authorization.

4.4.1. Insurance Agencies, Worker's Compensation and Other Third Parties: Third party authorization forms can be used if they meet the criteria and include the required statements as outlined in DoD 6025.18-R to include the name or organization authorized to make the disclosure (the MTF), the name or organization to whom the MTF is making the disclosure (the third party), the purpose of the disclosure, an expiration date or an expiration event, the signature of the individual, and signature date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual shall also be provided. Otherwise, authorizations are invalid under DoD 6025.18-R. If prepayment has not been received, then use a locally developed form to identify the fees. Prepare the form in three copies; send the original to the requester, file the second copy in part 3 of the health record with the patient's signed authorization for release of

information, and forward the third copy to the Resource Management Office. Send a copy of the form to the local SJA when answering requests for information on injury cases that appear to involve medical affirmative claims action.

4.4.1.1. Any requests identified as a potential third party liability case must be recorded on an AF Form 1488, Daily Log of Patients Treated for Injuries. This includes requests received from an attorney, worker's compensation appeals board, or an insurance company in a case involving work-related injury or disease. Forward these requests to the clinic where the patient was seen. The clinic will complete the AF Form 1488 and forward the AF Form 1488 to the Resource Management Office.

4.4.2. Patient or Authorized Representative: Information may be released directly to the patient or to a representative they designate in writing. An abstract of a patient's relevant medical history (or copies of pertinent pages of the record) may be furnished to the patient, or authorized representative, when the patient departs on a temporary absence from home and requires medical care while away. While DoD 6025.18-R, Chapter 11, provides conditions upon which a covered entity may deny an individual access to their PHI, since medical records are contained in Privacy Act systems of records, access is generally required under the Privacy Act. Consult with your servicing SJA prior to denying an individual access to their own medical records.

4.4.2.1. If a provider determines that direct disclosure to the patient could have an adverse effect on either the physical or mental health, safety, or welfare of the individual, or other persons with whom he/she may have contact, the disclosure will be made to a healthcare provider named by the individual, or to a person qualified to make psychiatric or mental determinations. See DoD 5400.11-R, para. C3.1.6. for additional guidance.

4.4.2.2. Provide patients or their designated representatives' access to their health records upon written request. The original record is always retained at the MTF, but copies will be provided if requested. Copy requests should be processed within 20 working days from the initial receipt of a written request preferably using the DD Form 2870. If, however, the requested medical record copies cannot be provided, contact the requestor in writing and inform them of the delay. Copy requests not completed by the 30th calendar day will be elevated to the MTF Commander for immediate explanation and resolution.

4.4.2.2.1. Military healthcare providers are encouraged to discuss, with their patients, the contents of their patients' health records at least once a year. Providers should encourage their patients to review the healthcare information stored in their medical record to ensure all necessary documents are included in the record, including referral results from civilian network providers. Healthcare providers may recommend ways of disclosing health records other than by direct patient access. On occasion, a healthcare provider may elect to disclose information on specific diagnoses of terminal illness or psychiatric conditions to a patient's designated representative, and not directly to the patient, with the patient's concurrence.

4.4.3. Providing Medical Information or Patient Status Information to the Public (Including News Media): Disclosure of medical information to the public is extremely limited under both HIPAA and the Privacy Act. If requested by a news media agency or upon receiving a general public inquiry, the Privacy Act only permits the release information that does not

constitute an invasion of personal privacy. HIPAA further restricts the disclosure of protected health information. If appropriate, notify the next of kin before releasing information to the news media or to the public. Contact the MTF HIPAA Privacy Officer before releasing information regarding a patient's status. Never release a patient's diagnosis or prognosis without patient consent. If the HIPAA Privacy Officer is not available, consult the SJA or in-house MLC prior to disclosing or providing any medical or patient status information. The releasing authority should check with the local HIPAA Privacy Officer to avoid unauthorized disclosures of patient information, especially those who have "opted out" of the hospital directory.

4.4.3.1. If the patient has been given the opportunity to agree or object to being in the patient directory, and has not objected, the following information may be released to those who ask for the individual by name: Individual's location in the facility; the patient's condition described in general terms that does not communicate specific medical information about the individual (using descriptions such as: stable, good, fair, serious, critical, conscious, semiconscious, and unconscious); and the individual's religious affiliation for use only by clergy.

4.4.3.2. The following information CANNOT be released without the patient's specific authorization: marital status (e.g., divorced, single, widowed), base, installation, station or organization of routinely deployable or sensitive units, description of disease or injury, general factual circumstances, and general extent of the injury or disease. Do not specify location or description that may prove embarrassing to the individual or reflect bad taste.

4.4.3.3. Do not release information listed in paragraph 4.4.3.2. if the patient is not conscious or is mentally incompetent. If the patient is under age or incompetent, the guardian, or legal representative may make the decision.

4.4.3.4. More specific medical information may be provided by the healthcare provider if approved by the patient, guardian or legal representative.

4.4.3.5. NEVER release a prognosis or sensitive medical information relating to the admission of the patient, such as sexual assault, criminal actions, drug or alcohol abuse, psychiatric or social conditions, venereal disease, or Acquired Immunodeficiency Syndrome (AIDS) – HIV (Human Immunodeficiency Virus) data or AIDS related syndrome. **Note:** In all cases in paragraphs 4.4.3.3. and 4.4.3.4., make the statement "Further details with regard to (individual's) admission to the hospital are not releasable at this time."

4.4.3.6. Consult the SJA or in-house MLC for assistance with problems relating to the release of information.

4.5. Disclosing or Releasing Information Not Requiring Patient Authorization.

4.5.1. Most disclosures made that are not for treatment, payment or healthcare operations, or pursuant to the patient's authorization must be tracked in the Protected Health Information Management Tool (PHIMT) or other tracking tool approved for that MTF. Record of disclosures will be maintained for six years. **Note:** There are instances when PHI disclosure is allowed without the patient's authorization. Refer to DoD 6025.18-R and Section 4.2. Laws and Provisions Affecting Disclosure of Medical Information, paragraph 6.6., Accounting of Disclosure for further explanation.

4.5.2. DoD Investigative Agencies: Special agents are granted access to health records when proper identification is provided and the request conforms with the requirements of DoD 6025.18-R. The agent must sign a dated statement which contains the identity of the record to be examined, the identity (file number) of the investigation for which the record is being examined, and a certification by the examiner that the examination is required as part of the official investigation. Obtain a signed receipt for any material or document/record copies (copied by the agent or by MTF staff) furnished to the agent. (**Note:** Do not file the statement or document receipt in the patient's health record. Maintain the statement in a separate folder in the general correspondence file until the investigation is concluded).

4.5.2.1. Requests must be specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought. The MTF may not disclose an entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the disclosure.

4.5.2.2. Investigative agencies, such as Air Force OSI have the authority to request a delay in disclosure reporting. The individual's right to receive an accounting of disclosures to the law enforcement may be temporarily suspended if the agency or official indicates that such an accounting would impede the agency's activities. Verbal requests for suspension shall not exceed 30 days; suspensions beyond 30 days require a written request. Account for the disclosure per DoD 6025.18-R if no request for temporary suspension is made or upon the expiration of a temporary suspension.

4.5.3. Litigation Cases: Refer requests for release of medical information required for pending litigation to the SJA or in-house MLC for advice or action.

4.5.3.1. When mailing medical records concerning medical malpractice claims use standard First Class U.S. mail with immediate delivery confirmation/acknowledgment, Certified Mail, or other commercially available option, e.g., FedEx, that offers package tracking and/or arrival confirmation. Use of standard First Class U.S. Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment or Certified Mail receipt, is prohibited. Return receipt confirmation must not be dependent upon the timeliness or willingness of the destination MTF to complete a DD Form 2825, Internal Receipt, or other manual delivery confirmation receipt option.

4.5.4. Government Departments and Non-DoD Agencies: Medical information is released upon request, to the following Federal and State agencies or departments that have a proper and legitimate need for the information. **Note:** Some requests do not require disclosure accounting. See below.

4.5.4.1. Release PHI to the Department of Veterans Affairs (DVA) to process a claim in which the person's medical history is relevant or upon the separation or discharge of the individual from uniformed service for the purpose of a determination by DVA of the individual's eligibility for, or entitlement to, benefits. If the patient has not authorized the release of information to DVA, account for the disclosure.

4.5.4.2. Release PHI to Federal and State hospitals and prisons for further medical treatment of a person in their custody. Give the First Sergeant or prisoner escort the original health records of active duty members, in a sealed envelope, when processing a

patient to go to a corrections facility. Disclosures under this paragraph do not need to be tracked.

4.5.4.3. Release PHI to the Occupational Safety and Health Administration to help detect, treat, and prevent occupational injuries and diseases. If the patient has not authorized the release of their information, account for the disclosure.

4.5.4.4. If the patient is a Reservist or Guardsman, release PHI to Air Force Reserve or Air National Guard medical personnel when required to determine the member's medical qualification for continued military duty.

4.5.4.5. Release the PHI of foreign military personnel to their appropriate foreign military authority using the same guidelines as outlined in Chapter 6.

4.5.4.6. Law Enforcement Agency Inquires: Upon approval of the MTF Commander and with SJA or MLC concurrence, provide requested or subpoenaed PHI to law enforcement agencies conducting official investigations. Provide either supervised access to health record(s) or certified copies only. Requests must be in writing, specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought. If the patient has not authorized the release of information to respective law enforcement agency, account for the disclosure.

4.5.5. RESEARCH PURPOSES: Follow the procedures in DoD 6025.18-R for releasing PHI for research that involves minimal risk; such disclosures would need to be tracked in the MTF's disclosure tracking system. Otherwise, the release would need to be made pursuant to an authorization signed by the patient or representative. Alternatively, MTFs can release information that is de-identified, without the patient's authorization and without tracking the disclosure.

4.6. Electronic Transmission of Protected Health Information (ePHI). All electronic PHI (ePHI) will be protected appropriately using administrative, technical, and physical safeguards.

4.6.1. Any question regarding electronic transmission of ePHI will be directed to the HIPAA Security Officer.

4.6.1.1. Previously listed guidelines pertaining to the release of information apply regardless of the method of release.

4.6.1.2. To protect patient privacy, only use fax transmission when the original record or mail-delivered copies will not meet requirements for immediate patient care. Only fax sensitive information when urgently needed for patient care or when required by a third-party payer for ongoing certification of payment for a hospitalized patient. Do not transmit information over unsecured telecommunications systems. Official DoD telecommunications systems are subject to monitoring. Using DoD telecommunications systems constitutes consent to monitoring.

4.6.1.3. Limit fax transmission to only that documentation necessary to meet the requester's needs. Utilize regular mail or messenger service for routine disclosure of information to insurance companies, attorneys or other legitimate users.

4.6.1.4. The cover letter sent with the documentation transmitted will include:

4.6.1.4.1. Information instructing the receiver to verify receipt of the fax.

4.6.1.4.2. Date and time of fax transmission.

4.6.1.4.3. Sending facility's name, address, telephone and fax numbers.

4.6.1.4.4. Sender's name.

4.6.1.4.5. Receiving facility's name, address, telephone and fax numbers.

4.6.1.4.6. Authorized receiver's name.

4.6.1.4.7. Number of pages transmitted including cover page.

4.6.1.4.8. Confidentiality notice. Include the TMA approved verbiage on each fax cover sheet, "THIS FAX IS INTENDED ONLY FOR THE USE OF THE PERSON OR OFFICE TO WHOM IT IS ADDRESSED, AND CONTAINS PRIVILEGED, SENSITIVE OR CONFIDENTIAL INFORMATION PROTECTED BY LAW. ALL RECIPIENTS ARE HEREBY NOTIFIED THAT INADVERTENT OR UNAUTHORIZED RECEIPT DOES NOT WAIVE SUCH PRIVILEGE, AND THAT UNAUTHORIZED DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS FAX IN ERROR, PLEASE DESTROY THE ATTACHED DOCUMENT(S) AND NOTIFY THE SENDER OF THE ERROR BY CALLING…." (Document the telephone number of the applicable MTF Privacy Office).

4.6.1.5. If the disclosure requires accounting, maintain the signed release authorization and the original cover letter with a notation of the disclosed information, date, and identity of the employee making the disclosure. File these in the patient's health record.

4.6.1.6. If the documentation is received by anyone other than the intended recipient, the burden is on the sender to remedy the error. Frequently used destination numbers should be preprogrammed into the fax machine to eliminate misdial errors.

4.6.1.7. If the transmission does not reach the intended recipient's system, check the internal logging system of the facsimile machine to determine where the transmission was sent. Send a request to the incorrect number explaining that the information was misdirected and asking for return of the documents via mail. Notify the HIPAA Privacy Officer and follow their instructions for any other action to take.

4.6.1.8. If the receiver of the documentation is a Covered Entity, they are bound by all the laws and requirements governing the use and release of medical documentation.

4.6.1.9. To help protect confidentiality, establish specific policies and procedures for handling documents received via facsimile. Include the following minimum rules:

4.6.1.9.1. All fax machines used to transmit and receive PHI must be located in a secure or supervised location.

4.6.1.9.2. Remove documents as soon as the transmission completes.

4.6.1.9.3. Count pages to ensure transmission of all intended information. Check for legibility and notify sender of problems.

4.6.1.9.4. Read the cover letter and comply with instructions for verifying receipt.

4.6.1.9.5. Process the documents, if appropriate, or notify the authorized recipient that a facsimile transmission has been received. Seal the documents in an envelope and deliver to the authorized recipient or hold for recipient "pick-up."

4.6.1.10. Documentation received via fax can be included in the patient's health record.

4.6.1.11. The use of a fax machine to transmit physician's orders is permissible. To verify their authenticity, the provider should sign the orders prior to transmission. If the orders were not signed, do not carry them out until the ordering physician verifies them. Unless otherwise required by state law or regulation, the facsimile copy does not require countersignature.

4.6.1.12. Documentation transmitted on thermal paper will fade over time. If a fax machine uses thermal paper, make a photocopy of the document and place the copy in the record. Destroy the thermal paper document after making the photocopy.

4.6.2. Tele-Health. A subset of e-Health, Tele-health is the use of electronic applications, systems, media, clinical information management, and encrypted telecommunications technologies to provide or support clinical healthcare, patient and professional health-related education, public health, and health administration when distance separates the participants. Tele-health embraces several innovative and exciting aspects of modern healthcare including, secure messaging between provider and patient, virtual patient e-health record access, on-line patient appointment booking, professional diagnostic imaging and remote surgical/specialty consulting capabilities, to name just a few.

4.6.2.1. Secure messaging between a provider and patient generally requires the patient to access a government sponsored internet website where once a patient's identity has been validated, the patient then has access to an internal website messaging account to use when corresponding with his or her healthcare team. E-mail correspondence between a patient and provider, where the patient's medical condition, situation, or personal medical information is discussed, is not allowed using personal e-mail accounts. The Corporate Dental Application (CDA), MiCare secure messaging, and any other AFMS approved secure messaging programs are authorized. Clinical e-mail between MTF personnel and beneficiaries is not authorized at this time. Refer to Section 6I, Use of e-Mail to communicate PHI for additional information regarding this subject.

4.6.2.2. Clinical Professional Consultation: When telemedicine is applied to conduct a real-time professional office visit or consultation between providers where the e-mail message is encrypted and the conversation occurs between two ".mil" e-mail accounts, the event must be fully documented in the patient's medical record by either or both healthcare providers.

4.6.3. Clinical Use of Electronic Mail in Provider to Provider or Provider to Patient Communications. Refer to Chapter 6 for guidelines on the use of e-mail to transmit PHI.

4.7. Personal Health Record Copy Requests. (Authority DoD 6025.18-R, DoD Health Information Privacy Regulation, Chapter 11). This section includes copies produced from paper-based and electronic-based medical records.

4.7.1. Urgent copy requests for referral appointments: If a patient requests to remove the medical record from the medical facility, MTF personnel are required to inform the patient of

the DoD policy prohibiting patients from hand-carrying their record(s). Primary care managers and/or referring MTF providers are responsible for ensuring that a patient has copies of any necessary paperwork from the outpatient, inpatient, dental or other paper or electronic health record required to ensure adequate medical reference and continuity of care between the MTF and the external provider or civilian medical facility. These copies are provided free of charge. There may, however, be instances when a patient has not obtained the necessary documents for the referral visit for an external MTF patient appointment. In these cases, copy the pertinent section/document(s) and provide the copy to the patient. Requests of this type must be expedited so the patient can provide this information to the referral provider at the time of the appointment. Unless specifically requested by either the referring or accepting physician, do not copy the entire medical or dental record. Copies of pertinent medical documents may also be faxed or mailed from the MTF to the receiving provider or civilian medical facility provided the necessary coordination with the external provider has been accomplished.

4.7.2. Urgent copy requests to meet short-notice or "no-notice" Service Member separations or discharges resulting from accelerated Force Management related personnel action: When informed or notified by an appropriate service separation or discharge authority of a Service Member's request to obtain a complete copy of his or her Service Treatment Record (STR) to meet expedited Force Management related separation or discharge installation out-processing requirements, MTF records copy personnel will immediately prioritize the request above all other non-urgent, routine requests. The Service Member is required to complete the necessary record copy request form at the MTF Release of Information office.

4.7.3. Non-Urgent, Routine Copy Requests. Refer the patient to the appropriate Release of Information (ROI) office. ROI personnel will inform the patient of the average MTF wait-time for non-urgent requests and should use the most current DD Form 2870. **Note:** the timeline for such request are established in 4.4.2.2. The time duration may be based upon a variety of factors, including, but not limited to the staffing, the size of the individual record(s) or record portion(s) to be copied, the number of non-urgent daily and weekly requests, the number of emergent and/or urgent daily and weekly requests and the time it takes to redact SSNs. The staff assigned to the ROI office should keep their supervisors appraised on any current or impending delays. Unforeseen delays can be documented by the leadership and affected beneficiaries should be notified.

4.7.4. When the medical record copy request is complete, provide the patient with his/her copies at no charge. Health record copies may be provided in the form of electronic or digital media format (e.g., compact disc) only if the patient agrees to accept the copied record(s) in this format. Inform the Service Member the VA will not accept a digital copy or CD copy of the record if the patient's intent is to give this copy to the VA for processing their claim.

4.7.5. Repeated personal requests for the same document copies or repeated requests for partial or complete volume copies, that have already been provided to the patient or his representative, within the same 12-month period may result in a financial charge to the patient or his representative. Upon local approval of the MTF Commander, the ROI function may charge beneficiaries or their agents/representatives, a reasonable fee for excessive and repeated requests for copies of medical records. Record copying fees documented in AFI 33-332, Air Force Privacy Program may be used to establish a baseline pricing schedule. At no

time will any patient be charged more than $.15 cents per single-sided paper page. Maximum charge will not exceed $75.00 for each personal paper-record request.

4.7.6. Radiographs or Radiographic Images or Film: Generally, only the provider's paper document radiographic "interpretation" or analysis report is provided to requestor. The cost of producing this paper report is usually free, unless repeated request for the same document are submitted (see above paragraph for excessive paper record copying charges). Copies of actual radiographs, sometimes referred to as the, "radiographic film, x-ray film or x-ray images," may be provided upon specific request.

4.7.7. All provider SSNs must be redacted from the health record before issuing a copy. This mandate applies to all forms of health records (including, but not limited to, the outpatient medical, dental treatment, inpatient, and extended ambulatory record). This policy applies to copies provided for any purpose or request, including an individual's request for copies of his or her own health records. Original medical records shall remain intact and unaltered. The original provider's SSN must never be deleted from the original health record. Other SSNs should be redacted when warranted.

4.7.8. Before issuing a record copy (partial or full), redact all sponsor SSNs from every aspect of the health record, unless the copy request originates from the actual sponsor. This mandate applies to all forms of health records (including, but not limited to, the outpatient medical, dental treatment, inpatient, and extended ambulatory record). This policy applies to copies provided for any purpose or request. Original medical records shall remain intact and unaltered. The original sponsor SSN must never be deleted from the original health record. Other SSNs should be redacted when warranted.

4.7.9. If an MTF chooses to provide health records electronically (e.g., scanned copy in lieu of paper), the MTF must use standardized nomenclature when naming the file. This will allow outside agencies and others, as applicable, to easily identify a beneficiary's treatment record. At a minimum, the file name should contain the following: the term "Outpatient Record," "Dental Record," or "Inpatient Record" (as applicable), last name of the beneficiary, and date the copy was made, e.g., OUTPATIENT RECORD_[SMITH]_15MAR2010].pdf.

4.8. Entering Into Agreements to Manage Health Record Copy Requests.

4.8.1. MTFs are authorized to establish relationships with external businesses or document copy service providers to maximize the MTF ROI mission and decrease copy request wait times. Agreements should be coordinated with the HIPAA Privacy Officer, the TOPA Flight Commander, the Resource Management Flight Commander, the Medical Support Squadron Commander, the MTF Commander, MLC or installation SJA, the installation contracting squadron, and the installation Plans and Program office or equivalent installation function that oversees support agreements.

Section 4B—Patient Registration & Multiple Healthcare Eligibility

4.9. Patient Registration.

4.9.1. The Patient Administration function has direct oversight of MTF patient registration. MTF clinical work centers such as the pharmacy, laboratory, emergency department, and the local TRICARE Service Center require the ability to register patients in CHCS. To ensure a

balanced and responsible registration process throughout the MTF, Patient Administration personnel, in partnership with CHCS System Administrators and Information Management officials, will provide user training and are the only MTF approval authorities authorized to grant registration access and/or similar capabilities. The practice of granting blanket CHCS registration access to all MTF staff members upon unit in-processing will cease. Registration capabilities will only be granted to authorized MTF staff members who have demonstrated the correct registration procedures and have received documented patient registration training validated by the MTF TOPA or Patient Administration function or flight commander. Requests for CHCS registration training must be coordinated and approved by the flight superintendent or flight commander before submitting requests to the MTF TOPA Flight Commander, Patient Administration Officer, Systems or Information Management Flight Commander. Training requests submitted by individual users seeking CHCS registration training, without documented flight level approval, will not be accepted.

4.9.2. At MTF point of service locations, e.g., outpatient clinic reception or customer service front desk, laboratory front desk, radiology department reception desk, etc., only supervisors and personnel that regularly receive patients and confirm appointments will be authorized CHCS registration keys. CHCS registration capabilities or the CHCS File Man code "&" with the appropriate CHCS registration related security keys will not be automatically granted or added to any MTF staff member's CHCS user profile without flight commander justification. The MTF TOPA Flight Commander, Patient Administration Officer, Systems Flight Commander and /or designated Information Management Officer have shared approval authority to grant training permission. TOPA officials are responsible for conducting periodic reviews of all MTF personnel with CHCS registration capabilities to verify training requirements have been met and registration capabilities remain valid.

4.9.3. When registering a patient for the first time, MTF personnel should obtain as much information as possible without degrading medical care. At a minimum, the following patient information must be captured:

4.9.3.1. Patient's name (first, last & middle initial).

4.9.3.2. Sponsor's name.

4.9.3.3. Sponsor's Social Security Number (SSN).

4.9.3.4. Patient's relationship code/Family Member Prefix (FMP) e.g., 20-Sponsor, 30-Spouse, 01-Child, etc.

4.9.3.5. Patient Category (e.g., F11/Active USAF, A11/Active US Army, F31/Retired USAF Service Member, M12/Marine Corps Reserve Component Member, N41/Active Duty Navy Family Member, etc.).

4.9.3.6. Patient's date of birth.

4.9.3.7. Patient's gender.

4.9.3.8. Patient's Service (sponsor only).

4.9.3.9. Patient's station/unit (sponsor only).

4.9.3.10. Patient's rank (sponsor only).

4.9.3.11. Patient's address & telephone contact information.

4.9.3.12. Organ donor declaration (yes, no, or unknown).

4.9.3.13. Third party health insurance information.

4.9.3.14. MTF where medical record(s) are normally maintained.

4.9.3.15. Marital Status (if Full Registration is used).

4.9.3.16. Race (if Full Registration is used).

4.9.3.17. Ethnicity (if Full Registration is used).

4.9.3.18. Individual Patient SSN or available/authorized unique "Person or Personal Identifier" (DoD ID Number, FIN, TIN, ITIN, etc.).

4.9.3.18.1. Person or Personal Identifiers. Most patients treated in the AFMS possess Social Security Numbers (SSN). Individual identification using a person's unique Social Security Number provides a solid framework from which to build a personal eligibility profile in DEERS and within the MTF. SSNs are considered Person or Personal Identifiers and are used as the default numeric "account number" for which CHCS partly bases individual identification. Some patients, however, may not possess a SSN for various reasons. Frequently, alternative Person or Personal Identifiers are used to reduce the use of SSNs or identify patients as individuals who may not possess a SSN. There are multiple alternative Person Identifiers issued, used, and/or created depending on the patient's particular situation.

4.9.3.18.1.1. In an effort to reduce the unnecessary use of SSNs, DoD has begun the use of alternative Personal Identifiers in place of the SSN. The alternative Personal Identifiers include the DoD Identification (ID) Number which uniquely identifies individuals and the DoD Benefits Number that identifies individuals eligible to receive DoD benefits such as commissary, exchange, and TRICARE benefits.

4.9.3.18.1.1.1. The Military Health System, when feasible, will limit the use and display of SSNs while migrating systems and business processes to use the DoD ID Number. Refer to the MHS Interim SSN Reduction Plan, 17 Oct 2011 for more SSN reduction information.

4.9.3.18.1.2. Foreign Identification Numbers (FIN) are issued to foreigners who are eligible for healthcare but who are not eligible to obtain a SSN. The FIN takes the place of a SSN. The FIN begins with the number "9," e.g., 9XX-XX-XXXX and is issued by DEERS. An example of someone who may be issued a FIN: A military service member from a participating SOFA country here in the United States enrolled in a pilot training program.

4.9.3.18.1.3. The Temporary Identification Number (TIN) is an ID number issued by DEERS to patients who are eligible for SSNs but who either do not possess an issued SSN or those who have been issued a SSN but have not reported the SSN to DEERS. The TIN takes the place of a SSN. The TIN begins with the number "8," e.g., 8XX-XX-XXXX. The TIN resembles a "Pseudo" SSN which is generated only in CHCS. Although the TIN begins with the number "8" it is different from the "Pseudo" SSN. A TIN should appear on the beneficiaries ID card and remain constant between different CHCS computer server hosts. Pseudo

SSNs are only relevant or applicable to the local CHCS host computer server (at the MTF where the number was created) and are based on the patient's date of birth or date of emergency medical treatment when a Patient Identifier is not known. Patients can legitimately have different Pseudo SSNs on different CHCS host computer servers.

4.9.3.18.1.4. According to the Internal Revenue Service (IRS), the definition of an Individual Taxpayer Identification Number (ITIN) is, "A tax processing number issued by the Internal Revenue Service. It is a nine-digit number that always begins with the number 9 and has a range of 70-88 in the fourth and fifth digit, example 9XX-70-XXXX. The IRS issues ITINs to individuals who are required to have a U.S. taxpayer identification number but who do not have, and are not eligible to obtain a SSN from the Social Security Administration (SSA)."

4.9.3.18.1.5. Other alternative Personal Identifiers do exist but the three previous examples are the most common forms for which an MTF will be presented. When using these Personal Identifiers during patient registration, the user must insert the Person Identifier in place of the SSN. Users may also be required to add the Personal Identifier again when and if prompted for the Person ID Type Code, e.g., "F" for FIN, "T" for TIN, and "I" for ITIN, etc. If the patient is eligible for a SSN and does not yet posses the official number, encourage the patient or sponsor to provide the SSN to the local DEERS office following SSN issuance from the SSA. The new SSN will replace the alternative Personal Identifier in DEERS and CHCS.

4.9.3.19. Command Security, if applicable, e.g., PRP/PSP (Personnel Reliability Program/Presidential Support Program).

4.9.3.20. Active Flight Status (if patient is assigned to an active flight position). This is a Full Registration demographic question and minimal Full Registration data must be available to properly complete the registration for this category of patient.

4.9.3.21. Length of Service (Years).

4.9.4. Registration Options. All MTF staff involved in Patient Registration or who periodically update demographic information from DEERS during eligibility checks must have the CHCS "DG REG SYNCH" security key. This will allow the user to update the patient's registration data from DEERS while synchronizing the patient with their DEERS entry. Synchronization prevents the patient's SPONSOR from being edited as well as key registration fields (to include patient SSN (if patient is SPONSOR) DOB, SEX, and NAME, etc.) within CHCS. Seven types of patient registration mechanisms are available through the automated CHCS system. The first two types of registration (FULL and MINI) are the types of "manual" registration that are authorized for use. Both of these registration options involve a DEERS check/synchronization/population of the Electronic Data Interchange Person Number (EDIPN), also known as the DoD ID Number, from DEERS to CHCS during the registration process, which will prevent specific types of patient duplication while satisfying most eligibility concerns between DEERS and CHCS. A successful DEERS check/synchronization is a critical part of patient registration (if the patient is known to exist in DEERS with or without eligibility). Choosing the correct registration method depends on intent, MINI REGISTRATION is the default registration within CHCS while FULL

REGISTRATION is more commonly used for INPATIENT/ADMISSIONS (every MTF inpatient admission requires FULL REGISTRATION). The difference between these two forms of registration is the amount of demographic data available for input as there are data fields within FULL REGISTRATION that are not available within MINI REGISTRATION (such as Next of Kin, Emergency Contact Information, Flying Status, etc.). Each MTF should determine which registration type best fits the current mission, depending on the individual patient's needs. In either case, the minimal required data should be collected to allow the registration to be completed correctly.

4.9.5. Another form of patient registration is Auto-Registration via initial enrollment/PCM assignment from DEERS through PIT (PCM Information Transfer). Patients are normally registered automatically without incident, but an error (PIT ERROR) may occur during auto-registration that requires manual intervention to complete and correct the registration/enrollment. Other registration-related PIT ERRORS can occur that affect the patient appearing eligible within CHCS, or a change in eligibility can cause a PIT error (as PIT errors are resolved that result in a change of eligibility, the patient's hard copy records should be checked as this may cause a change in terminal digit that can affect the patient's records jacket and where the record is filed; this rule also applies to any registration that changes sponsorship and physical records are present). PIT errors should be resolved and the errors that caused them followed through each system. File and Table PIT errors, which are related to the PCM should be forwarded to the PCM/Managed care department for resolution.

4.9.6. The following two types of registration are related to the lab functionality. MAIL-IN REGISTRATION is used by the lab to register patients when printing results for the requesting location (to disseminate the results by fax or print out to the referring or requesting location). This type of registration does not involve a DEERS check and (if the patient is a dependent and the sponsor is not already registered on the system) automatically creates a false or "fake" sponsor registration; additionally, a PATCAT is not present or required. For this reason, MAIL-IN REGISTRATION should not be used to add patients to the CHCS host computer server. Instead, FULL or MINI REG should be used. After the patient has been correctly added to the system, MAIL-IN REGISTRATION may be used to set the referring/requesting location for bulk printing of the results.

4.9.7. LAB INTEROPERABILITY REGISTRATION is a type of registration used by MTF laboratories that perform laboratory analysis on specimens collected from external MTFs. These MTFs utilize CHCS operating from other CHCS host computer servers. LAB INTEROPERABILITY REGISTRATION utilizes the LAB MAIL-IN functionality to add patients. MTF TOPA flights should work with Clinical Pathology departments through periodic reviews to ensure that patients are being added to the local CHCS host properly.

4.9.8. NON-HUMAN REGISTRATION is a type of registration used for animals, such as military working dogs, that require ancillary services at the MTF. It is important that animals requiring ancillary services are added utilizing the NON-HUMAN REGISTRATION function and not MINI or FULL registration as these types of registration require data elements such as SSNs.

4.9.9. CREATING MTF MANUFACTURED OR "PSEUDO" SOCIAL SECURITY NUMBERS. Manufactured or "Pseudo" SSNs are created within CHCS when a patient's SSN or formal Person/Personal Identifier is not known or available. A Pseudo SSN looks

like a standard SSN but the number sequence always begins with the number "8," e.g., 8XX-XX-XXXX. A Pseudo SSN is automatically generated during CHCS registration by inserting the letter "P" into the SSN data entry field. During John Doe registration, the Pseudo SSN is automatically generated based on the patient's date of birth. The CHCS will sequentially number the Pseudo SSN for any other patients registered (on the local CHCS host computer server) who also received a Pseudo SSN with the same date of birth. For example, when trying to register a current patient with a date of birth of 21 March 1969, an MTF staffer discovers another patient was previously registered in the local CHCS host with a Pseudo SSN (with the same date of birth). In this instance, the Pseudo SSN for the current patient would look like this: 801-69-0321. The number for the first patient to receive a Pseudo SSN with the same date of birth would look like this: 800-69-0321. The first three digits of the Pseudo SSN identify the patient sequence number. The second two digits identify the patient's year of birth. The last four digits identify the patient's birth month and day. Pseudo SSNs are "placeholder" numbers only. These temporary patient identification numbers should not be used for definitive identification. The Pseudo SSN for a particular patient registered at one MTF may not be the same number at another MTF outside the local CHCS host computer server. When legitimate Person Identifiers (SSN, FIN, ITIN, and TIN) are later identified or become available, the patient's registration profile must be updated with the correct formal Person Identifier. In some circumstances, MTFs may feel it is necessary to create customized SSN identifiers to register and identify patients (not normally authorized MHS or Direct Care) who are being treated or offered MTF Direct Care in accordance with unique community healthcare partnerships, professional, continuing, or specific medical education programs, or other HQ USAF/SG approved healthcare eligibility extension agreements or programs. MTFs are required to obtain permission from AFMOA/SGAT prior to initiating a customized registration program whereby patient SSNs are manufactured or where Pseudo SSNs or similar SSN substitution process is expected on a reoccurring basis.

4.9.9.1. Caution: A TIN and Pseudo SSN look alike. The Pseudo SSN should not be confused with a TIN, which also begins with the number "8." A TIN is generated by DEERS and remains constant between CHCS computer server hosts unlike an MTF manufactured SSN or Pseudo SSN that only applies to the local CHCS host computer server and/or MTF where the number was created.

4.9.10. CIVILIAN EMERGENCY or "JOHN DOE" REGISTRATION is a type of registration that should only be used in an emergency. The creation of a temporary manufactured SSN or "Pseudo" SSN is authorized to complete the registration process in an emergency. When using either the automated CHCS John Doe system driven options or when using an MTF customized John Doe registration process tailored for a specific patient circumstance (for which AFMOA/SGAT has approved), this registration type is authorized when it is necessary to administer urgent healthcare and the patient's Person Identifier is not known or impossible to obtain. Following initial emergency treatment, replace or correct the temporary Pseudo SSN and any other missing or manufactured patient demographic information entered during the John Doe registration process. The patient's registration profile must be updated with the correct patient information or merged if another or second patient registration profile was created with the correct Person Identifier on the local CHCS computer server host. If possible, the Person Identifier may need to be corrected in each

affiliated computer application or system affected by the CHCS John Doe registration, including AHLTA.

4.9.10.1. Use the John Doe or Civilian Emergency registration type if the patient does not a) possess or know his or her formal Person Identifier, e.g., SSN, TIN, FIN, ITIN, etc., b) is unconscious, or c) is not capable of providing his or her personal information. In this scenario, let's assume today is 15 Dec 2010 and its 10:00 a.m. An unknown, unconscious patient is transported to the MTF emergency department and is undergoing emergency medical care necessary to save his life. Personnel from the Patient Administration function, Admissions and Dispositions office, or the Emergency Department are authorized to create a temporary Pseudo SSN to complete the patient's CHCS registration. During the John Doe or Civilian Emergency registration process, a Pseudo SSN is automatically generated by inserting the letter "T" for Today or today's date into the SSN data entry field. This temporary Person Identifier is automatically generated based on the current or present date (today's date). The CHCS will create a temporary patient Pseudo SSN that looks like this: 800-10-1215. The first three digits of the Pseudo SSN identify the patient sequence number. The "800" represents the first person to be registered into the local CHCS host computer server on any particular day. The second two digits identify the current year. The last four digits identify today's date (present month and day). The CHCS will sequentially number the Pseudo SSN for any other patients registered (on the local CHCS host computer server) who may also have received a Pseudo SSN with today's date. Let's further assume that later in the evening at 2030hrs on the same day, 15 Dec 2010 an infant girl is born upstairs in the Labor and Delivery department. Since babies are born without pre-issued SSNs or other formal Person Identifiers, the use of a Pseudo SSN would also be necessary to complete the registration process for the new baby girl. Using the "T" automated date creation mechanism in the SSN data entry field, her Pseudo SSN would look like this: 801-10-1215. The only difference between this temporary patient Pseudo SSN and the Pseudo SSN created earlier for the John Doe civilian admission patient is the inclusion of the number "1" in the first three digits of the Pseudo SSN. Since this is the second person registered into the local CHCS host computer server on the same date, the last number in the first three-digit patient sequence number changes to "1." If a third infant or unknown person (for which a date of birth could not be obtained) was registered into the local CHCS host on the same day, the last number in the first three-digit patient sequence number would change to "802" or 802-10-1215.

4.9.10.2. Pseudo SSNs are "placeholder" numbers only. These temporary patient identification numbers should not be used for definitive identification. The Pseudo SSN for a particular patient registered at one MTF may not be the same number at another MTF outside the local CHCS host computer server. When legitimate Person Identifiers (SSN, FIN, ITIN, and TIN) are identified or become available, the patient's registration profile must be updated with the correct formal Person Identifier.

4.9.10.3. The use of a temporary Pseudo SSN registration process (for patients for whom their date of birth information can be obtained as well as those patients for whom this information cannot be obtained) is authorized and may be repeated many times when treating multiple patients received during a mass casualty incident.

4.9.11. NEWBORN INFANT REGISTRATION. Authorized newborn infant family members will be registered under their sponsor's SSN. If both mother and father are ADSMs, the parents must choose to which sponsor's SSN the infant will be affiliated or attached. The sponsor affiliation may be changed if, at a time shortly following the child's birth, the parents register their infant with DEERS under the opposite sponsor's information used during the infant's birth.

4.9.11.1. The Electronic Health Record (EHR) patient registration cannot continue without the entry of the infant's own SSN. A newborn infant, however, does not possess a SSN and is not issued a SSN or other Person Identifier at the time of birth. The use or entry of a temporary Pseudo SSN to complete the registration process is authorized.

4.9.11.2. During the Newborn Infant registration process, a Pseudo SSN is automatically generated by inserting the letter "T" for Today or today's date into the SSN data entry field. The temporary Person Identifier is automatically generated based on the current or present date (today's date). For this example, let's assume today is 15 Jan 2011. Captain and Mrs. Smith's infant son was born at 0600hrs earlier today. The CHCS will create a patient Pseudo SSN that looks like this: 800-11-0115. The first three digits of the Pseudo SSN identify the patient sequence number. The "800" represents the first baby or person to be registered into the local CHCS host computer server on any particular day. The second two digits identify the current year. The last four digits identify today's date (present month and day). The CHCS will sequentially number the Pseudo SSN for any other patients registered (on the local CHCS host computer server) who may also have received a Pseudo SSN with today's date. Let's further assume later in the afternoon on the same day, 15 Jan 2011, a baby girl is born to MSgt Johnson and Mr. Johnson at 1400hrs. The CHCS will create a patient Pseudo SSN that looks like this: 801-11-0115. The only difference between this temporary patient Pseudo SSN and the Pseudo SSN created earlier for infant boy Smith is the inclusion of the number "1" in the first three digits of the Pseudo SSN for infant girl Johnson. Since this is the second infant or person registered into the local CHCS host computer server on the same date, the last number in the first three-digit patient sequence number changes to "1." If a third infant or person was registered into the local CHCS host on the same day, the first last number in the first three-digit patient sequence number would change to "802" or 802-11-0115.

4.9.11.3. Newborn infant admissions pose a unique identity problem within the MHS. During CHCS registration there is very little personal/patient identifying information available. Due to this unique situation, extra care must be taken when registering and identifying newborn infants. Due to a lack of normal available patient identification, e.g., a formal Person Identifier and even a full patient name, the practice of selecting the correct FMP and Sponsor SSN is very critical. If multiple births occur (twins, triplets, etc…) each infant should be clearly and consistently identified (SMITH, INFANT A, SMITH, INFANT B, etc.). Each MTF should have a method to clearly and uniquely identify newborns in addition to using the correct FMP and Sponsor SSN and have a process in place to update a newborn's personal identification as soon as it becomes available. MTF admissions and dispositions personnel should encourage the sponsor to obtain a SSN for the child and then register their newborn child with DEERS as soon as possible. Inaccurate or outdated patient information associated with a newborn admission, if not updated or corrected, can also negatively impact AHLTA. Ensure

current MHS guidelines are followed when merging/unmerging patients within AHLTA and other interfaced systems.

4.9.11.4. Upon birth, register an infant child born to a family member dependent daughter into CHCS using the PAT CAT "F29" and FMP "60." The use of this PAT CAT and FMP will generate a bill for services. The bill will be waived if Secretarial Designee status has previously been granted. Refer to paragraph 2.18. for information regarding limited MTF direct healthcare coverage for newborns born to family member dependents under the Secretarial Designee Program.

4.9.12. ADDRESSING AND REGISTERING OSI AGENTS. Address military Service Member agents of the Office of Special Investigation (OSI) as "Special Agent," followed by their last name. Refrain from addressing a military Service Member agent using his or her military rank.

4.9.12.1. When registering military Service Member OSI agents, into the EHR, enter the agent's rank as Airman Basic (E-1). If an MTF staff members discovers an agent's rank has automatically changed back to his or her actual military service rank following a healthcare eligibility verification or DEERS "check" or following any event where CHCS and DEERS synchronize patient demographic information, ensure the agent's military service rank is changed again to "Airman Basic."

4.9.12.2. Some security experts may argue that any accidental disclosure of an OSI's agent's military service rank could undermine the agent's ability to conduct current or future criminal investigations. While the AFMS supports reasonable efforts to mask an agent's military rank to afford the individual some level of personal identity protection and/or anonymity, given the limited ability to override the automatic DEERS sponsor identity update mechanism that populates the Military Rank field in CHCS, the actual military rank for military Service Member OSI agents may occasionally be visible in CHCS and AHLTA.

4.10. Patients with Multiple-Eligibility. Beneficiaries are registered according to the highest level of eligibility. However, patients may be eligible for medical and dental care under more than one FMP/SSN and patient category, or PATCAT. These patients pose a unique problem and careful management of this issue must be fulfilled to prevent cascading effects that may negatively impact patient safety, continuity of care, medical records tracking, and financial reimbursement processes, as well as other MHS systems that use CHCS for registration and identity (for example, AHLTA). Currently, CHCS is not designed to support patients that have multiple concurrent (or historic) eligibility categories, e.g., patients who are eligible or who once were eligible for care under another or multiple FMPs, SSNs, or PATCATs. Key patient identifiers (the patient SSN and DoD ID Number) are only allowed to be used one time on any CHCS host computer server. However, to work around this restriction, patients with dual or multiple-healthcare eligibility have been historically registered more than once using a "Pseudo" SSN. The entry of more than one SSN into CHCS (for the same patient) fools the system by inaccurately identifying the patient according to two different patient identity registration profiles.

4.10.1. The practice of inserting or creating a "Pseudo" or manufactured SSN into any CHCS patient registration data entry, so that a patient's healthcare may be differentiated according to different beneficiary categories for which the patient may be eligible, may

temporarily solve an immediate records management, records tracking requirement, or third party insurance payer reimbursement requirement. This practice however, places the patient's safety at risk by fragmenting their medical history, to include medication and allergy profiles, into separate records. Interfaced systems are affected by the "splitting" or division of the patient's record within CHCS, AHLTA, etc. FOR THIS REASON, NO PATIENT (TO INCLUDE DUAL OR MULTIPLE HEALTHCARE ELIGIBILITY PATIENTS) SHOULD BE PURPOSEFULLY DUPLICATED WITHIN CHCS; PATIENTS SHOULD BE REGISTERED ONE TIME UNDER THEIR HIGHEST LEVEL OF ELIGIBILITY. This mandate will certainly cause confusion in terms of records tracking/filing paperwork and billing, but the safety of the patient must be considered above all other factors. When a patient is identified with more than one eligibility account, profile, or record, and/or if clinical data has been entered under more than one record, FMPs, or SSNs, MTF TOPA staff or system managers are authorized to merge the duplicate records and "alias" the surviving record using the Former Patient Name functionality within CHCS. Changes must be processed IAW current MHS merge/unmerge guidelines. While this practice successfully merges or identifies duplicate multiple-eligibility patient accounts or records, this action does not correct duplicate records or entries already documented in AHLTA and other associated MHS automated systems. Providers and MTF staff must be aware of the potential problems associated with dual or multiple-eligibility patients and how to implement corrective measures and alternative processes to ensure the patient's healthcare is properly documented. With greater emphasis placed upon training and identification of multiple-eligible patients during the initial CHCS registration training course and through the practice of limiting CHCS registration keys to users who truly need access, future occurrences of PIT errors and/or record/account linking or "aliasing" problems associated with accidental or purposeful registration of patients with more than one eligibility level, are expected to significantly decrease.

4.10.2. Securing the correct patient identity for patients with multiple healthcare eligibility categories remains a noteworthy AFMS and MHS challenge. Significant issues related to dual or multiple eligibility (to include maintaining multiple hardcopy records for the same patient while having one electronic record), or resolving data alignment problems between different medical systems (such as FMP/SSN discrepancies between CHCS, AHLTA, and DEERS using different identifiers for patient status) have not yet been resolved. The medical facility's TOPA and MTF systems (IM/IT) personnel are responsible for ensuring all MTF personnel are aware of current policies and procedures designed to mitigate these problems, and how new systems or procedures may impact the overall patient identity process. The TOPA and systems offices must also ensure that any and all MTF staff members, who possess CHCS registration capabilities, are aware of the problems associated with multi-eligible patients and other current patient identity problems. Actions that may lessen the confusion associated with these particular patients are: aliasing a patient within CHCS registration, noting a patient's multiple eligibility within CHCS registration, and placing records aside that cannot be retired properly (patient is active duty, but a dependent child record exists that needs to be retired to the National Personnel Records Center (NPRC); collect these records for later resolution). Other actions include cross-referencing physical records when the patient has more than one physical record within the MTF (e.g., when the patient's highest level of eligibility is a dependent family member but he or she also has a Reserve Component health record within the MTF). MTF records managers should take

necessary steps to identify as many of their dual or multiple eligibility patients and keep track of their records for resolution when an acceptable "work around" solution is identified. These actions may lessen, but will not completely eliminate the confusion caused by current system design deficiencies.

4.10.3. Potential Duplicate Patient Report. Produce and review this report monthly to identify potential duplicate patients. Research each error and develop a process to correct errors. Incorrect registration information should be corrected or edited. All duplicate registrations should be merged into one account so the patient is registered one time under that patient's highest level of eligibility, with all pertinent data moved under the correct CHCS registration (patient SSN, DoD ID Number, FIN, TIN, etc.). When necessary, records managers should take appropriate action to properly research each duplicate patient issue and merge, retire, or forward the associated hard-copy health records. Patient entries on the report that are not true duplicate patients should be excluded. Use caution before merging any registration account or data regarding potential dual or multiple eligibility patients. Use this report as a training tool when specific personnel continuously create unnecessary duplicate accounts or make critical registration errors. CHCS System Administrators, Patient Administration, and Information Assurance officials will aggressively find, fix, and prevent unnecessary duplicate patient registrations. Always ensure MHS merging/unmerging guidelines are followed when resolving patient duplication within the local CHCS host or within AHLTA or other interfaced systems.

4.10.4. Only one patient registration entry should be established for each patient treated in the MTF. However, there are instances when patients have multiple eligibilities or are eligible for care under more than one patient category. In each of the examples below, the patients' eligibility and enrollment status, the SPONSOR/DEPENDENT relationship for each eligibility, and the possible presence of dependents must be considered when modifying the registration long-term or to address a change in eligibility for a specific patient care episode. It must be noted that CHCS/AHLTA cannot currently support every type of patient identity scenario; however, the following scenarios represent some of the most common examples of multiple eligible patients:

4.10.4.1. When the patient is a military retiree AND a family-member dependent, for example, a retired Captain who is married to an active duty Major. The retired Captain is likely to be DEERS eligible under his or her own SSN and also eligible for care under his/her spouse's SSN. In this situation, the patient should be registered in the local MTF CHCS host under the patient category and SSN returned by the automated DEERS eligibility interface or the patient category and SSN that is most advantageous to the patient. Also consider that the patient's enrollment status to the MTF and the presence of dependent patients whose eligibility depends on the patient will be deciding factors. In both of these circumstances, only one physical record should exist under the applicable FMP/SSN/terminal digit, cross-reference the patient using the CHCS "alias" functionality to identify that there are current or historic multiple eligibilities.

4.10.4.2. When a patient is a Reserve Component Service Member (RCSM) and a family-member dependent. For example, an Air Force Reserve SMSgt assigned to a local reserve unit who is married to an active duty TSgt. This situation will depend on the eligibility status of each entitlement. If the patient is an enrolled dependent and a RCSM, but is not an activated RCSM (on active orders for 30 or more days) with

verifiable eligibility within DEERS (Health Care Delivery Plan) Code 001, 106, etc. the patient should appear as a family-member dependent within CHCS. If the patient presents for care as a RCSM (for example treatment for a periodic RC physical) it will not be possible to initiate order entry procedures or view the patient under their own FMP/SSN and correct PATCAT due to system registration limitations (without breaking the sponsor/dependent relationship and if enrollment to the MTF is present, it will not be possible to modify the registration). If the RC patient is on active orders for 30 or more days, (with verifiable eligibility within DEERS, HCDP 106 or 001, for example) the patient should be moved under their own FMP/SSN (although still enrolled to the MTF as a dependent, break the enrollment within CHCS, if needed). Cross-reference the patient using the CHCS "alias" functionality to identify that there is current or historic multiple eligibility (and cross-reference physical records, if possible). In both cases, two physical records will be present. In this scenario, a RCSM, not on active orders for 30 or more days, but one who is seeking LOD service-related treatment at the same MTF where he or she normally is enrolled as a dependent will likely not have his or her healthcare documented under their own FMP and SSN. Later, as the RCSM separates or retires, identifying all of his or her LOD service-related healthcare encounters, so that potential VA disability evaluation and/or compensation consideration processes may be accomplished, will be challenging. Air Force Medical Service leadership is aware of this issue. However, given the limited registration options for patient with multiple healthcare eligibility levels, separating or "breaking" a patient's medical profile or account to satisfy record keeping requirements may pose a greater patient safety concern.

4.10.4.3. When a patient is a military retiree and eligible for care as Veterans Affairs beneficiary and a local VA-DOD joint sharing partnership exists. The PATCAT for this type of patient may change based upon whether the retiree is being treated for injuries or illnesses that resulted from a service-related disability and whether or not he/she has been referred to the MTF from a VA medical facility. This type of potential dual or multiple eligibility registration should not create a multiple "same-patient" problem because the SSN is the same for both patient categories and only the PATCAT is required to be changed depending on the type of care required for each episode of care. In both of these cases, the patient's eligibility exists under the same FMP/SSN and one physical record should be present.

4.10.4.4. When a patient is an authorized family-member dependent and a federal civilian employee, the patient will likely be DEERS eligible and registered in the automated CHCS system under the sponsor's SSN and the appropriate dependent PATCAT. However, required occupational healthcare and/or emergency healthcare associated with a work-related injury or illness is required to be provided and documented under the patient's SSN. **Note:** Automated DEERS eligibility interface will likely return "Ineligible or Not Authorized for Care" under the patient's SSN. However, similarly to other federal civilian employees with no other related beneficiary/eligibility status, do not deny care to treat occupational-related examination, injuries, or illnesses. In this situation it will not be possible to initiate order entry or view the patient under their FMP/SSN and correct PATCAT due to system registration limitations (without breaking the sponsor/dependent relationship and if enrollment to the MTF is present, it will not be possible to modify the registration). Cross-reference the patient using the

CHCS "alias" functionality to identify that there is current or historic multiple eligibility. In this case, a physical occupational health record and a dependent health record will be present (cross-reference physical records if possible).

4.10.4.5. When a patient is a federal civilian employee and a RCSM, the patient will likely be registered in DEERS under his/her SSN as a reservist or guardsman and will likely be registered in the automated CHCS system under his/her SSN, appropriate sponsor FMP and PATCAT. However, required local, state, or federal occupational healthcare examinations and/or emergency healthcare visits associated from an employee work-related injury or illness are required to be provided under the federal employee PATCAT. This type of potential dual or multiple eligibility registration should not create a multiple "same-patient" problem because the SSN is the same for both patient categories and only the PATCAT is required to be changed depending on the type of care required for each episode of care. Two physical records will be present for this patient, (occupational health and reserve record, cross-reference physical records, if possible) when there is documentation of care/treatment under both patient statuses.

4.10.5. The PATCAT is not static and can be changed; however, it is not automatically updated when the beneficiary's status changes in DEERS. The PATCAT can and must be changed within CHCS by MTF personnel, when required. Careful attention must be paid when booking appointments or admitting patients to ensure that the episode of care is documented under the appropriate PATCAT. Improperly booking appointments or admitting dual or multiple eligibility patients under the wrong PATCAT may have a significant negative impact to continuity of care, medical records tracking, and potential third party collection processes. One example of this potential negative impact: When dual or multiple-eligibility is present, completion or performance of the order/entry process within CHCS may not produce the desired effects if the action is prescribed using an incorrect PAT CAT.

4.10.6. Managing EHR Patient Registration errors, now and in the future. The deployment of AHLTA and the advent of the EHR pose new challenges for TOPA and the AFMS. CHCS registration errors, to include purposeful and accidental CHCS patient duplication, prior to AHLTA's deployment, only affected the local CHCS host (and some interfaced systems). However, now that the MHS has deployed AHLTA, a single patient registration error for a patient with multiple healthcare eligibility levels at one MTF has the potential to cause significant patient safety and records management problems that extend beyond the patient's primary MTF to other MTFs that share access to AHLTA and the Central Data Repository. Patient registration, if not completed properly, causes patient duplication within AHLTA and can lead to demographic data errors. TOPA and Information Systems officials should work together to develop a process for identifying and correcting these errors as they are encountered within AHLTA while following current MHS guidelines on patient merging/unmerging and error correction within AHLTA and CHCS.

4.10.7. Variations in the patient's identifiers (FMP/SSN) are to be expected between the AHLTA record and the local CHCS host. This may be due to the current controlled "freezing" of some of the updates to the FMP/SSN within AHLTA from the CHCS hosts, as well as the AHLTA record being linked to multiple CHCS hosts where the patient is registered under different FMP/SSNs. A patient's concurrent or historical multiple-eligibility categories could complicate this problem as the patient may appear under more than one FMP/SSN in both CHCS and AHLTA. TOPA officials should explain any record-related or

dual or multiple-eligibility identity management problems with the affected patient to prevent confusion and ensure the patient is aware of the system limitations. Follow current MHS demographic error (including FMP and SSN error) correction guidelines when addressing registration errors and inconsistencies within and between AHLTA and CHCS as well as other interfaced systems.

Section 4C—Patient Travel

4.11. Patient Accountability for Service Members Traveling to Attend Medical Appointments. Patient Accountability Management for Active Duty Service Members (ADSMs) Traveling to Air Force MTFs for Outpatient Medical Appointments and/or Specialty Care.

4.11.1. All Service Members traveling to any MTF for outpatient medical follow-up or referred specialty medical care require the following messages annotated on their travel orders, DD Form 1610, Request and Authorization for TDY Travel of DoD Personnel:

4.11.1.1. Section 11 shall indicate, "Medical Treatment Facility – TRICARE Operations and Patient Administration (TOPA) function and/or Patient Squadron."

4.11.1.2. Section 16 will indicate, "Service Members must report to the MTF TOPA function to have their travel orders validated within 24-hours of arrival, or the next duty day if arriving on a weekend or holiday. All Service Members, traveling to attend official, medical-related appointments or treatment, are required to contact the MTF TOPA function every two weeks to revalidate their orders."

4.11.2. This policy includes all Service Members traveling to any MTF via military air (aeromedical evacuation), civilian commercial airline, train, bus, personally owned conveyance, personally owned vehicle, or other means of travel recognized by the Joint Federal Travel Regulation. For all modes of travel, a Patient Movement Record must be created TRAC2ES application prior to travel.

4.11.3. Prior to travel, the TOPA function will ensure each Service Member has a functioning, activated, Government Travel Card and multiple copies of medical TDY orders.

4.12. Patient Travel Benefit.

4.12.1. Travel Reimbursement/Funding. For patients enrolled to a direct care MTF, the travel benefit is administered by the MTF. For patients enrolled to a network PCM, the TRICARE Regional Office administers the travel benefit. Travel costs for non-Air Force military Service Members are the responsibility of the Service Member's and their family members' respective Service branch.

4.12.2. TRICARE Prime Travel Benefit. When MTF TRICARE Prime enrollees (family members or military retirees) are referred by their primary care manager (PCM) for medically necessary, non-emergency specialty care to a location greater than 100 miles from the referring PCM's office, the patient must be reimbursed for reasonable travel expenses in accordance with the JFTR (U7960). Travel expenses are charged to the MTF.

4.12.2.1. Military retirees with a combat-related disability who are not enrolled in TRICARE Prime. When a retired Service Member with a combat-related disability, who is not a TRICARE Prime enrollee, is referred by a PCM for follow-on specialty care,

services and supplies, for that particular disability, to a location greater than 100 miles from where the military retiree resides, the patient must be reimbursed for reasonable travel expenses. **Note:** The TRICARE Regional Office located in the region where the retiree resides determines if the specialty care is more than 100 miles from the retiree's residence. Transportation expenses are reimbursed for the official distance from the patient's residence city to the specialty care provider's city. This also applies to subsequent specialty referrals authorized by a primary care provider.

4.12.3. Non-Medical Attendant Travel. Non-medical attendants (NMA) are appointed by medical authority. Local area travel/transportation expense coverage is authorized when serving as a NMA for a Service Member traveling on official business. Non-medical attendants assisting patients who are referred to medical facilities located beyond the local Permanent Duty Station (PDS) area will be reimbursed travel/transportation expenses in accordance with the Joint Federal Travel Regulation (JFTR) or Joint Travel Regulation (JTR), whichever is applicable.

4.12.3.1. Active Duty and RCSMs (on Active Duty status) may travel as NMAs to support an immediate family member TRICARE beneficiary at the recommendation of the attending physician. Service academy cadets and ROTC cadets may not travel as NMAs.

4.12.3.2. Non-Concurrent NMA Travel. Non-concurrent NMA travel may be authorized or approved when the need for an attendant arises during treatment or when there is need for an attendant only during a portion of the patient's travel.

4.12.4. Civil Service Family Member of a Seriously Ill or Injured Uniformed Service Member. A civilian employee, who is authorized travel under a competent travel authorization/order as a family member of an Active Duty Service Member who is seriously ill, seriously injured, or when death is imminent, is treated as an employee in a TDY status. A TDY travel authorization/order for a family member's travel per JFTR (U5246) must be issued and cite JTR C7800 as the authority. Refer to para 4.38. (Reporting Patients in Casualty Status), and para 4.40. relating to the Emergency Family Member Travel (EFMT) Program. Consult the local EFMT representative (typically the Casualty Affairs office) for further guidance.

4.12.4.1. Travel for Families of Inpatient Service Members who are VSI/SI, or Hostile NSI. Travel for Family members of inpatient Service Members who are VSI/SI or Hostile NSI is governed by the Emergency Family Member Travel (EFMT) Program (AFI 36-3002 para 2.27, 37 U.S.C. § 411h). EFMT is not funded by the MTF. EFMT is centrally funded by the Air Force, and managed by AFPC/DPWC.

4.12.5. Medical Referrals within the Local PDS Area. Travel by personally owned conveyance (POC) to obtain medical care within the local PDS area is reimbursable only when a Service Member is ordered (see note below) to a medical facility within the local area to take a required physical examination, or to obtain a medical diagnosis and/or treatment. When ordered, Service Members are considered to be on official business and must be reimbursed for the transportation, unless government transportation is available (see JFTR U3500). **Note:** "Ordered" in this context is defined as an order/command that could result in disciplinary action if not obeyed (e.g., commander-directed).

4.12.5.1. Medical Referral Travel at the Member's Expense. Travel to medical appointments within the PDS other than as described in the above paragraph is not reimbursable. Service Members traveling on official travel orders outside the PDS are authorized travel and transportation allowances in accordance with the JFTR. Travel must be authorized by the proper medical authority.

4.12.6. Medical Referral Travel for Government Employees Overseas and Their Family Members. When local medical facilities (military or civilian) at a foreign OCONUS area are not able to accommodate an employee's needs, transportation to another location may be authorized when seeking appropriate medical/dental care. Healthcare related travel expenses are funded by the employee's unit. Travel and transportation expenses and/or reimbursement are authorized in accordance with the JTR.

4.12.7. Convalescent Leave Transportation for Illness/Injury. (Reference JFTR U7210 and 37 U.S.C. § 411a). A Service Member is authorized transportation allowances (without per diem) for one trip when traveling for convalescent leave for illness/injury incurred while eligible for hostile fire pay under 37 U.S.C. § 310. The convalescent travel will be funded by the fund cite on the member's deployment travel orders. TDY orders are prepared by the member's unit.

4.12.8. Travel and Per Diem Allowance. Service Members traveling to a medical facility to obtain an examination or when traveling to Lackland AFB TX to attend a formal Physical Evaluation Board (PEB), receive travel and per diem (including meals and lodging) allowance based on their retired grade (10 U.S.C. § 1210 and JFTR volume 1, Chapter 7, Part 1). The Service Member is authorized an escort to accompany him or her to the place of examination when the he or she is not physically or mentally able to travel without assistance. Approximately 20-30 days prior to the reporting date, HQ AFPC/DPSD will send travel orders to the Service Member. The order will indicate the exact date, time and place to report and includes the authority for payment of travel costs. The destination or examining medical facility will endorse the order with the date and time the Service Member reported as verification that the Service Member was examined as an inpatient or outpatient. The endorsement also serves to verify the Service Member was released following the examination. If the Service Member received his or her examination as an outpatient, the destination MTF must indicate whether the Service Member occupied government quarters during his or her stay. The examining or destination facility must ensure the Service Member has an indorsed order to submit the claim for reimbursement. Upon return to the departure location, the Service Member is required to submit a travel voucher to their local accounting and finance office to obtain reimbursement for travel-related expenses. Refer to the JFTR for further travel entitlement information.

4.13. Transferring Patients Through the Aeromedical Evacuation (AE) System. See AFI 41-301, Worldwide Aeromedical Evacuation System and DoDI 6000.11, Patient Movement for instruction on AE operations.

Section 4D—Quarters Administration

4.14. Quarters Status.

4.14.1. Quarters is a full duty excuse provided to active duty uniformed service members receiving medical or dental treatment for a disease or injury that, based on sound professional judgment, does not require inpatient care. A "quarters" patient is treated on an outpatient basis, and is to remain in their home during the quarters period. Quarters periods generally last 24-72 hours depending on the providers prescribed rest/recovery period.

4.14.2. The provider or support staff will notify the member's unit commander or commander's designee regarding the patient's quarters status. Refer to Chapter 6 for commander designee processes. Command authority notification must be documented on DD Form 689, Individual Sick Slip, or a locally created form. See Attachment 3 for an example. Disclose only the minimum information necessary and account for the disclosure in the PHIMT or MTF approved centralized disclosure accounting tool. Notwithstanding any other installation document creation and approval mechanism, the Health Records Review Committee must approve locally created clinical forms. Forward a copy of the quarters notification or sick slip to the member's unit Commander or authorized representative to receive quarters information. Provide a second copy to the member so he/she may give it [quarters sick slip] to their supervisor.

4.14.3. Develop local procedures for program management, including, but not limited to:

4.14.3.1. Notifying Public Health for communicable disease tracking.

4.14.3.2. Mechanism for extending quarters past the initial rest period.

4.14.4. Non-Physician Restrictions: Physician assistants/nurse practitioners may not place a patient on quarters for longer than 48 hours without approval by a physician.

4.14.5. Obstetrical Quarters: As a general rule, Obstetrical (OB) Quarters should be the primary method for managing OB patients with prenatal medical issues when continued duty must be temporarily limited or suspended. The use of OB Quarters is designed for on-going medical issues that may require medical re-evaluation, not convalescence, which implies a period of recovery. For ongoing medical problems during pregnancy, providers are encouraged to use quarters and the profile system rather than recommending convalescent leave. Definitive OB quarters guidelines are discussed in AFI 44-102, Medical Care Management.

4.14.6. Unit Commanders and supervisors have the authority to grant up to 24 hours sick status at their discretion if a member's illness/injury does not require MTF intervention. If the illness/injury persists beyond 24 hours, then the Commander or supervisor must refer the member to the MTF for treatment and subsequent clinical examination.

Section 4E—Line of Duty (LOD) Program Administration

4.15. LOD Determinations.

4.15.1. Authority: AFI 36-2910, Line of Duty (Misconduct) Determination and AFI 36-3212, Physical Evaluation for Retention, Retirement and Separation.

4.15.2. According to AFI 36-2910, an LOD determination, "Is a finding made after an investigation into the circumstances of a member's illness, injury, disease or death." A service member who dies or is injured due to his or her own misconduct may lose substantial government benefits.

4.15.3. Following the start of a LOD determination, initial direct care and/or TRICARE network healthcare may not be denied to any ADSM or RCSM.

4.15.4. Following the completion of a LOD determination:

4.15.4.1. Direct care and/or TRICARE network healthcare may not be denied to any ADSM for which a LOD determination of Not in Line of Duty is found or identified.

4.15.4.2. Continued direct care and/or TRICARE network healthcare entitlements of RCMS may be impacted by LOD determinations. See para. 4.15.13 for specific guidance.

4.15.5. The LOD determination process is a Line of the Air Force program. The Air Force Medical Service is not the Office of Primary Responsibility. However, the LOD determination process is initiated with a medical officer's review of the member's illness, injury, disease, or death. The LOD determination process must be accomplished IAW AFI 36-2910.

4.15.6. Refer to AFI 36-2910 for information regarding when to initiate a LOD determination.

4.15.7. The Service Member's personnel status and branch of Service usually dictates what type of LOD form should be used when initiating a LOD determination case.

4.15.7.1. For ADSMs and members of the Air National Guard, MTF providers must use the AF Form 348.

4.15.7.2. For Air Force Reserve members, MTF providers must use the AFRC Form 348.

4.15.7.3. For Service Members assigned to other Service branches (i.e., US Army, Navy, Marines) Air Force MTF providers should use the specific Service LOD form or the DD Form 261, Report of Investigation Line of Duty and Misconduct Status when initiating a LOD determination case.

4.15.7.4. Most illnesses and injuries sustained by Service Members in an active duty status or in IDT status are presumed to have occurred In the Line of Duty unless one of the specific LOD determination/case initiation triggers or mandatory circumstantial occurrences, identified in AFI 36-2910, is identified that would otherwise cancel the automatic presumption and require the initiation of the LOD determination process. Refer to AFI 36-2910 for definitive information regarding when to initiate a LOD determination for ADSMs and RCSMs.

4.15.8. For ADSMs, the inability to perform one's job for 24 hours or more, and the subsequent placement upon simple Quarters for minor injuries and illnesses (including obstetrical quarters) will likely not require the submission of an AF Form 348 provided:

4.15.8.1. None of the mandatory circumstantial factors or LOD determination/case initiation "triggers," identified by AFI 36-2910, are present.

4.15.8.2. The injury or illness is minor and meets the criteria provided under the Administrative LOD Determination allowances of AFI 36-2910.

4.15.9. If an injured RCSM is taken to a non-MTF for care, the medical officers assigned to the MTF or RCMU who provided the initial treatment or had first contact with the RCSM should initiate the LOD determination process.

4.15.10. The medical officer initiating the AF Form 348 will complete blocks 1-12 of the AF Form 348, sign, stamp or type his/her printed name and title, and date the form. The provider will then contact the appropriate MTF or RC LOD patient administration representative to initiate the administrative coordination process. The LOD patient administration representative shall ensure that all applicable supporting medical documents and/or any other medical-related incident or information reports are attached to the AF Form 348 before forwarding the package to the appropriate officials designated in AFI 36-2910. The LOD administrative representative will fill in the "TO, THRU, and FROM" blocks at the top of the form.

4.15.11. In cases where the healthcare provider has determined an LOD determination review is required for an inpatient admission, the admitting clerk must obtain the time, place, and manner of occurrence of the incident from the patient, other witnesses, and/or available sources and records the information on the reverse of the AF Form 560, Authorization and Treatment Statement. Again, the initiating provider completes the appropriate blocks on the AF Form 348, signs the form and coordinates with the appropriate MTF or RCMU LOD representative. The LOD representative will forward the package to the Service Member's MPS.

4.15.12. The MTF or RCMU LOD representative shall be appointed in writing by the MTF or RCMU Commander. The LOD representative is responsible for:

4.15.12.1. Educating MTF or RCMU staff on medical responsibilities for the LOD process.

4.15.12.2. Accurate and timely processing of all LODs within the MTF.

4.15.12.3. Routing LODs to the appropriate MPS special actions unit or RC personnel processing office IAW AFI 36-2910.

4.15.12.4. Ensuring LODs are initiated for local unit attached IMA and Participating Individual Ready Reserves (PIRR) reservists.

4.15.12.5. Identifying cases requiring LOD and determinations for active duty and RCSMs.

4.15.12.6. Ensuring the appropriate medical officer signs the AF Form 348 before distributing the AF Form 348 as follows:

4.15.12.6.1. Original: Forward the original and all supporting medical summaries and supporting documentation to the member's servicing MPS Special Actions Office.

4.15.12.6.2. Copy: File one copy in the member's inpatient or outpatient medical record, as applicable.

4.15.12.6.3. Copy: File one copy in the LOD-MFP Office.

4.15.13. LOD Requirements for Members of the RC. Reference AFI 36-2910, Line of Duty (Misconduct) Determination and AFI 36-3212, Physical Evaluation for Retention, Retirement and Separation.

4.15.13.1. Government sponsored (Direct Care or TRICARE) healthcare is not authorized at government expense beyond the period of IDT or "drill" status orders for any medical condition that is determined to be "Not in Line of Duty." Attempts to complete Line of Duty determinations should occur prior to the end of the AD orders.

4.15.13.2. If an injured RCSM is taken to a non-MTF for care, the medical officers assigned to the MTF or RCMU who provided the initial treatment or had first contact with the RCSM should initiate the LOD determination process as the LOD determination process should be accomplished at the first opportunity. If the LOD determination process cannot be initiated by the point of first contact, the process will be initiated by the RCSM's servicing MTF or RCMU. The LOD determination process must be accomplished IAW AFI 36-2910.

4.15.13.3. Air Force Reservists: If the MTF initiates the AF Form 348 or AFRC Form 348, the form must be submitted to the reservist's Air Force Reserve unit or to the Air Force Reserve medical unit (AFRMU) responsible for uploading the information into the Duty Determination Management System (DDMS). The AFRMU will initiate the AFRC Form 348 through the RC DDMS.

4.15.13.4. For IMA and PIRR Service Members: The MTF should initiate an AF Form 348 (1st side with provider signature) and forward to the Base IMA Administrator (BIMAA) for routing and input into the DDMS application. Notification of HQ ARPC and AFRC/SGP of initiated LODs for IMA and PIRR Service Members is not necessary. Instead, the Service Member's BIMAA should be notified.

4.15.13.5. Air National Guard Service Members: The medical officers who first provide treatment or the medical officers stationed nearest to the non-Air Force medical facility that first provide treatment, in cooperation with the MTF or RCMU patient administration or LOD representative should initiate the AF Form 348.

4.15.13.6. If the MTF initiates the AF Form 348, the form must be submitted to the ANG Service Member's unit or to the ANG medical unit (ANGMU) responsible for uploading the information into the Duty Determination Management System (DDMS). The Air National Guard Service Member's unit or the ANGMU will initiate the automated AF Form 348 through the DDMS.

4.15.13.7. Any RCSM seeking government sponsored healthcare must produce at least a partially completed AF Form 348 (1st side completed and signed by the provider initiating the LOD determination process) or an AFRC Form 348 (with sections 1-5 completed and signed by the provider initiating the LOD determination process). The partially completed LOD determination form may be used as healthcare eligibility verification source when the Service Member seeks government sponsored healthcare without possessing current active duty status orders or when a DEERS healthcare eligibility check indicates no current coverage.

4.15.13.8. If an LOD determination cannot be made before the tour of duty ends, and the individual requires further hospitalization or treatment, continue with any necessary healthcare related to the potentially service-connected injury or illness.

4.15.13.9. If the final determination is "Not in Line of Duty," medical care at government expense ends. Document the notification of the LOD determination in the patient's medical record(s). If the Service Member is still hospitalized, advise the patient that as of the day of notification, care will be provided at the full reimbursement rate (FRR) until transfer to a civilian medical facility.

4.15.13.10. If the final LOD determination is "In Line of Duty," document the notification and advise the patient that care continues at government expense.

4.15.13.11. "Provisional" LOD Determination for Healthcare: An informal or formal LOD investigation, still ongoing, and where a final LOD determination has not yet been determined. A Provisional LOD determination for Healthcare is comprised of the completed medical portion (front part) of the AF Form 348 (with a provider signature) or the completed sections 1-5 and provider signature on the AFRC Form 348 for Air Force Reservists. Each form should contain a description of the Service Member's illness, injury or disease, and date of occurrence. IAW AFI 36-2910, Line of Duty (Misconduct) Determination, the military officer's signature does NOT constitute a completed LOD determination. The Provisional LOD determination for Healthcare is used to provide eligibility for direct or TRICARE network healthcare when DEERS indicates a RCSM may not be eligible for medical or dental benefits. In other words, the completed first side of the AF Form 348 or completed sections 1-5 of the AFRC 348 (including a provider signature for each form) may be used to verify a RCSM's entitlement to medical care at government expense when not on active duty orders.

Section 4F—Air Force Secretarial Designee Program Administration

4.16. Authority. Title 32, Code of Federal Regulations (CFR), Part 108 and DoDI 6025.23, Health Care Eligibility Under the Secretarial Designee Program and Related Special Authorities. The use of regulatory authority to establish DoD healthcare eligibility for individuals without a specific statutory entitlement or eligibility shall be used very sparingly, and only when it serves a compelling DoD mission interest. The Secretary of Defense (or his/her designee) and/or the Secretary of the Army, Navy, and Air Force may designate individuals not otherwise entitled, for DoD healthcare (medical and dental) in military MTFs, per AFI 36-3026V1_IP. Emergency care (life/limb/eyesight/relief of undue suffering) does not require Secretarial Designee (SECDES) status. Under Headquarters Air Force (HAF) Mission Directive 1-6, the Secretary of the Air Force (SECAF) has delegated authority to the Administrative Assistant to the Secratery of the Air Force (SAF/AA). Healthcare authorized under this section shall be provided on a reimbursable basis, unless non-reimbursable care is authorized by this instruction or waived by the Office of the Under Secretary of Defense for Personnel and Readiness, OUSD (P&R) or the Secretaries of the Military Departments as the approving authorities. The level of benefit and reimbursement rate is determined by the Service, using Service-specific criteria.

4.16.1. Reciprocity Among all Military Departments. Secretarial Designees from other Military Departments may receive treatment in Air Force MTFs based upon, but not limited

to, the capabilities of the MTF professional staff, availability of space and facilities, and MTF proximity to the individual's home address.

4.16.2. Each approved Secretary of the Air Force Designee must obtain a signed letter from the SAF/AA establishing eligibility for care. Exceptions: When an MTF Commander authorizes care for newborns of dependent daughters as referenced in paragraph 2.18 and when an overseas MAJCOM Command Surgeon authorizes healthcare for family member dependents of contractors as referenced in paragraph 2.38. The letter will include an effective date, coverage period, aeromedical evacuation/transport determination, the specific treatment or care authorized in relation to the specific medical condition/incident, and the rate (charges) for care. The letter must reflect that care is authorized at the designated MTF only.

4.16.3. Authorization does not entitle a Designee to utilize TRICARE benefits/entitlements; however, it does include a supplemental care benefit for diagnostic procedures only. Approved Designees receive space-available care at the MTF Commander's determination. Unless the authorization letter specifies otherwise, individual Designees may not use the aeromedical evacuation system. If aeromedical evacuation becomes a requirement after the SAF/AA has approved the initial request, a supplemental Designee request must be submitted. Designated MTF personnel may contact AFMOA/SGAT for assistance.

4.16.4. The SAF/AA may authorize care for up to two years. This program is not intended to provide life-long medical care. Individuals may request renewal of Designee status and reapply for Designation as outlined in this chapter, however continued approval is not guaranteed. Secretarial Designee requests will not be approved for financial or humanitarian purposes.

4.16.5. Individuals being considered for Secretarial Designee status (not currently eligible for care) shall not receive treatment at Air Force MTFs until Designee status has been approved. An exception to this requirement is Extracorporeal Membrane Oxygenation (ECMO), or partial heart-lung bypass. In this situation, the MTF is required to initiate a verbal request via telephone communication with the SAF/AA.

4.16.6. MTF Secretarial Designee Program Managers should educate MTF professionals, medical support (outpatient & inpatient) and ancillary staff members of the purpose of the Secretarial Designee Program and its basic requirements. Clinical professionals and immediate medical support staff are best positioned to identify patients who may benefit from potential Secretarial Designee status. If Secretarial Designee status is identified as a potential option, clinicians and medical support staff, either through the normal course of treatment for an MHS beneficiary for whom healthcare benefits are soon to expire or from the presentation of a civilian emergency patient, should proactively determine eligibility loss date and submit an application in a timely manner. MTF requests must be received by AFMOA/SGAT no later than 30 days prior to expiration of medical benefits. Individuals who have lost their military medical benefits and are being considered for Secretarial Designee status will no longer receive treatment at Air Force MTFs until Designee status has been approved. Situations where patient healthcare eligibility has expired and SECDES approval has not been granted could potentially leave the patient without healthcare coverage and/or force the applicant to incur a financial burden, especially if the Designee request is disapproved. Application denials for healthcare already provided will automatically generate

charges at the FRR. Retroactive requests should be limited to absolute unavoidable situations such as short-notice separations or emergency care. The MTF must notify AFMOA/SGAT immediately of urgent cases.

4.16.7. Each application shall include a 100% DEERS and ID check to verify the status of the patient and sponsor .

4.17. US Air Force Secretarial Designee Criteria. Individuals who meet one or more of the following criteria may apply for Secretarial Designee status through the requesting MTF using the format in Attachment 6.

4.17.1. Military is Only Source of Care. This category is appropriate for patients (currently ineligible for DoD medical care) for whom the MHS is the only source of care, for example, patients who may benefit from urgent or emergency hyperbaric medicine oxygen therapy which is not commonly available in the civilian sector, may apply for Designee status.

4.17.2. Teaching Case. When the case presents a unique teaching opportunity for the MTF staff or residency programs, an individual may request Designee status. If this option is selected, the MTF attending physician or primary physician advocate must include a thorough, written, signed statement that identifies the specific benefits to the Air Force. The application should then be endorsed by the attending physician's department chairperson, the Director of Graduate Medical Education, and the Chief of the Medical Staff. Each signature is required to validate the teaching significance of the case. For example, the case is critical for continued accreditation of a training program; is an extremely rare case; the case is a necessary part of a training program protocol and the patient "case mix" is not available in the beneficiary population. MTF healthcare will, under most circumstances, be provided at the FMR.

4.17.3. SAF/AA Delegated Approval Authority Programs.

4.17.3.1. Civilian Trauma Program. Upon expiration of eligibility initially established through this program, additional or continued care requires a SECDES application and approval by the SAF/AA. If approved, the Designee will pay the FRR for healthcare provided under the SECDES program. Currently the only exception is if the SECDES application utilizes the criteria of "Best Interests of the Air Force."

4.17.3.2. ECMO Program (partial heart-lung bypass). If a patient requires Extracorporeal Membrane Oxygenation (ECMO) or partial heart-lung by-pass, the MTF will initiate the application with a verbal request to the SAF/AA. The full and complete electronic application shall follow within 24 hours.

4.17.3.3. HIV Research Program.

4.17.4. Best Interest of the Air Force. This category of Designees includes those for whom it is in the best interest of the Air Force to provide continued care. For cases when the justification is in the best interest of the government, include a letter from the MTF, addressing the effects of denying Designee status (e.g., litigation risk, cost, negative press coverage). Cases will be reviewed by the MTF law consultant or base Legal Office, and will be included as part of the Designee request. Care will under most circumstances be provided at the FMR.

4.17.5. Continuity of Care. If continuity of care is a significant clinical issue in the individual's course of treatment and civilian medical care is not available or appropriate, this individual may request Designee status. For cases when the justification is continuity of care, the case must be medically supportable. Include a statement on the medical impact if the Air Force were to deny the individual Designee status. Care will generally be provided at the FRR.

4.17.5.1. Obstetrics, Maternal, and Pediatric Care Sub-Category: The MTF Commanders or designated representative may approve Designee status for applicants identified below at the FMR. MTF healthcare is generally limited to pre-partum obstetrical care, MTF newborn delivery, one post-partum check-up (for the mother), one post-partum well-baby outpatient visit for the infant and any necessary immunizations for the infant to be provided no later than six weeks following delivery.

4.17.5.1.1. Newborns of eligible family member daughters.

4.17.5.1.2. Pregnant former Active Duty members and their newborns.

4.17.5.1.3. Spouses of former Active Duty and their newborns.

4.17.5.1.4. Family member dependent daughters who became pregnant prior to losing eligibility.

4.17.6. Involuntary Separation. If a sponsor is involuntarily separated for medical reasons under honorable conditions and the sponsor's wife is pregnant, the wife may request Designee status.

4.17.7. Abused Family Members/Dependents. This section is only applicable if all or some transitional benefits are denied by the Air Force Personnel or Finance Authorities, and/or the DFAS. If all or some transitional benefits are denied, a discharged or separated Service Member's family member/dependents may apply for consideration of limited (MTF direct care only) medical benefits under the SECDES program. Approval is not guaranteed. If approved, healthcare is specifically limited to medical services necessary to treat injuries or illnesses suffered as a direct result of the sponsor's abuse. See Chapter 2, para. 2.19, Abused Family Members/Dependents, for definitive information regarding processing medical sufficiency letters to support transitional healthcare benefits for abused family members/dependents of discharged or separated Service Members.

4.17.7.1. Notification or receipt of denial of transitional compensation benefits (from the installation MPS or Finance Office) does not necessitate MTF obligation to automatically submit a SECDES application on behalf of the abused family member(s). The MTF is only required to submit an Air Force SECDES application to the SAF/AA (via AFMOA/SGAT intermediary), if requested in writing by one or more family members of the discharged Service Member. Confirmation of this action must be coordinated with the abused family member dependent(s) or his/her legal guardian(s). The MTF location responsible for assembling the SECDES package should include the standard application package documentation identified in paragraph 4.18. and Attachment 6, to include the application letter signed by MTF Commander and medical summary or statement that clearly identifies the medical illness, injury or condition (related to, or as a consequence of abuse) for which military healthcare is requested.

4.17.8. Alcohol Rehabilitation. Alcohol rehabilitation treatment often requires that members of the family support the active duty member receiving treatment at an authorized DoD MTF. These family members may receive transportation to the treatment facility via aeromedical evacuation aircraft at no cost to them. However, these individuals must cover the costs of their transportation from their homes to the pickup point that the Theater or Patient Movement Requirements Center (PMRC) designates. The PMRC makes all reasonable attempts to keep ground travel times and distances to a minimum. Only one individual may receive transportation under this authority, exceptions require approval from HQ AMC/SG or designated PMRC.

4.17.9. Aeromedical Evaluation for Foreign Military Members. Foreign governments may request Designee status for their military members in order to receive aeromedical evaluations at the United States Air Force School of Aerospace Medicine, Aeromedical Consultation Service (ACS), at Wright Patterson AFB, OH. The ACS is not an MTF. Medical care/treatment is not available at this facility. The ACS evaluates, diagnoses, and provides aeromedical recommendations to return aviators to flying status. The foreign member's embassy must submit a foreign visitor's request/application to the Secretary of the Air Force International Affairs Disclosure Division (SAF/IAPD). The office of SAF/IAPD will notify the School of Air Space Medicine's designated representative who will submit a Designee application to AFMOA/SGAT. At least 60 calendar days is required for SAF/IAPD and AFMOA/SGAT to process the request. SAF/IAPD and AFMOA require at least 30 calendar days per agency to process the foreign visitor's request PRIOR to the appointment date. The Foreign Service member's Washington DC embassy must include the basic SECDES requirements identified in Attachment 6, plus the following information:

4.17.9.1. Nationality.

4.17.9.2. Service affiliation.

4.17.9.3. Age.

4.17.9.4. Aeronautical rating.

4.17.9.5. Type of aircraft flown and total number of flying hours.

4.17.9.6. Case history, supporting medical documents (see Attachment 6).

4.17.9.7. Justification for the request (see Attachment 6).

4.17.9.8. Type of evaluation or test required.

4.17.9.9. Date for which the applicant is requesting service.

4.17.9.10. Where to report the results of the evaluation or test.

4.17.9.11. Billing/payment information.

4.17.10. If the country has an open Foreign Military Sales (FMS) case, the Air Force may bill the costs for the additional study to that case number. In other situations, the requesting country may have the Air Force bill costs to another US controlled fund or may have the bill sent to their Embassy. The applicant must provide billing information before the Air Force decides on the availability of the requested service.

4.17.11. Special Foreign Nationals. The SECAF may authorize Air Force healthcare benefits to foreign nationals considered to be critically important to the interests of the United States. The SECAF may use this authority for individual designations, on a case-by-case basis. Such a designation does not create a new category of beneficiaries. Approval Authority for these types of requests rests with OUSD/P&R.

4.17.11.1. Criteria for selection as a SECAF Designee for foreign nationals:

4.17.11.1.1. Foreign nationals nominated for Designee status must be Heads of State, Cabinet members (Minister), Chiefs of Staff of the Armed Forces, or hold equivalent positions.

4.17.11.1.2. Appropriate healthcare must not be available in the nominee's country or in a civilian healthcare facility in the United States.

4.17.11.1.3. The nominee or his government must agree to assume responsibility for payment of DoD healthcare services (at the FRR) and, if the individual requested and the Air Force approved the cost of aeromedical evacuation.

4.17.11.2. Designation procedures:

4.17.11.2.1. Foreign governments seeking Designee status will submit requests to the State Department through the mission chief of the country involved. The request must contain the full name and title of the individual, an explanation of why the individual is critical to US interests, the pertinent medical information, the billing address individual or office, and a certification that the nominee meets all of the necessary criteria.

4.17.11.2.2. Refer inquiries from foreign embassies in Washington, or other sources to the US Chief of Mission in the country concerned.

4.17.11.2.3. The State Department reviews the request and refers it to the appropriate agency Secretary with a recommendation for approval.

4.17.11.2.4. The Request is submitted to the SECAF for review. If approved, the Secretary's office forwards it to the Office of the Air Force Surgeon General for appropriate action. AFMOA/SGAT prepares the request and assigns responsibility for moving the Designee through the Patient Movement Requirements Center to the specific overseas or CONUS MTF.

4.18. Applying for Air Force Designee Status. When evaluating a Designee application, MTF Commanders should consider the availability of MTF capabilities and resources. If adequate capabilities exist, and the applicant does not meet or qualify for any initial or continued sponsor service affiliation for DEERS enrollment, eligibility, and/or medical entitlement identified in AFI 36-3026V1_IP, then the MTF Commander should accept, review, and sign the application package recommending whether or not Designee status is warranted. The package should then be forwarded to AFMOA/SGAT for processing. The MTF shall electronically submit (via e-mail encryption) a Secretarial Designee application to AFMOA/SGAT (Health Benefits) no later than 30 days prior to expiration of medical benefits or requested Designee start date (using the format in Attachment 6). The 30 day window allows enough coordination time to submit the SECDES application to the SAF/AA for review and approval consideration.

4.18.1. The application must contain:

4.18.1.1. The patient's full name.

4.18.1.2. The patient’s date of birth.

4.18.1.3. The patient’s relationship to sponsor.

4.18.1.4. Sponsor's full name.

4.18.1.5. Sponsor’s rank.

4.18.1.6. Sponsor’s branch of service.

4.18.1.7. The last four numbers of the Sponsor’s SSN.

4.18.1.8. Sponsor’s military status (active duty retired, deceased) and reason for discharge or separation.

4.18.1.9. The exact date Designee status should begin.

4.18.1.10. The recommended length of designation.

4.18.1.11. Transportation aboard an aeromedical evacuation aircraft is/is not requested. Identify whether the patient requesting Designee status might require transportation on aeromedical evacuation. If so, include patient's home address.

4.18.1.12. Reason for Designation: for example, age (specify date of birth), marriage status, sponsor leaving the service.

4.18.1.13. Justification: Identify both the primary program category/criteria best suited for the situation and a supporting narrative.

4.18.1.14. Diagnosis: The application should include diagnosis in both clinical and layman's terms.

4.18.1.15. Brief Case History: The application needs a brief (one or two paragraph) case history. For complex cases, attach a separate letter with additional details. Include a long-term prognosis, the patient's age when medical providers first diagnosed the problem, and when and where DoD sponsored care began. Histories must be understandable to non-medical personnel.

4.18.1.16. Name of attending physician.

4.18.1.17. Medical specialty required: Application should specify the type of medical specialist (orthopedics, pediatrics, etc.) who would provide care for the patient and the expected treatment plan.

4.18.1.18. Name, rank, and duty phone (DSN and commercial) of the MTF Secretarial Designee caseworker.

4.18.1.19. Third Party Insurance Carrier: Identify if the sponsor, and or, applicant has Third Party Insurance.

4.18.1.20. Third Party Insurance Carrier Policy Number.

4.18.1.21. Space Availability: Indicate if the MTF has the capacity to treat the applicant.

4.18.1.22. Indicate if other TRICARE Prime beneficiaries with the same diagnosis are/are not being deferred to the network.

4.18.1.23. Right of First Refusal (ROFR) status: Indicate whether the MTF accepts/does not accept ROFRs.

4.18.2. Forward all USAF Secretarial Designee requests electronically to AFMOA/SGAT. Because designee applications may contain PHI or sensitive medical information, e-mail messages must ONLY be forwarded to higher headquarters using government Common Access Card (CAC) digital signature and encryption protocols. Simply assigning a document password and forwarding the information unencrypted to higher headquarters is not authorized. The message must be digitally signed and encrypted IAW HIPAA standards. No exceptions. If unable to send an encrypted message, the package may be mailed using a commercial overnight express mail shipping company or First Class USPS overnight or express mail with return receipt or other package tracking option.

4.18.3. Each request is required to be coordinated with an AFMOA/SGAT representative. AFMOA/SGAT will review and coordinate the request package prior to submitting to the SAF/AA. AFMOA will submit all "Retroactive" requests to the Air Force Surgeon General (AF/SG) for coordination and approval consideration prior to further submission to the SAF/AA. All request packages must contain the AFMOA electronic Staff Summary Sheet, the MTF application, and the MTF medical law consultant's review endorsement.

4.18.4. If the request pertains to a sponsor or member who is separating and or discharged from the Air Force, the request package must include a copy of the sponsor's or member's separation orders and DD 214 (if available) and when applicable, the line of duty determination for RCSMs.

4.18.5. AFMOA Health Benefits officials, with concurrence of respective MAJCOM Command Surgeons, are authorized to reject applications that do not meet the requirements identified in this chapter. Applications that are denied or rejected by AFMOA officials and the MAJCOM Command Surgeon do not need to be routed through or submitted to the SAF/AA. Ensure request packages are accurate, current and contain all necessary supporting documentation.

4.18.6. AFMOA will forward USAF Secretarial Designee requests via e-mail to the SAF/AA.

4.18.7. The electronic Staff Summary Sheet must contain (at a minimum) purpose, background, discussion, options and recommendation. The discussion must include a justification that specifies which of the criteria in paragraph 4.17 the request is based upon, and an explanation of how the request relates to those criteria. The discussion must also include the eligibility duration being requested.

4.18.8. The SECDES approval letter must contain the designee's name, eligibility duration, designation criteria being met, aeromedical evacuation determination, reimbursement rate, statement limiting care to MTF authorized care only for the specified illness or injury and any applicable third party insurance. See example of the SAF/AA approval letter at Attachment 5.

4.18.9. The determinations of all designee cases and respective application packages submitted to and returned from the SAF/AA will be returned to AFMOA/SGAT who will then notify the applicable MTF and/or MAJCOM so the individual can be notified. MTFs will file a copy of the letter in the individual's outpatient medical record.

4.18.10. Reporting. The annual Secretarial Designee Log will be forwarded annually (CY) to AFMOA/SGAT NLT 15 January. Following report collection and quality review, officials at AFMOA/SGAT will then forward the reports to the SAF/AA NLT 15 February.

4.18.10.1. OVERSEAS MAJCOM Commanders and MTF Commanders will report data on the individuals approved under authority delegated them by the SAF/AA (locally approved).

4.18.10.2. Reporting will be in the format found in Attachment 7 to this AFI.

4.18.10.3. Each individual will be categorized as to primary reason for designation as follows:

a. Military is Only Source of Care.

b. Teaching Case.

c. Best Interest of the Air Force.

d. Continuity of Care.

e. Newborns of eligible family member daughters.

f. Other Reasons (briefly describe reason).

4.18.10.4. All reporting data is Private Health Information and will be transmitted in accordance with appropriate safeguards.

4.19. Secretary of Defense Designees. Secretary of Defense Designees. Certain civilian officials within the Government, including the Department of Defense and the Military Departments, have secretarial designee status for medical care and emergency dental care in military medical/dental treatment facilities when a designee does not qualify for further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement AFI 36-3026V1_IP. These designees are eligible to receive care in all DoD medical/dental treatment facilities. The following individuals are Secretarial Designees for space-available care in MTFs on a reimbursable basis, unless specified otherwise by a Service Secretary.

4.19.1. The SECAF recognizes these Secretary of Defense Designees (family members are not included unless otherwise stated):

4.19.1.1. The President and Vice President and their spouses and minor children.

4.19.1.2. Members of Congress.

4.19.1.3. Members of the Cabinet

4.19.1.4. Officials of the Department of Defense appointed by the President and confirmed by the Senate (includes the Secretaries, the Under Secretaries, the Assistant Secretaries, and the General Counsels of the Military Departments).

4.19.1.5. Article III Federal Judges. (Article III courts are: The Supreme Court of the United States, U.S. Courts of Appeal, U.S. District Courts, U.S. Court of International Trade, United States Foreign Intelligence Surveillance Court, United States Foreign Intelligence Court of Review). **Note:** Notify HQ USAF/SG8Y immediately if you treat an Article III Federal Judge. Article III Federal Judges have an identification card proving their association with the courts.

4.19.1.6. Judges of the U.S. Court of Appeals for the Armed Forces.

4.19.1.7. Assistants to the President.

4.19.1.8. Director of the White House Military Office.

4.19.1.9. Former Presidents of the United States and their spouses, widows, and minor children.

4.19.2. Applicable charges for Secretary of Defense Designees. The SECAF has authorized the individuals listed above to receive space-available medical and dental care at Air Force MTFs on a reimbursable basis.

4.19.2.1. For outpatient care within the National Capital Region (Joint Base Andrews and Joint Base Anacostia-Bolling): charges are waived.

4.19.2.2. For outpatient care outside the National Capital Region:

4.19.2.2.1. Members of the Congress: FRR.

4.19.2.2.2. All others: Interagency rate.

4.19.2.3. For inpatient care anywhere:

4.19.2.3.1. Members of the Congress: FRR.

4.19.2.3.2. All others: Interagency rate.

4.19.3. See AFI 41-301 and DoDI 6000.11 for instructions on Aeromedical Evacuation operations.

4.20. Operating the Air Force Secretarial Designee Program Overseas. Command Surgeons at Headquarters United States Air Force Europe (HQ USAFE) and Headquarters Pacific Air Forces (HQ PACAF) for their respective theater have the authority to designate individuals for care in overseas military MTFs. This authority does not extend to authorizing transportation to the CONUS. MTF TOPA staff will keep a log of individuals designated under this paragraph according to the instructions in this AFI. In general, MTF Commanders authorize admission to an Air Force MTF, if space, facilities, and professional staff capabilities are available. In the case of foreign nationals, the desired/requested healthcare may be denied if the same care is available elsewhere in their country. Charges for foreign national care are at the FRR. In circumstances where it would serve the best interest of the overseas command, the MTF Commanders may authorize charges at the subsistence rate.

4.20.1. U.S. Citizens. The Air Force tries to keep the number of US citizens that the Commander designates under this paragraph to an absolute minimum. Most US citizens that fall under this paragraph are returning hostages and individuals involved in prisoner exchanges. There may be some occasions when designating US citizens other than those above would be appropriate.

4.20.2. Foreign Nationals. Commanders who use the authority under this paragraph must issue guidelines on medical care for nationals of foreign governments. These guidelines must identify the categories of persons, both military and civilian, who have authorization for medical care within the provisions of this paragraph. Individuals, whom the Commander designated under this paragraph, must contribute to the advancement of US public interests. Generally, only officials of high national prominence are made Designees. Sometimes, a

Commander grants Designee status when there are special, unusual, or extraordinary circumstances. The Air Force may not provide care for foreign nationals with incurable diseases or who require excessive nursing care. Commanders should seek recommendations from the chief of the diplomatic mission or embassy to the country involved before authorizing care to any foreign national. The Air Force collects charges for the Designee's care locally. The Commander waives charges on an exception basis only.

4.21. Designee Status Used in Claims Against the United States. Designee status is not used in the claims process.

Section 4G—Exceptional Family Member Program (EFMP)

4.22. Exceptional Family Member Program (EFMP).

4.22.1. The mission of the EFMP is to identify medical and educational service requirements of family members in support of active duty sponsor reassignment and civilian employment overseas. MTFs will standardize the location of Exceptional Family Member Program (EFMP) enrollment and relocation clearance functions within Medical Management offices. Refer to AFI 40-701, Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP), for additional information.

4.23. Family Member Relocation Clearance Coordinator (FMRCC).

4.23.1. The individual responsible for ensuring administrative process requirements are met is the FMRCC. Refer to AFI 40-701, Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP), for additional information.

Section 4H—Admissions and Dispositions Program Administration

4.24. Responsibility for Admission Processing.

4.24.1. Unless otherwise specified, patient administration is responsible for administrative needs required for the admission and disposition of patients. All patients that are admitted to the medical facility; Carded for Record Only (CRO); reported as Emergency Room Deaths (ERD); while as an inpatient, transferred from one inpatient nursing unit to another, while as an inpatient; transferred into or from the MTF; discharged, or for which administrative responsibility is assumed, are processed through the Admissions & Dispositions (A&D) function of the medical facility. Air Force MTFs also assume administrative responsibility for service members hospitalized in non-military medical facilities (including CRO, reporting and processing for AD and/or RCSMs who may have died at a civilian medical facility or other non-federal installation or location). Patients will be registered, admitted, and discharged using the current automated CHCS computer system.

4.25. Administrative Admission & Disposition Requirements. The A&D office will verify authorized eligibility for healthcare for 100% of inpatient admissions. The admitting Provider initiates and signs AF Form 560, Authorization and Treatment Statement. A&D clerks shall complete remaining blocks of the AF Form 560 and process the admission in the current automated computer system once the provider digitally signs the admission order. Use a manual method or other computer generated form to assign registration number when the current automated computer system is not available.

4.25.1. For all admissions, enter the patient's demographic and personal data via the FULL patient registration menu. For Service Member's, enter all of the patient's military identification (including unit name and address). Contact the member's commander, first sergeant, or other appropriately appointed commander's designee upon the member's admission to the MTF and subsequent discharge/transfer from the MTF. Contact RMG/IRMS for all Individual Mobilization Augmentee (IMA) admissions. Provide the minimum necessary amount of information aka Sanitized Healthcare Information regarding the Service Member's status only to the commander, first sergeant, or appropriately appointed commander's designee. All disclosures of PHI to commanders will be tracked in accordance with DoD 6025.18-R.

4.25.2. If communication with the member's commander, first sergeant, or other appropriately appointed commander's designee is not possible, then contact the Service Member's installation command post or installation operations/control center. Release only Sanitized Healthcare Information to the member's installation command post or control center staff. All disclosures of PHI to commanders will be tracked in accordance with DoD 6025.18-R.

4.26. Assuming Administrative Responsibility for Military Members Hospitalized in Non-Military Medical Facilities "aka" Absent Sick Status.

4.26.1. The MTF Commander at the nearest Air Force MTF shall assume the primary administrative support responsibility, (including appropriate Service Member identification, monitoring, "tracking," clinical secondary support, advice, analysis, and/or consultation) for any ADSM referred to, hospitalized, or admitted to a non-military medical facility. AFSMs admitted to non-military civilian medical facilities are referred to as being in an "Absent Sick" or ABS status.

4.26.2. If necessary, the nearest Air Force MTF shall serve as an information "conduit" between the civilian or non-military medical facility, the Airman's family, and the Service Member's chain of command.

4.26.3. Each MTF TOPA function or A&D office is responsible for identifying and "tracking" each known Air Force ADSM hospitalized or admitted to a civilian or non-military medical facility. Established or perceived geographic boundaries, TRICARE Prime Service Areas, or other distance or mileage restrictions or arguments, shall not prohibit an MTF from its obligation to identify, monitor, track, or support a hospitalized Airman unless another Air Force MTF, has, or will assume primary administrative support responsibility. Support obligations may extend hundreds of miles if no other Air Force MTF exists in a particular region or if no other Air Force MTF has already been identified as having primary administrative support responsibility.

4.26.4. Notwithstanding the provisions identified immediately above this paragraph, the nearest MTF will assume primary administrative support responsibility for all known Air Force ADSMs, regardless of type of injury or illness, whether hospitalization was planned, scheduled, resulted from emergent, urgent, non-emergency, non-urgent, battle or non-battle related circumstances.

4.26.5. All known Air Force Wounded Warriors, will be identified, tracked, and supported by the nearest Air Force MTF.

4.26.6. Any Air Force seriously ill or injured ADSMs will be identified, tracked, and supported by the nearest Air Force MTF.

4.26.7. All Air Force ADSMs referred from the MTF, to a civilian or non-military medical facility will be monitored and tracked.

4.26.8. Minimum Processes Required to Identify, Monitor, and Track, Absent Sick Patients.

4.26.8.1. Tracking Requirements for Inpatient or Bedded MTFs:

4.26.8.1.1. At a minimum, the A&D office will use the CHCS automated computer system to support their identification, monitoring, and tracking, efforts of each known Absent Sick patient. Contact the CHCS site manager to obtain appropriate security access keys.

4.26.8.1.2. Use an AF Form 560, Authorization and Treatment Statement to collect and document as much demographic information as possible. Since the form is only being used to support administrative tracking at this point, a physician is not required to sign the form. Create a suspense folder to hold any documents received from the civilian medical facility or to hold miscellaneous administrative documents. Documents from the suspense folder may be required later for entry into the inpatient record. An inpatient record is required to summarize and permanently document the care provided to the Service Member at the civilian or non-military medical facility.

4.26.8.1.3. Record the admission in the CHCS Patient Administration (PAD) module using the Admissions, Discharges, and Transfer (ADT) secondary menu and Admissions (ADM) sub-menu. This menu includes all "inpatient activity" functions including admission & disposition processing, inter-ward transfer options, "remain overnight" (RON) entries, and admission cancellation options. **Note:** Menu path shortcuts may vary from one MTF to another.

4.26.8.1.4. Document the Absent Sick (ABS) admission by entering YYYA ABSENT SICK Medical Expenses and Performance Reporting System (MEPRS) code. An inpatient unit or nursing ward is not required. Source of admission type should be ABS…however, because current automated system limitations do not allow conversion of the Source of Admission type from ABS to ABI when a Service Member is transferred from a civilian facility to the MTF, the A&D staff should use ABI as the Source of Admission type.

4.26.8.1.5. If a decision to transfer the Service Member-patient from the civilian or non-military medical facility to the MTF is authorized, then the MTF Chief of the Medical Staff is responsible for identifying the admitting MTF physician. The Admissions and Dispositions office leaves the admission category type as ABI and enters the transfer date and time into CHCS. Maintain the same register number.

4.26.8.1.6. If the Service Member-patient remains in the civilian or non-military facility for the duration of inpatient treatment, the MTF A&D office will change the admission category type from ABI to ABS. After confirming the Service Member-patient has been discharged from the civilian or non-military medical facility, then discharge the Service Member-patient in CHCS.

4.26.8.1.7. Request a complete summary of the patient's treatment from the civilian or non-military medical facility before the patient is transferred to the MTF or after the patient has been discharged from the civilian medical facility.

4.26.8.2. Tracking Requirements for Outpatient or Non-Bedded MTFs:

4.26.8.2.1. The requirement to create an inpatient record and transmit a Standard Data Inpatient Record (SIDR) to higher headquarters using the CHCS computer system is no longer required at outpatient MTFs that:

4.26.8.2.1.1. Do not currently employ either the necessary inpatient coding personnel, and,

4.26.8.2.1.2. Do not possess the necessary supplemental CHCS inpatient coding software.

4.26.8.2.2. Outpatient or non-bedded MTFs who employ at least one experienced inpatient coder and possess the necessary supplemental CHCS inpatient coding software are required to use CHCS as their primary mechanism to identify, monitor, and track ABS patients.

4.26.8.2.3. Place any medical documents received from the civilian or non-military medical facility into a secure, locked transitory file within the office responsible for providing or facilitating the majority of the administrative support responsibility. Upon discharge from the civilian medical facility, forward the documents to the ADSM's MTF so they may be filed into the outpatient medical record.

4.26.8.2.4. Until the Air Force and/or the Military Health System deploys a standardized ABS tracking solution, outpatient MTFs are required to identify, monitor, and track ABS patients using a local mechanism that, if necessary, is capable of providing higher headquarters or the admitted ADSM's chain of command with minimum necessary amount of information aka Sanitized Healthcare Information, when required.

4.26.9. The TOPA or PA Flight Commander and/or A&D department supervisor should establish a Memorandum of Agreement (MOA) with local & regional civilian and non-military medical facilities or provide these same medical facilities with written justification of the necessity to obtain biographical and medical information whenever ADSMs are admitted to civilian or non-military medical facilities. Special emphasis regarding timely hospital notification, patient condition updates, transfer arrangements, and patient disposition expectations should be identified in any agreement.

4.26.9.1. The TOPA or PA Flight Commander is required to meet with officials of local & regional civilian and non-military medical facilities (at least annually) to establish and reinforce sound business relationships and agreements.

4.26.9.2. Inform civilian and non-military medical facilities that in accordance with DoD 6025.18–R, the use and disclosure of PHI of individuals who are Armed Forces personnel for activities may be deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.

4.26.9.3. Inform each civilian or non-military medical facility the timely submission of critical medical information will a) provide the member's primary care manager (or other

SGH appointed provider) and the member's unit commander with information to better ascertain the member's fitness for duty, b) provide continuity of care if, and, when the Service Member is stable enough to transfer to an MTF and, c) ultimately better facilitate potential financial reimbursement from the government.

4.26.10. The nearest MTF to the hospitalized ADSM should recommend to the Service Member that he or she should sign an information release authorization to allow the civilian or non-military medical facility to disclose treatment information to the supporting MTF.

4.26.11. Obtain full patient identification from the civilian or non-military medical facility and promptly notify the ADSM's unit commander by telephone with the patient's name and location.

4.26.12. When possible, obtain comprehensive medical information regarding the ADSM's condition. The civilian medical or non-military medical facility is financially reimbursed for the patient's care based on the Diagnosis Related Group (DRG). A complete summary of the patient's treatment, while under the care of the civilian healthcare provider is required after the patient has been discharged.

4.26.13. If contacted by the TRICARE Managed Care Support Contractor, TRICARE Regional Office, the civilian or non-military medical facility, an ADSM family member, unit commander, or if information is known or communicated to MMSO, about an ADSM's civilian or non-military facility hospitalization, before the nearest Air Force MTF is aware, Air Force POCs at MMSO should contact the MTF located nearest to the ADSM's location, so the MTF may assume administrative support responsibility.

4.26.14. Prepare AF Form 1488, if applicable, and forward to the Resource Management Flight.

4.26.15. Prepare AF Form 348, if applicable. See AFI 36-2910.

4.26.16. When hospitalized at a uniformed services treatment facility (USTF) or VA hospital, the nearest MTF to the USTF or VA medical facility assumed administrative support responsibility and will arrange for a transfer to an MTF when the patient is stable and it is safe to transport the Service Member.

4.26.17. If the Service Member is referred to a USTF or VA hospital, the referral MTF maintains administrative support responsibility.

4.26.18. When known, unit commanders of hospitalized:

4.26.18.1. Reserve Component members (related to an In-Line-of-Duty occurrence or incident),

4.26.18.2. Active Duty Service Members assigned to geographically separated units,

4.26.18.3. TRICARE Prime Remote ADSMs, must notify the nearest Air Force MTF and the MMSO, Great Lakes, Il at 1-888-647-6676 as soon as possible when one of their members is hospitalized in a civilian or non-military medical facility.

4.26.19. Notify the base ground safety office in accident cases using AF Form 1488.

4.27. Assuming Administrative Responsibility for Active Duty U. S. Air Force Members Hospitalized in Army or Navy MTFs.

4.27.1. The nearest Air Force MTF Commander assumes administrative responsibility and ensures that the following procedures are carried out for Air Force personnel hospitalized in Army or Navy MTFs:

4.27.1.1. Facilitates necessary communication between member's unit commander, and officials at the Army or Navy MTF.

4.27.1.2. Keeps rosters and pertinent data on hospitalized Air Force patients and notifies the member's unit commander immediately upon notification.

4.27.1.3. Prepares AF Form 348, when applicable, in accordance with AFI 36-2910.

4.27.1.4. See Section 4I, Casualty Reporting Program Administration, for Seriously Ill and/or death cases.

4.27.1.5. Notifies the base ground safety officer in accident cases.

4.27.1.6. Within the CONUS, patients may be administratively assigned or attached to the closest Air Force MTF Patient Squadron nearest to the Army or Navy MTF providing medical care. The decision to permanently assign a patient to the closest AF MTF Patient Squadron versus keeping the member's current duty assignment location is based, in part, on the Service Member's wishes. However, final assignment approval rests with the closest MTF Commander based on the clinical evaluation by the member's military provider(s) responsible for the patient's overall case management. Ideally, if there is a reasonable expectation that the member could be returned to duty at his home unit, the aforementioned officials shall be expected to render a decision that supports the patient's emotional and physiological status, during medical treatment, without regard to whether or not the patient's home unit requests or recommends that the patient be removed from their unit personnel assignment register. AFPC/DPAMM retains the final authority to direct Patient Squadron assignments when the involved parties are unable to come to an agreement.

4.27.1.7. Prepares AF Form 1488 when applicable and forwards it to the Resource Management Flight.

4.27.1.8. Serves as the admitted member's local representative for all patient administration related matters.

4.27.1.9. All disclosures of PHI to commanders will be tracked in accordance with DoD 6025.18-R.

4.28. Admitting Infants Born Outside the MTF.

4.28.1. Infants born outside the MTF (e.g., at home or enroute to the hospital) are admitted to the MTF as "Liveborn" or "Newborn" when the mother is also admitted for post-partum care within 24 hours following delivery. If the infant is admitted outside the 24 hour window or if the mother is not admitted at the same time as the infant, then the infant is admitted as a Direct admission.

4.28.2. If the infant's birth and subsequent admission first occurred in a civilian hospital and the mother and baby are later transferred to an MTF, admit the infant in CHCS using the CIV-INITIAL ADM TO NON-US MILITARY HOSP, MOVED TO MIL MTF (NON AD)

admission/transfer code (Source of Admission Code 5) instead of a Direct, Newborn, or Liveborn admission.

4.28.3. When a newborn infant is transferred from one MTF to another MTF, the receiving MTF generally admits the infant using the TAF-TRANSFER FROM AF HOSPITAL; TAR-TRANSFER FROM ARMY HOSPITAL; or TNF-TRANSFER FROM NAVY HOSPITAL admission/transfer code instead of a Direct, Newborn, or Liveborn admission.

4.29. Admitting Generals/Admirals (Flag Officers), Colonels, and Prominent Persons. All disclosures of PHI to Commanders will be tracked in accordance with DoD 6025.18-R.

4.29.1. Terms:

4.29.1.1. General/Admiral Officer (GO): Includes all Active Duty, Reserve Component (of any Uniformed Service branch) and foreign general flag officers (0-7 and above).

4.29.1.2. Colonel: Applies only to active duty Air Force colonels that are seriously ill (SI), very seriously ill (VSI), expected to be hospitalized for a non-scheduled emergency hospital stay greater than 10 days, or any Air Force colonel provided a profile change for any serious medical or surgical condition affecting the member's assignment availability or command obligation. This reporting rule also includes any Air Force Medical Service (AFMS) colonel (MC, DC, NC, MSC, BSC) who has been admitted as an inpatient under emergent circumstances.

4.29.1.3. Prominent Persons: Includes Senior Executive Staff (SES) federal civilian officials, political officials or officers, high-ranking public officials, federal judges, current Chief Master Sergeant of the Air Force (CMSAF) and any Active Duty AFMS Chief Master Sergeant expected to be hospitalized for a non-scheduled, emergency hospital stay greater than 10 days. Notifications for persons in this category, other than the CMSAF, require the patient's authorization.

4.29.1.4. Admission and Extended Ambulatory Care: Admission to an MTF, non-federal hospital, or any facility for which the nearest MTF assumes administrative responsibility. This includes inpatient units and other extended care services (e.g., ambulatory patient visits, observation and partial hospitalization).

4.29.1.5. Information Conduits: Command Posts, Operations Centers at the installation or MAJCOM level. HQ AF/SGXO, Air Force Medical Operations Center (MOC) can be reached at DSN 227-9075 or commercial (703) 697-9075.

4.29.2. Local and MAJCOM Notification Procedures when a General/Flag Officer, Colonel, or Prominent Person (fitting the description listed in the above paragraphs), is Admitted.

4.29.2.1. The admission and dispositions office (or similar PAD location or office) will contact the MTF Commander and provide sanitized information regarding the admission.

4.29.2.2. The admission and dispositions office (or similar PAD location or office) will contact the local base or wing command post and the command post or operations center of the admitted military official. Provide only sanitized information.

4.29.2.3. The admission and dispositions office (or similar PAD location or office) will contact their MAJCOM Command Surgeon or AFMOA patient administration official(s).

4.29.2.4. The MTF Commander will notify the installation commander (via appropriate information conduits), and release only minimum necessary information.

4.29.2.5. Notifications will be made as soon as possible, no later than 12 hours after admission or initial treatment.

4.29.3. HQ USAF Notification Procedure when a General/Flag Officer, Colonel or Prominent Persons is Admitted or Remains in the MTF.

4.29.3.1. Inpatient/bedded MTFs will contact the Pentagon HQ USAF/SG Military Operations Center (MOC) by 0600 EST every duty day to include negative replies.

4.29.3.2. Provide only sanitized information to the MOC. Include telephone call back phone numbers so MOC officials can obtain comprehensive medical information as needed.

4.29.3.2.1. In unusual circumstances, if the MTF Commander determines the AF/SG should be notified during non-duty hours, call the Air Force Service Watch Cell, (DSN 227-6103, commercial (703) 697-6103.

4.29.4. HQ USAF/Medical Operations Center Responsibilities:

4.29.4.1. MOC officials will create two word-processing (letter) documents from the information.

4.29.4.1.1. The first document includes sanitized information only.

4.29.4.1.1.1. The sanitized information document is transmitted, in password protected or encrypted mode only, to the Chief, U.S. Air Force General Matters Office (GOMO) via his/her Pentagon e-mail address.

4.29.4.1.1.2. HQ USAF Surgeon General (SG)/Deputy Surgeon General (DSG) or his/her representative will receive the information via live brief or in password protected or encrypted electronic format. HQ USAF/SG/DSG or his/her representative will provide the information to CSAF.

4.29.4.1.1.3. If the document contains information regarding any colonel that has been admitted or treated and meets the criteria indicated in paragraph 4.29.1.2., the password protected or encrypted electronic transmission will be provided to the U.S. Air Force Colonel Matters Office Support Division.

4.29.4.1.2. The second document will include comprehensive medical information and be provided only to HQ USAF/SG/DSG or his/her representative.

4.30. Reporting Aircraft Accident Admissions.

4.30.1. For specific instructions, see AFI 91-204, Safety Investigations and Reports. The Command Surgeon for the MAJCOM for which the aircraft was assigned, notifies AFMSA/SG3P, DSN 425-6420, of admission resulting from any aircraft accidents (active Air Force, Reserve, or Air National Guard).

4.30.2. Provide the diagnosis, estimated period of hospitalization, and probable disposition of personnel.

4.30.3. During regular duty hours, notify AFMSA/SGSP (Aerospace Medicine) by telephone. After duty hours, notify HQ USAF/SG Duty Officer through the Air Force Medical Operations Center, DSN 227-9075 or commercial (703) 697-9075. The MAJCOM Command Surgeon is required to provide the date of the victim's initial clinic visit, diagnosis, estimated period of treatment, and the probable disposition of all personnel who are examined or received treatment for injuries incurred as a result of an aircraft accident.

4.31. Managing Military Patients Expected To Be Hospitalized Over 90 Days.

4.31.1. Notify the patient's servicing MTF and MPS when a patient will be reassigned or hospitalized over 90 days.

4.31.2. The staff at the admitting MTF must advise the local traffic management office (TMO) and MPS of the person's hospitalization and the expected duration when a patient is hospitalized while traveling to a Continental United States (CONUS) port for PCS overseas.

4.31.3. The patient may be assigned or attached to the Patient Squadron.

4.31.4. Under this section, all disclosures of PHI to commanders will be tracked in accordance with DoD 6025.18-R.

4.32. Deployed Military Members who are Aeromedically Evacuated from Contingency Operations to CONUS MTF.

4.32.1. Deployed Air Force Service Members (who are on Contingency, Exercise, Deployment (CED) orders) and are aeromedically evacuated to a CONUS MTF from a Contingency AOR (for example, from Landstuhl Regional Army Medical Center to National Naval Medical Center), will remain on CED orders until returned to their home station (Permanent Duty Station). Medical TDY orders will not be prepared. The member's per diem is covered by their CED orders.

4.32.2. CED orders will be extended, if necessary, until the member returns to their home station.

4.32.3. Ambulance Transport for members on CED orders (is funded by DHP Overseas Contingency Operations (OCO) Supplemental Funds).

4.32.4. Travel/per diem expenses of AF members transported from an MTF to a Comprehensive Care Facility: Covered by member's CED orders.

4.32.5. Travel/per diem expenses of AF members transported from an MTF to Home Station: Covered by member's CED orders.

4.32.6. Travel/per diem expenses of AF members from home station MTF to a referral facility: Refer to the Patient Travel section.

4.33. Readmission of Patients.

4.33.1. Re-activate an inpatient record of hospitalization if a patient is re-admitted before midnight (2400 hours) on the same day as previously discharged only if the re-admission is for the same diagnosis or reason documented during the initial admission process. The attending provider annotates the reason for re-admission and the hospitalization is considered as one continuous period.

4.33.2. If the patient is readmitted after midnight, or the reason or diagnosis for re-admission is different from that of the previous admission, create a new record.

4.34. Canceling Admissions. Canceling an admission or inpatient encounter may be appropriate in some instances. Annotate the admission work sheet with the reason for cancellation, gather all paperwork gnerated by the admission (e.g., History and Physical, progress notes, laboratory and x-ray reports, etc.) as one package and place into the patient's outpatient record folder in Section III, or mail to the package to the MTF where the patient's outpatient medical record is normally maintyained. Recording the episode as an outpatient visit may be a suitable option to ensure the documents related to the canceled inpatient episode are documented.

4.34.1. If a decision to cancel an inpatient admission or inpatient encounter is determined, only a physician may order the cancelation if the episode of care exceeded 24 hours.

4.35. Inpatient Disposition Procedures.

4.35.1. Discharge to Duty (Military Patient) or Discharge (Non-military Patient).

4.35.1.1. Review the AF Form 577, Patient's Clearance Record, to ensure the patient has cleared all necessary sections. Annotate the form with the date and time of discharge and enter the information into the current automated system. The patient is then released from the MTF.

4.35.1.2. Maintain the AF Form 577 in the Admission and Dispositions Office for a period of three months and then destroy.

4.35.1.3. Remove any pertinent information from the suspense file and place in the patient's inpatient record.

4.35.2. Discharging Non-active Duty Patients Requiring Domiciliary or Custodial Care.

4.35.2.1. Discharge retirees eligible for care in VA facilities as follows:

4.35.2.1.1. Arrange for admission and transportation to a VA medical facility, if acceptable to the patient or Next of Kin (NOK).

4.35.2.1.2. Release retirees declining assistance in getting into a VA facility to the NOK.

4.35.2.1.3. If NOK declines acceptance, contact civil authorities in the patient's state of residence for permission to transfer the patient to their custody. If the original request for permission is disapproved, repeat the procedure with civil authorities of the state where the patient entered the Service (when different from the state of residence).

4.35.2.1.4. Provide complete information from the attending healthcare provider (in narrative form) on the diagnosis, date the condition started, history of previous hospitalization(s) for the condition, patient's legal residence, place and date of birth, length of patient's military service, and name and address of patient's NOK.

4.35.2.1.5. Coordinate the patient's move, with proper escort, to the NOK or to the civilian authority accepting custody. Advise the accepting party of the expected time of patient's arrival.

4.35.2.2. Discharge other non-active duty patients requiring domiciliary or custodial care following procedures similar to those in paragraph 4.35.1 and 4.35.2.1.

4.35.2.2.1. Discharge alternatives must be acceptable to the patient or NOK.

4.35.2.2.2. Release the patient to the NOK if the arranged or recommended alternatives are declined.

4.35.2.2.3. Request permission to transfer patient custody to civil authorities if the NOK declines acceptance. Contact the SJA if the request is denied.

4.35.3. Discharging Patients Not Eligible for Care at VA Expense.

4.35.3.1. Discharge a military patient who, upon expiration of term of service (ETS), has physical or mental disabilities as follows:

4.35.3.1.1. Contact the NOK to determine whether they are assuming custody of the patient and responsibility for care.

4.35.3.1.2. The NOK must produce affidavits certifying their willingness to make suitable arrangements for the patient and the financial means to do so.

4.35.3.1.3. See 4.35.2.1.3 – 4.35.2.1.4 for procedures to follow when NOK declines acceptance.

4.35.3.1.4. Coordinate the patient's move, with proper escort, to the NOK or to the civilian authority accepting custody. Advise the accepting party of the expected time of the patient's arrival.

4.35.3.2. Discharge a federal civilian employee patient with a physical or mental disability requiring hospital care that exceeds the MTF's capabilities if he or she is not a beneficiary under the Federal Employees' Compensation Act. Coordinate proposals to move a civilian employee hospitalized in a medical facility outside the U.S., or when it is necessary to separate him or her for medical or other reasons, with the appropriate Civilian Personnel Office.

4.35.4. Discharging Patients With Chronic Physical or Mental Conditions. The following instructions apply to a civilian or military member who is separated or retired because of a chronic physical or mental condition.

4.35.4.1. A patient who does not exhibit suicidal or homicidal tendencies may request release to the NOK. See 4.35.3.1.2.

4.35.4.2. Discharge a patient who exhibits suicidal or homicidal tendencies as follows:

4.35.4.2.1. Transfer a member or former member of the Uniformed Services entitled to treatment by the VA to a location designated by the VA. This requires the request of the NOK and authorization for admission from the hospital concerned.

4.35.4.2.2. Discharge a military or civilian patient not entitled to treatment by the VA to civil authorities who are legally authorized to assume care in such case; to the Federal Bureau of Prisons, if treatment there is authorized; or to an acceptable private hospital at the written request of the NOK. This will also require authorization from the destination hospital.

4.35.4.3. A non-military psychotic patient admitted to an Air Force MTF overseas is handled by the liaison, through the American Embassy and civil authorities, to resolve problems associated with hospitalization and transfer to CONUS. Under this section, all disclosures of PHI will be tracked in accordance with DoD 6025.18-R.

4.35.4.3.1. By law, the Department of Health and Human Services (HHS) may receive and provide care for non-military mental patients returned to CONUS.

4.35.4.3.2. If the patient is not releasable to the NOK, and is not authorized further Air Force hospitalization, the overseas Commander will ask local US diplomatic representatives to arrange, through the Department of State, for the HHS to receive the patient upon arrival in CONUS.

4.35.4.4. For instructions on the discharge of psychotic prisoner patients see 4.35.5.1.

4.35.5. Disposition of Prisoner Patient. When discharging prisoner patients, the Federal Bureau of Prisons exercises administrative control over prisoners confined in a DoD regional or long-term corrections facility. This agency's responsibility extends to all matters except clemency, parole, restoration to duty and enlistment. When a prisoner is under the administrative control of the Air Force, the Air Force is responsible as follows:

4.35.5.1. If a prisoner, whose sentence includes an executed punitive discharge, has a disabling condition (including psychosis requiring closed unit treatment), hospitalize the prisoner at the nearest DoD hospital which can provide the required care. Move the patient in accordance with AFI 31-205, Air Force Corrections System or the latest joint service medical/patient regulating guidance.

4.35.6. Discharging Patients with Communicable Diseases. Notify Force Health Management if a patient has a communicable disease when the term of service ends and he or she elects to separate and be discharged from the hospital.

4.35.7. Discharging Non-active Duty Patients Refusing to Comply with Rules. Contact the SJA for assistance when a non-active duty patient fails or refuses to comply with established rules.

4.35.8. Discharging Patients with Terminal Illness.

4.35.8.1. Transfer non-Air Force members according to the latest joint service medical/patient regulating guidance.

4.35.8.2. Final decision on the discharge of the patient depends on MTF capability, demand for services and humanitarian considerations.

4.35.8.3. If the active duty terminal patient is referred to the Physical Evaluation Board (PEB), follow the procedures in Section 4K and AFI 36-3212, Physical Evaluation for Retention, Retirement and Separation. Under this section, all disclosures of PHI to commanders will be tracked in accordance with DoD 6025.18-R.

4.35.9. Discharging Patients Absent Without Leave (AWOL). Report a military patient who is AWOL from a medical facility to the individual's servicing MPS. Do not carry AWOL patients on the Admissions and Dispositions (A&D) list or the census reports more than 10 days. Close out the medical records after 10 days. Under this section, all disclosures of PHI to Commanders will be tracked in accordance with DoD 6025.18-R.

4.35.10. Discharging Patients through action by MEB and PEB. See Section 4K and AFI 36-3212.

4.35.11. Retention of Enlisted or Officer Patients Beyond the Discharge Date. See AFI 36-3208, Administrative Separation of Airmen.

4.35.12. Discharging Persons Refusing Professional Care. See Section 4K.

4.35.12.1. Notations are placed in the health record documenting the refusal and explaining the risks of refusal that were provided to the patient. Beneficiaries are encouraged to sign the notation.

4.36. Convalescent Leave. Initiate convalescent leave for military patients in accordance with AFI 36-3003. Convalescent leave is not to be used as an alternative for placing a member in an excused from duty status or when an individual could instead be returned to limited duty without adversely affecting full recovery.

4.36.1. MTF Commanders may recommend convalescent leave up to a total of 90 days for a single period of hospitalization. Convalescent leave over 30 days requires additional medical review and consent with the exception of obstetrical leave. Convalescent leave in excess of 90 days must be approved by the MTF's MAJCOM Command Surgeon's Office.

4.36.2. The attending healthcare provider may recommend up to 42 days of postpartum convalescent leave upon discharge, unless the mother's medical condition warrants a longer period.

4.36.3. The discharge clerk coordinates all arrangements for an inpatient's departure on leave. AF Form 988, Leave Request/Authorization, is cleared through the discharge clerk.

4.36.4. For directed convalescent leave above 30 days, not directly related to OB post-partum reasons, the provider completes and signs Block 7 and the Chief of the Medical Staff (SGH) reviews and approves the leave by signing in the "Remarks" section of Block 8 of the AF Form 988. The patient's unit Commander completes Blocks 23 through 25.

4.36.5. For recommended convalescent leave, procedures are the same as in 4.49.4, except the patient's unit commander completes Blocks 22 through 25 on the AF Form 988. In addition, the inpatient record is closed out upon discharge to convalescent leave.

4.36.5.1. Except as provided in 4.36.2, unit Commanders may approve initial convalescent leave up to 30 days. Further approval of convalescent leave beyond 30 days requires additional medical review and consent.

4.36.5.2. Recommendations for convalescence are also used for outpatients (without related inpatient episode) when the medical condition warrants it.

4.37. Reporting Active Duty Soldiers, Sailors, and Marines Hospitalized in Civilian or Non-Military Medical Facilities.

4.37.1. Upon notification of an Active Duty Soldier, Sailor, or Marine hospitalized in a nearby or regional civilian or non-military medical facility, the TOPA or Patient Administration Function at the nearest Air Force MTF shall obtain the patient's name, rank, unit name and location, and additional identifying data and notify the nearest Army or Navy MTF, as appropriate, and notify the individual's unit commander.

4.37.2. Contact the MMSO at 1-888-647-6676 when notified of active duty Soldier, Sailor, or Marine hospitalized at a local or regional civilian or non-military medical facility. The Air Force MTF will make every effort to contact the ADSM's unit commander. On occasion, the Air Force MTF nearest to the hospitalized Soldier, Sailor, or Marine may be asked to assume temporary administrative support responsibility. In this event, TOPA personnel at the nearest Air Force MTF shall initiate the necessary action to keep the designated parent service representative and member's unit commander informed of the patient's status.

4.37.3. Coast Guard, US Public Health Service or foreign military personnel admitted to civilian or non-military medical facilities are not admitted and/or tracked as "Absent Sick" and are not entered into the current automated inpatient admission system. Additionally, there is no need to contact the MAJCOM Command Surgeon's Office, AFMOA Health Benefits, or the Air Force Medical Operations Center at the Pentagon unless the admitted Coast Guard, US Public Service or foreign military member meets the "prominent persons" definition listed in paragraph 4.29.

4.37.4. In any situation where the MTF receives information about any Uniformed Service Member admitted to a local or regional civilian or non-military medical facility, it is imperative that the MTF Commander or his/her designee notify the nearest appropriate sister service MTF and/or member's unit commander, first sergeant, or other appropriately appointed commander's designee, of the hospitalization.

4.37.5. Notify the base ground safety office in accident cases using AF Form 1488.

Section 4I—Casualty Reporting Program Administration

4.38. Reporting Patients in Casualty Status.

4.38.1. This section describes patients and MTF reporting procedures for patients placed in a casualty status IAW DoDI 1300.18, Department of Defense (DoD) Personnel Casualty Matters, Policies, and Procedures and AFI 36-3002, Casualty Services. Categories of patients requiring special casualty reports are as follows:

4.38.1.1. Very Seriously Ill/Injured (VSI) Patients. A VSI patient requires medical attention and medical authority declares it more likely than not that death will occur within 72 hours.

4.38.1.2. Seriously Ill/Injured (SI) Patients. A SI patient requires medical attention, medical authority declares that death is possible, but not likely within 72 hours, and/or the severity is such that it is permanent and life-altering.

4.38.1.3. Under this section, all disclosures of PHI to commanders will be documented in accordance with DoD 6025.18-R. Disclosure of PHI associated with the SI-VSI status of NON-Active duty patients to external MTF agencies (including, but not limited to, the installation command post or Casualty Affairs office) is authorized only after obtaining the patient's consent. In situations where the patient is incapacitated or otherwise unable to agree or object to the disclosure, the MTF may, in the exercise of professional judgment, make such notification in accordance with DoD 6025.18-R, C6.2.1.2. All disclosures of PHI must be properly documented in the PHIMT or MTF disclosure accounting tool.

4.39. Assigning Responsibility.

4.39.1. The patient's attending healthcare provider classifies a patient as VSI or SI and records an entry on the AF Form 3066, Doctor's Orders, 3066-1, Doctor's Orders, or in Essentris. The provider is also responsible for completing the clinical condition/status portions of the AF Form 570, Notification of Patients Medical Status, and sign and apply signature stamp where required. Additionally, MTF patient Administration staff or designated Casualty Affairs Liaison (CAL), may be required (depending on local installation Casualty Affairs Office reporting rules) to complete an additional local form to secure emergency government sponsored travel for an active duty patient's immediate family member(s). The MTF CAL is responsible for submitting all MTF Casualty reporting forms/documents/information to the installation Casualty Affairs or Casualty Assistance Representative (CAR). At inpatient MTFs, the CAL is usually the A&D office supervisor, one or more members of the A&D staff, and/or the on-call administrative NCO or Officer of the Day. At outpatient MTFs, the CAL is usually the NCOIC, Patient Administration.

4.39.1.1. Preparation of AF Form 570, Notification of Patients medical Status.

4.39.1.1.1. Complete sections I, II, and, III when the report is prepared. Complete section IV when reporting SI and VSI patients. If the patient is an organ donor, check the appropriate block and indicate organ to be donated. The CAL will complete section V. Section VI may be used to continue entries from other sections, provide additional information, or request administrative action.

4.39.1.1.2. Upon receiving the AF Form 570, the CAL completes section V and immediately notifies the installation Commander via the command post and/or Casualty Assistance Representative (CAR) in accordance with AFI 36-3002. The CAL provides enough information to make the first notification and required progress reports on the patient's status. If the patient has not authorized the release of their information, ensure only the minimum necessary amount of information is released and properly documented in the PHIMT or MTF disclosure accounting tool.

4.39.2. For active duty personnel in a SI, VSI, or Not Seriously Ill/Injured (NSI) casualty status, the attending physician, MTF Commander, member's Commander, or designated representative or HQ AFPC/DPWCS notifies the NOK IAW AFI 36-3002, Casualty Services.

4.39.3. When the physician or dentist determines that the status of a patient previously reported as SI or VSI changes, an AF Form 570 is prepared.

4.39.4. Regardless of the patient category, document all notifications for SI and VSI status in the appropriate casualty status remarks module/section in the CHCS or other automated inpatient monitoring and documentation system. The patient must be admitted and an active inpatient register number must exist before casualty status changes can be made. To record a status change in the CHCS, a) enter the Patient Affairs/Administration (PAD) menu, b) then choose the ADT menu, c) next, select the Casualty Status (CS) option, d) enter the start time and post the appropriate status: SI or VSI, or other. Likewise, when notified of a patient's removal from the SI or VSI List, access the ADT - CS menus, enter the stop time, and remove the status. Inform the Casualty Affairs Representative (CAR) and member's unit Commander or installation command post. Contact your CHCS site manager to obtain

appropriate security access keys. For non-active duty patient, seek patient permission before releasing casualty reporting information. Document the release of information (for all patient categories) in the PHIMT or MTF disclosure accounting tool.

4.39.5. Absent Sick Patients: The Chief of the Medical Services (SGH), his/her designee, or other appropriate medical authority at the MTF assigned to monitor the civilian medical facility admission, should contact the member's attending physician and obtain enough medical information to determine appropriate SI or VSI status (if warranted). If such a condition exists, an AF Form 570 must be completed by the physician and forwarded to the office responsible for coordinating with the CAR and member's unit Commander or installation command post. If the patient has not authorized the release of their information, ensure only the minimum necessary amount of information is released and properly documented in the PHIMT or MTF disclosure accounting tool.

4.40. Requesting and Arranging Travel for Next of Kin (NOK) under the Emergency Family Member Travel (EFMT) Program.

4.40.1. In situations where an AD or RCSM patient in a "On Duty" and/or "In-Line of Duty status" has been placed on the inpatient SI or VSI roster, the attending physician must provide written recommendation to the MTF Commander that indicates the presence of the designated travelers is considered beneficial to the patient's recovery or when the member's designated travelers' presence is warranted given the patient's critical or terminal prognosis. If the MTF Commander approves the request (in writing), the CAL or the administrative officer or noncommissioned officer of the day must immediately contact the installation CAR. The CAR is then responsible for coordinating the MTF Commander's recommendation/approval for EFMT Program with AFPC Casualty Affairs officials. AFPC Casualty Affairs Program management officials are responsible for arranging military or commercial transportation arrangements (including commercial airline travel) for no more than three designated travelers provided all the required NOK information is obtainable. A comprehensive explanation of the entire EFMT Program is available in AFI 36-3002.

4.40.2. The MTF Commander or designee must concur and approve the attending physician's request on EFMT Request Memorandum prior to AFPC Casualty Affairs Program securing emergency designated traveler travel arrangements. Prior to approving the EFMT Request Memorandum, the MTF Commander or designee must ensure there are no more than a total of three designated travelers between the EFMT and Non-medical Attendant Program.

4.40.3. Final emergency designated traveler travel approval is not to be authorized at the MTF.

4.40.4. The EFMT Program benefit does not apply to Service academy cadets, high school, college, or university ROTC participants.

4.41. Preparing the AF Form 1403, Roster of Seriously Ill Very Seriously Ill.

4.41.1. The CAL prepares the AF Form 1403, Roster of Seriously Ill/Very Seriously Ill, just after midnight each day to document the preceding 24-hour casualty status activity period. Negative activity rosters are not required. Typically, this report is generated automatically or user requested from the CHCS automated system. Distribute the report internally within the MTF in accordance with local guidance. External MTF reporting should be limited to the

installation Casualty Affairs office and/or the installation Command Post (in case of VIP reporting). Report initial SI/VSI placement status and again if the status changes or is removed. Reporting SI and VSI status PHI to external MTF agencies (including, but not limited to, the installation command post or casualty affairs office) regarding non-Active Duty Service Members, is generally authorized only after obtaining the patient's consent or obtaining consent from the patient's parent or legal guardian. If permission is obtained or release is deemed necessary by the attending physician to secure emergency government sponsored travel for an active duty patient's immediate family member(s), document the release with the appropriate facility HIPAA official(s) and/or standard disclosure tracking mechanism.

4.41.2. Providing Follow-up Information. The CAL provides the installation Commander and CAR with information received from the patient's healthcare provider for follow-up action in accordance with AFI 36-3002.

4.41.3. Removing Patients from the Roster.

4.41.3.1. When the attending healthcare provider determines that the patient can be removed from the Roster of Seriously Ill/Very Seriously Ill prepare AF Form 570 and send it to the CAL.

4.41.3.2. The CAL will notify the installation Commander and CAR once the patient is removed from the roster so that action can be taken in accordance with AFI 36-3002, Casualty Services. Notify interested persons or agencies, as defined by local guidance, quickly and complete Section V of AF Form 570. File AF Form 570 in the patient's suspense file. Annotate the remarks section of the work copy of the AF Form 1403 to indicate the time of removal.

4.42. Responsibility for Preparing Death Cases.

4.42.1. Death of a person while being attended outside the MTF: The attending Air Force medical officer.

4.42.2. Death of a person in an Air Force-owned or leased aircraft: The medical treatment unit serving the base that investigated the accident.

4.42.3. Death of other Air Force personnel who are not patients in an MTF at time of death: The MTF serving the base that investigated the circumstances of death.

4.42.4. Death of a non-military person on an Air Force base: The MTF serving the base.

4.42.5. Death of a person being staged through an aeromedical staging flight (ASF): The MTF supporting the ASF.

4.42.6. Death of a person while in transit and in inpatient status: The MTF receiving the remains. **Note:** Treat as transfer-in patients those who die while in transit (either while in flight or in an ambulance between facilities) or while being staged through an ASF.

4.42.7. Notwithstanding any other international, federal, state, or county law, or any other DoD or USAF instruction, MTF providers, (usually the member's PCM or specialist), may be asked to sign the death certificates for retired military members or family members who have died in their (off-base) homes of natural causes. Check with the wing or base mortuary

affairs office, local county sheriff's office, or county coroner before preparing the death certificate or authorizing or obtaining an MTF provider's signature.

4.43. Policies Regarding Deaths.

4.43.1. See AFI 34-242, Mortuary Affairs Program, for instructions on preparing, inspecting and shipping remains and completing related forms and reports.

4.43.2. A healthcare provider verifies all deaths occurring at an Air Force MTF and on an Air Force installation.

4.43.3. Do not remove the body without permission of civil authorities or local coroner, when a member of the Uniformed Services on active duty dies outside the limits of an Air Force installation.

4.43.3.1. The Commander consults with the Office of the Armed Forces Medical Examiner (OAFME) when uniformed services personnel die within installation limits under exclusive federal jurisdiction. When uniformed services personnel die beyond installation limits the Commander consults local civil authorities to identify procedures to follow.

4.43.3.2. Obtain a transient or burial permit from the proper civil authority before removing a body from an Air Force base for shipment or burial.

4.43.3.3. Release remains to mortuary personnel within 24 hours after death unless extenuating circumstances exist. Ensure that the death certificate is completed and signed by the responsible medical officer before releasing the remains. The mortuary representative (military or civilian) taking custody of the remains signs a receipt for the remains. File the receipt in the deceased's inpatient or outpatient record, as appropriate.

4.43.4. Initial movement of remains is accomplished as follows:

4.43.4.1. Typically, a provider pronounces death at the site or at the MTF; prepares a death certificate; and obtains a decision regarding an autopsy. If no autopsy is required, officials from Mortuary Affairs are responsible for arranging transportation to move the body from the site or from the MTF to the internment location.

4.43.4.1.1. If an autopsy is required, it must be authorized by the base commander or by the OAFME. If the local coroner has right of first refusal (in accordance to applicable state law) to conduct the autopsy and the local coroner defers to the Government, the following guidance takes effect:

4.43.4.1.1.1. For deaths occurring on a military installation, or under federal jurisdiction, if the MTF on that installation has the capability and capacity to perform the autopsy, then the MTF is responsible for performing the autopsy. If the installation MTF does not have the capability or capacity to perform the autopsy then the installation Mortuary Affairs office is responsible for either arranging transportation of the body to another MTF where autopsy capabilities exist or arranging a post-mortem examination with a contracted civilian pathologist.

4.43.4.1.1.2. If the death of an Air Force Active Duty Service Member occurs outside a military installation, the nearest Air Force installation Mortuary Affairs office is

responsible for arranging transportation of the body from the death site or local coroner's office back to the closest MTF with histopathology-autopsy capabilities or to a contracted civilian pathologist in accordance with local and Air Force Mortuary Affairs policy. In accordance with AFI 65-601V1, Budget Guidance and Procedures, paragraph 10.25.10.2., autopsies performed by civilian pathologists, not employed by the Air Force, are funded using "O&M funds of the organization to which the deceased was assigned."

4.43.4.1.2. If an autopsy is required and the local coroner is authorized right of first refusal (in accordance to applicable state law) to conduct the autopsy and the coroner decides to conduct the autopsy themselves, officials from Mortuary Affairs are responsible for arranging transportation to move the body to the coroner and then to internment location. Refer to AFI 34-242 for more information regarding available post-mortem Mortuary Affairs responsibilities and services.

4.43.4.2. Local civil authorities, namely the local coroner, exercise control over the movement of remains in the event of an off-installation death. Once the remains of an active duty member are released from the civil authorities, determine if an autopsy will be performed. If yes, medical personnel provide or arrange transport of the remains to the MTF. If an autopsy is not required, mortuary services transports the remains to the contract funeral home or government mortuary. **Note:** In the event of a military aircraft accident, an autopsy is usually required and will be funded with DHP money regardless of who performs the examination.

4.43.4.2.1. For overseas locations the same procedures identified in paragraph 4.43.4.2. may be used for family members and other eligible beneficiaries.

4.43.4.2.2. In a disaster or multiple death situation everyone available assists in any way possible. The mortuary officer calls the motor pool for transportation to move the remains during search and recovery operations. Remains are placed in body bags for movement.

4.43.5. When a patient dies, notify the CAL or their representative immediately.

4.43.6. Collect and inventory all personal property of the deceased in the presence of a witness as soon as possible following the death of any patient. Send personal effects of a military patient to the summary court officer. Send personal effects of civilians to an executor or administrator, or (if none appointed) to the nearest NOK. The executor, administrator or nearest NOK, as appropriate, signs the inventory as a receipt for effects. File the receipt in the patient's inpatient or outpatient record, as appropriate.

4.43.7. Certificate of Death. Usually the provider pronouncing death, or other authorized personnel, prepares a death certificate and sends it to the proper authorities according to state and civil requirements. However, the death certificate must be signed by a physician with knowledge of the primary and contributory cause(s) of death. This may be the pronouncing physician, the deceased's primary physician, or another member of the medical staff with that knowledge. File one copy of the certificate in the deceased patient's inpatient health record or extended ambulatory record. In overseas locations, prepare DD Form 2064, Certificate of Death (Overseas), per AFI 34-242.

4.43.8. Reporting Deaths. The MTF Commander reports deaths as required by AFI 36-3002 when a person dies at an Air Force MTF or en route to the MTF. Establish local procedures regarding other required notifications.

4.43.9. Reporting Stillbirths. Prepare a certificate of death and file it as required by state and civil law. File one copy of the fetal death certificate with the mother's inpatient record. In the case of an abortion, send the surgical specimen to the laboratory the same as for other surgical specimens. **Note:** Even when not required by state law, a fetal death certificate may be issued if the NOK requests the coroner or medical examiner to do so.

4.43.10. Comply with AFI 34-242 when deceased, uniformed services personnel cannot be identified by local means. Utilize the resources of the OAFME to the maximum extent possible to support the identification of remains.

4.44. Performing Post Mortem (Autopsy) - Non-Forensic Cases.

4.44.1. For hospital/non-forensic autopsies, file the authorization to perform a post mortem examination in the deceased's inpatient or outpatient record, as appropriate. Perform a post mortem only with the consent of the surviving spouse, NOK, person(s) having right of burial, or at the request of the local coroner or medical examiner except in the circumstances described in paragraph 4.60.5.

4.44.2. Under normal circumstances, complete the post mortem within 24 hours after the remains are received, appropriate records are available and authorization has been granted.

4.44.3. Record the post mortem on SF 503, Medical Record-Autopsy Protocol. Except those performed under AFI 91-204. File the original copy with either the inpatient record or Extended Ambulatory Record of the deceased. Maintain a completed copy of the certificate in the clinical laboratory.

4.44.4. A death, military or civilian, is a medical examiner case subject to forensic autopsy when it meets the criteria listed under DoDI 5154.30, Armed Forces Institute of Pathology Operations, enclosure 2, paragraph E2.2. These cases do not require consent from the next of kin. If the death meets any one of the criteria listed in either of these regulations, it must be referred to the OAFME. The OAFME may be contacted 24 hours a day, seven days a week at commercial 301-319-0000.

4.44.5. Authorization for Post Mortem on US Uniformed Services Personnel. The installation Commander or Armed Forces Medical Examiner (AFME) is the approving authority for the post mortem examinations in areas exclusive to Federal jurisdiction and in other areas when the civil authority has released jurisdiction to the Uniformed Services. In areas outside the US and its Territories, existing Status of Forces Agreements apply. When the host government relinquishes its authority, the AFME or installation Commander authorizes the post mortem. This approving authority may be delegated to the MTF Commander, but must be written and always current.

4.44.6. Performing a Post Mortem Examination on a Civilian.

4.44.6.1. Obtain the written, signed permission of the nearest NOK, or an order by an appropriate civil or military authority if the death occurred in unusual or suspicious circumstances. Develop procedures incorporating the requirements of this instruction,

relevant laws, existing legal agreements and other legitimate requirements of local authorities.

4.44.6.2. For post mortem purposes, treat as civilians the remains of members of the National Guard, Reserve Officers Training Corps and other Reserve Components not on active duty for training.

4.44.6.3. When consent of NOK is required, check to verify notification and obtain the required consent on SF 523, Medical Record-Authorization for Autopsy.

4.44.6.4. After deliverance of casualty notice to the family or NOK and confirmation of its receipt, the MTF Commander sends a condolence letter to the family or NOK and requests permission for a post mortem. The consent is filed in the patient's inpatient or outpatient record, as appropriate.

4.44.6.5. At overseas installations, request the family or NOK send the reply to request for post mortem consent to AFMOA/SGH. Upon receipt of reply, AFMOA/SGH will send a priority wire through military message channels advising of the decision and then send the original message by mail to the MTF for filing in the patient's inpatient or outpatient record, as appropriate.

4.44.7. Performing a Post Mortem examination on Foreign Military Personnel. Obtain permission for post mortem examination from the military attaché of the foreign embassy. Include this request for permission in the casualty report required by AFI 36-3002.

4.44.8. Organ Disposal Following Post Mortem. Return all organs and tissues removed during post mortem to the body, except those organs, tissues and tissue fluids essential to diagnose the cause of death or intended for studies authorized by the family or NOK or required by law (see DoDD 6465.2).

4.45. Disposition of Outpatient Records on Deceased Active Duty Personnel. See AFI 36-2608, Military Personnel Records System and AFI 36-3002, Casualty Services for guidance on the disposition of the outpatient record when an active duty member of the US Armed Services expires.

4.46. Deceased Patient Kit.

4.46.1. Although local or state government jurisdictional law may require the local medical examiner or coroner to respond, manage, review or pronounce death for each fatality that occurs on a military installation, sometimes this responsibility is deferred to the installation MTF, especially when no suspicious circumstances exist that require an investigation by the local medical examiner/coroner or when the MTF has histopathology/post-mortem examination capability. When practical and only when approved by the appropriate installation Plans, Programs, and Operations officials, the MTF may enter into a support agreement with the local medical examiner or coroner and the installation Mortuary Affairs office. Any agreement should identify specific forms and instructions necessary to process a deceased body. To adequately prepare for any contingency, each non-bedded Air Force MTF is required to compile and maintain at least FIVE pre-positioned death processing packages. Each package will contain all of the forms and documents (described below). When the MTF is required or authorized to officially respond and process a human being's death occurring on a military installation, each package will be used to document the fatality

whether the death occurred in the MTF or elsewhere on the military installation. Inpatient MTFs will maintain a minimum of TEN packages. The packages should be kept in a central location such as the TRICARE Operations and Patient Administration Flight, admissions and dispositions office, or the emergency department. Each package shall contain, at a minimum, the following forms in the specified quantities:

4.46.1.1. SF Form 523.

4.46.1.2. AF Form 146, Death Tag.

4.46.1.3. AF Form 570.

4.46.1.4. Release of Remains.

4.46.1.5. Request for Postmortem Examination.

4.46.1.6. AF Form 1122, Personal Property and Effects Inventory.

4.46.1.7. Fax Notification.

4.46.1.8. Death Certificate Worksheet.

4.46.1.9. Death Certificate (Issued by state. If overseas use DD Form 2064).

Section 4J—Birth Registration Program Administration

4.47. Birth Registration in the CONUS.

4.47.1. A birth certificate will be prepared for each infant born in an Air Force MTF. Follow State laws with regard to the forms used, format, and number of copies required. File a work copy in the infant's inpatient record. Contact local department of Vital Statistics to obtain a copy of birth certificate.

4.47.2. Updating Personnel Records. Advise parents to report to the MPS to update personnel records and register the child in DEERS as part of birth registration. This must be accomplished within 120 days or the member will receive a bill for care. When both the parents are active duty, recommend that the same sponsor be identified in CHCS and DEERS in order to eliminate confusion with the records. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

4.47.3. Refer parents to the TRICARE Service Center for TRICARE options, including TRICARE Prime enrollment.

4.48. Registering Births Overseas.

4.48.1. Overseas Air Force MTFs must cooperate with consular officers in registering births of infants born to US citizens in areas overseas. EXCEPTIONS: Register births in American Samoa, Guam, Puerto Rico, the Trust Territories, and the US Virgin Islands through the special offices of the Vital Statistics Division, Public Health Services, US Department of Health and Human Services, or specified local US Government offices. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

4.48.2. Reporting Births. Births are reported to local authorities on the forms provided by US Consular Offices.

4.48.3. Notifying the US Consular Office. Notify the US Consular Office where the Air Force MTF is located no later than 10 days after the birth of an infant whose parent or parents are US citizens.

4.48.4. Completing Department of State Foreign Forms FS-240, Consular Report of Birth Abroad of a Citizen of the United States of America. The form FS-240 will be completed in four copies. The (US citizen) parent will sign each copy of the forms under oath before a military officer qualified to administer oaths. The officer administering the oath completes the section reading, "This section to be completed by consular officer, notary public or other person qualified to administer oaths" **Note:** Obtain a supply of form FS-240s from the nearest US Consular Office.

4.48.5. If the mother is not a US citizen, the US citizen father must sign form FS-240 if he is available. If the father is not available (or if there is any question about his citizenship status), ask the parent(s) to get in touch with the US Consular Office.

4.48.6. If the mother dies or is in very serious condition and the father, who is a US citizen, is not available, send the form FS-240 to the US Consular Office as soon as the healthcare provider delivering the infant signs the form to attest the delivery.

4.48.7. Contact the nearest US Consular Office concerning necessary procedures to establish US citizenship when a child is born out of wedlock.

4.48.8. Advise the parents about the following procedures:

4.48.8.1. If the US citizen parents have the proper documentation to support entries on form FS-240, inform them that they need not go to the US Consular Office in person.

4.48.8.2. If the necessary documentation is questionable or not available, send the form FS-240 to the US Consular Office and advise the parents to visit the office with documents establishing marriage and citizenship.

4.48.8.3. In addition to proving birth fact, the US Consular approved form FS-240 is considered full proof of US citizenship in all courts, tribunals and public offices of the US both inside and outside the CONUS; the District of Columbia; and each state, territory, and outlying possession of the US. The form FS-240 is equal to the certificate of citizenship or naturalization that the US Immigration and Naturalization Service (USINS) issues.

4.48.8.4. FS-545, Certificate of Birth, (also known as form DS-1350 in the US). Obtain information from the form FS-240 to prepare the Certification of Birth. This certification is a short form record of birth that the Department of State uses to provide persons born outside the CONUS and its possessions with a birth certificate form similar to those that State Vital Statistics Registration Offices in the US issue. However, this Certification of Birth does not replace the form FS-240 in any way.

4.48.9. Registration of Birth. Advise the parents that a fee for registering the child's birth will be charged. The US Consular Officer issues them a copy of the form FS-240 when the birth is reported, as well as a copy of the form FS-545.

4.48.10. Additional Copies of forms FS-240 and FS-545 (or form DS-1350). Parents, or the child at a later date, can obtain additional copies of the forms FS-240 and FS-545 (form DS-1350) from the Vital Records Section, Passport Services, 1111 19th Street, N.W., Suite 510,

Washington, DC 20522-1705. The State Department's web site has information on how to make the request, what information to include, and payment of associated fees. The web site address is **http://www.travel.state.gov/law/family_issues/birth/birth_593.html**.

4.48.11. Updating Personnel Records. Advise DOD personnel whose children are born overseas to report to the MPS to update personnel records and register the child in DEERS and passport application as part of birth registration in an overseas area.

Section 4K—Medical Evaluation of SMs for Continued Military Service

4.49. Purpose and Program Introduction.

4.49.1. In order to maintain a fit and vital force, the SECAF relies on statutory authorization (10 U.S.C., Chapter 61) to remove Service Members (SMs) from the Air Force who can no longer perform their military duties because of a mental or physical defect. If a SM's identified medical diagnosis, condition or physical or mental limitation prohibits or limits the individual from completing his or her duties and/or routinely interferes with his or her ability to obtain complete individual deployment readiness or worldwide duty reassignment qualification, and/or imposes unreasonable requirements on the military to either maintain or protect the member, the SM may be separated, discharged or retired from military Service.

4.49.2. A SM's medical diagnosis, condition, physical or mental limitation may also be considered a medical disability. SMs identified with a potential Service-disqualifying medical diagnosis, condition, physical or mental limitation will be evaluated, and when indicated, referred through the Disability Evaluation System (DES).

4.50. Eligibility for Disability Evaluation Processing.

4.50.1. Active Duty SMs who are not on "Excess Leave" status, unless the status is granted in order to participate in an educational program or for emergency purposes, are eligible.

4.50.2. Air Reserve Component (ARC) eligibility is established in IAW AFI 36-3212, Physical Evaluation for Retention, Retirement and Separation, Chapter 8.

4.50.3. USAF Academy Cadets are eligible for disability processing according to 10 U.S.C. § 1217.

4.50.4. College or University Reserve Officers' Training Corps (ROTC) cadets are not authorized entry to the US Air Force Disability Evaluation System. ROTC cadets, who incur (while in the line of duty) injury, illness, or death, during official military training, or while traveling to or from the location of official military training, may be entitled to disability benefits or compensation from the Department of Labor. Refer to the Federal Employees Compensation Act or 5 U.S.C. Part III, Chapter 81, § 8140 for information related to disability benefits external to the Air Force or Department of Defense.

4.50.5. The following are NOT eligible for disability evaluation processing unless it is clearly evident that a medical impairment and/or extenuating circumstance were likely the cause of the conduct:

4.50.5.1. SMs pending an approved, unsuspended, punitive discharge or dismissal.

4.50.5.2. SMs who are pending separation under provisions that authorize a characterization of service of Under Other Than Honorable (UOTH). This restriction is

based on the provisions under which the member is being separated and not on the actual characterization the member receives. For example, because separation for misconduct authorizes a UOTH, a member who is being separated for misconduct with a general characterization is ineligible for disability processing.

4.50.5.3. SMs facing court martial charges are not eligible for disability processing unless there is a question of mental capacity or responsibility or when the member's sentence of dismissal or punitive discharge is suspended. Refer to AFI 36-3212 for additional information regarding eligibility for disability evaluation consideration.

4.50.5.4. SMs in an Absent Without Leave (AWOL) status, in "Deserter" status, or those who have been apprehended or arrested and are in police custody, are not eligible for disability processing until the SM returns to military custody and only after HQ AFPC/DPSD determines eligibility for disability processing.

4.50.5.5. Air Force SMs sentenced to Service dismissal or punitive discharge by a court martial, or those who have been formally charged with a crime, are not eligible for disability evaluation processing. Medical Hold is not authorized unless court martial sentences are suspended, or court martial charges are dropped to permit separation or retirement in lieu of court martial, or charges are held in abeyance pending a sanity determination. Refer to AFI 36-3212, for further information regarding eligibility for PEB consideration.

4.50.6. Sometimes, SMs who are pending involuntary separation or discharge are eligible for DES processing. The Secretary of the Air Force (SECAF) will make the final disposition on these cases, which are termed "dual-action cases" since they are adjudicated under both directives. Refer to AFI 36-3212, Physical Evaluation for Retention, Retirement, and Separation, and AFI 36-3206, Administrative Discharge Procedures for Commissioned Officers, for additional information related to DES eligibility consideration.

4.51. Entrance into the Integrated Disability Evaluation System (IDES).

4.51.1. The IDES integrates the Air Force DES with the Veterans Administration (VA), and delivers the advantage of single-sourced disability ratings that are accepted by both the DoD and the VA, so the member will receive a VA benefits decision shortly after separation or retirement.

4.51.1.1. One of the goals of the DoD component services is to carefully screen SMs with potentially unfitting conditions, so they are appropriately referred into the IDES only when a "return to duty" adjudication is not likely.

4.51.1.2. In order to minimize inappropriate referrals to the IDES, there will be a two-step "pre-IDES" screening process on all potential MEB cases. The first step will be accomplished by the MTF Deployment Availability Working Group (DAWG). The second step will be accomplished by HQ AFPC/DPAMM (Medical Retention Standards Branch) or the appropriate ARC/SGP. Cases that AFPC/DPAMM (DPAMM) or ARC/SGP directs for MEB will be entered into the IDES process. DPAMM and ARC/SGP may also adjudicate a case as "Return to Duty" (RTD). An RTD disposition by DPAMM or ARC/SGP is final, and has the same effect and authority as an MEB.

4.51.1.2.1. The "Review-in-Lieu-of" (RILO) MEB will be used as the pre-IDES screening process. Cases submitted for pre-IDES screening will be referred to as "Initial RILO" packages and will contain a Narrative Summary (NARSUM), associated consult reports and/or studies, a current AF Form 469 (reviewed IAW AFI 10-203), a commander's letter, and a standardized cover sheet checklist (found on the AFPC Medical Retention Standards Branch page of the AFMS Knowledge Exchange [go to Headquarters ViewMoreOtherAFPC Medical Retention Standards].) **Note:** A "Modified RILO" can also be used to obtain an expedited case disposition when needed (e.g., separation, retirement, pending assignments, pending deployments, etc.) and does not require a commander's letter unless directed by DPAMM. Modified RILOs are also used as recurring updates (e.g., Annual RILO) for members with an Assignment Limitation Code-C (ALC-C) and do not require commander's letters unless requested by DPAMM.

4.51.1.2.2. Initial RILO packages are reviewed by the DAWG. Once reviewed by the DAWG, the packages are forwarded to DPAMM for adjudication. For RCSMs, refer to 4.52.6.

4.51.1.3. If DPAMM or the appropriate ARC/SGP directs that an Initial RILO should undergo an MEB, the SM formally enters the IDES as of the date that the referring provider signs and dates the VA Form 21-0819 VA/DoD Joint Disability Evaluation Board Claim form. The provider will provide the form to the Physical Evaluation Board Liaison Officer (PEBLO) who will then enter the initial case information into the Veteran's Tracking Application (VTA).

4.52. Trigger Events that Require Preliminary DAWG Review.

4.52.1. A trigger event is a condition or occurrence which may indicate a SM has (a) medical and/or mental health condition(s) that is (are) inconsistent with retention standards or deployability. After a provider recognizes a trigger event, the provider must notify the MTF PEBLO and Medical Standards Management Element (MSME), so a summary of the member's information can be obtained for preliminary presentation at the next scheduled DAWG meeting. Each DAWG should establish procedures and guidelines for reporting trigger events at its respective MTF. Trigger events include, but are not limited to, the following:

4.52.1.1. **(1)** Provider identification of duty limiting condition(s) or deployment limitation(s). Although not an "all-inclusive" list, Chapter 5 of AFI 48-123 specifies conditions that require evaluation for continued military service. (During any pre-MEB clinical evaluation or "work-up" period, providers will ensure the SM is placed on AAC 31.) Each MTF provider, after discovering a potential or questionable Service-disqualifying medical condition for any Airman regardless of rank, is responsible for submitting the case to the DAWG via the PEBLO or MSME.

4.52.1.2. **(2)** DAWG Surveillance Tracking of AAC 31 determines that a member has a chronic condition which may preclude him/her from performing duties or deploying to field conditions. Regardless of the diagnosis, after 12 months of cumulative AAC 31 status for the same or related issue(s), the full case must be referred to DPAMM via a RILO for adjudication review.

4.52.1.3. **(3)** Commander Requests evaluation due to poor duty performance or deployment concerns stemming from a potential medical or mental health condition.

4.52.1.4. **(4)** DPAMM directs. DPAMM may identify conditions via an Annual or Modified RILO and direct the MTF to submit an Initial RILO package.

4.52.1.5. **(5)** PCS, TDY or Deployment Cancellation or Curtailment for a medical or mental health reason.

4.52.2. Preliminary review of a trigger event should occur at the next scheduled DAWG meeting, and not more than 45 days after the case is referred to the PEBLO or MSME by the provider. The DAWG will review each case using the following criteria:

4.52.2.1. **(1)** Is timing appropriate for Initial RILO Referral? Verify the Member's hospitalization or treatment progress appears to have medically stabilized (and the course of further recovery is relatively predictable). This wording replaced the term "Optimal Medical and Hospital Benefit" under E3.P1.6.1 DoDI 1332.38 [see Personnel and Readiness Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008, 14 Oct 08]. There is no minimum medical evaluation time period and no need to wait for complete or near-complete recovery. There should be no delay in referral of a member's case as long as the course of recovery is relatively predictable, and a reasonable determination can be made that the limiting condition is not likely to resolve or improve within 12 months to an extent which renders the SM capable of fully performing the duties of his/her office, grade, rank or rating, to include the ability to deploy to field conditions.

4.52.2.1.1. In cases where there is no definitive diagnosis, but the preponderance of clinical evidence suggests a probable underlying cause in which the treatment progress, and/or progression of the condition, appears to be reasonably predictable, Initial RILO processing may proceed without a definitive diagnosis.

4.52.2.1.2. Neoplastic Diseases. A diagnosis of cancer or neoplastic disease may require additional time (beyond 90 days) to establish a clear prognosis. However, if it is clear the SM will require lengthy treatment, or will be unable to perform his/her job for a protracted period of time, referral of Initial RILO to DPAMM should expeditiously occur regardless of prognosis.

4.52.2.1.3. Solid Organ Transplants. When it is determined that a patient requires a solid organ transplant, an Initial RILO shall be submitted within 90 days of the initial organ transplant determination date.

4.52.2.2. **(2)** Is the case appropriate for Initial RILO Referral? Only unfitting conditions are eligible for referral. Unsuiting conditions must be distinguished from unfitting conditions because they are handled using administrative action. Unsuiting conditions are listed in Enclosure 5 of DoDI 1332.38 and AFI 36-3208, Administrative Separation of Airmen, and do not qualify for disability processing. (EXCEPTION: History of anaphylaxis and severe reactions requiring venom immunotherapy, although unsuiting conditions, require an Initial RILO for ALC-C consideration.)

4.52.2.3. **(3)** Is the member unable to reasonably perform the duties of his or her office, grade, rank, or rating due to a physical or mental condition which is not likely to resolve

or improve such that he/she can perform the duties of his/her office, grade, rank or rating within 12 months?

4.52.2.4. **(4)** Is this a chronic condition which imposes unreasonable requirements on the military to either maintain or protect the member?

4.52.2.5. **(5)** Is this a chronic condition which may preclude or limit the member's ability to safely and effectively deploy to field conditions?

4.52.2.6. **(6)** Has an Initial RILO package been directed by DPAMM?

4.52.2.7. **(7)** Is this a condition with 12 months of cumulative AAC 31 status for the same or related issue(s)?

4.52.2.8. **(8)** Is the Member refusing required professional, medical or dental care which would be necessary to achieve fitness for continued military service? See 4.63.8.1.

4.52.3. Upon preliminary review of a case referred due to a trigger event, if it is determined that above criteria (1) and (2), plus any of one of criteria (3), (4), or (5) are met, OR if any one of criteria (6), (7), or (8) are affirmed, the Initial RILO package will be completed. If additional review of the Initial RILO package is required, this will be accomplished at the next scheduled DAWG meeting. However, the Initial RILO case may be referred to DPAMM without another DAWG review if the SGP and SGH concur the entire RILO package meets all requirements.

4.52.3.1. Application of AAC 37 will be directed by the DAWG Chair, and applied in Preventive Health Assessment and Individual Medical Readiness (PIMR) by the MSME as soon as a case is identified as meeting the criteria in 4.52.3. Only the DAWG (as a committee, or the Chair, as representative) and DPAMM may direct an AAC 37 personnel status. Once applied, the AAC 37 will remain in effect until DPAMM directs removal via the AFPC/FL 4. For Reserve Component Service Members (RCSM), the PEBLO should notify the Reserve Component Medical Unit (RCMU) to initiate AAC 37 and verify the SM's entitlement to disability processing.

4.52.4. Once a case is identified to meet criteria in 4.52.3, the PEBLO should: (1) notify the member he/she is being referred for potential MEB, (2) contact the member's commander to request a commander's letter, which clearly describes how the unfitting condition(s) affect the member's ability to perform the duties of his/her office, rank, grade and/or rating, and forward the standardized letter template to the commander via e-mail, and (3) contact the provider (or providers, in cases where multiple specialty consult narratives are required) to request a copy of the RILO Narrative Summary (NARSUM), supporting consultant notes/studies, and current AF Form 469 prior to the next scheduled DAWG.

4.52.4.1. Any extenuating circumstances resulting in delays in receipt of NARSUM or other package documentation should be documented in the DAWG minutes.

4.52.4.2. In unique circumstances, the DAWG chair may request the provider expedite the package and/or may call an ad hoc DAWG meeting for expedited case review. These circumstances should also be documented in DAWG minutes.

4.52.4.3. NARSUMs. The same format is used for both the Initial RILO and for the formal MEB narrative, and is found on the AFPC Medical Retention Standards Branch page of the AFMS Knowledge Exchange [go to Headquarters ViewMoreOtherAFPC

Medical Retention Standards]. A single NARSUM format is used throughout the process, to alleviate the need for complete NARSUM rewrites if an Initial RILO is later directed for MEB.

4.52.4.4. Consultant Notes and/or Special Studies. Conditions which require a consultant note and/or studies are found on the AFPC Medical Retention Standards Branch page of the AFMS Knowledge Exchange [go to Headquarters ViewMoreOtherAFPC Medical Retention Standards]. Include the latest consultant note and/or update in the package. **Note:** Additional consultant notes and/or studies not directed as described may be included in the Initial RILO package at the discretion of the referring provider; however inclusion of these additional notes should not delay processing of the case. The consultation reports or updates, shall not be older than 180 days old when received at HQ AFPC Physical Disability Division (DPSD).

4.52.4.5. AF Form 469. If the AF Form 469 is more than 30 days old, the provider must review the AF Form 469 restrictions, updating restrictions as needed to ensure clear and accurate portrayal of the current restrictions (specifically relating to the potentially unfitting condition(s)). A comment will then be made in the Restrictions section: "Provider reviewed restrictions and they are deemed accurate and appropriate on (date inserted)." The importance of a clear and accurate AF Form 469 cannot be overemphasized, as this is the vital information that will be used, concurrently with the commander's letter and NARSUM/consults, to ascertain a member's fitness for duty.

4.52.5. DAWG Screening of Initial RILO package. The PEBLO will assemble the (1) NARSUM and accompanying consults/studies; (2) current AF Form 469 (reviewed and dated by provider within 30 days prior to submission); and (3) commander's letter; the package will be reviewed at the DAWG meeting. If desired by DAWG membership, the referring PCM/provider may attend to present the case and answer any questions. Categorization by the DAWG is as follows:

4.52.5.1. MEB Recommended. It is reasonably determined the member is most likely not capable of performing the duties of his/her office, grade, rank or rating. The package is forwarded to DPAMM by the PEBLO for adjudication. The standardized cover sheet checklist must be signed by the DAWG chair stating the package is "MEB Recommended."

4.52.5.2. Return to Duty Recommended. Member has a condition which is listed in Chapter 5 of AFI 48-123 and/or has a potentially unfitting condition which may limit or preclude deployment, yet the member is most likely capable of performing the duties of his/her office, grade, rank or rating AND the condition(s) is/are stable, controlled, and with a low risk of sudden deterioration. The package is forwarded to DPAMM by the PEBLO for adjudication. The standardized cover sheet checklist must be signed by the DAWG chair stating the package is "Return to Duty Recommended."

4.52.5.3. Other. Armed with the information available in the NARSUM, consults, AF Form 469 and commander's letter, the DAWG may make a determination that the case does not require DPAMM review at this time, and may dismiss the case entirely or schedule it for DAWG surveillance. The DAWG should work to minimize the number of cases that fall into this category by completing efficient and effective screening in the preliminary process, as outlined in 4.52.2.

4.52.6. For RCSMs, the RILO will be forwarded to the appropriate ARC/SGP for review. The appropriate ARC/SGP, who possesses the same authority for ARC cases as DPAMM possesses for active duty cases, will provide final disposition instructions (i.e., assignment of ALC-C, DAC-42, or IDES entry via MEB initiation) to the SM's supporting RC and AD medical facility.

4.53. HQ AFPC/DPAMM Medical Retention Standards Branch. The AFPC Medical Retention Standards branch (DPAMM) is the reviewing body for all active duty RILO reviews, and the sole approval authority for active duty ALC-C, Medical Hold, and non-emergent surgery during a SM's final six months of service (defined as surgery, which may or may not be necessary, but which is not required urgently or emergently to save life, limb, or eyesight). DPAMM is the office of primary responsibility for implementing HQ USAF/SG policy on medical standards for continued active duty service, and may provide interpretations of gray areas within this AFI consistent with current HQ USAF/SG intent. DPAMM also has the authority to direct Patient Squadron assignments when a facility is otherwise unable to obtain an accepting Patient Squadron for a patient with a valid requirement, and the MTF/TRICARE network of that Patient Squadron has the necessary healthcare capability the patient requires.

4.53.1. DPAMM pre-IDES Screening and Adjudication of Initial RILOs:

4.53.1.1. Following DAWG review of an Initial RILO, cases classified per 4.52.5.1 and 4.52.5.2 are forwarded to DPAMM for adjudication. Adjudication disposition shall be forwarded to the base PEBLO via the AFPC/FL 4.

4.53.1.2. The disposition by DPAMM is final and has the same effect and authority as a MEB. Dispositions are:

4.53.1.2.1. Return to Duty (with/without an Assignment Limitation Code) and remove AAC 37.

4.53.1.2.2. Direct an MEB and maintain AAC 37.

4.53.1.2.3. Direct an MEB at another MTF and maintain AAC 37.

4.53.1.2.4. Returned without Action (reason and disposition of AAC 37 will be specified).

4.53.1.2.5. Continued Military Medical Observation and Care and maintain AAC 37.

4.53.1.3. If a MEB is required on a Flag Officer, DPAMM will designate a MTF to conduct the board. DPAMM will forward initial notification to AF/DSG and AF/SG by electronic secure transmission and provide final notification when the MEB/PEB action is complete if the Flag Officer is returned to duty. (AFPC/DPSD will make the final notification if the Flag Officer is medically separated or retired.)

4.53.1.4. Presumption of Fitness. For those with an approved retirement date within the next 12 months, the "Presumption of Fitness" policy may be applied to a case decision during the DPAMM RILO adjudication process, resulting in a RTD decision without a full MEB. Presumption of fitness applies to retirement, not to separation of members who are not eligible for retirement. Refer to DoDI 1332.38, Paragraph E3.P3.5.1. and AFI 36-3212, Paragraph 3.17. for additional information.

4.53.1.5. Only DPAMM, ARC/SGP, AFPC/DPSD (IPEB and Formal Board), and the SECAF may invoke Presumption of Fitness. MTF providers, the DAWG and MTF MEB members are prohibited from using or claiming Presumption of Fitness to deny a SM MEB consideration.

4.53.1.6. Medical Hold is a method of retaining a SM beyond an established retirement or separation date for reason of disability processing, when presumption of fitness does not apply. It may be necessary to place members on Medical Hold if DPAMM directs an MEB, and the member is within 60 days of separation or retirement. It will not be used for the purpose of evaluating or treating chronic conditions, performing diagnostic studies, elective treatment of remedial defects, non-emergent surgery or its subsequent convalescence, civilian employment issues, preservation of terminal leave, or for any other condition which does not warrant termination of active duty. Separation or retirement processing continues until Medical Hold is approved.

4.53.1.6.1. Medical Hold is requested by a provider (generally the PCM), directly contacting DPAMM, or the appropriate RCMU when the individual is a RCSM. For ANG SMs, ANG/SGP is the approval authority. For Air Force Reserve SMs, AFRC/SGP is the approval authority. The requesting physician should have the following information readily available, in addition to being familiar with the medical aspects of the case:

4.53.1.6.1.1. Date of projected separation or retirement.

4.53.1.6.1.2. Whether Initial RILO processing has been initiated, and if so, the estimated time until the Initial RILO package will be ready for submission to DPAMM.

4.53.1.6.1.3. Whether administrative separation or Court Martial charges are pending.

4.53.1.6.1.4. Servicing Military Personnel Section (MPS) implementing separation or retirement.

4.53.1.6.1.5. Whether SM desires to be retained in duty status for disability processing.

4.53.1.6.1.6. Member's AFSC.

4.53.1.6.1.7. Confirmation that the PEBLO and either the SGH or SGP has been notified of the provider's intent to request Medical Hold.

4.53.1.6.2. DPAMM (or ARC/SGP) may direct a modified (expedited) RILO prior to approving Medical Hold.

4.53.1.6.3. Enlisted SMs may refuse Medical Hold beyond their Date of Separation (DOS) or Expiration of Term of Service (ETS), and must agree, in writing, to a Medical Hold. For officers, Medical Hold does not require consent, but DPAMM may request consent in writing. The PEBLO must contact DPAMM immediately when notified that a SM may decline Medical Hold.

4.53.2. DPAMM Initial RILO results returned to MTF:

4.53.2.1. If the SM is RTD with or without an ALC-C, the PEBLO is notified by DPAMM via the AFPC/FL 4. In turn, the PEBLO notifies the PCM and the MSME. AF Forms 422 and 469 will be generated or updated as indicated IAW AFI 10-203.

4.53.2.2. If DPAMM directs an MEB, the PEBLO is notified via AFPC/FL4. The PEBLO, in turn, notifies the PCM, the DAWG chair, and the SGH. The PCM (or alternate provider if PCM is unavailable) will complete the VA Form 21-0819 VA/DoD Joint Disability Evaluation Board Claim form and return it to the PEBLO. The date the provider signs the VA Form 21-0819 is the date that the member officially enters into the DES.

4.53.3. SMs may not refuse, decline, nor stop any RILO, MEB, PEB, or fitness for duty evaluations except in cases prescribed in DoDI 1332.38, para E3.P2.7, Waiver of MEB/PEB Evaluation.

4.53.4. Leave/TDY. Once the SM is notified by the PEBLO that an MEB has been directed, the SM will be required to be available for VA appointments, PEBLO counseling, and the MEB process. MTFs must develop local processes and procedures with unit commanders regarding the availability of SMs in the IDES to meet all appointments (e.g., requesting SMs not be placed on leave outside the local area or TDY, except for emergencies, notifying the PEBLO when a SM cannot make an appointment, etc).

4.53.4.1. Once the MEB package has been sent to the IPEB, the member may not take leave or go TDY without permission from AFPC/DPSD.

4.54. DES Program.

4.54.1. Regardless of the date that the information is electronically populated into VTA by the PEBLO, the date of entry into the DES is the date the provider signs the VA Form 21-0819. DES timeliness goals are detailed in separate DoD guidance, and includes VA appointments for disability evaluation.

4.54.2. Once the VA medical evaluations have been completed in the form of the Compensation and Pension (C&P) evaluation, the PEBLO will receive the C&P results and provide them to the PCM, referring provider, or to a reviewing provider who has been assigned by the DAWG.

4.54.3. NARSUM Review, Update and Completion. Once the PCM, referring provider, or reviewing provider receives the C&P exam results, he/she will (1) review the C&P report; (2) verify the NARSUM covers the full spectrum of potentially unfitting conditions; (3) addend/update the NARSUM appropriately; and (4) return the updated NARSUM to the PEBLO. A signed/dated addendum with pertinent updates must be located at the end of the NARSUM, and must clarify inconsistencies between the initial NARSUM and C&P only for conditions which are considered unfitting for continued military service. If there are no inconsistencies or updates, the provider will sign/date the following statement at the end of the NARSUM: “I have reviewed the C&P exam results and find the information within the NARSUM to be current and complete.” This date now becomes the new date for NARSUM currency. The provider’s duty title must be clearly discernable.

4.54.3.1. For cases in which a single NARSUM is replaced by multiple specialty consult NARSUMs, a single reviewing physician may review both the C&P Exam and the

multiple specialty NARSUMs, and provide a signed and dated addendum on a continuation sheet, which will accompany the complete MEB package through routing. In this case, the date on the continuation sheet now becomes the new date of the NARSUM.

4.54.4. The preparing and reviewing physicians will not include verbal or written comments relating to the expected disability process outcome.

4.55. Non-physician providers preparing the NARSUM. When non-physician providers (optometrist, podiatrist, clinical psychologist, physician assistant, nurse practitioner) prepare the NARSUM, it must be reviewed and counter-signed by a physician trained or experienced in the same or a related specialty area as the non-physician provider; e.g., ophthalmologist for optometry, orthopedics for podiatry, and psychiatry for psychology. Board certified family physicians and internists may countersign if they are currently holding privileges in fields related to the patient's condition.

4.56. Conducting the MEB. After the NARSUM is reviewed, updated and the completed NARSUM has been returned to the PEBLO (see 4.55.), the MEB shall meet. Sections 4.57. through 4.68. provide guidance for the MEB Process.

4.57. Where MEBs should be accomplished.

4.57.1. SMs should receive MEB processing at the MTF where they receive the majority of their care, or at the MTF closest to their duty location. However, if the identified MTF cannot provide the necessary care or assessment, the MTF may, upon acceptance by an alternate MTF, refer the case to an MTF with appropriate services.

4.57.2. If an AD member is hospitalized away from his/her installation of assignment or in a non-Air Force facility, the nearest Air Force MTF will accept administrative responsibility for the LOD and MEB process. The member's PCM should remain informed of the patient's condition.

4.57.3. Commanders at all levels, and officers who have convening and approval authority for medical boards, will not have their own MEB or their clinical evaluation and board processing at an MTF that is within their command and control or official influence. In this circumstance, DPAMM will designate an MTF to accomplish the board.

4.57.4. Any MTF-assigned officer requiring an MEB shall not meet the MEB at his/her own MTF without a policy waiver from DPAMM. The MTF Commander may submit a waiver request detailing why an MEB should be conducted at his/her own facility, as well as why the commander has no concern for a conflict of interest.

4.57.5. An MTF will not conduct an MEB on an assigned enlisted staff member who has been or is currently a disciplinary problem, or when there would be concern for a conflict of interest. If a waiver is requested from DPAMM, the MTF Commander is required to include a brief statement indicating the nature of the disciplinary problem. Once received, DPAMM will respond with disposition instructions.

4.58. MEB Support for SMs assigned to Geographically Separated Units (GSUs) or enrolled to TRICARE Prime Remote (TPR) location. If unique circumstances or mission requirements mandate that some or all pre-MEB or clinical case "work-up" be completed via

TPR network providers, approval to use TPR providers for MEB assessment must be granted by the DAWG assigned to manage that GSU or remote location.

4.58.1. The DAWG must review the status of GSU SMs undergoing pre-MEB workup every 30 days. The PEBLO will become the liaison and (1) notify the Military Medical Support Office (MMSO) Case Management Division that the SM's pre-MEB medical care will be provided by TRICARE/TPR network providers; (2) obtain medical release authorization from the patient, contacting the civilian provider(s) every 30 days for written clinical updates/consults; and (3) notify the MMSO of the MEB outcome.

4.59. Multi-Service MEB Processing.

4.59.1. Historically, Air Force MTFs have accepted MEB referrals from non-Air Force MTFs, PCMs and/or specialists for Airmen assigned to their Military Personnel Section (MPS). The PEBLO at the Air Force MTF receives a NARSUM and supporting diagnostic/clinical consultation(s). In these cases, the DAWG at the receiving MTF will review the case and decide whether the submitted NARSUM and consults are appropriate, or if new or supplemental documentation is required.

4.59.2. Referral date entry into any joint-service DES tracking application for an Airman, by a non-Air Force MTF, is premature. Only the Air Force MTF that receives the non-Air Force MTF MEB referral has the authority to initiate the formal MEB process, after Initial RILO screening has been completed by DPAMM, and then enter a referral date into a joint-service DES tracking application.

4.59.3. It is the responsibility of a SM's parent Service to make the Fitness for Duty decision.

4.60. Processing MEBs for SMs from other Services. Air Force MTFs may refer a Soldier, Sailor, or Marine, who is enrolled or empanelled to an Air Force MTF, to their local DAWG provided all the following requirements are met:

4.60.1. **(1)** The DAWG Chair approves the action.

4.60.2. **(2)** The MEB president has reasonable operational knowledge of the specific Service's medical retention standards.

4.60.3. **(3)** Prior to the referral, written permission, from the MTF Commander, senior physician responsible for evaluating occupational medical standards and/or profiles, or senior operational physician at the nearest MTF that shares the same Service affiliation of the SM in question, must be obtained.

4.60.4. **(4)** The MTF approving official from the nearest MTF that shares the same Service affiliation of the SM must acknowledge that Air Force MEBs may be processed differently from Army or Navy processes and medical/service retention standards may be different.

4.60.5. The Air Force MTF will forward the results of the MEB and all related medical supporting documents to the nearest MTF that shares the same Service affiliation of the SM after the MEB has met so that the package can go to the appropriate Service's PEB or DES system.

4.60.6. Air Force MTFs that regularly agree to process MEBs for SMs from the Army, Navy, or Marines are highly encouraged to establish agreements (memorandum of understanding or agreement) with the referring medical unit.

4.61. Composition of the Medical Evaluation Board (MEB).

4.61.1. Only physicians may participate as voting members. The board is comprised of three privileged physicians, ideally active duty Medical Corps officers of the United States Uniformed Services. Physician interns and residents are not authorized members. Civilian physicians and/or consultants, and retired medical officers who hold privileges at the MTF may serve as board members. Note that privileges refers to a physician's granted privileges to practice medicine at the MTF, and not to a specific "serve as MEB member" privilege on the privilege list.

4.61.2. Before appointment, and annually thereafter, each MEB member is required to complete training to be familiarized/updated with MEB processes and DES program objectives. The SGH is encouraged to contact AFMOA/SGH to obtain the latest training information. Physicians are also invited to attend PEBLO training courses (when offered).

4.61.3. The SGH or the SGP will serve as the MEB President. Deputies SGH and SGP, when appointed by the MTF Commander in writing, are authorized the same MEB authority as the permanent or primary officials in absence of the primary official.

4.62. Required Medical Documentation for the local MTF MEB.

4.62.1. NARSUM. See 4.54.3.

4.62.2. Consultation Notes. See 4.52.4.4.

4.62.3. Standardized Commander's Letter using the template found on the AFPC Medical Retention Standards Branch page of the AFMS Knowledge Exchange [go to Headquarters ViewMoreOtherAFPC Medical Retention Standards].

4.62.4. AF Form 469. Duty Limiting Condition Report. See 4.52.4.5.

4.62.5. AF Form 618. Medical Board Report.

4.63. Convening the MEB.

4.63.1. Whenever possible, the MEB members should meet at the same time for interactive discussion and case review. Exceptions to this can only be granted by the SGH or SGP.

4.63.2. Personal appearance of the SM is not required, but the board president may allow (at his or her discretion) the SM to appear before the board for statements. There is no right to counsel or to challenge the MEB or its members.

4.63.3. MEB recommendations. The MEB membership may choose from the following two actions: (1) Return to Duty or (2) Refer to IPEB. **Note:** Even though the MEB was initially directed by DPAMM following Initial RILO screening, rare instances may arise where, at the time of MEB, new information will be available (e.g., condition changes, updated consults, information from C&P Exam, updated commander's letter, etc.) that result in a vote for Return to Duty instead of Refer to IPEB. When this occurs, the complete case will be forwarded to DPAMM, instead of being forwarded to HQ AFPC/DPSD (IPEB).

4.63.4. MEB members will sign AF Form 618, block 26.

4.63.5. Whenever discussion does not result in a unanimous decision, the MEB clerk must record dissenting vote counts and each respective reason on the reverse of AF Form 618, and mark block 27 appropriately.

4.63.6. Boards for a mental health diagnosis or when cognitive dysfunction is expected:

4.63.6.1. Whenever the MEB convenes to review a case involving a mental health diagnosis, or if cognitive dysfunction is suspected due to either head trauma or intracranial disease, at least one member must be a psychiatrist, and is identified by marking an "X" in the box to the right of his/her signature on AF Form 618, block 26.

4.63.6.2. Psychiatric evaluations must include the degree of social and industrial impairment for civilian life, and degree of impairment for military service.

4.63.6.3. The MEB members must ensure that special provisions for reporting psychiatric cases have been followed: Multi-axial Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis reporting is required with all five axes, including personality assessment and Global Assessment of Function (GAF). When describing the degree of impairment for civilian, social and industrial adaptability for all boardable Axis I cases, use of degree term references is limited to: Total, Severe, Considerable, Definite, Mild, or None. For degree of impairment for military service, use the degree of the SM's current and projected impairment for military service: No Impairment, Minimal, Moderate, or Marked.

4.63.7. Competency Boards and Sanity Boards. In a case where a SM's competency for pay and records is called into question, or in a Court-Martial case where a SM's sanity is called into question, the MEB must be composed of three Uniformed Services Medical Corps officers, one of whom must be a psychiatrist. [If the member is comatose, he/she is presumed incompetent and no psychiatrist is required]. For Competency Boards, in addition to signing the AF Form 618, the board determines whether the attending physician was correct in his/her determination of the member's competence and annotate this in block 23a of the AF Form 618. If the member is declared incompetent for pay and records, add to block 22, "DFAS DEM 177-373." For Sanity Boards, findings are annotated in block 24 of the AF Form 618. The psychiatrist on the Board must be identified by marking an "X" in the box to the right of his/her signature on AF Form 618, block 26.

4.63.7.1. When incompetence is determined, additional copies of AF Form 618 are distributed to accounting and finance authorities. This must be done without delay. Failure to safeguard the pay of members declared mentally incompetent to manage their own affairs has caused serious hardship to members and their families.

4.63.8. Boards under unique situations:

4.63.8.1. SMs who refuse required professional, medical or dental care, and/or other necessary treatment options may be required to meet an MEB. Refer when:

4.63.8.1.1. The SM was clearly advised of the necessary course of treatment, therapy, medication, or duty limiting or physical restriction.

4.63.8.1.2. The SM's failure or refusal was willful or negligent and not the result of mental disease or of physical inability to comply.

4.63.8.1.3. The SM refuses to submit to medical, surgical, or dental treatment or diagnostic procedures. If the refusal is based on religious grounds, arrange for the appointment of a military chaplain as a special advisor to the board. The MEB determines:

4.63.8.1.4. Whether or not the SM requires the procedure in order to properly perform military duties or establish medical qualification for continued service.

4.63.8.1.5. Whether or not the procedure, according to accepted medical or dental principle, will be likely to produce the desired results. If analysis confirms the required procedure or treatment is necessary to continue military service and if the required procedure or treatment will likely achieve the desired effect, and the SM still refuses, forward the Initial RILO package to DPAMM.

4.64. MEB Review and Approval Authority. Clinical sufficiency review authority rests with the SGH and SGP. The MEB President, whether the SGH or SGP, must review each completed MEB package before it is submitted to HQ AFPC/DPSD IPEB, attesting to the following final review:

4.64.1. The SM's potential Service-disqualifying medical condition and associated healthcare, has been adequately documented in the NARSUM which will not be older than 30 days when received by HQ AFPC/DPSD, and with appropriate attached consults that will be no older than 180 days when received by HQ AFPC/DPSD. [**Note:** the 30 day age limit is excluding the time the member is granted to submit a rebuttal, and the time the Convening Medical Authority is granted to respond to the rebuttal. See 4.67.]

4.64.2. A physician review of the C&P is recorded via an addendum. A NARSUM with updated comments, or with a dated statement that no additions or clarifications were required, or a continuation statement, is substituted if multiple NARSUMs are present. See 4.55.

4.64.3. A standardized commander's letter is present that clearly describes how the unfitting condition(s) affect the member's ability to perform the duties of his/her office, rank, grade and/or rating. Ensure that the commander's letter used the template required by HQ AFPC/DPSD, and will not be more than 120 days old when received by HQ AFPC/DPSD.

4.64.4. The AF Form 469 has been reviewed by a physician, preferably the PCM and/or provider submitting the NARSUM, within the last 30 days, and a dated statement of review is located in the "restrictions" section of the AF Form 469. See 4.52.4.5.

4.64.5. SM's hospitalization or treatment progress appears to have medically stabilized (and the course of further recovery is relatively predictable), and it is unlikely that the member would be capable of returning to duty within 12 months.

4.64.6. The MTF Commander is not required to sign AF Form 618, blocks 28 (a-d). Until the new AF 618 is produced, "not required per AFI 41-210" will be printed in block 28(c), prior to having the SM sign AF Form 618.

4.65. Notification of MEB Results to SM. Following the recommendation of the MEB, the PEBLO or MEB clerk should ensure that blocks 1-27 of AF Form 618 are completed. The PEBLO will meet with the member, provide a copy of the AF 618 and Narrative Summary/consults, and Commander's letter to the member, and explain the findings of the MEB

(without speculating as to potential PEB outcome), and answer any questions the SM may have regarding the content.

4.65.1. The PEBLO will then explain the options of the Impartial Review and/or Rebuttal Letter, and give the SM three duty days to decide if he/she requests (1) an Impartial Review (with or without subsequent Rebuttal Letter); (2) to decline the Impartial Review and submit a Rebuttal Letter within seven duty days of the decision; or (3) to decline the Impartial Review and the Rebuttal Letter options.

4.65.2. If the SM declines the Impartial Review and Rebuttal Letter options, the PEBLO will ask the SM to sign and date the AF Form 618 Medical Board Report, blocks 29(a) and 29(b) signifying that he or she has been informed of the findings and recommendations of the MEB.

4.65.2.1. After the member signs the AF Form 618, the PEBLO shall assemble and forward the MEB package to the IPEB per the instructions of the checklist in the Disability Counseling Guide for Physical Evaluation Board Liaison Officers, published by HQ AFPC/DPSD.

4.66. Impartial Review. If the SM requests an impartial review, an impartial physician or other appropriate healthcare professional (not involved in the SM's MEB process) must be assigned to offer a review of the medical evidence presented by the NARSUM and associated consults.

4.66.1. The impartial health professional should advise the SM within five duty days on whether the MEB findings adequately reflect the complete spectrum of injuries and/or illnesses. For cases in which the Impartial Review does not validate the MEB findings, the Impartial Reviewer will contact the MEB Board President (SGH or SGP who signed block 26 on AF Form 618) concurrently with notification to the SM.

4.66.1.1. In such cases, the MEB Board President must consider whether changes to the MEB package are warranted, and whether to reconvene the MEB once changes have been documented.

4.67. Rebuttal Letters. Armed with the decision of the MEB and, if requested, the information from the Impartial Review, the member may choose to submit a Rebuttal Letter to the MEB Convening Medical Authority (CMA).

4.67.1. Per DoDI 1332.38, E2.1.33, the CMA must be a senior medical officer, appointed by the MTF Commander, with detailed knowledge of directives pertaining to standards of medical fitness and disposition of patients, disability separation processing and familiar with the Veterans Affairs Schedule for Rating Disabilities (VASRD). It is recommended that the MTF Commander consider the SGH, SGP and Senior Profile Officer as the appointed MTF Convening Medical Authority primary and alternates, if the MTF Commander is not a physician. See Personnel and Readiness Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008, 14 Oct 08.

4.67.1.1. The acting CMA for any particular case may not be one of the three physicians who served on the MEB, and may not be the Impartial Reviewer for that particular case.

4.67.2. If the SM requested an Impartial Review, the SM shall be afforded seven calendar days from the date of Impartial Reviewer notification of review results to prepare a Rebuttal Letter and submit it to the MEB Convening Medical Authority, who shall be afforded seven

calendar days to consider the Rebuttal Letter and return the fully documented decision to the SM.

4.67.3. If the SM did not request an Impartial Review, but chooses to submit a Rebuttal Letter, the SM will be afforded seven calendar days from the date of decision established in section 4.65.1. (2) to prepare a Rebuttal Letter and submit it to the MEB Convening Medical Authority, who shall be afforded seven calendar days to consider the Rebuttal Letter and return the fully documented decision to the SM.

4.67.4. If the member submits a Rebuttal Letter, the MEB results shall not be forwarded to the PEB until the Rebuttal process is finalized and MEB results indicate the SM may be unfit for duty. The fully documented Rebuttal Letter, and response, will be included with the MEB package sent to the PEB. Exceptions to timelines may be granted by an authority appointed by the SAF.

4.67.5. At the conclusion of the Impartial Review and/or Rebuttal process, the PEBLO will counsel the SM and ask him/her to sign and date the AF Form 618, blocks 29(a) and 29(b) signifying that he or she has been informed of the findings and has received the response to the Rebuttal Letter, and recommendations of the MEB. After the PEBLO meets with the member, the PEBLO assembles the package and forwards it to IPEB per the instructions of the Disability Counseling Guide for Physical Evaluation Board Liaison Officers, published by HQ AFPC/DPSD.

4.67.6. If the SM submitted a Rebuttal Letter, the PEBLO will assure the member that both the Rebuttal Letter and the Convening Medical Authority's response to the Rebuttal Letter will be included in the package which will be forwarded to HQ AFPC/DPSD to the Informal Physical Evaluation Board (IPEB).

4.67.7. If the SM has been determined to be incompetent (blocks 22 and 23 of AF Form 618, or the case has been designated deleterious (AF Form 1172), the MEB recorder or PEBLO addresses the above mentioned actions to the SM's next of kin (NOK) or legal guardian, who is entitled to the same rights, privileges, and counseling benefits as the SM.

4.68. PEBLO MEB Special Considerations.

4.68.1. For privileged providers undergoing MEB, the Chief of the Medical Staff will submit a statement regarding the current status of the privileges. A simple memorandum format is acceptable, although a DD Form 2499 is recommended if the provider is unlikely to return to full and unrestricted duty. For non-credentialed providers enrolled to GME training programs, the Program Director will provide this statement for the package.

4.68.2. Waivers. A copy of DPAMM waiver approval to conduct MEB locally for certain SMs assigned to the MTF. Refer to paragraphs 4.57.3-4.57.5.

4.68.3. AF Form 565, Record of Inpatient Treatment, if applicable.

4.68.4. Other reports as needed or requested for RCSMs.

4.68.5. Cases Returned from HQ AFPC/DPSD. If additional information is required or requested from AFPC, the MTF Commander, or designee, is required to respond by endorsement confirmation, that the requested information was obtained. AFPC determines the package return suspense date.

4.68.5.1. The MTF Commander or designee will advise members of the MEB and examining physician that the case was returned, the reason for its return, and suspense any requests.

4.68.6. Changes in Condition/New Condition in SMs undergoing IPEB adjudication.

4.68.6.1. If a SM, for whom an MEB case has already been sent to the IPEB, is diagnosed with a new "boardable" condition, the case may require a recall of the previously submitted case. If a recall is indicated, the MTF Commander or designee (SGH or SGP) will contact AFPC/DPSD in writing per AFI 36-3212, Chp 2, to request the recall.

4.68.6.2. If a SM receives or possesses orders for separation or retirement as a result of a disability determination, and the SM has not yet been released from active duty and then experiences a significant clinical change in their condition, the MDG/CC or designee (SGH or SGP) will contact AFPC/DPSD (not DPAMM) to ascertain whether retirement or separation orders should be revoked and another MEB be initiated.

4.69. MTF Commander Responsibility for MEB Process. Every MTF Commander must establish and maintain a viable MEB process. Each MEB physician member will be appointed, in writing, by the MTF Commander. Primary and secondary Convening Medical Authorities will be appointed in writing by the MTF Commander.

4.69.1. Copies of current appointment letters will be updated, at least annually, and whenever new members are appointed. Letters are maintained in the TOPA Training Records (PEBLO Continuity Binder). The SGA will ensure a copy is forwarded to HQ AFPC/DPSD with each update. The MTF is responsible for maintaining all written appointment orders, formal appointment letters, and Convening Authority delegation orders for at least three calendar years from the date of the appointment or delegation. Maintain these documents within the MTF TOPA Training Records (PEBLO Continuity Binder).

4.69.2. The MTF Commander should appoint a mature and experienced NCO, SNCO, officer, federal civilian employee or contract employee (with commensurate experience and/or skill level) as the PEBLO in writing. If the PEBLO is an active duty member, it is recommended MTFs maintain them in the position for a minimum of 24-months. The MTF Commander shall forward a copy of this published order or letter to HQ AFPC/DPSD. The MTF is responsible for maintaining all written appointment orders, formal appointment letters, and annual PEBLO proof of training documents (copies of training certificates and/or letters of training certification or validation) for at least three calendar years from the date of the appointment or training event. Maintain these documents within the MTF TOPA Training Records (PEBLO Continuity Binder).

4.69.2.1. PEBLO responsibilities are numerous, and many of them have been detailed throughout the processes in this instruction. Others are detailed in the DES Implementation Guide. Processes are further outlined in the following locations: The Disability Counseling Guide For PEBLOs, published by AFPC/DPSD, and AFI 36-3212, Physical Evaluation for Retention, Retirement, and Separation.

4.69.2.2. Additional PEBLO Responsibilities prior to MEB include, but are not limited to: Ensure LOD determination complete (if required). Verify SM's separation or retirement date. If a SM's DOS or ETS is within 60 calendar days from the date the

patient enters VTA, notify HQ AFPC/DPAMM to ascertain whether Medical Hold status is in place. For Medical Hold consideration affecting RCSMs, contact the appropriate ARC agency. Obtain all health records, including dental records. When notifying SM of MEB, advise member to report to the Family Support Center, Airman or Warrior and Family Readiness Support Center to obtain pre-separation transition assistance counseling. Notify the SM's commander of leave and TDY restrictions. Ensure the SM was placed in an AAC 37 personnel status. Note that Personnel and Readiness Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008, 14 Oct 08, Enclosure 6, covers PEBLOs's assignment guidelines, training, duties and qualifications.

4.69.2.3. Each PEBLO must have the ability to manage the important tasks of counseling military members undergoing this complicated process. A PEBLO must possess knowledge of a) the Disability Evaluation System, b) basic VA Health Benefits, c) the Line of Duty Determination program, d) overall MTF operations, e) the Air Force Office of Airmen's Counsel. PEBLOs must effectively communicate with internal professional staff, external referral organizations that may be able to provide non-clinical support to the SM and his/her family, and officials at HQ USAF.

4.69.2.4. If a formal PEBLO training course is available, each active MTF PEBLO must attend at least one time in his/her career. A formal course is defined as a training program recognized either by AETC or other standardized joint-service academic certification authority with identified academic learning objectives and goals. Students completing Internet web-based, or physical classroom environment courses are required to test and successfully pass smaller periodic knowledge proficiency examinations, or pass at least one end-of-course examination that evaluates overall course comprehension. If sending all MTF PEBLOs to this course at the same time jeopardizes the overall MTF MEB mission, the MTF Commander may choose to send only one PEBLO. This decision must be documented and maintained on file in the TOPA Training Records for at least three years from the date of the signed memorandum.

4.69.2.5. If a semi-formal annual training course, class, or conference is offered as a program not formally recognized by AETC or any joint-service academic certifying authority, then at least one MTF PEBLO should attend. Although a semi-formal course may not offer the same structured learning requirements and environment as a formal class, an informal course allows a PEBLO to obtain the latest DES processing updates, speak with senior AFMS and AFPC officials, share best-practice information and "network" with other MTF PEBLOs.

4.69.2.6. In rare cases, in lieu of a formal or informal training certificate or standardized training verification document or mechanism, and based upon the recommendations by 1) the Patient Administration Officer, TOPA/Patient Administration Flight Commander, 2) the Chief of the Medical Staff (SGH), and 3) the Chief of Aerospace Medicine (SGP), the MTF Commander must determine when a PEBLO "trainee" has reached a reasonable minimum training and job qualification experience level typically expected of a fully trained PEBLO. This determination must be documented and maintained in the TOPA Training Records for a period of no less than three years from the date the MTF Commander determines there is adequate evidence to consider the PEBLO's fully qualified.

4.69.3. Each new PEBLO is required to spend at least three full work weeks working with another experienced PEBLO before assuming full duties. If no other experienced PEBLO is available within the MTF to provide required training, then the MTF Commander shall, a) arrange for the new PEBLO to travel to another MTF to receive training or, b) sponsor a PEBLO from another MTF to travel to their MTF to provide required training. Verification of required PEBLO training shall be forwarded to AFMOA, Health Benefits Division (AFMOA/SGAT) on a quarterly and annual basis according to the established reporting format. On-the-job training should be documented and specifically targeted to meet the requirements identified on a standardized AF Form 797, Job Qualification Standard Continuation/Command (JQS) form.

4.69.4. The PEBLO's active MEB caseload (MEB and TDRL cases) should not exceed 20. If exceeded, MTF Commanders are expected to appoint and train an additional PEBLO to adjust the caseload. For fluctuations in caseload that consistently exceed a ratio of 20:1, MTFs may explore programming options to increase the number of PEBLOs. If funding is available, contracting vehicles via the AF/SG Commodity Council at Wright-Patterson AFB, Ohio may be pursued.

4.70. Performance Reporting and Oversight.

4.70.1. Quarterly Reports:

4.70.1.1. Caseload & Training Reporting. Quarterly, each MTF responsible for processing MEBs, RILOs, and/or TDRL cases, will report the number of active cases under review or "open" for each workload category, e.g., MEB, RILO, and/or TDRL patient. Each MTF will report:

4.70.1.1.1. The total number of cases (separated by category) for each PEBLO and/or MEB clerk responsible for processing the case.

4.70.1.1.2. The number of PEBLOs assigned that are fully trained, including data reporting for those PEBLOs at least 50% trained and 100% trained.

4.70.1.1.3. The average number of days (for all combined) active MEB cases, that it takes an MTF to process a typical MEB.

4.70.1.2. Report this information to AFMOA/SGAT no later than the fourth calendar day following the close-out of each reporting quarter. Officials at AFMOA/SGAT will transfer information into a report with both singular data and MAJCOM and AFMS totals for each category. This report will be forwarded to AFMSA/SG3SA no later than the sixth duty day following the close-out of each reporting quarter. AFMSA will then forward the report to AFPC/DPSD. Once received, officials at AFPC will combine this information with other DES adjudication reporting data and forward the total quarterly Air Force DES Performance Metric Report to the Office of the Under Secretary of Defense, for Personnel & Readiness (OUSD/P&R) no later than the 15th calendar day following the close-out of each reporting quarter.

4.70.2. Annual Report:

4.70.2.1. Following the close-out of each fiscal year, each Service is required to submit an annual DES Report to OUSD/P&R that covers several areas. HQ AF/SG will in-turn require from AFMOA for each MTF responsible for processing MEBs, RILOs, and or

TDRL cases, (at a minimum) an annual summary of the caseload information submitted quarterly, verification that all PEBLOs and physicians (who participated in an MEB for the previous FY) were properly trained, and whether there were enough skilled PEBLOs assigned to meet the DoD caseload ratio restrictions.

4.71. Patient Squadron Assignment.

4.71.1. Authority. This section contains the authority for administratively assigning patients to an Air Force medical unit for the purpose of obtaining medical care, and/or for MEB processing.

4.71.2. Active Duty Airmen may be considered for potential PCS reassignment to an MTF under one or more of the following conditions.

4.71.2.1. Required medical care is not available at the MTF or reasonably available in the local or regional areas.

4.71.2.2. There is overwhelming medical evidence that suggests a SM is not likely expected to return to Active Duty.

4.71.2.3. When hospitalization beyond the SM's Date of Separation is expected. (Contact AFPC/DPAMM to request Medical Hold).

4.71.2.4. For overseas SMs; when the required medical care is not available in the overseas area.

4.71.2.5. For overseas SMs; when hospitalization beyond the member's DEROS is expected.

4.71.2.6. When HQ AFPC/DPAMM directs.

4.71.3. General Information: Consistent with the needs of the Air Force, the intent of the patient assignment program is to place SMs in MTFs best suited to address their medical needs. Although placement of the member near family or Home of Record may be considered when appropriate, it is not the goal of this program.

4.71.4. Patient Squadron Assignment vs. Attachment. A Patient Squadron can be established at any Air Force MTF regardless of size. When an Airman is assigned to a Patient Squadron, the SM is relocated via official orders in either PCS or PCA capacity. The word "assigned" implies a permanent personnel duty assignment status, such that the member does not count against the losing unit or the gaining MTF's medical staffing positions. The term "permanent" does not mean the Member is permanently reassigned to an MTF. Following medical treatment, the SM will either be reassigned, or will separate/retire through the Disability Evaluation System.

4.71.4.1. MTF Commanders may publish TDY orders to move patients between MTFs. These Airmen are temporarily attached to a MTF Patient Squadron while in a medical TDY status, but remain assigned to their home unit. Following TDY medical treatment, the Patient Squadron commander will return the Airman to his or her home unit commander.

4.71.4.2. Permanent Change of Station assignment action does not apply to ARC Airmen who may travel to an MTF to receive LOD-related, pre-MEB diagnostic treatment, and/or MEB case processing. While at the MTF, RCSMs are considered attached to the MTF.

4.71.5. The MTF Commander shall assume assignment and command authority over officers and enlisted members assigned to this unique "squadron." The MTF Commander may appoint an officer under his/her command to serve as the Patient Squadron commander. The Patient Squadron commander is responsible for placing both assigned and attached outpatient SMs in an MTF or external line unit work center, provided:

4.71.5.1. the SM is physically and/or mentally capable of completing reasonable normal daily activities, and,

4.71.5.2. the temporary placement of a SM within a work center can be safely accomplished without interfering with his or her treatment, MEB evaluation, or clinical or non-clinical case processing, and,

4.71.5.3. the SM's attending provider supports the decision, and,

4.71.5.4. the SM is able to wear his/her uniform (shoe waiver may be used), and,

4.71.5.5. the Patient Squadron commander is able to secure placement approval or permission to place the SM within the work center from the receiving unit commander or work center officer or NCO in charge.

4.71.6. When Hospitalization Over 90 Days is Expected. Traditionally, when an Airman's hospitalization was expected to exceed 90 days, assignment to an MTF Patient Squadron was mandatory. However, the decision to automatically reassign Airmen to Patient Squadrons sometimes created unforeseen family and/or financial hardships that complicated or worsened the patient's medical status. As more of our Airmen, especially Wounded Warriors, seek to return to their home military units following hospitalization, any official responsible for deciding whether or not to reassign an Airman to a Patient Squadron, especially at another installation, should consider each patient's unique situation. While considering the patient's wishes, the attending physician, the MTF Commander, and the Airman's unit commander shall recognize the medical needs of the patient must be regarded above all other considerations.

4.71.7. Assignment approval rests with the gaining MTF Commander (or designee). DPAMM retains the final authority to direct Patient Squadron assignments when the involved parties are unable to come to an agreement and the MTF/TRICARE network of that Patient Squadron has the necessary healthcare capability the patient requires.

4.71.8. Permanent Assignment Process: When deemed appropriate by the local MTF or HQ DPAMM that a PCS move is required, the MTF Commander of the gaining facility requests (refer to Attachment 18) the losing MPS to publish PCS or PCA orders. The losing MPS will publish orders, citing this instruction and section and the MTF Commander's message as the authority in the remarks section of the AF Form 899, Request and Authorization for Permanent Change of Station - Military. No assignment action number is required. The reporting identifier for officers is 93P0 and the number for enlisted personnel is 9P000. The official fund cite used to pay for SM travel and other related moving expenses is obtained from the servicing base accounting and finance officer. Refer to Attachment 19 for additional information regarding the assignment selection or "load" process. Other personnel requirements or actions, if applicable, may be addressed in AFMAN 36-2622, Base Level Military Personnel System User's Manual. A SM may not be assigned to the Patient Squadron if a LOD determination (formal or informal) is pending.

4.71.9. Special Circumstances.

4.71.9.1. Officers pending judicial or adverse administrative action may not be assigned to the Patient Squadron unless approved by the court martial convening authority or discharge authority.

4.71.9.2. Enlisted members pending judicial or adverse administrative actions are attached TDY or assigned PCS without PCA to the Patient Squadron unless PCA is approved by the court martial convening authority or discharge authority.

4.71.9.3. The Patient Squadron commander in each case above is required to continue the administrative or discharge action.

4.71.9.4. Officers or Enlisted in a non-Air Force MTF who meet requirements for assignment to a Patient Squadron are administratively attached to the nearest Air Force MTF Patient Squadron.

4.71.9.5. Re-assignment from Patient Squadron to Duty. Airmen assigned to the Patient Squadron should receive MEB screening under sections 4.52.-4.54. of this instruction. If, following treatment, an Airman is found to have recovered from his/her injuries or illnesses and has been medically "cleared" or deemed fully capable of returning to full duty, send a RILO to HQ AFPC/DPAMM. If the member is returned to duty, the PEBLO must send reassignment information, located on the AFPC Medical Retention Standards Branch page of the Knowledge Exchange [go to Headquarters ViewMoreOtherAFPC Medical Retention Standards] to HQ AFPC/DPAMM. **Note:** Members must meet PCS minimum "retainability" requirements.

4.71.9.5.1. When a SM is medically cleared by HQ AFPC/DPAMM, the appropriate officer or enlisted assignments department will send a message to the local MPS with assignment instructions.

4.71.9.6. Members will not be retained as hospital patients for rehabilitation in order to gain retention on active duty.

4.71.9.7. Members will not be placed in the Patient Squadron in order to preserve terminal leave or otherwise to retain a member beyond his or her date of separation or retirement without specific guidance from HQ AFPC/DPAMM. Once a member is placed on terminal leave, he or she is not permitted to change duty status without prior approval for Medical Hold or admission to a hospital for an emergency.

4.72. Veterans Administration (VA) Office. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

4.72.1. Eligibility for VA Care. Normally, members are eligible for VA benefits and healthcare if they will soon be released from Active Duty, they have a service-connected disability that was incurred while receiving basic pay or was aggravated by LOD circumstances, and they will receive any Service discharge other than dishonorable. The VA may also treat active duty members by means of inter-agency agreements.

4.72.2. Request for Bed. A VA bed may be obtained for a SM if prolonged hospitalization will be required. This request is processed through the TRANSCOM Regulating Command and Control and Evacuation System (TRAC2ES).

4.72.3. Movement of Patient. Movement to a VA bed must not occur until after the member or next of kin concurs with the PEB findings or submits a rebuttal. If movement is critical, the MTF Commander must contact HQ AFPC/DPSDS and the MTF nearest to the VA hospital where the patient is being transferred.

4.72.4. Patient Status. Active Duty SMs who must be treated at a VA Hospital before retirement are ordered PCS without PCA. The servicing MPS retains responsibility. If prolonged disability processing ensues, the member may PCA to the VA hospital, but will be assigned to the Patient Squadron of the nearest Air Force MTF.

4.72.5. Required Records. Records transmittal to include all appropriate medical records and completed VA Form 10-1204, Referral for Community Nursing.

4.72.5.1. The PEBLO will establish a positive communication link with the VA and follow patient until final Air Force disposition is made.

4.72.6. Spinal Cord Injuries. Significant spinal cord injuries should be moved to a VA spinal cord center as soon as possible, but not later than 12 days post injury. Movement of members should be via the most expeditious means of suitable convenience. Global Patient Movement Requirements Center (GPMRC) will assist. Categorize the patient as urgent or priority. Patients are then assigned or attached as described in Attachment 22 and Attachment 23.

4.73. The Recovery Care Coordinator.

4.73.1. When a SM has an injury or illness that makes return to duty unlikely, he/she is referred to a Recovery Care Coordinator (RCC). Along with other duties, the RCC is responsible for facilitating an efficient, effective and smooth transition from the initial treatment phase through recovery, rehabilitation and reintegration back into a military position or into “civilian life” as a veteran. The RCC collaborates with multidisciplinary Recovery Care Teams that include the Recovering SM’s (RSM) unit commander, medical providers and/or resources, medical and non-medical case managers, military personnel specialists, military family support specialists, VA Military Service Coordinators or liaisons, and the Federal Recovery Coordinator.

4.73.1.1. The Recovery Coordination Program is under the direction of the Under Secretary of Defense for Personnel and Readiness. The fact that RCCs are often provided office space within the MTF should not be interpreted as meaning the RCC is assigned to the Medical Group. The placement of RCCs within the MTF is a convenience for the RSM. RCCs perform services in furtherance of personnel activities, not as a function of Treatment, Payment, or Healthcare Operations (TPO) on behalf of the MTF. RCCs are not considered part of the AFMS, nor do they meet the definition of a Business Associate (BA).

4.73.1.2. Health Insurance Portability and Accountability Act (HIPAA) Training is not required for RCC personnel in Air Force facilities.

4.73.1.3. SMs may self-refer to the program, or be referred by their command or medical provider after medical screening. The MTF should establish procedures to verify the identity of Recovering Service Members participating in the Recovery Coordination Program. It is imperative that MTFs establish effective communication processes with local RCCs to ensure timely referrals of SMs who might benefit from the program’s

services. Healthcare providers and Medical Care Case Managers should be well versed with the Recovery Coordination Program and understand their role in communicating with the RCC. Conversely, RCC personnel should not be allowed unfettered access to PHI, or otherwise access/receive PHI pertaining to any individual not directly participating in the Recovery Coordination Program.

4.73.1.4. Disclosures of PHI to RCC personnel fall under the category of Required by Law, and must be properly documented in the Protected Health Information Management Tool (PHIMT) or the MTF's centralized disclosure accounting tool. The Recovering SM (RSM) does not have to give his/her authorization for disclosure of the PHI as part of the initial referral process, nor is permission required for any subsequent disclosures made throughout the duration of the RSM's participation in the program. RCC access to PHI is limited to service members participating in the RCP, therefore, no disclosure of PHI should occur beyond the service member's tenure in the program, or for those service members who decline participation in the program. As an alternative to accounting for each disclosure, MTFs may use the recurring event provision found in DoD 6025.18-R, paragraph C13.2.3 to avoid logging each disclosure. MTF Privacy Officers may obtain additional information on proper use of this provision by contacting the HIPAA Support team at AFMOA.

4.73.1.4.1. The concept of "minimum necessary" should always be appropriately applied when making disclosures. With this in mind, minimum necessary does not apply to disclosures made pursuant to "required by law", to the extent the disclosure complies with and is limited to the relevant requirements of the law.

4.73.1.4.2. As applied to the Recovery Coordination Program, DoDI 1300.24 offers no specific guidance regarding the amount or types of information RCCs require to perform their duties. This raises the potential for MTF and RCC personnel to have differing opinions. When situations such as this arise, medical personnel should discuss the issues with the RCC to determine his/her specific needs, then exercise professional judgment in the disclosure of relevant information.

4.73.2. The primary tool used for coordinating the RSM's care as well as the RSM's family care, is the Comprehensive Recovery Plan (CRP) or Comprehensive Transition Plan (CTP).

4.73.3. While the Recovery Care Team develops a recovery plan, evaluates its effectiveness, and adjusts the plan when medical or personal transition occurs, it is the RCC who makes sure the plan is complete and that it meets the RSM's and the family's needs and goals. The RCC works with the unit commander and case managers to coordinate resources identified in the plan.

4.73.4. PEBLOs should develop a solid partnership with the RCC assigned to their MTF, location, or region.

4.74. Temporary Disability Retired List.

4.74.1. Temporary disability retirement occurs when a SM is found unfit for duty, and subsequently entitled to disability retirement status, yet the SM's medical condition is not yet stable enough to ascertain whether the medical condition may improve or warrant permanent disability retirement status.

4.74.2. Title 10, U.S.C. § 1210, requires reexamination of all members on the TDRL at least every 18 months to monitor changes in the condition(s). The medical facility conducts the examination according to AFI 48-123. HQ AFPC/DPSD usually schedules the initial examination 16 months after placing the member on the TDRL so the medical facility can complete it before the end of the 18th month. Exams are scheduled at the Air Force medical facility closest to the member's home with the required capability, or the closest DoD medical facility if indicated by the member's medical condition. Extensive guidance is located in AFI 36-3212, Chapter 7. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026V1_IP.

4.74.3. Procedures for Periodic Examinations.

4.74.3.1. Approximately 60 days prior to the reporting date, HQ AFPC/DPSD will send the previous TDRL medical records and instructions to the examining facility and request a TDRL medical appointment. The MTF must respond within 10 days and provide date and time of the appointment. If the medical facility cannot conduct the examination, they must return the records within 15 days to HQ AFPC/DPSDS. The member shall provide to the examining physician, for submission to the PEB, copies of all his or her medical records (civilian, VA and all military medical records) documenting treatment since the last examination. If the member fails to report for the examination on the scheduled reporting date, the medical facility must advise HQ AFPC/DPSDS immediately.

4.74.3.2. The Commander of the examining facility or designated representative ensures the examination is completed as quickly as possible. The DoD requirement is to provide medical reports to HQ AFPC/DPSD within 30 days of examination. Ensure all laboratory studies and consultations have been completed and included in the report. Advise HQ AFPC/DPSD in writing of any delay and provide an estimated date of report completion.

4.74.3.3. If the member was mentally incompetent when last examined and there has been a change in competency since then, or if there is a question as to mental competency, the examining military facility must convene a competency board IAW AFI 48-123.

4.74.3.4. TDRL members who are imprisoned or confined by civil authorities must also have a periodic examination. HQ AFPC/DPSD requests a report of examination and a copy of the commitment order, when appropriate, from the confinement institution.

4.74.4. If a military retiree on the TDRL requires a mental competency status determination, it will be accomplished in accordance with DFAS DEM 177-373. HQ AFPC/DPSD will designate an MTF to conduct this board along with the TDRL periodic evaluation.

4.74.5. Travel and Per Diem Allowance. SMs traveling to a medical facility for examination, or to Lackland AFB TX for the formal PEB, receive travel and per diem (including meals and lodging) allowance based on their retired grade (10 U.S.C. § 1210 and JFTR volume 1, Chapter 7, Part 1). The SM is authorized an escort to accompany him or her to the place of examination only when the member is not physically or mentally able to travel without help. Approximately 20-30 days prior to the reporting date, HQ AFPC/DPSD sends travel orders to the member. The order indicates the exact date, time and place to report and includes the authority for payment of travel costs. The medical facility endorses the order to

verify whether they examined the SM as an inpatient or outpatient, as well as the dates and times the member reported and was released after completing the examination. If the examination was in outpatient status, indicate whether the member occupied government quarters. The examining facility must ensure the SM has an indorsed order to submit the claim for reimbursement. The SM submits a travel voucher to 902 CPTS/FMFC for reimbursement. Reference the Joint Federal Travel Regulation (JFTR) for further travel entitlement information.

4.75. Reserve Component and Reserve Command Surgeon or Air Surgeon. For Reserve Component (RC) personnel, the RC/SGP is the approval authority for ALC-C, Medical Hold decisions, and non-emergent surgery requests within final six months of service. Active Duty MTFs should contact the appropriate RC/SGP when confronted with these issues involving RC personnel. For Air National Guard (ANG) personnel, ANG/DP is the approval authority for ALC-C, Medical Hold, and non-emergent surgery. The ANG/SGP office will work in conjunction with ANG/DP when confronted with these issues involving ANG personnel.

4.75.1. Procedures for Reserve Component (RC) SMs. Medical Evaluation Boards for RCSMs entitled to disability evaluation processing shall be convened at Active Duty MTFs. Refer to AFI 36-3026V1_IP for further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement.

4.75.1.1. Determining Eligibility and Pre-MEB Case Processing. MEB initiation or case processing cannot begin for any RCSM without a properly completed AFRC Form 348, Informal Line of Duty Determination, AF Form 348, Line of Duty Determination, or DD Form 261, Investigation, Report of – Line of Duty and Misconduct Status. Whenever a RCSM is referred for an MEB, the PEBLO will establish contact with the medical Air Reserve Technician (ART) or Air National Guard Fulltime Point of Contact at the RCSM's supporting RCMU. For IMA personnel, the Base Individual Mobilization Augmentee Administrator (BIMAA) or RMG/IRMS will be contacted. The medical ART, Air National Guard Fulltime Point of Contact or BIMAA will assist the PEBLO in confirming the member's eligibility for medical care and provide general administrative support (for any required action specifically related to RC pre-MEB action, to include arrangements of any medical TDY). The medical ART, Air National Guard Fulltime Point of Contact, or BIMAA and PEBLO will maintain contact with the RCSM to obtain all required documents and arrange for medical TDY. The PEBLO will notify the ART, Air National Guard Fulltime Point of Contact or BIMAA prior to initiating the MEB. If the PEBLO is unable to contact the medical ART, Air National Guard Fulltime Point of Contact, or BIMAA, the PEBLO shall contact the respective RC Command level Medical Support (SG) or Aerospace Medicine (SGP) office for assistance.

4.75.1.2. Line of Duty. A completed AFRC Form 348, AF Form 348, or DD Form 261 with an "In Line of Duty" determination is required before any RCSMs can be considered for disability consideration. If the necessary LOD determination form is not in the medical records, or if the LOD determination is unclear or confusing, the RCSM will be referred to his or her supporting RC medical facility for LOD review. After entitlement to disability processing has been established, only the medical diagnoses (resulting from known actions, events, origin, or etiology) determined to be "In Line of Duty" following completion of the AFRC Form 348, AF Form 348, or DD Form 261, shall be identified on the AF Form 618 as the reason for MEB processing.

4.75.1.3. The appropriate administrative LOD representative at the RCSM's unit must contact the MMSO and inform the service office that the RCSM has been referred for MEB review. The unit LOD representative will also furnish a completed copy of the LOD report to the MMSO.

4.75.1.4. Medical Records on RCSMs undergoing MEB or RILO of MEB will be forwarded along with the MEB report, supporting documentation, and the following:

4.75.1.5. A copy of the orders or other directives placing a member in a duty status at the time of onset of illness, injury, or disease.

4.75.1.6. A completed and signed copy of the AFRC Form 348, AF Form 348, or DD Form 261, as appropriate.

4.75.1.7. Medical documentation and medical information unique to Reserve personnel.

4.75.1.8. Expedited Processing of Reserve Component Medical Evaluation Board Continuation Cases at 59th Medical Wing.

4.75.1.8.1. Reserve Component members who are injured or become ill while on US Code, Title 10 military orders are eligible for Medical Continuation (MEDCON) orders while receiving treatment for their condition. During the treatment process, it may be determined that the RCSM requires an MEB. It is at this time that the MTF historically responsible for providing the majority of medical support to the RC military unit, was generally responsible for processing the MEB.

4.75.1.8.1.1. The objective of MEDCON is to enhance utilization and readiness of personnel while preserving their health and preventing further injury or illness. MEDCON extends active duty for RCSMs when further medical evaluation is warranted, as set forth in AFI 48-123. Refer to SAF/MR Memorandum on Medical Continuation for Air Reserve Component (ARC) Members, 9 Dec 2011 for information regarding policy, responsibilities, and procedures for authorizing MEDCON orders.

4.75.1.8.2. Processing RC MEB cases can prove to be difficult at MTFs with limited direct care capabilities or limited TRICARE network medical specialty availability. In an effort to alleviate caseload build-up at the MTF due to these limitations, some select RC MEB case processing may shift from the primary MTF to the 59th Medical Wing. Medical centers, hospitals, and clinics with the necessary medical capability and available TRICARE network specialties, within a reasonable distance from the MTF, will be expected to continue the MEB process locally.

4.75.1.8.3. The criteria established for expedited processing of Medical Continuation cases at the 59th Medical Wing are as follows:

4.75.1.8.3.1. Cases identified for imminent MEB processing AAC 37 personnel status – with completed Line of Duty determination).

4.75.1.8.3.2. Medical/surgical specialty appointment(s) required either not available at the local MTF or within a reasonable one day's travel (by automobile) at a TRICARE network provider.

4.75.1.8.3.3. Mental health appointment(s) required either not available at the

local MTF or within a reasonable one day's travel (by automobile) at a TRICARE network provider.

4.75.1.8.4. Reserve Component personnel with significant medical conditions that require persistent clinical care may be attached, never assigned, to an MTF Patient Squadron during MEB processing.

4.75.1.8.5. The MTF Commander will notify the appropriate RC Command Surgeon when an MEB is required for a RC flag officer.

4.75.1.8.6. Appropriate RC/SGP:

4.75.1.8.6.1. Air Force Reservists.

HQ AFRC/SGP

135 Page Road

Robins AFB, GA 31098

4.75.1.8.6.2. Individual Mobility Augmentees (IMA)

RMG/IRMS

233 North Houston Road, Suite 131A

Warner Robins, GA 31098

4.75.1.8.6.3. Air National Guardsmen

HQ NGB/SGPF

3500 Fetchet Avenue

Joint Base Andrews MD 20762-5157

4.75.1.8.7. Air Force Reserve members not entitled to disability processing will be evaluated IAW AFI 48-123 and AFRC medical policy guidance. Air National Guard members not entitled to disability processing will be evaluated IAW AFI 48-123 and ANG medical policy guidance. For mission purposes, commanders and their designees, to include personnel offices, must receive medical information. Only the minimum necessary will be provided. If disclosures of this information have not been previously authorized by the SM, the MTF will account for the disclosures in accordance with DoD 6025.18-R.

4.76. Assignment Limitation Code-C.

4.76.1. Definition. When an active duty member has been returned to duty by the Air Force DES as fit, DPAMM will review the case to determine if an Assignment Limitation Code (ALC)-C needs to be placed in the Personnel Data System (PDS). This action is taken by the appropriate ARC/SGP when the member is an RCSM. This code restricts assignment and deployment availability to only CONUS, Alaska (Elmendorf), and Hawaii assignments, and will prevent reassignment anywhere else without prior approval by designated approval authorities described in detail further in this section. The intent of the ALC-C is to protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening medical condition and to prevent the assignment of non-

qualified personnel to overseas locations. This will further ensure the safe and effective accomplishment of the Air Force mission.

4.76.2. Authority. HQ AFPC/DPAMM retains sole authority to assign or remove the ALC-C on active duty members, while the ARC/SGP is the authority to assign or remove the ALC-C or DAC-42 for RCSMs.

4.76.2.1. DPAMM (or the appropriate ARC authority) may assign the following ALC-C codes based on risk and medical requirement. The code will be valid indefinitely, but should be reviewed or renewed at least annually unless otherwise specified by DPAMM or the ARC/SGP.

4.76.2.1.1. ALC-C1 This code will be used primarily to identify individuals with temporary or mild conditions requiring medical follow-up but whose condition is clinically quiescent or unlikely to cause serious impact if untreated or treatment is limited to primary care during periods of deployment or assignment.

4.76.2.1.2. ALC-C2 This ALC-C will be used for medical conditions for which specialist medical care and referral within one year is likely but who could be deployed or reassigned OCONUS or to non-fixed environments if appropriate specialty care is available, or for short periods of time.

4.76.2.1.3. ALC-C3 This ALC-C stratification designates members who should not be deployed or assigned away from specialty medical capability required to manage their unique medical condition.

4.76.2.2. Officials at DPAMM (or ARC/SGP) will stratify ADSMs during each annual RILO review.

4.76.2.3. Active Duty and RC medical facility Commanders are responsible for tracking and keeping Wing Commanders updated on those members of the command who are on ALC-C or DAC-42 and will assure timely medical review as specified by DPAMM or the appropriate ARC/SGP during the year indicated. Medical reviews are conducted periodically, as specified by the appropriate authority, depending on the diagnosis.

4.76.3. Requests to Allow Deployment or Overseas Assignment or deployment for Airmen with ALC-C Limitations. The ALC-C is NOT designed to limit deployment and/or overseas assignments. It is designed to ensure that members with medical conditions are assigned and/or deployed to the appropriate location where care is available. This requires that waiver coordination between the losing base and the medical waiver approval authority occur in a timely manner.

4.76.3.1. Initiation of Waiver Requests. When a SM who carries an ALC-C restriction is notified of an overseas PCS or deployment, the member's garrison MTF must initiate and process an ALC-C waiver request in an expeditious manner. The MTF may become aware of the member's selection for deployment/PCS via notification from the member, the member's commander, the MPS, Force Health Management, Medical Readiness, or other source. It is recommended that Force Health Management or equivalent point of contact in the MTF validate the possible overseas assignment with an official source (e.g., the member's unit First Sergeant or deployment manager) to avoid unnecessary

processing of waivers. The waiver review package should contain the following information:

4.76.3.1.1. The most recent RILO narrative.

4.76.3.1.2. A current AF Form 469 with all duty and deployment limitations reviewed/validated within the last 30 days.

4.76.3.1.3. The most recent medical record entry (typically from AHLTA or similar electronic system) that addresses the condition for which the SM was issued an ALC-C. If the most recent medical record entry is greater than 30 days old, the PCM will add an addendum to the most recent note updating the member's currently known clinical status, to include any specialty consults or laboratory or radiology study results since the medical record entry (copies of these results may be included). Such results should include routine maintenance testing (e.g., HgbA1C values for diabetics; the most recent Peak Flow, spirometry, and/or pulmonary function tests for asthma; etc). The PCM should include an assessment of the stability of the condition, any need for clinical follow-up or testing, and the impact of the condition upon the member's duty performance and ability to meet deployment criteria. If there have been no changes or updates of any manner, the provider may indicate this fact in the addendum. A clinical encounter with the PCM is not required, but may be accomplished within the 10-day window if the PCM feels it is indicated.

4.76.3.1.4. A memo, cover letter, or appropriate transmission that includes information on the assignment, such as projected departure date, duration of assignment, and location of assignment (with appropriate management of classified information). For example, for deployments, inclusion of the Unit Line Number (ULN) will allow the waiver authority to specifically assess the deployed assignment.

4.76.3.2. Within 10 duty days of MTF notification of the assignment, the waiver review package will be forwarded to the appropriate waiver authority. If it is determined that additional testing or evaluation is required to fully assess the SM's ability to meet the assignment requirements, the package may be delayed for an additional 10 duty days, upon approval of the SGH or SGP, in order to accomplish these clinical evaluations. However, if obtaining these additional evaluations will take longer than 20 total days from initial assignment notification, the waiver package will be sent to the waiver authority within the first 10 days of initial notification with an explanation of how long it is projected for the evaluations to be completed.

4.76.3.2.1. If the member is being followed by specialists, the most recent specialty note should also be included, if not fully detailed in the RILO. Do not delay in sending the waiver request to the waiver authority in order to update or repeat a specialty consultation, if there has been no change in the member’s condition since the last consult. If it has been determined by the PCM that the member’s condition is of questionable stability, and requires a new specialty consult in order to assess the condition, the package can be delayed up to ten (10) additional duty days before it is submitted to the waiver authority, but only with approval from the SGP or SGH. The PCM will notify the PEBLO, who will work with the TOPA office to ensure that the member’s consult for deployment clearance is expedited. Approvals for delayed (greater than 10 duty days) ALC-C waiver request submissions must be documented

in the DAWG minutes, and for any delayed waiver request, the time from initial request, to submission to the waiver approval authority, must be tracked by the DAWG. Any time submission of a waiver request exceeds 20 (twenty) duty days, the PEBLO must contact (1) the office that initiated the waiver request and (2) the SMs commander, to inform them of the delay in processing the waiver.

4.76.3.3. Waivers for Members with ALC-C1 Stratifications. All ALC-C waiver requests will be documented in the next DAWG meeting with explanations of any delays in processing. However, it is not necessary to delay processing a waiver package until the next DAWG meeting. This will allow the DAWG to monitor trends in this process.

4.76.3.3.1. ALC-C1: Deployable/Assignable to Global DoD fixed facilities with intrinsic Medical Treatment Facilities (except for the locations listed in 4.76.3.3.2), without an ALC-C waiver. For a list of "fixed MTFs", refer to the AFPC Medical Retention Standards Branch page of the AFMS Knowledge Exchange [go to Headquarters ViewMoreOtherAFPC Medical Retention Standards].

4.76.3.3.2. ALC-C1 requires a waiver for PCS, Deployment or TDY to any of our isolated or remote installations overseas, including bases at Soto Cano, Moron, Diego Garcia, Thule, Al Udeid, Izmir, etc. Lajes Field, Eielson AFB, and the installations in Korea also fall into this category; even though these bases may have "fixed MTFs," these locations are considered to be particularly remote and/or are generally considered to be "deployed" installations. Airmen with an ALC-C1 identifier require a waiver to be assigned.

4.76.3.3.3. ALC-C1 does NOT require a waiver for PCS/TDY to other "fixed bases" like those in Germany, England, Japan, Guam, or Italy, or to Elmendorf or Hickam.

4.76.3.3.4. The waiver approval authority for Airmen with ALC-C1 is usually the gaining MTF Commander (may be delegated to SGH or SGP). If no MTF is co-located, the gaining MAJCOM or COCOM command surgeon is the waiver authority. **Note:** The waiver approval authority for all PCS, Deployment and TDY to Southwest Asia is the AFCENT command surgeon's office, not the specific gaining MTF.

4.76.3.4. Waivers for Members with ALC-C2 Stratifications. Waiver authorities may approve or deny the waiver upon receipt of the initial waiver review package, or they may agree to wait for the additional clinical information. Additionally, the waiver authority may direct additional information (e.g., a new/updated RILO review by DPAMM). The MTF should make every effort to keep the member's unit (Commander, First Sergeant, or Unit Deployment Manager, for example) updated on the progress of the waiver package, particularly estimates on completion of any additional requirements of the waiver authority.

4.76.3.4.1. ALC-C2: Deployable/Assignable to CONUS installations with intrinsic fixed MTFs (TRICARE Network availability assumed) without a waiver, but requires a waiver for PCS, Deployment or TDY anywhere overseas.

4.76.3.4.2. ALC-C2 does not require a waiver for Elmendorf or Hickam Air Force Base assignments.

4.76.3.4.3. The Waiver Approval Authority for those with ALC-C2 is the gaining MAJCOM or COCOM command surgeon (may be delegated to MAJCOM/COCOM SGH or SGP).

4.76.3.5. Waivers for Members with ALC-C3 Stratifications.

4.76.3.5.1. ALC-C3: Limited to duty at specific CONUS installations, as well as Elmendorf or Hickam Air Force Bases, based on medical need. Requires a waiver for PCS, Deployment, or TDY anywhere else overseas.

4.76.3.5.2. The Waiver Approval Authority for those with ALC-C3 is HQ AFPC/DPAMM, 550 C Street West, Suite 26, Randolph AFB, TX 81150-4718 (for active duty members) or appropriate RC/SGP (for Air National Guard or Air Force Reserve Command).

4.76.3.5.2.1. Special Requirements for ALC-C3 Waiver Packages. In addition to the requirements for ALC-C waiver packages noted above in paragraph 4.76.3.2, there are special requirements for those with ALC-C3. Because ALC-C3 is assigned to Airmen with unique conditions, waivers of ALC-C3 are only granted when the benefit of deploying or assigning the member overseas outweighs the potential risks. The waiver request must be in the form of a memorandum, written or endorsed, by a General Officer, Wing Commander, or civilian equivalent, preferably from the gaining command. It should indicate that the commander is aware of the member's ALC-C, and that despite this, the SM is the best one qualified and available for the job, essential for mission accomplishment, and that the member will not be forward-deployed from the gaining location (unless another waiver is submitted). The memo must also state that care for the member's condition has been coordinated with the gaining MTF and MAJCOM/COCOM command surgeons. A corroborating statement from the gaining SG, indicating that care is available to meet the member's needs, is also required.

4.76.4. Medical Treatment Facility Action for Return to Duty with an ALC-C. The MTF will complete an AF Form 469 appropriate for the SM's current condition and C-code stratification.

4.76.4.1. ALC-C1:

4.76.4.1.1. Worldwide (mobility) qualified will be marked "YES."

4.76.4.1.2. The release date will be dashed or left blank.

4.76.4.1.3. The "Remarks" section will contain the phrase "SM has been found fit and was returned to duty with the following restrictions: Member may be assigned or deployed only to DoD facilities with fixed medical treatment facilities. Member may be assigned to a mobility position. The gaining MTF or MAJCOM SGH or SGP must approve exceptions to this restriction in writing. The appropriate RC/SGP must coordinate on all Palace Chase/Front assignment actions into the RC prior to final approval. This ALC-C must be reviewed by DPAMM periodically. Submit a RILO in _____ with specialty consultations by _____."

4.76.4.2. ALC-C2:

4.76.4.2.1. Worldwide (mobility) qualified will be marked "YES."

4.76.4.2.2. The release date will be dashed or left blank.

4.76.4.2.3. The "Remarks" section will contain the phrase "Member has been found fit and was returned to duty with the following restrictions: Member may be assigned or deployed to CONUS, (Hickam and Elmendorf included) facilities with fixed medical treatment facilities and (list specialty) treatment or referral capability. Member should not occupy a mobility position but may be deployed with approval of the gaining MAJCOM SGH or SGP. The MAJCOM or COCOM SG must approve exceptions to this restriction in writing. The appropriate ARC/SGP must coordinate on all Palace Chase/Front assignment actions into the RC prior to final approval. This ALC-C must be reviewed by DPAMM periodically. Submit a RILO in _____ with specialty consultations by _____."

4.76.4.3. ALC-C3:

4.76.4.3.1. Worldwide (mobility) qualified will be marked "NO."

4.76.4.3.2. The release date will be dashed or left blank.

4.76.4.3.3. The "Remarks" section will contain the phrase "Member has been found fit and was returned to duty with the following restrictions: Member may be assigned only to CONUS, (Hickam and Elmendorf included) facilities with fixed medical treatment facilities and (list specialty) treatment capability. Member is non-deployable and may not occupy a mobility position. Exceptions to this restriction must be approved in writing by AFPC/DPAMM. The appropriate ARC/SGP must coordinate on all Palace Chase/Front assignment actions into the RC prior to final approval. This ALC-C must be reviewed by DPAMM periodically. Submit a NARSUM in _____ with specialty consultations by _____.

4.76.4.3.4. The appropriate ARC/SGP must coordinate all Palace Chase/Front assignment actions into the RC prior to final approval.

4.76.5. Reserve Component members are placed on ALC-C or DAC-42 by the appropriate ARC/SGP. The appropriate ARC/SGP will provide profiling instructions and other guidance on AF Form 422 completion.

Section 4L—Tumor Registry Program Administration

4.77. The Tumor Registry Program.

4.77.1. All Air Force MTFs that diagnose and/or treat patients with malignancies must have a cancer program and will comply with the requirements of the American College of Surgeons' Committee (ACS) on Cancer, IAW AFI 44-110, The Cancer Program to the extent possible based on the size and services of the facility. The guidance in this chapter applies to patient administration only if the MTF is not authorized its own histopathology department.

4.77.2. At a minimum, cancer programs in MTFs must have an institutional cancer committee, a tumor registry and hold timely cancer conferences/Tumor Board meetings. Small MTFs (free-standing clinics and hospitals of fewer than 15 beds) may use the cancer

programs and the registry functions of a larger referral MTF. Establish a memorandum of agreement (MOA) or other comparable written agreement to define roles, responsibilities, and expectations between each MTF. If an agreement exists, the smaller, dependent MTF, must still continue to perform case finding and prevention activities. Additionally, when another larger MTF assumes this responsibility, the dependent MTF must continue to provide necessary coordination and support as required.

4.77.3. The Tumor Registry is the principal database for evaluating the care of cancer patients in the MTF. All MTFs that diagnose and/or treat cancer must maintain a registry. Patient Administration actions will include:

4.77.3.1. Use Automated Central Tumor Registry (ACTUR) to create and track cases.

4.77.3.2. Maintain follow-up information for the lifetime of each patient according to ACS guidelines.

4.77.4. Release of Information to Non-Air Force Tumor Registries. Refer to Section 4A on health information release procedures and requirements.

Chapter 5

HEALTH RECORDS MANAGEMENT

Section 5A—General Program Administration

5.1. Managing Health Records.

5.1.1. Health records are the property of the United States Government, not the individual beneficiary. This designated record set consists of electronic health records, outpatient records, inpatient records, extended ambulatory records (EAR), fetal monitoring strips (FMS), mental health records, dental records, obstetrical and gynecological (pre and post partum records), radiographic images and film, and any other official record or media format (physical, analog, digital, video) that provides a permanent record of a patient's medical/dental care. Maintenance of records at the MTF is required IAW this Air Force instruction. Refer to Army Regulation (AR) 40-66, Medical Record Administration and Healthcare Documentation for additional information on US Army health records maintenance. Refer to Navy Manual NAVMED P-117, Chapter 16, for additional information on health records maintenance of Navy personnel. Inform beneficiaries of this requirement through appropriate media. Initiate action to retrieve records maintained outside the MTF. Regardless of the status of the individual, if the beneficiary is enrolled to the MTF, it is mandatory that their health records will be maintained in the MTF of enrollment.

5.1.2. Management of medical records includes "assurance" which is the responsibility of administrative, clinical, and information technology staff.

5.1.3. The MTF Commander is the Custodian of Records and ensures that all health records are prepared, maintained, used, protected, and controlled as required IAW this instruction. The Commander also ensures that records and loose documents are retired or disposed of according to the Air Force Records Information Management System, (AFRIMS), and Records Disposition Schedule. Commanders must be knowledgeable concerning the control of health records and PHI, release of information from the records, and provider of care documentation requirements. Commanders ensure that these important functions are properly supported. The MTF Commander manages custody and control security assurance of paper-based and automated/electronic medical records.

5.1.4. The Dental Squadron Commander or MTF Dental Surgeon is the custodian of the dental records and is responsible to the MTF Commander for dental record management functions including custody and control security assurance of paper-based and automated/electronic medical records.

5.1.5. The RHIA/RHIT or Air Force member equivalent is responsible for the management of inpatient records to include the coding of inpatient and Ambulatory Procedure Visit (APV) records, management of medical transcription, and also provides oversight for outpatient record documentation and coding of patient encounters and professional services provided on inpatient episodes. The RHIA or RHIT works closely with the Information System Security Office (ISSO) and Privacy Officer to ensure security of and controlled access to both the paper-based and automated medical records, and to ensure release of information procedures conform to all legal requirements.

5.1.6. Healthcare providers (physicians, dentists, and other authorized healthcare providers) will include in appropriate health records, an accurate, legible, and complete description of all services rendered to patients. This description must adequately address current medical, administrative, and legal requirements. Healthcare providers will ensure that proper identification information is entered on various forms and that records are returned to the appropriate file as quickly as practical, but NLT 72 hours after treatment is rendered.

5.1.7. Records created and maintained at a joint Department of Defense/Veterans Affairs (DoD/VA) facility are shared by the two organizations. Develop local policies to ensure that the needs of both organizations are met. Records disposition instructions can be found at the AFRIMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website, the Medical Record Tracking, Retirement and Retrieval (MRTR2) System Internet website located at the AFMS Knowledge Exchange, and further along in this same section.

5.2. Documenting Health Records. Health records are completed to meet the highest possible standards of completeness, promptness, clinical pertinence, and standards of the Joint Commission and the Accreditation Association for Ambulatory Healthcare (AAAHC). Only authorized individuals make entries in the medical record using black or blue-black ink. No other annotations are authorized. Dental records are the responsibility of the base dental surgeon. See AFI 47-101, Managing Air Force Dental Services, for maintenance of dental records. For care received outside of the Direct Care System ensure that Memorandum of Understanding (MOU) and TRICARE contracts include a mechanism for obtaining documentation (i.e., summaries, operative reports, etc) to be incorporated into the individual's health record.

5.3. Correcting Health Records.

5.3.1. Patients have the right, under HIPAA, to access their health records and request amendment if they think the documentation is in error. However, there is no MTF requirement to agree to the proposed amendment. Furthermore, at no time should any documentation be removed from the record (including automated record documentation systems) unless it is determined that the documentation does not pertain to the patient in question or any one of the following two scenarios applies:

5.3.1.1. Records or PCM support staff may remove an out-dated DD Form 2766C, Adult Preventive and Chronic Care Flowsheet as long as the most current version of this form documents the latest immunization history for the patient.

5.3.1.2. Outdated or expired recommendations for special operations and/or flying status in accordance with Attachment 11 for AF Form 1042 an AF Form 1418.

5.3.2. The request to amend the record must be made in writing and be signed by the patient or guardian and filed in section 3 of AF Form 2100A or left side of AF Form 2100.

5.3.3. Reply to the requestor, in writing, within 30 days with either an acceptance or denial of the amendment. If this is not possible, a 30-day extension is allowed. However, the MTF will inform the patient, in writing, about the extension. The letter will include a reason for the delay and a date the response will be provided. Only one extension is allowed per amendment request.

5.3.4. Denial of requests is allowed if any of the following conditions are met:

5.3.4.1. The PHI is not part of a designated record set available for inspection under HIPAA.

5.3.4.2. The information requested to be amended is accurate and complete.

5.3.4.3. The MTF did not originally create the PHI requested for amendment (e.g., copies of records from treatment at another MTF or civilian facility provider). However, if the requestor can prove that the MTF that originally created the information no longer exists, the MTF will handle the request as if it had created the information.

5.3.5. Upon receipt of a request for record amendment, forward it immediately to the applicable provider for research.

5.3.6. Take the following action when an error is identified near in time to the erroneous entry date and the responsible practitioner has current memory of the circumstances.

5.3.6.1. Line through the incorrect data with one straight line. Do not erase, scratch out or otherwise destroy the original data. Amendment of erroneous data should be done by the initial provider/practitioner. If that is impractical, enter a brief explanation of why the originating provider did not make the correction. Enter the correct data next to the lined through data if space permits. Only privileged providers, authorized to document patient care, will make corrections. Each supplemental or corrected entry must be dated, signed and stamped.

5.3.6.2. If there is not enough space on the record next to the incorrect data to enter the correction, draw one straight line through the entry, initial, date and make a referral note to where in the record the correction is documented. Then enter the correction chronologically as indicated on the referral note. If the correction is not self-explanatory, also enter the reason for the correction. Provider will sign, date, and stamp the new entry. If other practitioners are associated with the patient's care and have a need-to-know concerning the change, inform them of the correction. Major changes may require documentation on a separate form (i.e., a new, blank form). Follow the same procedures stated above and file the corrected information as near as possible to the document containing the lined through information.

5.3.7. If an error is identified after a claim or lawsuit has been filed or after a substantial lapse, then the provider with personal knowledge of the erroneous data must consult Air Force legal counsel prior to correcting an erroneous entry in accordance with paragraphs 5.3.6.1. and 5.3.6.2. The provider with personal knowledge of the erroneous data should immediately notify all practitioners involved with the patient's care.

5.3.8. Patients who believe their medical records contain erroneous entries or information have several options to remedy perceived errors. Several laws and regulations, such as 5 U.S.C. § 552a and AFI 33-332, Air Force Privacy Program and AFI 36-2603, Air Force Board for Correction of Military Records, allow patients to seek relief when they believe their medical records should be amended and the MTF has denied their requests. If a patient files such a request to the Air Force Board of Correction of Military Records, SAF/MRBR, 550 C Street West, Suite 40, Randolph AFB TX 78150-4742, the MTF will take no action until contacted by the board representatives. See AFPAM 36-2607, Guide to Processing

Applications to the Air Force Board for Correction of Military Records (AFBCMR) for further guidance and AFI 36-2603 Chapter 3 for application procedures and who may apply. If there are questions regarding an amendment, contact the SJA or area MLC.

5.3.9. Legal correction of erroneous data or information in the electronic health record of a patient encounter. Since these legal corrections of erroneous data may involve sensitive situations and require Tier III Help Desk Support, TRICARE Management Activity has developed a specific process to request the legal correction of erroneous PHI. Refer to Attachment 15, Correction of AHLTA Erroneous Data or Information.

5.3.10. All provider SSNs must be redacted so as to be unreadable prior to issuing a copy of any health record (including, but not limited to, the outpatient medical, dental treatment, inpatient, ambulatory procedure visit, and extended ambulatory record). Specifically, the MTF will make an initial copy of the record(s), then within the copy, sanitize the entire SSN, and then recopy the health record(s) before releasing a copy to the requestor. This policy applies to copies for any purpose, to include individual's requesting copies of his/her own records for any reason. Original medical records should remain intact. The original providers SSN must never be deleted from the original health record.

5.4. The Electronic Health Record.

5.4.1. The Air Force Medical Service has transitioned much of its day-to-day outpatient care documentation processes into AHLTA; the DoD's approved EHR. Until we completely transition to an electronic health record, the AFMS will use a "hybrid" record consisting primarily of the EHR and including traditional paper-based records and forms to meet unique operational mission requirements.

5.4.2. The following applications are the only approved electronic health record applications authorized for use within the Air Force Medical Service:

5.4.2.1. AHLTA and CHCS – outpatient medical and dental care which is stored in the Central Data Repositories (CDR).

5.4.2.2. Essentris - inpatient medical care which is stored in the MTF Global Data Repositories (GDR).

5.4.2.3. Composite Healthcare System II-Theater (AHLTA-T).

5.4.3. Medical Systems and Applications Not Considered Part of the Official Air Force Medical System Electronic Health Record:

5.4.3.1. Acquisition, deployment, and use of other electronic health record applications, systems, or components (separate from the systems mentioned in the preceding paragraph) to temporarily or permanently document patient healthcare is prohibited unless approved by the Assistant Surgeon General, Health Care Operations, Deputy or USAF Surgeon General, or when directed by the Office of the Assistant Secretary of Defense, Health Affairs. Any non-AFMS or non-MHS standardized electronic system, application, or clinical management tool that does not provide for the permanent transferability of electronically generated or documented health information into the MHS Central Data Repository, individual or regional MTF inpatient GDR, MHS or Air Force standardized and approved data repository or database, and/or official Veteran Affairs single medical data repository, is not considered part of the official Air Force

EHR. If the clinical information and/or PHI contained therein is meant to be permanently stored or may possibly be relied upon in the future to support the delivery of healthcare, then all PHI must be immediately transferred to an approved EHR or standardized and AF/SG approved data repository or printed and filed into the patient's paper medical record.

5.4.4. MTF Commanders may require that all or some of the medical records maintained within the MTF may be filed in hard copy format, regardless of electronic record capabilities, to fulfill mission requirements and to ensure comprehensive continuity of care. MTF Commanders must be knowledgeable of health record management practices as they apply to members assigned to the following critical programs:

5.4.5. EHR Use and Documentation for Members Assigned to Sensitive Duties Programs: Service Members assigned to Sensitive Duties Programs, like the PRP, PSP, or other sensitive duty National Security program(s), may be temporarily or permanently decertified, suspended, or removed from their duty position(s) based on their medical, dental, or mental health status or the type of medications prescribed. The current DoD EHR cannot automatically provide for the mandatory notification and receipt confirmation documentation (between the MTF competent medical authority and individual unit commanders or installation operational assurance officials) of a Service Member's health status, operational capabilities/limitations, or his/her fitness for duty following each patient encounter. Because of this limitation, MTF personnel will print each patient encounter form(s) following each episode of care so that all administrative notifications regarding the patient's operational capability/reliability may be recorded (by hand) on the same document. Following notification documentation, any forms printed from the EHR will be filed into the Service Member's paper outpatient medical or dental treatment record.

5.4.6. The combination of the EHR and the paper record constitutes a complete health record for a beneficiary and both record types need to be available for inspection, review, and copying when required. Failure to maintain the paper medical record as outlined in this instruction will result in a program deficiency and may violate the Health Insurance Portability and Accountability Act of 1996, Air Force Inspection Agency and Joint Commission standards.

5.4.7. Since AHLTA is operational at all active duty military MTFs, MTF health records personnel are not required to print AHLTA patient encounter notes prior to a beneficiary's PCS reassignment, personal geographic location move, MTF reassignment, or change to TRICARE enrollment location. However, if a beneficiary is moving or PCSing to a remote location without access to AHLTA, then all historical AHLTA patient encounter notes and all laboratory and radiology CHCS results, must be printed and filed into the Service Treatment Record (STR).

5.4.7.1. Prior to any PCS reassignment, personal geographic location move, MTF reassignment, or change to TRICARE enrollment location, MTF records personnel will identify, print, and file into the patient's paper outpatient medical record, all CHCS laboratory, radiology, and/or clinical diagnostic results that have accumulated from the departure/losing MTF for each outgoing beneficiary. The losing MTF must still transfer the paper record to the gaining MTF. These procedures are required to ensure the gaining MTF has access to the beneficiary's complete health record. While laboratory and

radiology reports are usually available in AHLTA from any MTF location, printing all available laboratory and radiology reports prior to a beneficiary's MTF transfer will alleviate a portion of this burden prior to final record disposition.

5.4.8. MTF personnel must establish procedures to provide beneficiaries copies of their medical documentation from their electronic record when requested. The format of the documentation can be either paper or electronic; whichever is acceptable by the beneficiary. If the documentation is provided in electronic format, MTF personnel must ensure their facility is in compliance with the Health Insurance Portability and Accountability Act of 1996 in regards to modes of transmission to the beneficiary.

5.4.9. Documenting MTF Healthcare in AHLTA (Minimum Operational Rules).

5.4.9.1. It is a prohibited activity to enter, upload, or transfer information, documents, files, or images to the EHR that would not normally be available to patients, e.g., documentation created or governed by Quality Assurance (QA) business rules, including peer review results or any QA related information; root cause analysis or other information not normally considered part of a medical record. Information of this type will not be entered or uploaded into the CDR.

5.4.9.2. The usefulness of aggregate data sets is only as good as the individual healthcare professional's adherence to rules designed to make this database complete, secure, searchable, accessible, and accurate.

5.4.9.3. The operational processes listed herein were current at the time of this publication. Advances in technology often outpace policy development; therefore this policy guide attempts to outline rules for usage of the current technology and to clarify operating parameters when anticipated technological advances occur. This instruction also includes a transition timeline projection for moving to an electronic environment where (1) the paper record is only retrieved by exception, (2) the filing of all paper documents is eliminated, and, (3) when to "retire" or disposition paper records. The timelines includes firm policy guidance. When certain milestones are reached, a specific set of actions must occur.

5.4.9.4. The following instructions apply. The development of alternative plans independent of HQ AF/SG and/or DoD guidelines is not authorized without permission from AF/SG3. Alternative data capture and documentation methods not originally identified or engineered for permanent storage into the CDR, are not authorized without approval from AF/SG3. Any other use of technology contrary to guidance provided in this instruction must be discontinued until permission is granted for process continuation. Forward all waiver requests to the Chief, Health Benefits Branch, Air Force Medical Support Agency (AFMSA/SG3SA). Exceptions must clearly state why the facility cannot change to an approved methodology. Waiver requests will be considered with a global or Service-wide standardization impact perspective.

5.4.9.5. Every Air Force MTF will use AHLTA to document outpatient patient care. AHLTA also supports a dental record module. However, by the date of this publication, the AHLTA dental module was not yet deployed to every DTF. All outpatient MTF entries (except Emergency Department entries) must be entered into AHLTA. Use of structured text within AHLTA is highly encouraged. As other automated methods of

entry become available, these processes will likely be authorized following analysis by AF/SG3. Clinical data collection and document "template" use is encouraged, using AHLTA capabilities to leverage documentation technique.

5.4.9.6. Printing AHLTA Information and Encounters. Printing and filing of patient encounters stored in AHLTA is not required in most cases. Electronic signature capability eliminated the need to print and sign documents created in AHLTA. Any automated clinical encounters, results, or notes that a provider feels a patient would need or benefit from, by obtaining a printed paper copy, are authorized to be printed during a patient visit and handed to the patient.

5.4.9.6.1. Notable Exceptions:

a. Health Record Retirement or Disposition. Until further notice or until an automated solution is identified that provides for the secure and reliable transfer or disposition of stored AHLTA medical information from the MTF to either the National Personnel Records Center or to the Department of Veteran Affairs, MTF records personnel (including dental clinic staff) are required to print all of the electronic AHLTA information (e.g., patient encounter notes, Clinical Notes section entries, telephone consultations, referral management/consultation results, etc.) and file into the patient's paper dental and/or outpatient medical record before physically mailing the record(s) to the appropriate disposition center.

b. Health Records for Service Members Assigned to Sensitive Duties. See paragraph 5.4.5.

c. Reserve Component Health Records. Many RCMUs still do not have access to CHCS or AHLTA. For this reason, following each completely closed and properly coded patient encounter, the patient encounter note should be printed, filed, or forwarded to the MTF or medical unit normally responsible for maintaining the RCSM's health records. If a local written agreement is in place which delineates health record documentation and transfer requirements and expectations, the local agreement may be used (if current and documented in the MTF) as a suitable exception to this rule.

5.4.9.7. Electronic/Digital File Types and Files Size. Use ONLY the following electronic file types when capturing documents, files, or images into an AHLTA patient encounter note: TXT, RTF, HTML, TIF, JPG, BMP, and DOC. **Note:** PDF files cannot be directly uploaded into AHLTA; however, the information contained within a .PDF file may be copied and pasted into the "Add Note" using the Adobe Reader Snapshot tool. Imported documents, files, or images will not exceed 500kb.

5.4.9.8. Placement of Scanned/Uploaded/Imported Documents, Files, and Images into AHLTA.

5.4.9.8.1. Within a Patient Encounter **Note:** A scanned document, file, or image may be uploaded or imbedded into an AHLTA patient encounter note, provided the document or image is a) is directly related to the current patient encounter, b) will not delay the coding of the patient encounter note, and c) can be uploaded into the patient encounter note before the provider electronically signs the encounter. By signing the encounter, the provider is acknowledging that the scanned/uploaded image or document was acceptable for its intended purpose.

5.4.9.8.1.1. Appending a patient encounter note after the note is Closed/Signed.

If the document cannot be imbedded into the note before the provider electronically signs, or if an image is captured, or scanned and uploaded in support of a previous episode of care, the document or image should be "appended" to the desired note. This action will generate an automatic notification to the provider/user that created the original encounter note. The notification mechanism lets the original creator know that someone has “appended” his or her original patient encounter note. Appending a previously closed encounter with an uploaded image will not change the original encounter information. Appended patient encounter notes must also be electronically signed by the user adding the additional image or document. Appending a note is a permanent action and cannot be reversed. Appended documentation is not searchable. Without prior knowledge that a specific encounter note has been appended with an image, subsequent users may have significant difficulty finding the appended image or they may not even know of its existence.

5.4.9.8.2. Within Clinical Notes or as a “Stand-Alone” Document. The practice of creating, importing, or uploading scanned documents and images into AHLTA (not directly imbedded within a patient encounter note), is not authorized without approval from AFMSA/SG3SA. In the future, managing the capability to create, import, or upload, stand-alone scanned documents should be accomplished through the HAIMS application.

5.4.9.8.3. Alternative Methods to Capture Consults and Referral Results. AHLTA is not to be used for volume storage of TRICARE network consultation report or referral results storage without approval from AFMSA/SG3SA. An optional method that allows temporary data collection, storage, authorized user viewing, and data sharing of electronic copies of consultation reports and referral results received from civilian medical providers, is identified below.

a. MTFs are authorized to use a local, secure, shared computer server or data storage device, to temporarily store consultation reports and referral results received from civilian medical providers and specialists.

b. Electronic copies of consultation reports or referral results received, scanned, and imported into AHLTA, from external MTF providers (for which no authorized waiver has been approved by AFMSA/SG3SA that allows importing and/or uploading of reports or results into AHLTA) must be destroyed no later than 30 days following electronic file copy creation date (e.g., the date the document is imported into AHLTA).

c. There is no limitation (unless prescribed locally) to specific file size or type (in the MTF shared computer server).

d. The MTF is required to create specific processes and business rules to a) ensure the referring provider has access to the temporary electronically stored consultation report or referral results and is aware that said electronic document(s), file(s), or image(s), will only be available for viewing 30 days following the creation of the electronic copy, and b) processes are in place to ensure the original consultation report or referral result(s) are filed in the patient’s paper outpatient medical record.

e. The official government e-mail transfer of consultation reports and referral results aka PHI is

authorized as long as the message(s) is digitally signed and encrypted. Access to shared MTF computer folders and files, containing PHI, must be limited to users who can demonstrate a verifiable need for access. Shared computer folders and files must offer limited user access and password protection. Once a Data at Rest solution is deployed, PHI on shared drives must be encrypted in accordance with security standards.

5.4.9.9. Filing Documents into the Paper Health Record Following Scanning and Uploading into AHLTA. Until potential future document filing policies allow, any paper document, normally required to be filed into either the paper outpatient medical or dental treatment record, which has been scanned and the electronic copy uploaded into AHLTA (not including documents created in AHLTA), must also be filed into the outpatient medical or dental treatment record according to standard filing requirements. If a particular type of paper document is regularly reviewed and signed (by hand) by a provider, before filing into the outpatient medical or dental treatment record, the same document must still be signed (by hand) no matter if the document was scanned and uploaded into AHLTA. EXCEPTION: Hard copy civilian provider referral or consultation results received by the Referral Management Center and captured into AHLTA (and electronically signed by the referring provider or surrogate) are not required to be hand signed or "wet" signed by the referring provider. These same documents are not required to be filed into the patient's outpatient medical record.

5.4.9.10. Scanning Entire Paper Health Records for Importing or Uploading into AHLTA or other Secure Database.

5.4.9.10.1. The practice of scanning entire original paper health records for permanent storage, importing, or uploading into AHLTA or other secure database is prohibited. Mass or multiple record scanning initiatives intended to electronically copy entire health records, for any reason other than preservation of weather or fire damaged paper records, or Release of Information programs (copies for beneficiaries) are prohibited. This practice has been analyzed and deemed too costly and provides no significant value to providers during their day-to-day operations.

5.4.9.11. Scanning in Lieu of Paper Copies. The practice of scanning original health records in lieu of copying (for MTFs that offer this option) is authorized, as long as:

5.4.9.11.1. Digital or electronic memory compact or read-writable discs or storage media are marked with the following statement, "This electronic storage media may contain information covered under the Privacy Act, 5 U.S.C. § 552(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions."

5.4.9.11.2. Scanned documents, files, and images are not stored on any local computer, MTF computer hard drive or shared network drive or folder. Scanned images and documents must be deleted from all computer, copier, and scanner hard drives, or the computer drives or memory devices within these machines are secured from unauthorized access at all times.

5.4.9.11.3. Digital or electronic memory compact or read-writable discs or storage media are not accidentally or purposefully included with paper health records and

forwarded to the National Personnel Records Center (NPRC) or to the Veteran Affairs Records Management Center via approved Air Force health records disposition intermediary.

5.4.9.12. Electronic signatures on forms and documents. Handwritten ("wet") signatures and initials are not required on printouts of electronic forms and documents created by the following systems: CHCS, AHLTA, AHLTA-T, Essentris, and TRICARE Online. Electronic signatures and initials in these systems are equivalent to full handwritten signatures and initials.

5.4.9.13. Retrieving Outpatient Medical Records by Exception: The MTF Commander, with the recommendations from the Executive Committee of the Medical Staff (ECOMS) and Health Records Committee, may approve a "retrieve or pull records by exception" rule for paper outpatient medical records and suspend or discontinue the routine delivery of paper medical records to some or all providers in the requested work center(s). The decision to stop or suspend the practice of retrieving or pulling outpatient medical or dental treatment records must be carefully considered. Only after addressing the following minimum questions should a requesting work center, clinic, specialty group, or FHE team submit a request to the ECOMS function.

5.4.9.13.1. Have procedures been developed to validate the beneficiary's acknowledgement of the MHS Notice of Privacy Practices? Refer to paragraph 6.5. for additional information and requirements.

5.4.9.13.2. How will the requesting clinic identify patients with chronic conditions? Some providers prefer to quickly review the outpatient medical record or dental treatment record of patient with a chronic condition.

5.4.9.13.3. If a provider needs a paper record on a specific patient during treatment, how will the clinic ensure the patient's health record can be quickly obtained and delivered to the requesting provider?

5.4.9.13.4. How will the transition from the traditional health record "pull all" to "pull by exception" MTF business rule affect the requesting work center's record availability rate?

5.4.9.13.5. With recommendation from the Health Records Management Committee, medical record retrieval variations may exist within an MTF that require specific clinics to retrieve/receive the paper outpatient or dental treatment record in addition to accessing AHLTA. This requirement should be reviewed annually (at a minimum) in order to ensure that resources required to manage records are used to the best advantage of overall operations.

5.4.9.14. "Historic Scanning by Exception." If a provider identifies a document, file, or image (significant or absolutely critical to support patient care) from any portion of the patient's paper outpatient medical or dental treatment record and if said document, file, or image is to be scanned and uploaded into AHLTA for regular future reference, then the document, file, or image may be scanned and uploaded into the EHR. Following scanning, the original source document, file, or image must be re-filed into the paper health record. The provider should then determine whether the historic data is specific to the episode of care, and if so then imbed or upload to the current patient encounter note

without delaying the coding process, or if the document, file, or image should be scanned and uploaded into the AHLTA Clinical Notes section as an independent, "stand-alone" document. However, the practice of capturing electronic documents, files, and images in the AHLTA Clinical Notes section is only authorized when, 1) the capability to "lock-in" an absolutely critical uploaded document or image via an electronic signature mechanism is available, and 2) only after approval from AFMSA/SG3SA has been granted.

5.4.10. Healthcare Artifact and Image Management Solution (HAIMS). HAIMS is a Military Health System (MHS) strategic project that will enhance medical informatics through seamless integration of medical digital images into the EHR. The objective of HAIMS is to give healthcare providers global awareness and access to essential healthcare artifacts and images (A&I) throughout the continuum of care from Theater to the Sustaining Base to the Department of Veterans Affairs (VA). The HAIMS will provide a single enterprise-wide image sharing capability for all types of A&I, including radiographs, photographs, wave forms, audio files, video files and scanned documents.

5.5. Electronically-Generated Forms (EF).

5.5.1. Use only the AF-approved forms package. Word processing packages are directly forbidden because there is no method of locking the form so that it cannot be changed by the user, see AFI 33-360 Publications and Forms Management. Most Air Force (AF), Standard (SF) and Optional Forms (OP) can be obtained from the Air Force e-Publishing website at: **http://www.e-publishing.af.mil**. Additionally, DoD Forms may be retrieved at the Department of Defense site: **http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm**. Both websites have links to Standard, Optional, DoD, and other federal agency electronic forms.

5.5.2. The only exception to the policy in 5.5.1. is forms for which AFMOA/SGAT has identified standard data elements.

5.5.3. For these forms, the standard elements are required but mirror imaging of the paper form is no longer required. Additional data elements that would change the meaning of the form cannot be added. Standard patient information is required on these forms.

5.5.3.1. Patient information blocks on outpatient forms will include the following elements. Under Patient Information, include Name (last, first, middle), Sponsors SSN, Patient FMP, Sex, Date of Birth, Rank/Grade, Department/Service Where Records Maintained, and Relationship to Sponsor. Under Sponsor Information, include Name (last, first, middle) and SSN/Identification Number. Under Facility Information, include Name of MTF.

5.5.3.2. Patient information blocks on inpatient forms will include the following elements. Under Patient Information, include Name (last, first, middle), Patient FMP/Sponsors SSN, Sex, Date of Birth, Rank/Grade, Department/Service Where Records Maintained, Relationship to Sponsor, Register Number, and Ward Number. Under Sponsor Information, include Name (last, first, middle) and SSN/Identification Number. Under Facility Information, include Name of MTF.

5.5.4. To date, the forms for which standard data elements have been identified for the body of the form are: SF 93, SF 505, SF 506, SF 509, SF 526, SF 551, SF 558, SF 559, SF 600,

and OF 523B. Contact AFMOA/SGAT for a list of the identified standard data elements for these and any subsequent forms for which standard data elements have been identified.

5.5.5. Optional Form (OF) 275, Medical Record Report, may be used in lieu of Standard forms, Air Force forms and DoD forms. OF 275, if used, must indicate the form number and title of the form being replaced. Information entered on the form must include all of the same information as the form it represents. File the OF 275 in the same location as the form it replaces. This form is not to be used for the creation of local forms.

5.5.6. If an MTF desires to create a local form in lieu of a form that already exists, a waiver must be requested from AFMOA/SGAT.

5.5.7. In an effort to reduce the unnecessary use of SSNs, DoD has begun the use of alternative Personal Identifiers in place of the SSN. The alternative Personal Identifiers include the DoD Identification (ID) Number which uniquely identifies individuals and the DoD Benefits Number that identifies individuals eligible to receive DoD benefits such as commissary, exchange, and TRICARE benefits. According to the MHS Interim SSN Reduction Plan, 17 Oct 2011, the Military Health System, when feasible, will limit the use and display of SSNs while migrating systems and business processes to use the DoD ID Number.

5.5.7.1. Local MTF forms must be reviewed for the necessity of SSN use. MTFs are encouraged to use DoD ID Numbers in place of SSNs on local forms. To locate SSNs, MTFs may obtain the SSN from General Inquiry of DEERS (GIQD) Web Application by cross matching the DoD ID Number on the ID card or form with the DoD ID Number in the system. If the MTF determines the continued use of the SSN on a local form is necessary, the MTF must comply with the justification procedures set forth in AFI 33-332, Air Force Privacy Program.

5.6. Overprinting of Forms. Overprints do not change the information collected on a form and are authorized IAW DoD 7750.07-M, DoD Forms Management Program Procedures Manual and AFI 33-360. The specific overprint must be a) approved by the local body responsible for the medical record review function, b) recorded in the minutes of that body, and c) approved by the MTF Commander. Follow instructions in AFI 33-360 concerning inclusion of the name of your organization followed by "overprint" in the lower right margin of the form; for example, 579 MDG Overprint. This waiver concerns overprinting only and does not grant authority to reprint existing Standard Forms at the local level. The list of Air Force forms authorized for overprint follows:

5.6.1. AF Form 230, Request for Patient Transfer.

5.6.2. AF Form 250, Health Record Charge Out Request.

5.6.3. AF Form 560, Authorization and Treatment Statement.

5.6.4. AF Form 565, Record of Inpatient Treatment.

5.6.5. AF Form 569, Patient's Absence Record.

5.6.6. AF Form 570, Notification of Patient's Medical Status.

5.6.7. AF Form 577, Patient's Clearance Record.

5.6.8. AF Form 2700L, Health Record Year Grid.

5.6.9. AF Form 745, Sensitive Duties Program Record Identifier.

5.6.10. AF Form 1403, Roster of Seriously Ill/Very Seriously Ill.

5.6.11. AF Form 1942, Clinic Index.

5.6.12. AF Form 1976, Hematology.

5.6.13. AF Form 3066, Doctor's Orders (multiple copy format).

5.6.14. AF Form 3066-1, Doctor's Orders (cut sheet format).

5.7. Medical and Dental Treatment Record Disposition/Retirement Procedures. The following sections contains guidance regarding the proper disposition, also known at transfer or retirement of outpatient medical and dental records to the Department of Veterans Affairs (DVA) via the Air Force Personnel Center (AFPC), Central Records Disposition Center, National Personnel Records Center (NPRC), Civilian Personnel Office (CPO) or to a RCMU.

5.7.1. Service Treatment Records (STR) Disposition Process for Retiring, Separating, and Transitioning Airmen from the Active to the Reserve Component. Until necessary data communication links are permanently established between both the military and DVA electronic health record systems, MTF records personnel will print and file (into the patient's paper record) any and all available ancillary, diagnostic or clinical information electronically stored in standardized Military Health System or local MTF electronic health record systems prior to final records retirement processing and shipment. This rule applies to both military and family member health records.

5.7.1.1. The transition from paper-based health treatment records to electronic health records is progressing satisfactorily. However, as caretakers of the paper medical and dental records we still use, we must do all we can to guarantee this health information is properly maintained, tracked, stored, and transferred or "dispositioned."

5.7.1.2. Historically, MTF and Reserve Component (Air National Guard and Air Force Reserve) medical unit health records managers routinely forwarded the STR (the combination of outpatient medical and dental treatment records) for retiring and separating Airmen to the local installation MPS prior to an Airman's final out-processing appointment. Following the MPS retirement and/or separation out-processing appointment, MPS officials packaged and shipped the records to the Department of Veterans Affairs (DVA) Records Management Center (RMC) in St. Louis, MO, or to the regional DVA office responsible for processing the Airman's disability evaluation claim. Unfortunately, this process produced a number of process problems for DVA and the Principal Deputy Under Secretary of Defense for Personnel and Readiness (PDUSD (P&R)) directed the Services to institute management systems to ensure timely and accurate disposition of STRs to the DVA.

5.7.1.3. In late 2008, officials from the Air Force Personnel Center (AFPC) and the Air Force Medical Support Agency (AFMSA) created a new STR disposition process. This new process mandated that all Active Duty (AD) Air Force MTFs and Reserve Component (RC) medical units begin mailing STRs for retiring and separating Airmen (with a separation or retirement date effective 1 Jan 09 and thereafter) to the new AFPC Records Disposition Center at Randolph AFB, TX, instead of forwarding records to the installation MPS or individual unit Commander's Support Staff (CSS) offices. This new

centralized mailing requirement streamlines the STR disposition process by improving the accuracy and speed in which STRs are provided to the DVA as well as prevent misplaced records.

5.7.1.4. Total Force Applicability: This STR disposition policy applies equally to the Active Duty (AD) and RC. Although the following language specifically mentions MTF responsibilities and expectations, the guidance also applies to Air Force Reserve (AFR), Air National Guard (ANG) medical units, and organizations responsible for the day-to-day maintenance and storage of Reserve Component STRs. The AFPC Records Disposition Center at Randolph AFB, TX is the only Air Force records disposition unit authorized to forward AD and RC STRs to the DVA. MTFs and RCMUs are not authorized to mail records directly to the DVA.

5.7.1.5. All MTF and DTF records management personnel are expected to apply the following directions to their STR disposition plan. MTF records managers and supervisors are encouraged to work closely with their DTF counterparts and local MPS, Military Personnel Element (MPE), Military Personnel Squadron (MPS), or Force Support Squadron (FSS) officials to make this transition as smooth as possible.

5.7.1.6. Incorporate the following STR disposition instructions into all standard MTF, DTF, and RCMU service treatment records disposition instructions for retiring, separating, discharging, and transitioning members.

5.7.1.7. AFPC Retirement/Separation Notification Roster (aka LOSS Roster).

5.7.1.7.1. In order to streamline the process and standardize LOSS Rosters acquisition procedures, an Air Force Knowledge Now - USAF/SG Community of Practice (CoP) website was created so MTF, DTF, and RCMU records managers and installation personnelists could easily obtain this time sensitive information. The retirements/separations LOSS rosters were simultaneously posted to the SG and Personnel CoPs.

5.7.1.7.2. Personnel LOSS rosters include a listing of all projected retiring and separating AD and retiring and discharging RCSMs (including geographically separated unit (GSU) personnel). The Loss Roster was further refined in June 2009 to include Airmen scheduled for separation and retirement during the applicable retirement/separation action month. Additionally, the roster was updated to reflect those Airmen who retired or separated during a previous month and AFPC has not received a complete STR. The “Q” column on the LOSS roster indicates records which have still not been received by AFPC. These records will remain on the roster until AFPC receives the records.

5.7.1.7.3. Identified MTF, DTF, and RCMU personnel must obtain the LOSS roster from the AF/SG CoP each month. The local MPS, which has access to the Loss Rosters via the AFPC Field Operations CoP, will continue to provide support in the case of short-notice changes and any other questions which might arise. These LOSS rosters contain protected personnel information and the CoP will contain all rosters for all facilities. Therefore, access to the page will be restricted to only those individuals who require access to perform STR disposition duties.

5.7.1.7.4. Each MTF or RCMU is authorized one primary and four alternate points of contact (POCs). (Recommendation – include the dental records manager and the TOPA or Patient Administration element chief or flight commander as alternates.) A sample (template) is available on the AF/SG CoP and the AFMOA Health Benefits KX page. The roster is in Excel format and can be downloaded, saved and distributed locally as the MTF, DTF, or RCMU deem necessary. However, given the Personally Identifiable Information (PII) included on the spreadsheet, access must be limited to only those with a need to know. E-mail messages containing PII must be digitally signed and encrypted.

5.7.1.7.5. At MTFs with decentralized medical record filing rooms, the TRICARE Operations and Patient Administration office are responsible for distributing the LOSS rosters to each record room.

5.7.1.7.6. Use the following guidance to select and identify the responsible MTF, DTF, and RCMU personnel:

a. POCs must be appointed in writing.

b. The appointment letter must include the reason for request and must be signed by the squadron commander.

c. Address appointment letters to AFMOA/SGAT and either fax or e-mail the document. Contact AFMOA/SGAT for the latest fax telephone number. E-mail requests to: afmoa.sgat@us.af.mil.

d. Once the appointment letter is submitted and approved, the POCs must request access to the Medical Record Management section of the SG CoP at https://afkm.wpafb.af.mil/ASPs/CoP/EntryCoP.asp?Filter=OO-SG-AF-90.

5.7.1.7.7. The LOSS rosters are located in the main folder "Medical Record Rosters," and then in the sub-folder for the applicable month. The folders correspond with the month the roster was run. For example, the September 2010 roster is located in the "Sep 10" folder which reflects the September 2010 losses, even though the majority are not "actionable" until October (30-35 calendar days post- DOS).

5.7.1.7.8. Each roster in the CoP is listed separately by base. A few bases have Guard or Reserve units assigned in addition to the AD MTF. These bases will appear to be listed more than once. The first 2 digits of the PAS Code determine the applicability of the roster. Generally, AD PAS codes are two ALPHA characters. For instance, McConnell AFB could appear three times: McConnell (D6); McConnell (MK); and McConnell (R2). The MTF roster is identified by (MK), the Guard roster is identified by (D6) and the Reserve unit is identified by (R2).

5.7.1.7.9. Some of the larger facilities have more than one MPS providing services at their base. Military MTFs and RCMUs will also need to know the two-digit PAS Code for each of those MPS/GSUs for which they provide care/maintain records.

5.7.1.7.9.1. PAS Codes can be obtained from the AFPC secure web site at: **https://w20.afpc.randolph.af.mil/AFPCSecureNet20/PKI/MainMenu1.aspx**. After accessing the site, click "OK," then "PASS CODES." The PAS codes are also located on the AF/SG CoP in the Departure Rosters folder.

5.7.1.7.10. For questions regarding which roster to obtain, contact your local Force Support Squadron, or your AFMOA Health Benefits regional representative for assistance.

5.7.1.7.11. Facilities have a window of opportunity when records should be mailed to AFPC. The LOSS roster contains two columns for shipment dates, "Not Earlier Than" and "Not Later Than." The "Not Earlier Than" date is 30 days after the member's date of retirement/separation (DOS) and the "Not Later Than" date is 35 days after the member's date of retirement or separation. Medical records personnel at all Air Force MTFs and RCMUs must mail a retiring/separating member's STR to AFPC no earlier than 30 days past the DOS and no later than 35 days past the DOS.

5.7.1.7.12. Geographically Separated Units (GSUs): When the GSU member separates/retires; his name will appear on the LOSS roster of the MTF serviced by the MPS to which the member is assigned. However, STRs for retiring and separating Air Force service members assigned to remote units or GSUs are frequently maintained at the installation MTF located nearest to the GSU site. If the Airman is enrolled to a TRICARE network Primary Care Manager (PCM), his civilian medical documents are maintained at the network PCM office.

5.7.1.7.13. OCONUS Based Member Retiring/Separating: Based on AFPC guidance, retiring/separating members assigned OCONUS are directly retired/separated by the OCONUS MPS; members are no longer PCS'd to CONUS for retirement/separation processing. However, even if a retiring/separating member based at an OCONUS MTF returns stateside just for the purpose of retiring/separating, the OCONUS MTF STR Loss roster will normally reflect the member as retiring/separating and it is the OCONUS MTF's responsibility to ensure the STR is appropriately processed to AFPC.

5.7.1.7.14. Air Force Reserve Rosters: Each month, AF Reserve MPSs provide the servicing Reserve Medical Unit (RMU) a listing of all assigned Airmen serviced by the installation MPS, including geographically separated unit (GSU) personnel with a 60-day projected retirement, discharge, or transition to inactive status date. The RMU has the option of using the Reserve MPS list or downloading the AFPC retirement/discharge roster (LOSS Roster) from the AF/SG CoP. **Note:** the rosters used to compute metrics reside on the AF/SG CoP. It is highly recommended that RC staff pull the roster from the CoP to ensure all records are sent.

5.7.1.7.15. Air National Guard Rosters: Guard medical units will download the AFPC retirement/discharge roster (LOSS Roster) from the AF/SG CoP.

5.7.1.8. Retirement/Separation/Transition Orders.

5.7.1.8.1. Active Duty Personnel.

5.7.1.8.1.1. Member Responsibilities.

a. Retiring/Separating Airmen are required to report to the central MTF health records customer service location and the installation DTF with their retirement orders no later than five days prior to the member's final out-processing appointment. The member is required to provide four copies of their retirement orders (or, in the case of separations, the AF Form 100, Request and

Authorization for Separation); two for the MTF and two for the DTF records departments.

b. Airmen transitioning from the AD to the RC are required to report to the central MTF health records customer service location with their service transition order, PCS order, or Active Duty separation order no later than five days prior to the member's final out-processing appointment. The member is required to provide two copies of the service transition order, PCS order, or Active Duty separation order. (Specific rules regarding the disposition or the transfer of STRs for Airmen transitioning from the Active to the Reserve or Guard Component are identified later in this same section).

5.7.1.8.1.2. MTF/DTF Responsibilities:

a. The MTF and DTF will each place one copy of the orders in the member's outpatient medical and dental treatment records. (Placement Location 1) Outpatient medical record - Section II on top of all other pages; (Placement Location 2) Dental treatment record - Inside right-side folder section.

b. The second copy of the orders will be placed into a plastic AF Form 885-887 series, Medical Record Charge-Out Guide and filed in place of the record. It is also recommended to include a reference to where the record is located (transitory file) until the record is mailed.

c. Missing Orders: If, after contacting the MPS or accessing the Virtual MPS, a copy of the orders cannot be obtained, draft a memorandum (on squadron letter head stationary) and indicate this inability to obtain the orders and place in the Airman's outpatient medical and dental records. Include in the memorandum the name and number of the MPS POC who was contacted. Verifying or checking with the MPS is required to ensure the Service Member did not re-enlist or extend his or her enlistment. The applicable squadron commander or flight commander responsible for the operational day-to-day maintenance and storage of said records must sign the memorandum. (The signature block must reflect the job title of the person signing). See Attachment 14 for a sample missing order memorandum template. The example template is also available on the AF/SG CoP.

d. Active Duty Virtual MPS Checklist Confirmation. Historically, only the MTF Force Health Management (FHM) staff had access to the Virtual MPS. In May 2010, AFPC directed all MPSs to authorize MTF and DTF Records Rooms access. MTF health records offices have been added as mandatory out-processing checklist destinations for each outbound Service Member. Although the FHM may have additional medical out-processing checklist approval authority or obligations, they should not "sign off" or approve any outpatient medical or dental treatment record out-processing tasks on a Service Member's Virtual MPS out-processing checklist. Outpatient medical and dental records managers and FHM officials will work together to ensure each outbound Airmen has fulfilled all of his or her MTF out-processing responsibilities.

e. Checklist Operation: Multiple (at least two) staff members assigned to MTF and DTF records departments be granted Virtual MPS Checklist access to ensure each departing Service Member is informed of the requirement to provide the MTF and DTF with copies of his/her orders at the time of MTF/DTF out-processing. Access will also allow MTF records managers to obtain and print individual retirement/separation orders when necessary. Once added to the process or granted access to the Virtual MPS system, records managers can forecast the timeframe when separating and/or retiring Airmen will visit the MTF and DTF to out-process. MTF and DTF records managers may also be able to add special notes to the Virtual out-processing checklists

to inform out-processing Airmen to obtain a copy of their STR no earlier than 179 calendar days and no later than 30 days prior to the date of their final separation or retirement date.

5.7.1.8.2. Air Force Reserve Personnel. Each month, the servicing Reserve MPS will provide the servicing RMU a copy of the retirement/discharge/transition orders or AF Form 1288, Request for Ready Reserve for all assigned Airmen serviced by the installation MPS, including geographically separated unit (GSU) personnel with a 60-day projected retirement, discharge, or transition to inactive status date.

5.7.1.8.3. Air National Guard Personnel. Guard members receive their retirement/discharge orders from the Retirements/Separations department of the MPS located at their ANG Wing. These retirement/separation orders should be received at the monthly UTA (Unit Training Assembly) immediately preceding the final service obligation date.

5.7.1.9. The VA Claim.

5.7.1.9.1. During the Airman's out-processing visit to the MTF records department, records managers are required to ascertain whether or not the Airman plans to file a disability claim with the DVA.

5.7.1.9.2. If the member has already completed the online DVA claim application (VA Form 21-526), place this form in the member's outpatient medical record.

5.7.1.9.3. If the member indicates he intends to file a claim, and if the state DVA regional disability claims office is known, annotate the office location and address on the Memorandum for Retiring/separating Members Intent to File DVA Claim (Attachment 28). **Note:** this form is not mandatory/not used when determining records disposition completion metrics. This form is helpful when the record gets to AFPC for forwarding purposes. If the member doesn't intend to file a claim immediately, completion of the form is not necessary.

5.7.1.10. Making Copies of Outpatient Medical and Dental Records.

5.7.1.10.1. For the Active Duty Service Member:

5.7.1.10.1.1. Separating and retiring Airmen may request one complete copy of their STR no earlier than 179 calendar days and no later than 30 calendar days prior to the date of their final out-processing appointment. Only one copy is authorized. The goal is to have one complete STR copy ready for the separating or retiring Airman by the time of his final MTF/DTF out-processing appointment. The copy can be provided as a hard-copy record or in electronic or digital media format, whichever the member requests. **Note:** This copy is for the member's personal use, not for the VA as they require the record in hard-copy format. Ensure patient understands they are only authorized one complete copy free of charge. They will not receive another copy (free of charge) if they give their copy to the VA.

5.7.1.10.1.2. Copy requests should be fulfilled no later than 30 calendar days from the date of copy request receipt. Thirty days is a reasonable period of time to complete the copy request. Copy requests submitted within 30 days of the Service Member's separation or discharge out-processing appointment will likely

burden the office responsible for providing the copy. Records managers must use all available resources within their means to ensure separating and retiring Airmen understand the importance of submitting their STR copy requests as early as possible. The volume of electronic patient encounter documents generated from MTF or DTF visits that fall within the 30-day cut-off copy request date through the Airman's MTF/DTF out-processing date are usually not that significant. These few documents should be reasonably easy to identify and print from AHLTA or CHCS "on the spot" or copy from the paper outpatient medical or dental records and added to the copy package or provided to the member at the time of out-processing.

5.7.1.10.1.3. MTF records manager are expected to notify the Transition Assistance Program (TAP) of the member's right to one copy of their record upon separation or retirement. MTF records personnel will ensure local installation TAP officials are aware each AD Airman enrolled in TAP class may receive a copy of their STR no earlier than 179 calendar days, but not later than 30 calendar days prior to their final retirement or separation date. Patients requesting copies after their STR has already been mailed can request them from the VA directly by calling the VA Customer Service Center (1-800-827-1000).

5.7.1.10.2. For the Reserve Component Service Member:

5.7.1.10.2.1. Separating and discharging RCSMs may request one complete copy of their STR no earlier than 179 calendar days and no later than 90 calendar days prior to the date of their final out-processing appointment. Only one copy is authorized. The goal is to have one complete STR copy ready for the retiring or discharging Airman by the completion of his/her final medical unit out-processing appointment.

5.7.1.10.2.2. Requests for copies should be fulfilled no later than 90 calendar days from the date of the copy request receipt. Typically, RCMUs are not regularly staffed as well as full-time AD MTFs. Consequently, opportunities to make copies for retiring or discharging members may be diminished, sometimes limited to only drill weekends. Ninety calendar days is a reasonable period of time to complete the copy request. However, copy requests submitted within 90 calendar days of the service member's retirement or discharge out-processing appointment will likely burden the office responsible for providing the copy. Records managers must use all available resources within their means to ensure RC retiring and discharging Airmen understand to submit their STR copy requests as early as possible. The volume of electronic patient encounter documents generated from MTF, DTF or RCMU visits that fall within the period from the 90-day cut-off copy request date through the Airman's MTF, DTF or RCMU out-processing date should not be that significant. These few documents should be reasonably easy to identify and print from AHLTA or CHCS "on the spot" or copy from the paper outpatient medical or dental records and added to the copy package or provided to the member at the time of out-processing.

5.7.1.10.2.3. Some RCMUs do not have access to AHLTA and/or CHCS. For those RCMUs without AHLTA or CHCS access, records managers are required to

contact the AD USAF support MTF to obtain copies of all AHLTA/CHCS encounters, ancillary laboratory and radiology results. Provide a copy of the Service Member's pharmacy prescription medication history only upon specific request.

5.7.1.10.2.4. Although the TAP program may not be available for many RC Airmen, RC unit commanders, first sergeants, personnelists, and medics are encouraged to inform retiring or discharging RC Airmen of the necessity to obtain a complete copy of their STR as soon as possible.

5.7.1.11. STR Composition (Documents to Copy): Generally, the STR includes traditional paper outpatient medical and dental documents stored in the outpatient medical and dental records as well as ancillary laboratory, radiology reports stored and PRINTED from the CHCS as well as outpatient patient encounter notes and any other PHI reports, data, or information stored and PRINTED from AHLTA. Copies of clinical narrative summaries and operation reports from previous inpatient, ambulatory procedure visits (APV), and/or MEB actions should already be filed in Part I or III of the member's outpatient record. However, MTF records managers or Release of Information (ROI) staff will verify that any narrative summaries and/or operation reports generated from past inpatient, APV or MEB actions completed at the same MTF responsible for the STR disposition, are included in the paper outpatient medical record. Provide a copy of the Service Member's pharmacy prescription medication history upon specific request.

5.7.1.11.1. Patient encounter notes, radiology procedures, and laboratory test results electronically stored in AHLTA and/or CHCS are expected to be printed and added to the respective outpatient medical or dental record prior to copy generation and/or forwarding the STR to the AFPC disposition center. If MTF records personnel do not have access to necessary AHLTA or CHCS systems to identify and print patient encounters, radiology reports, and laboratory reports, then the patient's PCM support staff is expected to complete this requirement and forward the documents to the MTF outpatient medical and/or dental departments for inclusion into the STR.

5.7.1.11.2. To ensure reasonable continuity of care and or DVA disability evaluation/consideration, documents generated from civilian healthcare providers, stored in any MTF health record, are included in the STR. Examples include:

a. Reports and documents received from civilian referral healthcare providers.

b. Reports and documents from TRICARE Prime and TRICARE Prime Remote civilian network providers. When a service member assigned to a remote unit or GSU is enrolled to a TRICARE network PCM, his civilian documents are owned and maintained at the network civilian PCM office. At the time of the separating or retiring Airman's MTF, DTF or RCMU records department out-processing appointment, each Airman enrolled to a TRICARE civilian PCM should complete an authorization to obtain healthcare information from the civilian PCM and/or any civilian healthcare provider. These documents should be forwarded to the MTF where the STR is maintained so that ROI staff can make the patient a copy, then include these civilian documents into the STR. MTF records managers are expected to communicate this process to separating and retiring Airmen attending TAP class so "last minute" civilian PCM requests do not delay STR disposition.

5.7.1.12. Providing Copies for the Benefits Delivery at Discharge (BDD) Program:

5.7.1.12.1. The BDD Program is a joint initiative between the DVA and the DoD. This program enables DVA representatives to help transitioning Airmen assemble and prepare their disability claim packages for DVA disability compensation and benefits review prior to their service separation or retirement. The original STR is not provided to the BDD office. Instead, the MTF will provide the member with a paper copy of the STR at the member's request. The BDD office will only accept a paper record copy at this time. **Note:** this copy is counted as the member's one complete copy free of charge.

5.7.1.13. Collecting and Preparing STRs for Shipment:

See Attachment 29 for an example of the Active Duty STR Disposition Flow Chart and Attachments 30 and 31 for STR Disposition Process Checklists.

5.7.1.13.1. Once the LOSS rosters are obtained, retrieve the applicable outpatient medical records and place them in a staging area separate from the main file located within a secure, limited access room. File the STRs in chronological order according to the Loss Roster shipment date. This will help ensure the STRs are mailed to AFPC by the deadline (i.e., no earlier than 30 days after and no later than 35 days after the member's final date of separation).

5.7.1.13.2. No later than 20 calendar days after the Airman's date of separation, MTF and DTF records personnel will ensure the dental treatment records for each separating and retiring Airman are forwarded to a central MTF location where they will be bundled with the outpatient medical record and staged until ready for mailing to AFPC. **Note:** The outpatient medical and dental records for each Airman must be "bundled" together before shipping to the AFPC Records Disposition Center. DO NOT MAIL THE OUTPATIENT AND DENTAL RECORDS SEPARATELY.

5.7.1.13.3. Missing Records: With the DoD-wide implementation of AHLTA, almost all Active Duty Service Members (ADSM) have patient medical encounters documented electronically. If after an exhaustive MTF-wide search either the original paper outpatient medical or original dental record(s) cannot be located, there will likely still be at least a few electronically stored AHLTA patient medical encounter documents. In this scenario, MTF records managers are required to locate and print the AHLTA patient medical encounter documents and file in a new outpatient medical record jacket. The record jacket should be labeled "Volume II" and a record of the new volume must be documented in the CHCS MRT module. Records managers must flag the original paper record volume as "missing" in the same CHCS MRT module. The process of identifying and printing AHLTA dental patient encounter information and filing the printed documents in a new dental record jacket is required for all DTFs with operational AHLTA dental modules. A Letter of Non-Availability must be included in the STR package for the missing original volume.

5.7.1.13.4. Non-Availability Statement for Missing Original Paper Records:

5.7.1.13.4.1. If after due diligence, to include contacting the patient's previous MTF, either the original paper dental or original paper outpatient medical

record(s) are missing and absolutely cannot be located, then include in the bundled package, a Letter of Non-Availability indicating one or more original records are missing. A template for the Letter of Non-Availability is available on the AF/SG CoP. See Attachment 32 for the authorized format. **Note:** Two letters of Non-Availability will not clear the STR from the missing roster. DVA will not accept two letters of Non-Availability for one individual.

5.7.1.13.4.2. The Squadron Commander or Flight Commander responsible for the operational day-to-day maintenance and storage of the dental and/or outpatient medical records, as applicable, must wet sign the letter of Non-Availability. (The signature block must reflect the job title of the person signing.) Signature delegation is not authorized. The ANG is authorized to delegate a SNCO to wet sign a letter of Non-Availability.

5.7.1.13.4.3. **Note:** MTF records managers are required to print all patient encounters from AHLTA and add to the existing outpatient and/or dental treatment record at the time of the Airman's separation or retirement. If either the original outpatient medical or dental records are missing, create a new AF Form 2100A series record and add the printed documents to the paper record aka record jacket. Since this new jacket constitutes another record volume, MTF records personnel must create another medical volume in the CHCS MRT menu and record the transfer to the AFPC Records Disposition Center just as they would for the original record. The Letter of Non-Availability must be completed to reflect that the original paper record volume is missing.

5.7.1.13.5. Air Force Members Empanelled to Other-Service MTFs: STRs for active duty service members (ADSMs) are normally maintained at the MTF where the member receives his primary care, regardless of service affiliation. The health record management officials at the Air Force MTF located nearest to the member's Other-Service PCM/MTF location should establish a local STR Support Agreement (see Attachment 33 for example) with the Other-Service MTF. As this is DoD Policy, MOU verbiage should include both service processes. The agreement should identify how the STRs will be transferred from the Other-Service MTF. How this is accomplished is jointly decided by the MTFs, but acceptable methods include:

5.7.1.13.5.1. The Other-Service MTF may mail the STR to the nearest AF MTF for subsequent mailing to AFPC.

5.7.1.13.5.2. The Other-Service MTF may forward the STR directly to AFPC if they do so using the instructions outlined in this document. Include a copy of the STR disposition instructions with the agreement if this method is chosen.

5.7.1.13.5.3. There may be instances when the member is assigned to a Geographically Separated Unit (GSU) and the responsible Air Force MTF is not the nearest MTF to the member's Other-Service PCM/MTF location. In these cares, see rules for managing GSU records in the passages that follow.

5.7.1.13.6. Non-Air Force Service Members Empanelled to Air Force MTFs:

5.7.1.13.6.1. Service Treatment Records for non-AF service members are normally maintained at the AF MTF when the member is empanelled to the AF

MTF. Unless there is a local STR Support Agreement stating otherwise, STRs for Other-Service members should be mailed to the applicable address included in Attachment 34. If a local STR Support Agreement is established with another Service, the agreement should identify how the STR will be transferred to the applicable Service. DO NOT FORWARD HEALTH RECORDS FOR UNIFORMED SERVICE MEMBERS OTHER THAN AIR FORCE SERVICE MEMBERS TO THE AFPC RECORDS DISPOSITION CENTER. FORWARD AIR FORCE STRs ONLY.

5.7.1.13.7. Personnel Assigned to Geographically Separated Units:

5.7.1.13.7.1. If the MTF identified on the Loss Roster is not the MTF that maintains the retiring/separating member's STR, the Loss-Roster-named MTF must coordinate with the MTF where the record is regularly maintained in order to ensure the STRs are mailed to AFPC or RCMU by the deadline. (**Note:** Names and numbers of POCs at each Air Force MTF are located on the AF/SG CoP in the "COLLABORATE" section.)

5.7.1.13.7.2. Once contacted, the MTF maintaining the STR mails the STR to AFPC in accordance with this guidance with one exception -- the shipment container must be labeled with the return address for the Loss-Roster named MTF to ensure AFPC recognizes and correctly annotates receipt of the STR.

5.7.1.14. Packaging and Shipping STRs:

5.7.1.14.1. Items Included in STR "Bundles:"

5.7.1.14.2. Outpatient medical record and/or Letter of Non-Availability.

5.7.1.14.3. IMPORTANT! Include all patient encounter notes, telephone encounter notes, clinical summaries, clinical reports, consultation or referral results, radiology procedures, laboratory tests, and (only upon specific request for pharmacy medication histories) i.e., all PHI electronically stored in the EHR. This information is expected to be printed and added to the respective outpatient medical or dental treatment record regardless of the inability to locate the original paper health record(s).

5.7.1.14.4. Dental record and/or Letter of Non-Availability.

5.7.1.14.5. IMPORTANT! If the DTF has access to the new AHLTA Dental Module and original dental records cannot be located, DTF records managers are expected to include electronically stored AHLTA dental patient encounters.

5.7.1.14.5.1. Include a copy of the retirement/separation or discharge order in each record or memo regarding missing orders: (Placement Location 1) Outpatient medical record - Section II on top of all other pages; (Placement Location 2) Dental treatment record - Inside right-side folder section.

5.7.1.14.6. Include the DVA claim application (VA Form 21-526) or Memorandum for Retiring/Separating or Discharging Service Members Intent to File DVA Claim (if applicable).

5.7.1.15. Items Included in Shipment Boxes:

5.7.1.15.1. STR Bundles by chronological shipment date as identified by the DOS on the Loss Roster and/or orders.

5.7.1.15.2. AF Form 330, Records Transmittal Request (example at Attachment 24) in each shipped box. (This form is used to inform the recipients of the type of records being mailed and the purpose of the shipment.) In the "Name" box of the AF Form 330 type "SEE ATTACHED ROSTER" and staple the roster to the AF Form 330.

5.7.1.15.3. Include a copy of the LOSS roster - The downloaded LOSS roster has 3 additional columns on the right-hand side titled, "Date Record Mailed," "Remarks," and "NCOIC Signature." The NCOIC or records department supervisor must sign off the roster stating they have quality checked or "QC'd" the shipment, annotate the mailing date, and annotate any remarks needed. This is a communication tool for the MTF to AFPC. Do NOT type a separate inventory).

5.7.1.15.3.1. Due to the size of the LOSS roster, when printing - only certain columns are required to be included. The following columns are required. All other columns can be "hidden" prior to printing.

a. SSN.

b. Name.

c. DOS.

d. Medical Records (Yes/No).

e. Dental Records (Yes/No).

f. Date Record Mailed.

g. Remarks.

h. NCOIC Signature.

5.7.1.15.4. **Note:** MTF records management personnel are required to keep a copy of the AF Form 330 and LOSS roster permanently or until the Office of the Undersecretary of Defense for Personnel and Readiness (OUSD (P&R)) and the Services establish a disposition rule for active duty records. Place together with the postage tracking/arrival confirmation notice in a central location within the Outpatient Records department.

5.7.1.16. Shipment Containers:

5.7.1.16.1. Boxes - Records personnel are required to use standard white record retirement boxes or other same-sized box, purchased specifically for shipping. The maximum weight per shipping box is 50 pounds. Do not bundle standard shipping boxes within larger containers for shipment as the AFPC mailroom will not accept large or heavy packages or containers. MTF records personnel will ensure boxes are thoroughly and securely packed, labeled, and taped for shipping so as to prevent inadvertent opening during shipment and subsequent loss of STRs or delays in arriving at destination.

5.7.1.16.2. Envelopes – If the STR 'bundle" will easily fit into an envelope, one may be used. Ensure it is securely packed, labeled, and taped for shipping so as to prevent

inadvertent opening during shipment and subsequent loss of STRs or delays in arriving at destination.

5.7.1.17. Shipping STRs:

5.7.1.17.1. STRs will be mailed to AFPC no earlier than 30 calendar days and no later than 35 calendar days after the member's date of retirement/separation/discharge or transition to inactive status. It is highly recommended that OCONUS MTFs not using commercially available global delivery services mail the STR on the "No Earlier Than Date" to prevent the STR from arriving late at the AFPC Records Disposition Center.

5.7.1.17.2. DO NOT MAIL A MEMBER'S OUTPATIENT AND DENTAL RECORDS SEPARATELY; they must be mailed together as a "bundle."

5.7.1.17.3. STR "bundles" of outpatient and dental records for more than one individual may be combined into one shipment box provided the destination is to the same location.

5.7.1.18. Preferred Mailing Method:

5.7.1.18.1. Forward STR boxes to the AFPC Records Disposition Center using standard first class mail, certified mail, or other available commercially available option, e.g., FedEx.

5.7.1.18.2. If standard first class United States Postal Service (USPS) is used, return receipt confirmation or shipment via Certified Mail is required. These services are typically available via the Base Information Transfer System (BITS) or the Base Information Transfer Center (BITC) at each major installation.

5.7.1.18.3. Commercial priority mailing services are usually offered through the MTF mailroom.

5.7.1.18.4. Records personnel are required to keep postage tracking/arrival confirmation notice permanently or until the OUSD(P&R) and the Services establish a disposition rule for active duty records. Place together with the AF Form 330 and Loss roster in a central location within the Outpatient Records department.

5.7.1.19. Mailing Locations: There are only three STR mailing destination options:

a. The AFPC Central Cell,

b. The Airman's gaining Air Force Reserve or Air National Guard medical unit, or;

c. The Readiness Management Group for Airmen transitioning from the Active Component to the Participating Individual Ready Reserves (PIRR).

Note: MTFs are prohibited from mailing STRs or any medical or dental documents directly to the DVA.

5.7.1.19.1. For AD and RCSMs who are retiring, separating, discharging, or transitioning to inactive status, mail STRs to the AFPC Records Disposition Center at:

HQ AFPC/DPSIR

ATTENTION: Medical Records Central Cell

550 C STREET W, SUITE 21

RANDOLPH AFB TX 78150

5.7.1.19.2. For Airman Transitioning from the Active Duty to Reserve Component, mail the STR to the member's gaining RCMU listed on the LOSS Roster and/or the member's separation and/or service component transition orders. If the location of the medical unit is not on the orders, access the AF/SG CoP for the list of addresses. **Note:** MTF records managers are prohibited from mailing health records for these service members to the DVA.

5.7.1.19.3. For service members transitioning from AD to the Participating Individual Ready Reserves (PIRR), mail STRs to the Readiness Management Group (RMG) at Warner Robins, Georgia at the following address:

RMG/SG

233 N Houston Road, Suite 131A

Warner Robins, GA 31093

5.7.1.19.3.1. MTF records personnel are required to place a copy of the service transition orders or AF Form 1288 in the outpatient medical and dental records.

5.7.1.19.3.2. Annotate the LOSS roster stating where the STR was mailed and why.

5.7.1.20. MRT Transition in CHCS. Each time a record is mailed to AFPC, RCMU, or the RMG, the action must be documented in the CHCS MRT function. Health records personnel will TRANSFER the record in the CHCS MRT menu to the appropriate location.

5.7.1.21. Handling Clarification Queries from AFPC: AFPC queries for clarification on STRs (e.g., requests for missing documents) must receive immediate MTF record management action as AFPC only has a 5-day window from time of STR receipt to ship it to the VA.

5.7.1.21.1. Track AFPC queries and their outcome in a local database. The method is left up to the MTF and could include an electronic spreadsheet, simple ledger, or other method.

5.7.1.21.2. By AFPC/AFMS agreement, the MTF and/or DTF records managers have only two duty days from receipt of the AFPC inquiry to investigate and provide a response. DELAYED RESPONSES TO AFPC REQUIRE IMMEDIATE EXPLANATION TO AFMOA/SGAT.

5.7.1.21.3. The MTF/DTF may be contacted by phone or e-mail. MTF/DTF records managers may contact officials at AFPC via telephone (210) 565-1497 or DSN 665-1497 or return e-mail with the results of the inquiry, whether or not the record or missing item was found and when it will be sent to AFPC. Annotate the results in the computer spreadsheet or ledger book.

5.7.1.22. Managing Loose, Late-Flowing, or "Orphaned" Medical Documents Following STR Shipment. "Loose, late-flowing, or orphaned" medical documents are those medical or dental documents discovered in the MTF or DTF after the STR has already been mailed to AFPC or the departing member's guard or reserve medical unit. This may still occur even though the MTF/DTF holds the STRs until at least 30 calendar days after the member's date of separation to allow time for the majority of loose documents to be filed into the record.

5.7.1.22.1. After an Airman's paper STR is mailed to AFPC, to a RCMU, or to the RMG, late/loose flowing documents must be filed into the charge-out guide containing the member's retirement or separation orders.

5.7.1.22.2. Remove the charge-out guide after 90 calendar days from the date of the mailing of the original STR, during the normal monthly purge.

5.7.1.22.3. If there are no documents found in the charge-out guide, remove it from file location and destroy the remaining retirement or separation order.

5.7.1.22.4. If there are loose, late flowing documents found, then file these documents inside of a new AF Form 2100A series Outpatient Health Record or AF Form 2100 B-series Dental Health Record "jacket." Ensure each information box on the medical record cover or jacket is properly addressed and completed. The AFPC Records Disposition Center may return records that are not identified properly. Ensure there is a minimum of 10 pages in the new jacket. Print and file the most recent AHLTA patient encounter notes if needed to ensure the record is at least 10 pages.

5.7.1.22.4.1. Obtain the remaining retirement or separation order from the charge-out guide and file in Section II of the AF Form 2100A series record (ensure it is on top of all other documents) or in the AF Form 2100B series record on the right side of the jacket.

5.7.1.22.4.2. Write or stamp the appropriate volume number on the outside of the record jacket, e.g., "VOLUME 2 of 2 or VOLUME 3 of 3" in one-inch block print or stamp.

5.7.1.22.4.3. Since this new jacket constitutes another medical record volume, MTF records personnel must create another medical record volume in the CHCS MRT menu to satisfy inventory and tracking purposes.

5.7.1.22.4.4. Immediately after creating the new volume entry in CHCS, records personnel must either select or create a standardized transfer/disposition entry for AFPC matching the original STR disposition action, or they must select or create a transfer/disposition entry for the destination location from the CHCS MRT transfer record menu location listing.

5.7.1.22.4.5. If a CHCS Label cannot be printed with the correct 20 FMP/SSN, hand-writing the data in the patient ID area is acceptable.

5.7.1.22.4.6. Add the supplemental record jacket to the next shipment box bound for AFPC, the destination RCMU, or the RMG. Ensure the name and SSN for any supplemental STRs appear on the AF Form 330 inventory list. Identify on

the inventory list the original STR was previously mailed to AFPC and include the date mailed.

5.7.1.23. Pre 1 Jan 09 Medical and Dental Records/Loose Documents Processing:

5.7.1.23.1. The following guidance applies only to records and "loose, late flowing" medical documents collected for Airmen who separated/retired before 1 Jan 09. This is a temporary program for AFPC based on available Air Force Reservist man-days. The program will terminate when man-days expire. Due to limited space and storage capabilities at AFPC, Pre-Jan 09 STRs are being sent in phased shipments. MTFs must wait their turn to ship – all unauthorized shipments will be returned.

5.7.1.23.2. MTF records personnel are required to temporarily stage the outpatient and dental records together in a central records storage location, separate from the main MTF file or records room. Ensure the following steps are taken:

5.7.1.23.3. File all loose documents (including printed AHLTA and CHCS patient encounters and reports) in an appropriate AF Form 2100A or 2100B series record jacket.

5.7.1.23.4. If the original outpatient medical or the dental treatment record is not available, include a Letter of Non-Availability for the missing original record(s). Ensure the letter is wet signed by the Squadron Commander or Flight Commander responsible for the operational day-to-day maintenance and storage of the dental and outpatient medical records, as applicable. (The signature block must reflect the job title of the person signing).

5.7.1.23.5. Complete an AF Form 330 along with an inventory list. (See Attachment 36 for the list of required items).

5.7.1.23.6. If obtainable, include a copy of the member's retirement, separation or discharge orders in both the medical and dental record.

5.7.1.23.7. If orders are not obtainable, indicate this fact on the inventory list attached to the AF Form 330.

5.7.1.23.8. Additionally, annotate the AF Form 330 with the following statement, "An extensive search was accomplished to locate retirement, separation, or discharge orders for all included records. However, we were not able to obtain orders for item XX (number) identified in the attached inventory list."

5.7.1.23.9. AFPC queries for clarification on STRs (e.g., requests for missing documents) must receive immediate record management action. Follow the instructions in paragraph 5.9.1.21.

5.7.1.23.10. Maintain the records in the central records storage location until directed by AFMOA/SGAT to mail them to the AFPC Health Treatment Records Research Management Team. DO NOT MAIL THESE RECORDS UNTIL DIRECTED TO DO SO BY AFMOA. AFPC provides the Shipment Authorization Numbers.

5.7.1.23.11. DO NOT MAIL THE RECORDS TO THE AFPC CENTRAL DISPOSITION CENTER. Instead, use the following address for these pre-Jan 09 STRs:

HQ AFPC/DPSIR

ATTENTION: Research Section

550 C STREET W SUITE 21

RANDOLPH AFB TX 78150

5.7.1.23.12. If directly requested by a DVA office for records that fall within this category (i.e., pre-January 2009 retirement, separation, or discharge records) the MTF may release the STR (original outpatient medical and dental records) to the DVA requestor. Medical records staffs will document this transfer in the CHCS MRT module.

5.7.1.24. Active Duty and Reserve Component records disposition rules are subject to frequent changes. For the latest information, contact the Records Management Support Team, AFMOA/SGAT (Health Benefits) via e-mail at **afmoa.sgat@us.af.mil.**

5.7.2. Sequestered/Deceased Member's Records. In the event an STR is sequestered for legal reasons or has already been provided to the installation Casualty or Mortuary Affairs office in the event of an Active Duty or RCSM's death, MTF records managers must annotate "SEQUESTERED" in the COMMENTS column next to the Airman's name on the LOSS Roster. Records managers will include the LOSS Roster in the next-outbound shipment to AFPC. A Letter of Non-Availability is also required for each sequestered record not available at time of shipment.

5.7.2.1. Service Treatment Records for Service Members Killed in Action: Applies to STRs of ADSMs killed in action during combat operations from a deployed theater of operations. Immediately following an ADSM's death at an overseas battle zone or theater of operations, the on-site Casualty or Mortuary Affairs office is authorized to take possession of the remains and prepare the body for transport to the Dover AFB Port Mortuary Facility as soon as medical actions are complete. Available paper health treatment documents and records must be surrendered to the Mortuary Affairs/Casualty Affairs representative(s) upon request. Document the records transfer using the appropriate electronic records tracking mechanism.

5.7.2.2. If outpatient medical or dental treatment records are discovered (at a location not specifically identified as the ADSM's home-of-station support MTF), after the body has been transported to the Dover AFB Port Mortuary Facility, contact the nearest Casualty or Mortuary Affairs unit responsible for arranging transportation of the remains. If medical and/or dental records cannot be transferred to the nearest Casualty or Mortuary Affairs office, forward the medical record(s) to the MTF responsible for the regular maintenance and storage of the deceased member's record. Contact the deceased Airman's deployed unit chain of command or Personnel Support for Contingency Operations (PERSCO) unit to ascertain from which installation the Airman deployed. In the records package, include a completed AF Form 330, Records Transmittal/Request, DD Form 2138 Request for Transfer of Outpatient or other appropriate form or letter that informs the receiving MTF that, a) the ADSM has died, and b) informs the receiving MTF the health records they received were intentionally forwarded.

5.7.2.3. Home Station MTF Service Treatment Records Disposition Responsibility: If notified by an official agency or unit (e.g., unit commander or chain of command representative, installation Command Post, Mortuary or Casualty Affairs) that an ADSM was killed in action while deployed, remove the deceased Service Member's outpatient medical and dental records from the main file and contact the installation Casualty or Mortuary Affairs office. Print all AHLTA and CHCS patient encounter information and place inside the paper STR. Provide the STR to the Casualty or Mortuary Affairs office upon request. If the STR is not requested by the Casualty or Mortuary Affairs office or Air Force Institute of Pathology, forward the STR to the AFPC Records Disposition Center according to processes identified earlier within this section, no later than 30 days following notification of the service member's death. The AFPC Records Disposition Center will forward the STR to the DVA. Surviving family members may be eligible for Service or DVA death benefits or compensation. The deceased Airman's STR may be required as part of the DVA death benefits or compensation evaluation. If, at any time, while preparing to ship the STR to AFPC, the installation Mortuary or Casualty Affairs unit, or Air Force Institute of Pathology specifically requests the outpatient medical or dental records for official purposes, provide the STR and document the transaction in the CHCS MRT module. Provide a Letter of Non-Availability to the AFPC Records Disposition Center to indicate where the STR was mailed.

5.7.3. Service Members Placed in Appellate Review Leave Status or When a Prisoner is Transported to a Correctional Detention Facility Immediately Following a Trial.

5.7.3.1. Appellate Review Leave. Under the Uniform Code of Military Justice (UCMJ), a punitive service discharge or dismissal may not be executed until the appellate review is completed. During this appellate process, Service Members are still entitled to active duty healthcare benefits and are required to remain enrolled in TRICARE Prime. The appellate process can sometimes be quite lengthy and requires the Service Member to be placed on an involuntary excess leave status called "Appellate Review Leave." The following guidance provides instruction on how to manage the enrollment and medical records of members on appellate leave status.

5.7.3.2. Service members subject to appellate review may relocate and reside anywhere within the Continental United States, to meet unique administrative and personnel accountability requirements, Service Members placed on appellate review leave are assigned to the HQ Air Force Security Forces Center (AFSFC), Lackland AFB, TX.

5.7.3.3. While on appellate leave, the service member must remain enrolled in TRICARE Prime and be enrolled to an MTF. If the service member relocates to another area, the servicing MTF must brief the member on the processes required for obtaining health care for themselves and any dependents prior to departure. Service members on appellate leave cannot enroll into TRICARE Prime Remote or choose a civilian PCM. In accordance with HA Policy letter dated 08 Nov 06, enrollment of ADSM in Appellate Leave Status, the service member may choose to enroll at an MTF closer to their new residence.

5.7.3.4. Following the conclusion of all punitive discharge processing, punitive legal proceedings, or general court martial trial, unless otherwise required by law, court order, or urgent medical necessity, the service member's STR will be forwarded (in a sealed

envelope) to the 59th Medical Wing at Lackland AFB, TX where it [STR] will be maintained until the appellate review period has completed.

5.7.3.5. If the Service Member is available to complete MTF out-processing actions, obtain or reproduce two copies of the individual's discharge orders and follow the steps identified below.

5.7.3.6. Place one copy in a charge-out guide.

5.7.3.7. Locate and retrieve the Service Member's outpatient medical record.

5.7.3.8. Print all applicable AHLTA patient encounters and CHCS ancillary report data and file into the paper outpatient medical record.

5.7.3.9. Place the second copy of the discharge orders inside the record and file the document in Section II on top of all other medical documents.

5.7.3.10. Locate and retrieve the dental treatment record – bundle together with the Outpatient Medical Record.

5.7.3.11. Properly TRANSFER/INACTIVATE the medical records in the CHCS Medical Records Tracking menu. Select "APPELATE LEAVE" or create another easily identifiable records location destination that clearly distinguishes these types of medical records from medical records transferred to the 59 MDW under routine PCS transfer rules. See the MRTR2 User Guide to learn how to create or set-up new records borrower/destination locations.

5.7.3.12. Place the complete STR in shipping package.

5.7.3.13. Prepare, complete, and sign an AF Form 330 and insert the form into the package. Keep a copy of the AF Form 330.

5.7.3.14. No later than three days following the start of the appellate review period, mail the complete STR and AF Form 330 to the address identified below via U.S. Postal Service (USPS) Certified Mail or other commercially available shipping process that assures real-time package tracking and/or arrival confirmation receipt. Use of standard First Class USPS mailing method alone, without immediate delivery confirmation/acknowledgment or certified mail receipt, is prohibited. Return receipt confirmation must not be dependent upon the timeliness or willingness of the destination MTF to complete a DD Form 2825, Internal Receipt, or other manual delivery confirmation receipt option.

59th Medical Wing

Wilford Hall Ambulatory Surgical Center

ATTENTION: Outpatient Medical Records Dept.

2200 Bergquist Drive, Suite 1

Lackland AFB TX 78236-9908

5.7.3.15. Upon completion of the appellate review, if the Service Member is officially and permanently discharged from the Service, his/her name will appear on the installation personnel "LOSS" roster for Lackland AFB. The records department at the 59 MDW is

responsible for forwarding the original STR to the AFPC disposition center at Randolph AFB. The original STR will not be forwarded to the correctional detention facility. Records personnel at the 59 MDW may provide a complete STR copy to the correctional detention facility or provide a complete STR copy to the prisoner escort detail responsible for transporting the prisoner to the correctional detention facility (in instances when the individual has not already been sent to prison). If the case is overturned during the appeal process and the Service Member is returned to Active Duty status, the 59 MDW will transfer the original STR to the Service Member's previous assignment support MTF or to another MTF based upon AFPC direction. Medical records personnel will not release or forward the STR to anyone, any place, or any agency without obtaining written direction or orders.

5.7.3.16. Prisoners Transported to a Correctional Detention Facility Immediately Following Court Martial Trial. Following the court's Ruling and/or Sentencing, a Service Member may be immediately escorted to a correctional detention facility. The appellate review period will occur while the prisoner is confined.

5.7.3.17. During the appellate review period, even if a Service Member is immediately transported to a correctional facility, the MTF where the Service Member's STR is normally maintained is responsible for forwarding the original STR to the 59th Medical Wing in accordance with the instructions (associated with appellate review record disposition) previously identified in this section.

5.7.3.18. Records personnel at the Service Member's support MTF are prohibited from providing the original STR to any prisoner escort detail. Instead, provide the escort detail with a complete STR copy. If a copy cannot be immediately provided, a copy will be mailed to the destination military correctional facility within five duty days. Copies of STRs may be mailed to state and federal prisons upon proper request. If available, obtain a copy of the Service Member's orders or court confinement order from the prisoner escort detail.

5.7.3.19. Address questions concerning this program to the Records Management Support Team, AFMOA/SGAT (Health Benefits) at **afmoa.sgat@us.af.mil.**

5.7.4. USAF Academy Cadets and Airmen with Less than 180 days of Continued Service: Applies to members of the US Air Force Academy and all other Air Force recruits separated or discharged prior to accruing 179 days or less days of military service. Forward STRs for these two beneficiary categories to the Central Records Disposition Center at Randolph AFB, TX. Follow the same STR disposition instructions as identified for AD and RCSMs identified earlier in this instruction. Place a copy of the separation or retirement order or personnel document ordering the separation, discharge, or retirement inside the STR.

5.7.5. NATO Military Personnel and NATO Family Member Outpatient Records. Deliver outpatient records of NATO military personnel and their family members in a sealed envelope to the individual concerned upon transfer to another US military base. Upon return of personnel to the NATO country, transfer records to the specific national military medical authority. Contact AFMOA/SGAT to obtain the list of NATO medical command authorities by country. The list is also located on the AF/SG CoP in the Departure Rosters folder.

5.7.6. Non-NATO Foreign Military Personnel Outpatient Records. Retire outpatient records for non-NATO foreign military personnel to NPRC 2 years after the end of the calendar year of the last date of treatment, IAW AFRIMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website and the Medical Record Tracking, Retirement and Retrieval (MRTR2) System located at the AFMS KX Knowledge Exchange, Patient Administration website.

5.7.7. Non-military (including Uniformed Service Family Member Health Records and Retired Personnel "Retiree" Outpatient) Records. Air Force MTFs are required to, at least annually, (NLT the end of the same month from the previous year's record retirement) "retire" or purge outpatient medical records for family members and retired personnel to the National Personnel Records Center (NPRC) Annex, 1411 Boulder Boulevard, Valmeyer, IL 62295. If records were last retired in April 2010, the next records retirement process should be completed by 30 Apr 2011. Retire records two years after the end of the calendar year of the last date of treatment. CAUTION! Do not use the most current treatment date identified inside the paper health record. Review the patient's appointment history in the EHR. Retire or purge records IAW AFRIMS Records Disposition Schedule, Series 41, accessible via the Air Force Portal website and the Medical Record Tracking, Retirement and Retrieval (MRTR2) System User Guide located at the AFMS Knowledge Exchange, Patient Administration website.

5.7.8. Family Members of Service Members Assigned to Geographically Separated Units. Outpatient medical records are usually maintained at the MTF for two years after the calendar year in which the last treatment occurred. However, this rule does not apply to outpatient medical records for family members of Service Members assigned to GSUs. Although a family member's outpatient medical health record may be kept on file at the MTF closest to the Service Member's GSU, his or her family members may be enrolled to TRICARE Prime Remote. If this is the case, there may be no evidence in either the military EHR or paper health record to indicate the family member has received MTF care within the last two years. If records personnel suspect a family member, for whom the MTF maintains an outpatient medical record, may be receiving care at a civilian network healthcare provider, the record technician researching the record must verify the sponsor and family member TRICARE enrollment status via DEERS. If the enrollment information indicates the family member is enrolled into TRICARE Prime remote, then "flag" the outpatient medical record according to the instructions in paragraph 5.15. If the DEERS information indicates no TRICARE Prime or Prime Remote enrollment, then retire the record(s).

5.7.9. Federal Civilian Employee Outpatient Records. The Civilian Employee Medical Folder (EMF) is a chronological, cumulative record of occupational and non-occupational information pertaining to the health of a civilian employee during the course of employment. This record consists of personal and occupational health histories, exposure records, medical surveillance records, Office of Worker's Compensation Programs (OWCP) records, and the documented notes, evaluations and tests results generated by healthcare providers in the course of examination, treatment and counseling. Maintain outpatient records of civilian Air Force employees until the employee is transferred to another activity within the Federal government or is separated from the Federal Service. Upon employee transfer or separation, place the record in SF 66D, Employee Medical Folder, and forward to the MPS, Civilian Personnel Section within 10 days of transfer or separation. It is the responsibility of the MPS

to forward the EMF to the appropriate custodian. However, federal civilian employees must complete installation and unit and/or installation out-processing checklists similar to their active duty counterparts (as applied to MTF out-processing requirements). Typically, Active duty members are required to visit the installation OPR department to make sure their record(s) and the record(s) of their family members will be forwarded to the next base, regardless of any pre-arranged MPS-MTF transfer process. Federal civilian employees are also required to visit the local servicing MTF OPR department where their EMF is maintained. This process will ensure that the MTF receives notice from the civilian employee of an upcoming transfer or retirement, regardless of any MPS records relocation/retirement notification.

5.7.9.1. If civilian employee records are found years after the employee has relocated or retired, then:

5.7.9.1.1. Ensure records are in a SF 66D. Each employee will have his own folder.

5.7.9.1.2. Annotate the SF 66D with the employee's last name, first name, middle initial and SSN on the upper right hand corner - preferably typed on a white folder tab.

5.7.9.1.3. Box the records in a container which will safely make it through the USPS mailing process.

5.7.9.1.4. Create a shipping list for each container. Detail the contents by name and SSN of each employee's record. A SF 135, Records Transmittal and Receipt is not needed.

5.7.9.1.5. Mail the container(s) to: National Personnel Record Center, 111 Winnebago Street, St. Louis, MO 63118-4126.

5.7.9.1.6. Mail the record containers using standard first class mail, certified mail, or other available option. If standard first class USPS is used, return receipt confirmation is required.

5.7.10. Disposition/Retirement of Inpatient Records, Extended Ambulatory Records (EARs), and Fetal Monitoring Strips (FMS) to NPRC. (**Note:** For discharges in CY 03 and previous years, filing of multiple same patient episodes in a single folder is acceptable, e.g., multiple inpatient records in the same folder, multiple EARs in the same folder. However, beginning with discharges as of 1 Jan 04, each separate inpatient record, EAR episode, and FMS (includes all strips or segments created during a pregnancy) must be filed in separate folders.

5.7.10.1. Inpatient Records. Retire inpatient records of all service members and their family member dependents to NPRC, St. Louis, MO, IAW AFRIMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website and the Medical Record Tracking, Retirement and Retrieval (MRTR2) System User Guide located at the AFMS KX Knowledge Exchange, Patient Administration website.

5.7.10.1.1. Dispose or retire inpatient records according to the year of hospitalization discharge, not date of admission.

5.7.10.1.2. Teaching facilities will retire records 5 years after the end of the calendar year of the last date of treatment unless a waiver to retire earlier has been approved by the AF Records Officer and NPRC. Contact AFMOA/SGAT for assistance when

requesting a waiver. Non-teaching MTFs will retire inpatient records one year following the end of the calendar year of the last date of treatment.

5.7.10.2. NATO Military Personnel Inpatient Records: IAW NATO Standardization Agreement (STANAG) for Basic Military Hospital (Clinical) Records, dated 10 Mar 1998, Inpatient and/or Clinical records will accompany the patient upon transfer between hospitals, and will be forwarded to the patient's national military medical authority (NMMA). Contact AFMOA/SGAT to obtain the list of NATO medical command authorities by country. The list is also located on the AF/SG CoP in the Departure Rosters folder.

5.7.10.3. Non-NATO Military Personnel Inpatient Records: Retire inpatient records IAW AFRIMS, Records Disposition Schedule, Series 41 and the MRTR2 System User Guide located at the AFMS KX Knowledge Exchange Patient Administration website.

5.7.10.4. Extended Ambulatory Records (EARs). The retirement rules for EARs are the same as those for inpatient records. For teaching MTFs, the EAR should be retired five years following the end of the calendar year of the last documented episode of care unless a waiver to retire earlier has been approved by the AF Records Officer and NPRC. Contact AFMOA/SGAT for assistance when requesting a waiver. For non-teaching facilities, the EAR will be retired one year after the end of the calendar year of the last documented episode of care.

5.7.10.4.1. Retire the EAR folder to NPRC along with the inpatient records and any applicable fetal monitoring strips (i.e., in the same box.)

5.7.10.4.2. Place the EAR folder behind any fetal monitoring strips for that patient, or behind the applicable inpatient record folder if there are no fetal monitoring strips.

5.7.10.4.3. If the patient does not have an inpatient record but does have an EAR, the EAR is still included in the shipment of inpatient records.

5.7.10.5. Fetal Monitoring Strips (FMS). Retire the FMS to NPRC IAW AFRIMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website and the Medical Record Tracking, Retirement and Retrieval (MRTR2) System User Guide located at the AFMS KX Knowledge Exchange, Patient Administration website. (**Note:** Digitized, or other format, fetal monitor strips that can be printed out on an 8 1/2"X 11" sheet of paper are filed in the infant's inpatient record or the mother's if the infant is stillborn and are retired as a part of the inpatient record).

5.7.10.5.1. Retire the fetal monitoring strips to NPRC using the same disposition schedule as that for inpatient records.

5.7.10.5.2. Attach the envelopes containing the fetal monitoring strips to the inside of an appropriately labeled folder (only two envelopes per patient per folder).

5.7.10.5.3. Annotate the outside of the folder with the name and register number of the infant, sponsor's name and SSN, name of the MTF and date of infant's birth.

5.7.10.5.4. File these folders in the same box as the applicable inpatient record (baby's or mother's) directly after that record.

5.7.11. General Inpatient Records Disposition Procedures:

5.7.11.1. Prepare NPRC required index of records shipment file. Outpatient and Inpatient medical records require separate indexes. (FMS and EAR records must be included on the Inpatient records index.).

5.7.11.2. Follow the applicable tables and rules IAW AFRIMS, Records Disposition Schedule, Series 41, to determine record retirement eligibility.

5.7.11.3. Utilize the step-by-step instructions provided in the Medical Record Tracking, Retirement, and Retrieval (MRTR2) User Guide to set up the CHCS record rooms, create pull lists of retirement eligible records, and to create the final shipment index. A copy of the User Guide can be obtained from the AFMS Patient Administration Knowledge Exchange website at **https://kx.afms.mil/patientadmin**.

5.7.11.4. The CHCS system will maintain shipment indices until all records listed have been destroyed or transferred to the National Archives, or when no longer needed, whichever is later. It is recommended that you also print out and maintain a copy of each index for future use. This information is invaluable when determining whether or not a record has been retired to NPRC.

5.7.11.5. Forward a copy of each shipment index to the Base Records Management Office for their files.

5.7.11.6. Requests for Medical Records from the National Personnel Records Center (NPRC).

5.7.11.7. When requesting medical records retired to NPRC prior to CY 2003, use the DD Form 877-1, Request for Medical/Dental Records or other specific form identified by NPRC records managers. NPRC request forms contain space for the minimal information required for their agency to institute a search for the requested record.

5.7.11.8. To obtain medical records retired to the NPRC from CY 2003 and beyond, use the NPRC Medical Registry System (MRS) to request the record(s). This computer application can be accessed through a web interface. To register, requesting MTF personnel must complete the VA Form 9957, ACRS Time Sharing Request Form. An electronic version of the form along with instructions for completion can be obtained at the Medical Registry System website. Additionally, MTF personnel may use the step-by-step records retrieval instructions provided in the Medical Record Tracking, Retirement and Retrieval (MRTR2) System User Guide located at the AFMS KX Knowledge Exchange, Patient Administration website.

5.7.11.9. Use the DD Form 2138 or 877 when requesting records from another MTF.

5.8. Base Closures and Medical Records Management.

5.8.1. Inpatient Records are retired to the NPRC upon inactivation of the hospital (or upon downsizing to a clinic) IAW AFRIMS Records Disposition Schedule, Series 41 Internet website and the Medical Record Tracking, Retirement and Retrieval (MRTR2) System User Guide located at the AFMS KX Knowledge Exchange, Patient Administration website.

5.8.2. If early retirement is desired (i.e., out of cycle), the MTF Commander must request early retirement from SAF/XCPP. Coordinate the request with the local Information Management Office before submission.

5.8.3. Submit requests for early retirement as soon as possible because of the time required for approval. The request is coordinated with NPRC who will notify the MTF Commander of the decision. The request must include the following:

5.8.3.1. Reason for request.

5.8.3.2. Closure date (or date realigning to a clinic).

5.8.3.3. Type(s) of records to be retired.

5.8.3.4. Number of records (volume) involved.

5.8.3.5. All information normally included on the shipment index when requesting an accession number from NPRC.

5.8.4. Outpatient records of active duty members and their family members are transferred to the member's gaining base.

5.8.5. Outpatient records of retirees and others are transferred as follows:

5.8.5.1. If another MTF is identified by the patient as the new facility of treatment, forward the medical records to that facility with a cover letter explaining why the records were forwarded.

5.8.5.2. If a civilian MTF is identified as the new treatment facility, copy pertinent portions of the record for the patient to take to that facility. Retire the original record to NPRC IAW AFRIMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website and the Medical Record Tracking, Retirement and Retrieval (MRTR2) System User Guide located at the AFMS KX Knowledge Exchange, Patient Administration website. Maintain an AF Form 1942, Clinic Index, for six months or until the base closes, whichever comes first, then destroy.

5.8.6. For sequestered records, each MAJCOM will designate repository bases within the command to administer medical records involved in projected or active litigation.

5.8.7. If a medical malpractice claim was filed for active duty family members, forward the original inpatient or outpatient record (as applicable) to the Risk Manager or Hospital Administrator at the gaining MTF. Do not allow the patient to hand-carry the record. In addition, send a letter explaining why the records are being forwarded.

5.8.8. Use the following guidance if a medical malpractice claim was filed for a retiree or other patient.

5.8.8.1. If the continued care will be provided at an Air Force MTF, forward the original record with the appropriate letter of explanation.

5.8.8.2. If the care will be provided by a civilian or non-Air Force MTF, provide the patient with a copy of the record and forward the original with the appropriate letter to the Risk Manager or Medical Facility Administrator at the designated repository.

5.8.9. Use the following guidance for potential claims.

5.8.9.1. If there is a potential claim in reference to inpatient records, forward the original inpatient record with the accompanying letter of explanation to the Risk Manager or Quality Services Manager at the gaining Air Force MTF or designated repository base.

5.8.9.2. If there is a potential claim in reference to outpatient records, as a general rule, follow procedures outlined in this section. Coordinate special concerns and circumstances with the local base SJA. Maintain the record in a sequestered location.

5.8.10. Closure bases must establish a "Chain of Custody" document that lists each patient's name, SSN and location to which the medical record was forwarded. Forward a copy of the Chain of Custody document to the MAJCOM Command Surgeon or AFMOA office responsible for execution of AFMS medical records policy.

5.8.11. On inactivation of the MTF, the old retained SF 135s, Records Transmittal and Receipt (these were produced prior to CY 03) and copies of the CHCS shipment indices (produced CY 03 and later) will be forwarded to the next higher records management office at the MAJCOM Command Surgeon's office or the AFMOA Health Benefits office.

5.9. Health Record Review Committee/Functions.

5.9.1. Record review functions are performed at each MTF by either an established Medical Record Review Committee or incorporated into other committees that review records. These functions will include evaluation of the quality, clinical pertinence, information assurance, locally created form approval, and timely completion of inpatient and outpatient records and the assurance that the records are prepared and maintained according to Air Force directives, Joint Commission, and AAAHC standards. Cross-service representation will be included in the performance of these committees, i.e., representatives of the various clinic services, dental services, nursing services, medical record departments, management and administrative services, and other departments, as appropriate. These review functions are part of the Air Force Quality Assurance program under 10 U.S.C. § 1102. Responsibilities of this committee will include but not be limited to the following items:

5.9.1.1. Cross-Functional Sampling of Clinical Documentation: The review function should include an adequate number of both inpatient and outpatient records (sampling ratio should represent clinical facility workload levels). For example: Provider monthly workload < 30, review 100% of cases; Workload = 30-100, review 30 cases; Workload = 101-500, review 50 cases; Workload > 500, review 70 cases. Records will be reviewed to ensure the highest possible standards of quality control, record completion periods, legibility, promptness in documentation, and clinical pertinence are met. Records of recent deaths, hospital infections, complications and unusual problem cases are reviewed. A representative sample of records from every provider will be reviewed throughout the year.

5.9.1.2. Review the monthly medical record availability and accountability rates and report to the Executive Committee of the Medical Staff (ECOMS) or as directed by the MTF Commander.

5.9.1.3. Review the STR disposition process and progress on meeting the standards of completeness and timeliness and report to the Executive Committee of the Medical Staff (ECOMS) or as directed by the MTF Commander.

5.9.1.4. Written reports of the review function contain conclusions, recommendations, actions taken and after-action results. These data reports are quality assurance records under 10 U.S.C. § 1102. These data reports are then forwarded to the ECOMS for review or as directed by the MTF Commander.

5.9.2. Committees tasked with records review must approve locally overprinted Standard Forms (SF) filed in health records. Overprints are authorized only when the material added does not conflict with the purpose for which the form was intended. See AFI 33-360 and DoD 7750.07-M for further instructions on the authorized use of overprinted forms.

Section 5B—Outpatient Records Administration

5.10. Creating Outpatient Record Folders. Creation of folders, arrangement of content, and record filing methodology is consistent throughout Air Force MTFs. Number folders according to the social security number (SSN) as follows:

Table 5.1. Preparing Outpatient Record Folders Table.

If the patient is:	Use SSN of:
Active Duty/ARC	Member
Family Member	Sponsor
Family Member and RCSM	Sponsor
Civilian Employee	Employee
Retired Military	Retired Military (Note paragraph 5.10.4.)
Civilian Emergency	Patient

5.10.1. Normally, only one medical record will be established and maintained for each individual treated in the MTF. However, there are instances when patients can be "dual eligible" or eligible for care under more than one patient category. There are several instances when one individual may be "dual eligible" for care. Refer to paragraph 4.10. for additional information regarding multiple "same-patient" dual eligibility situations. However, for this section, the two most notable dual eligible scenarios that usually apply to medical records are covered:

5.10.1.1. A dependent who is also a member of the RC. Usually, in this instance, the dependent is a spouse of another active duty or retired military member. However, another possibility, may indicate that the dependent is a child (son or daughter); under 21 years of age or under 23 years of age if enrolled in a full-time college program.

5.10.1.2. The second likely scenario may be a dependent spouse who is also a retired military member.

5.10.2. Generally, medical records personnel should create a record based upon the highest level of eligibility. If a cross-reference situation exists, specifically for family members who are also RCSMs, locate the block labeled, "Specify Service & Grade for Military & Retired Military Member," near the middle of the front of the outpatient medical record jacket. Of the three categories, select the NONMILITARY category. This is the selection that should correspond to the patient's primary MTF dependent empanelment status. Then blot the corresponding square/block. Next, print the member's dependent status and his/her own SSN here and their status as a member of the Air Force Reserve or Air National Guard, or other

multi-service Reserve or AGR/Guard component as appropriate. Additionally, print in black felt-tip marker or stamp the words, "CROSS-REFERENCE" in 2-inch block letters on the upper left side of the front of the jacket. See paragraph 4.10 for guidance on creating records on patients with multiple eligibility.

5.10.3. Keep in mind that outpatient medical and dental records for (CAT A) RCSMs are usually maintained with the member's reserve unit. However, if the RCSM is also a family member-dependent, another outpatient medical record should be created at the servicing MTF to document all medical care the patient received under the dependent patient category. The following provides guidance for establishing two record volumes – using 000-00-0000 as the patient's SSN and 999-99-9999 as the sponsor's SSN:

5.10.3.1. Volume 1 will be the PRIMARY record used for the DEPENDENT information (30/999-99-9999). Dependent documentation will be filed in this record jacket (99-RED). The label should be the printed label from CHCS (30/999-99-9999). Write "CROSS-REFERENCE" on the cover and annotate ARC/AD FMP/SSN 20/000-00-0000.

5.10.3.1.1. File the record in the main central file WITH a Charge-out Guide. Inside the guide place a word document referring to the separate RC record, e.g., "STOP! This member is also a Reservist/IMA/ANG Member. Separate RC record maintained on xxxxxx shelf."

5.10.3.1.2. In the small pocket where the AF Form 250 would go, print/place an extra label from CHCS that states where to re-file the guide.

5.10.3.2. Volume 2 will be the record used for the RC/AD paperwork (20/000-00-0000). Activated RCSM documentation will be filed in this jacket (00-ORANGE). The label can be handwritten OR, if printed label from CHCS is used, cover the 30/999-99-9999 FMP/SSN with a label or white tape and annotate the correct FMP/SSN for this record (20/000-00-0000).

5.10.3.2.1. Write "CROSS-REFERENCE" on the cover and annotate "RC/AD FMP/SSN 20/000-00-0000.

5.10.3.2.2. File the record in a separate location from the main central file.

5.10.3.3. When records are retrieved for appointments, pull both volumes, the dependent record and the RC/AD record, and wrap a rubber-band around both record volumes. Ensure the clinic staff knows in which record to annotate the encounter.

5.10.4. Military retired patients who are also eligible for care as a dependent spouse may produce a unique situation when selecting appropriate CHCS automated system registration formats and when creating the corresponding outpatient medical record. Generally, medical records for dual or multiple healthcare eligibility patients should be created using the FMP and SSN that corresponds to highest level of eligibility or according to the patient category that is most advantageous to the patient.

5.10.5. If a beneficiary has received medical care under a previous social security number (SSN) as a result of remarriage to another military sponsor, record forms filed under the former SSN should be consolidated under the current sponsor SSN. Once the patient has been registered in CHCS under the current sponsor's SSN, merge the old and new patient

file. For future inquiries, a cross-reference from the old number to the new number should be indicated in the outpatient files as well as in the current automated system.

5.10.6. A temporary or "pseudo" SSN may be created for beneficiaries without a SSN. This process occurs in DEERS when the personnel technician issues an ID card or enters the beneficiary into DEERS. Either a Foreign Identification Number (FIN) or a Temporary Identification Number (TIN) is generated. See paragraph 4.9. for more information regarding the creation of "pseudo" SSNs, TINs, or FINs.

5.10.7. Select the appropriate AF Form 2100A series according to the last two digits of the applicable SSN. **Note:** File outpatient civilian emergency records by SSN in a manila folder. Maintain folders separately from the main file if desired. However, they must be interfiled by SSN with the rest of the records when retired to NPRC.

5.10.8. Maintain civilian employee medical records in manila folders or SF 66D. Place the record in SF 66D when the employee transfers to another Federal agency or is separated from Federal Service. Send the record to the civilian personnel office (CPO). Civilian employees [including Air Reserve Technicians (ART)] who are also members of an RC will have one medical record maintained as indicated in paragraph 5.14. The only exception will be if the individual is not employed as a civilian at the same base where his/her RC unit is assigned. In these cases, a civilian medical record will be maintained as described in the beginning of this paragraph. Civilian employees who are also assigned to a PRP/PSP or Sensitive Duties Program position or job will have one medical record maintained as indicated in paragraph 5.12.5.9. until such time as they are removed from the program or are transferred to another federal agency or separated from federal service.

5.11. Labeling File Folders.

5.11.1. AF Forms 2100A Series, Forms 2100A, 2110A, 2120A, 2130A, 2140A, 2150A, 2160A, 2170A, 2180A and 2190A, Health Record – Outpatient.

5.11.2. Select an AF Form in the 2100A series according to the last two digits of the applicable SSN:

Table 5.2. Terminal Digit Health Record Filing System.

Last two digits of SSN:	Use AF Form:
00-09	2100
10-19	2110
20-29	2120
30-39	2130
40-49	2140
50-59	2150
60-69	2160
70-79	2170

80-89	2180
90-99	2190

5.11.3. Print the first name, middle initial, and last name of the patient in the space provided with a black pen or black felt-tip marker. Address labels prepared by the Personnel Data System may be used to provide names of military personnel. DO NOT use pencil for any entry except rank. Always place information in the upper right-hand corner of the cover in the patient ID area.

5.11.4. Print the sponsor's SSN in the preprinted blocks in the upper right-hand corner of the record.

5.11.4.1. Print the family member prefix in the two circles next to the SSN. Check the TRICARE DEERS website for the DEERS Dependent Suffix (DDS) for the patient or if not available, number in birth date order for family member children.

5.11.4.2. The FMP will not change as long as the patient is still associated with the same sponsor and SSN.

5.11.4.3. When a military member marries a person with children, assign family member prefix numbers in sequence following the last family member prefix already assigned to children of the sponsor (if any). Assign the oldest child the next number in numerical sequence, etc.

5.11.4.4. Spouse Prefix Assignment: Assign the family member prefix "30" to the first spouse authorized care. If the member remarries due to spousal death, divorce, etc., assign the number "31" to the next authorized current spouse. Increase prefix numbers by 1 (e.g., 32, 33) for any additional dependent spouse authorized care. Only one current dependent spouse is authorized medical care.

5.11.4.5. Un-remarried Former Spouses: All un-remarried former spouses are now self-sponsored. Un-remarried former spouses who have met the requirements in accordance with AFI 36-3026V1_IP are treated in the MTF as their own sponsor. Create medical records for these patients using a "20" FMP and the un-remarried spouse's own SSN. If the patient's previous record, filed under the deceased sponsor's SSN, is still in the file, remove the documents and place in this new record. Annotate previous folder with cross reference to new folder. If the patient is still in CHCS under the deceased sponsor's SSN, work with the Systems Office to correct this. See paragraph 2.16. for more definitive information regarding authorized care for former spouses of military members.

5.11.5. Standard Folder Markings: Blot out the ½ inch square block, along the right edge of the rear leaf of the folder that corresponds to the sponsor's last SSN digit. Use a black felt-tip marker or ½ inch-wide black tape. If a marker is used, be sure to darken the digit block on the reverse side of the record jacket. For tape, cover the appropriate digit on the front side of the folder, then fold an equal amount of ½ inch-wide tape to the rear side of the folder and cover the digit on the reverse. Keep tape cuts neat and even.

5.11.5.1. Do not make any entries in the small preprinted, numbered blocks, the "R" and "S" blocks at the top of the folder, or the "R" block on the side of the folder (these are for Army use only).

5.11.5.2. On the front leaf cover, on the right side of the record jacket, blot out the year that corresponds to the patient's most recent documented visit with a black felt-tip marker. **Note:** Attach AF Form 2700L Health Record Year Grid, to AF Form 2100A series. Do not prepare another folder if the available year selections on the original record jacket fill-up. Place AF Form 2700L over the old year markings.

5.11.5.3. Located near the center of the outside of the record jacket, in the block labeled, Specify Service & Grade for Military & Retired Military Member, select the appropriate category, blot the corresponding block, and document the patient's status. Enter the Service and rank for active duty and retired military personnel. Enter the country for non-US military personnel. (A copy of the non-US military member's orders should be placed in the health record). Use pencil for rank only. For family members who are also members of an Air Force Reserve or Air National Guard, write the member's own SSN here as well as their status as a member of the ARC/ANG, or other multi-service Reserve or AGR/Guard component as appropriate. Additionally, print in black felt-tip marker or stamp the words, "CROSS-REFERENCE" in 2-inch block letters on the upper left side of the front of the jacket.

5.11.6. PRP/PSP, or Sensitive Duties Program Folder Markings: Use RED permanent marker or RED tape instead of black to identify a PRP/PSP member's folder. Cover the appropriate last SSN digit (both sides of the record jacket) located along the folder's right edge.

5.11.6.1. Stamp or label the outside of the record jacket with the abbreviation "PRP" or "PSP" in 2-inch RED block letters. The stamp marking should be placed on the left hand side of the front of the record jacket to identify persons who participate in the Personnel Reliability Program. Cover the red marking with a black marking or black tape when a member is removed from the program.

5.11.7. Aerospace or Flight Medicine Record Markings: To help identify patients in the categories listed in paragraph 5.13.5., blot out with black felt-tip marker or place a ½ inch-wide strip of black tape along the right side of the folder beginning at the bottom of the "9" block and end at the bottom of the folder. Cover the "R" and "S" blocks. One inch-wide black tape may also be used. If using 1 inch-wide tape, place the tape on the folder so that half of the strip folds to the rear side of the folder. If a marker is used, mark out the same distance on the rear of the folder jacket. If the record is filed in a filing cabinet instead of on a shelf, apply another narrow strip of black tape to the top edge of the rear folder leaf. Place the tape strip over the left side of the first numerical digit block of the sponsor's last 4 digits of the SSN. Place the tape on the folder so that half of the strip folds to the rear side of the folder. Never cover the FMP or SSN.

5.11.7.1. Stamp or label the outside of the record jacket with the acronym "FLY" in 2-inch BLACK block letters. The stamp marking should be placed on the left hand side of the front of the record jacket to identify persons who participate in an aerospace/flying program or dependents of persons who participate in an aerospace/flying program.

5.11.8. Stamping or labeling the front cover of the medical record with any large-letter identifiers OTHER than a) FLY, b) PRP or PSP, c) CROSS-REFERENCE, d) with infant-adoption related notifications (see paragraph 4.3.) or, e) MEDICATION ALLERGIES is discouraged.

5.11.9. If the member is a food handler, the Force Health Management office enters the date of the current food handler examination in pencil on the appropriate line of the preprinted format.

5.11.10. If the patient is allergic to medication, display this information prominently under the patient identification data on the right hand side of the folder.

5.11.11. Attach the CHCS MRT bar code label to the health record folder in the upper right hand corner. See the MRTR2 User Guide for instructions on label requirements.

5.11.12. Acknowledgement of Notice of Privacy Practices Procedures (NoPP). Each patient will receive a copy of the MHS NoPP. See Chapter 6 for additional information on providing the notice and documenting receipt.

5.12. Contents of the Outpatient Record.

5.12.1. Outpatient records must contain enough information to identify the patient, support the diagnosis/condition, justify the care, treatment, and service, accurately document the results of care, treatment and service rendered, and promote continuity of care. Documents will contain the name and location of the MTF maintaining the record to ensure the document is sent to the proper MTF. The documents will also contain the name of the outpatient record location.

5.12.2. Embossed plastic cards may be used to record patient identification information on forms. Each document in the record contains, as a minimum, patient's name, family member prefix, full SSN under which the record is to be filed, name of the MTF maintaining the patient's record, and name of the outpatient record location. The only exception is the display sheet on which laboratory and x-ray slips are filed. Since the individual slips contain the necessary data, it is not necessary to repeat identification information on the same sheet. However, if the information is not there, it needs to be added. The patient's mailing address may be added to any document.

5.12.3. Paperwork Filing Order for the AF Form 2100A Series, Health Record-Outpatient (four-part folder). The AF Form 2100A series is divided into four sections. Section I is located on the left side of the folder immediately inside the front cover, with the fastener at the bottom. Sections II and III are located on the middle flap of the folder, with fasteners at the top. Section IV is located inside, back cover, with the fastener at the top or bottom. Folders are prepared for new patients, or when the present folder no longer protects the contents as intended. Forms are filed in each section in the order as listed in Attachment 9 for section I, Attachment 10 for section II. Careful attention must be paid to ensure inter-related documents for the same episode of care or subsequent referral care documents are filed on top of the initial encounter document. For example, place subsequent DD Form 2161, Referral for Civilian Medical Care, SF 513, Consultation Report, or AF Form 1535, Physical Therapy Consult, on top of the SF 600 that documented the initial encounter. SF 600s from single-visit encounters, with no other associated supporting paperwork, should be filed in chronological order, most current on top. See Attachment 11 for placement of documents within section III and refer to Attachment 12 for documents filed in section IV.

5.12.4. Electronically generated forms.

5.12.4.1. Clinical Optimization for Military Provider AHLTA Satisfaction Strategy (COMPASS). The COMPASS program offers a synergistic approach to maximizing provider efficiency. The COMPASS solution takes full advantage of new and improved alternate input method (AIM) forms and automated data capture templates and processes designed to increase patient-provider interaction, reduce time spent writing notes, improve note readability, and standardize documentation throughout the clinic. Although the COMPASS AIM workflow solution is still in the preliminary phase of deployment, expect expanded data documentation applicability and integration with the DoD's automated EHR.

5.12.4.2. No matter the form automation mechanism, when electronically generated forms are used in place of SF, DD, or AF forms, each automated form must be a mirror image of the non-automated form and contain the statement "SF, DD or AF Form XXXX (EF) [name and producer/vendor (if any) of the software used]." See Section 5A for guidance on overprinted and electronically generated forms.

5.12.5. Documenting the DD Form 2766, Adult Preventative and Chronic Care Flowsheet for Active Duty Service Members – Continuity of Care Documentation.

5.12.5.1. The DD Form 2766, Adult Preventive and Chronic Care Documentation Flowsheet is the primary folder used to document medical and dental treatment for active duty, Air Force Reserve, Air National Guard, and deployable federal civilian employees while in a deployed environment. The original outpatient medical and dental records for each deployed Active Duty, Reserve Component (RC) Service Member and deploying federal employee remain at the host base. During a deployment, the cardstock DD Form 2766 is the only authorized folder used to document a Service Member or federal employee's adult preventative and chronic care history. During non-deployment periods the DD Form 2766 is filed inside the Service Member's outpatient medical record. Federal civilian employees who have not deployed in support of a contingency operation will not have a DD Form 2766.

5.12.5.2. Automated Alternatives: The Air Force Medical Services Preventive Health Assessment and Individual Medical Readiness (PIMR) application and/or (fully operational) automated DD Form 2766 mechanism or similar type automated data capture module or AIM operated from or within a standardized Air Force or MHS electronic health record may be used in place of DD Form 2766 and all continuation forms.

5.12.5.2.1. The COMPASS Core 2.0 AIM template in AHLTA will serve as the initial intake form for all primary care visits (both active duty and non active-duty) and serves as the primary mechanism for communicating "continuum of care" information between healthcare team members and MTFs.

5.12.5.3. The electronic PIMR DD Form 2766 is the official electronic DD Form 2766 for Active Duty, Reserve Component, and deploying federal civilian employees. In accordance with DoDI 6490.03, Deployment Health, August 11, 2006, each PIMR DD Form 2766 contains a relevant master problem list or summary of care, IMR (including immunization history) and deployment related medical history report. The PIMR DD Form 2766 is populated with continuum of care information (past medical and surgical information, family history, medications, social history and required relevant clinical

preventive services) from available sources, e.g., COMPASS core AIM forms, standardized electronic health record DD Form 2766 data, and information from the cardstock DD Form 2766.

5.12.5.4. The electronic PIMR DD Form 2766 will be updated during the annual PHA and/or from information obtained from pre and post-deployment questionnaires, patient interviews, patient-provider encounters, clinical reviews, and updated prior to any Service Member Permanent Change of Station. The most current version of the PIMR DD Form 2766 and DD Form 2766C (Immunization History Continuation Form) will be printed and placed into the cardstock DD Form 2766 (secured with the metal prongs) for all Active Duty and RCSMs during their annual Preventive Health Assessment, during pre-deployment screening, and prior to completing PCS out-processing. Insert a copy of the most current DD Form 2766 and DD Form 2766C into the cardstock DD Form 2766 for any Federal civilian employee during the pre-deployment screening process.

5.12.5.5. Obsolete copies of other automatically generated DD Form 2766 documents are to be removed and destroyed when new PIMR DD Form 2766 printouts are inserted. No medical information is to be hand-written on a PIMR DD Form 2766 generated document. Information collected on the card stock DD 2766 during a deployment will be merged with the electronic PIMR DD Form 2766 within 30 days following a Service Member's return from deployment IAW DoDI 6490.03.

5.12.5.6. MTF providers and clinical support staff are not required to review or update the cardstock DD Form 2766 at each patient visit. If obsolete information is handwritten on the card stock DD Form 2766, it should be erased (if pencil) or lined out with one single straight line, and initialed with the reviewer's name initials and date to indicate the information is no longer valid. The form should then be marked (with a stamp or hand-printed in bold letters) "Data Transferred to Electronic PIMR DD Form 2766 in PIMR on _____" (insert date of transfer) at the top of each card stock page. (Date)

5.12.5.7. Absent an automated DoD solution that captures and transfers the same preventive and chronic care medical information from non-combat host MTFs to a deployed theater location, the card stock DD Form 2766 will remain a permanent part of the paper-based outpatient medical record.

5.12.5.8. Immediately following the pre-deployment clinical review/screening, photocopy all sections of the cardstock DD Form 2766 and file the copy in the original outpatient medical record.

5.12.5.9. For Service Members assigned to Sensitive Duties Programs (e.g., PRP and PSP), MTF records personnel will attach an AF Form 745, Sensitive Duties Program Record Identifier inside the DD Form 2766 cardstock record. Stamp "PRP" or "PSP" in 2-inch letters on the cover of the DD Form 2766 prior to a Service Member's deployment.

5.12.6. Documenting Preventative and Chronic Care for Non-Active Duty Adult Beneficiaries.

5.12.6.1. The COMPASS Core 2.0 AIM template in AHLTA will serve as the initial intake form for all primary care visits (for both active duty and non active-duty adult

patients) and serves as the primary mechanism for communicating "continuum of care" information between healthcare team members and MTFs. Use of the COMPASS Core 2.0 template/form will replace the need for completing the card-stock DD Form 2766 for non-active duty adult beneficiaries. All discontinued DD 2766 forms, already filed in the medical record, must remain in the outpatient medical record. Do not destroy old or seemingly irrelevant medical documents.

5.12.7. Documenting and Filing the DD Form 2882, Pediatric and Adolescent Preventive and Chronic Care Flowsheet.

5.12.7.1. This form will be used for all Department of Defense (DoD) TRICARE Prime pediatric and adolescent beneficiaries to provide continuity of care in the TRICARE system. The form may also be used for non-TRICARE Prime pediatric and adolescent beneficiaries at the discretion of the MTF or provider. The DD Form replaces the AF Form 4320. All AF Forms 4320 and AF Forms 3923 already in the medical records must remain in the outpatient medical record. Do not destroy old or seemingly irrelevant medical documents.

5.12.7.2. Pages one and two are mandatory for all newborns and all current Service specific forms used for the summary of care that are worn, torn or which otherwise need to be replaced.

5.12.7.3. Pages 3 and 4 are used to track immunizations and are available for use if there is not a Service specific form currently in use.

5.12.7.4. Pages 5, 6, and 7 are designed to track clinical preventive services (CPS), as identified by the current edition of the US Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services and the TRICARE Prime benefit package. This form is not intended to be used as current age-specific recommendations for care of newborns through adolescents ages (0 - 18 years).

5.12.7.5. The DD Form 2882 is available in hard copy only. To obtain copies of the current form, contact the MTF Forms Management Office.

5.12.7.6. Pending completion and AF/SG approval of the automated COMPASS Core AIM Form (Pediatric version), the form will replace DD Form 2882 for documentation of pediatric and adolescent preventive and chronic medical information.

5.12.8. Documenting and Transcribing Information from Historical Patient Preventative and Chronic Care Flow Sheets.

5.12.8.1. Health records support personnel are not authorized to transcribe pertinent information from the old form to the new form. Only the patient's PCM medical staff are authorized to transcribe pertinent medical information from this document to the EHR or to another DD Form 2766.

5.12.8.2. Do not remove or destroy the old AF Form 1480, Summary of Care, 1480A, Adult Preventive and Chronic Care Flowsheet (aka Summary of Care); DD Form 2766; or DD Form 2882, Pediatric and Adolescent Preventive and Chronic Care Flowsheet from the paper outpatient medical record. Keep these documents in outpatient medical record. Instead, for an outdated DD Form 2766 (from the current filing position in part I of the AF Form 2100A Series Outpatient Medical record), close the form and then

"double hole punch" the bottom of the form/folder and replace the form back into Section I with page 1 of 4 face-up.

5.12.8.3. For Service Members, place the new DD Form 2766 on top of the old form so that the form can be opened inside the medical record. Non-active duty adult beneficiaries do not need a replacement DD Form 2766 – see automated COMPASS AIM form.

5.12.9. Unauthorized Storage of "Second, Back-up, or Shadow Files" Maintained in Clinical Work Centers. Serious patient safety issues may develop if MTF work centers maintain copies of their patients' permanent medical records and/or documents separately from where the official medical and dental records are regularly maintained. Storing medical information which documents, illustrates, depicts, or describes the same clinical data, including but not limited to outpatient encounters, dental encounters, inpatient healthcare, same day surgeries, ambulatory surgery, or diagnostic care may not be stored in more than one MTF location.

5.12.9.1. Official medical records and medical documents created to permanently document the healthcare provided to a patient are maintained in either the EHR or officially recognized rigid, cardstock record (for which an approved Air Force or DoD record/form number exists). Copies of original medical or dental treatment records, sometimes referred to a "back-up" or "shadow files" kept in any work center for the purpose of convenience, "quick reference availability," or to maintain a clinic "mini-file" system, are unauthorized.

5.12.9.2. The minimum official record sets used by the AFMS include: outpatient medical, dental treatment, inpatient, ambulatory procedure, extended ambulatory, and mental health record folders. Any officially recognized paper/cardstock record(s) are stored with like records in a central or decentralized, secure, limited access records file room(s). Following each individual treatment or patient encounter, and only after all necessary administrative and/or coding or quality review processes are complete, original medical or dental treatment forms or records documenting provider-patient interaction, will be placed or filed into the patient's EHR or applicable cardstock medical record. Copies will not be maintained anywhere.

5.13. Filing Outpatient Records.

5.13.1. "Terminal Digit" Filing System: File records by SSN, according to a terminal digit, color-coded and blocked filing system. Divide the central files into 100 equal sections. Establish a minimum of 100 files guides identifying primary Terminal Digit numbers, "00" through "99."

5.13.2. File record folders in numerical sequence according to their secondary numbers within each section. The secondary number is the pair of digits immediately to the left of the primary number.

5.13.3. All outpatient records and forms will be maintained in a single numerical file in a central location except when the MTF Commander authorizes decentralization of the numerical file to the patient's major primary or family care team location or to the Flight and Operational Medicine Clinic, if applicable. See 5.13.5. The numerical files of personnel assigned to the PRP, PSP or any other sensitive duty program are also maintained in a separate secured location. See 5.13.6. In MTFs with authorized decentralized records rooms,

the CHCS MRT function will identify where the numerical file is regularly stored and will document inter-facility borrower history. Use of AF Form 614s will not be required unless the CHCS MRT function is not used or the MTF Records Custodian deems non-use appropriate.

5.13.4. Establish local procedures to perform an annual inventory all Active Duty Air Force records by 31 March. Medical records personnel will contact the local MPS and obtain a roster of all assigned and/or attached active duty personnel. Sort the roster by terminal digit order. If missing records are discovered during the initial inventory audit, records personnel will perform monthly follow-up audits until the missing record(s) are retrieved or located. Missing records must be added to the Global Records Search until found.

5.13.5. Flight and Operational Medicine Records: If authorized by the MTF Commander, outpatient records for Airmen and family members empanelled to the Flight and Operational Medicine Clinic may be maintained in the Flight and Operational Medicine Clinic. Flight and Operational Medicine records are usually maintained on individuals assigned to: air crew duty, missile launch duty, air traffic control duty, physiological training duty, parachute duty, and weapons control duty, and on the family members of Airmen on flight status who are empanelled to the Flight Clinic.

5.13.6. Outpatient medical and dental treatment records for personnel assigned to the PRP, PSP, or any other sensitive duty program will be maintained in a separate, secured location. Again, as mentioned in paragraph 5.13.3., proper use and management of the CHCS MRT module will provide MTF personnel with the mechanism to determine where a "paper" medical record is located.

5.13.7. Outpatient and dental health records for authorized family members and sponsors who reside at locations outside of approved MTF TRICARE PRIME enrollment catchment areas or who are assigned to a) USAF Recruiting Service posts, b) ROTC units, c) GSUs, and d) authorized TRICARE Prime Remote locales, and e) health records for TRICARE Prime family members enrolled to civilian PCMs will be maintained at the nearest MTF to the member/sponsor's remote assignment location or home address, whichever is more advantageous to the sponsor and family member(s). There may be instances when the responsible AF MTF is not the nearest MTF to where the member is assigned or the family member is enrolled. In these instances, the responsible AF MTF must coordinate with the nearest MTF maintaining the records to ensure the records are correctly processed when the member retires, separates, PCS's to another location or enrolls to another MTF. Exception: Outpatient and dental records for active duty members attached to GSUs who are assigned to highly critical or sensitive duty programs are maintained in a separate, secured location IAW paragraph 5.13.6. Health records for GSU Service Members are maintained IAW paragraph 5.15.

5.13.8. "Splitting" Records aka Closing Record Volumes: In order to optimize file space for current and future outpatient records, it is permissible to "split" or separate outpatient records that consist of more than one volume.

5.13.8.1. If an additional record volume is needed or to separate the current volume from older volumes, records personnel will mark on the front cover of the new outpatient record volume jacket cover, in the upper left corner or in another area where other identifying record information is not obscured, in 2" capital letters, with bold, black

marker, the appropriate volume number, e.g., "Volume 2, 3, or 4" or "Volume II, III, or IV," etc.

5.13.8.2. Login to CHCS and from the MRT module, verify that the multi-volume record is properly referenced, and if not, create a new electronic volume reference, print a new bar-scan ID label and affix to the new record volume jacket in the upper right corner.

5.13.8.3. Place the new record volume back into main file and relocate older volume(s) to a designated location within the secure records department. Label older volume(s) with the same type of bold, black marker, clearly indicating the volume number and be sure the bar-scan ID label reflects the older volume number(s).

5.13.9. Deceased Patients: Place outpatient records of deceased patients in a separate, secured file location within the records department. Retire the non-Active Duty medical record to the NPRC IAW with established record retirement procedures. For records of deceased Active Duty and RCSMs, refer to the Sequestered/Deceased Member's Records. See 5.7.2.

5.13.10. Use of AF Form 1942, to manage records is optional. However, if an MTF Records Custodian chooses to continue using the form, prepare and maintain an AF Form 1942 for each record permanently forwarded or hand-carried to another facility. Keep the form in an alphabetical file for 180 days, and then destroy. See paragraph 5.29. for further information regarding permanently transferring medical records to other MTFs.

5.13.11. Record custodians will comply with Air Force records management and maintenance instructions when maintaining Army and Navy records.

5.13.12. When personnel from the US Army and US Navy are:

5.13.12.1. Attached to an Air Force facility for medical care, the Air Force assumes custody of their health records. When patients from other Services are treated in Air Force facilities and require certain Service specific forms be completed and filed in the records, the documents will be filed in their record. The documents will be placed in the appropriate section of their outpatient record based on the type of form.

5.13.12.2. Treated in an MTF but their records are not available, send documents, routinely included in Air Force outpatient records, to the custodian of their records. If unknown, forward these documents using guidelines provided in appropriate subsections of paragraph 5.19.

5.13.13. When Air Force personnel are treated at a US Army or US Navy facility; send the documentation to the MTF where the record is maintained.

5.13.14. Interfile Army and Navy records with Air Force records. Replace folders with the AF Form 2100A series only if the color and blocking do not permit interfiling.

5.13.15. Do not use the AF Form 2100A series to document or maintain Mental Health or Family Advocacy notes, documents, or records. These files are separated from the outpatient record and are secured in either the Mental Health Clinic or Family Advocacy Office.

5.14. Managing Reserve Component Outpatient Records.

5.14.1. Health records for members of the RC (Category A) and ANG/AGR are normally maintained with their respective medical units, unless a local agreement or MOU exists between the MTF and the RC/ANG unit(s) requires the MTF to maintain them.

5.14.1.1. The MTF may maintain health records for members of the RC (Category A) and ANG who have or are, a) placed on active duty orders for more than 30 days; b) are currently empanelled to an MTF primary care manager; or c) the Service Member or unit has provided the MTF records department with the original health record and a copy of the member's activation orders. In these instances, the member is required to notify the MTF records department upon completion or removal from active duty and/or removal from active MTF enrollment. If the Service Member's reserve/ANG unit does not provide the outpatient medical records to the MTF during the RCSM's period of active duty activation and/or empanelment, the missing outpatient record will not negatively count against the MTF's paper records availability and accountability percentages.

5.14.2. Maintain separate paper-based health records for dual or multiple healthcare eligibility patients, (e.g., a patient who is a family member husband and a RCSM). See Section 4B and paragraph 5.10.1. for additional guidance regarding dual or multiple eligibility patient record maintenance. Medical and dental records for Category B (IMA) and E (PIRR) are maintained at the IMA Service Member's servicing USAF MTF usually co-located at or near the Service Member's unit of attachment. IMA medical and dental records will be maintained IAW the paragraph below.

5.14.3. Maintain health records for individual mobilization augmentees (IMA) (Cat B) according to the following instructions:

5.14.3.1. Maintain records for centrally managed IMAs (HC, JA, and SG) with the active duty MTF unit of attachment.

5.14.3.2. Maintain records of non-centrally managed IMAs with the active duty MTF unit of assignment.

5.14.3.3. Complete an annual inventory of all RC health records on file as of 31 March.

5.14.3.3.1. RMG/IRMS maintains a registry of IMA/PIRR records/locations, and can furnish a list of the records identified in paragraph 5.14.3.1. Notify HQ AFRC/SGP if records are not located or if a records transfer (due to reassignment, retirement) is required.

5.15. Geographically Separated Units (GSU) Outpatient Records Management.

5.15.1. Active duty service members, and their family members, assigned to a GSU (with no on-site military medical support), and/or those who reside more than 50 miles or approximately one hour of driving time from the nearest MTF may be eligible for care through TRICARE Prime Remote (TPR). Reference the TPR website at **http://www.tricare.osd.mil/tpr**.

5.15.2. The original health records of GSU Service Members and their family members (if family members accompany the sponsor) will NOT be maintained by the sponsor, his or her family members, or provided to the sponsor or family members' civilian PCM office. Instead, the records will be maintained at the Air Force MTF nearest to where the sponsor and/or family members reside.

5.15.3. Affix the following statement to the outside of each original health record(s) using an address label: "Assigned to a GSU at or near (Enter City, State, Territory, or Province name here). IAW AFI 41-210, Section 5B, DO NOT RETIRE THIS OUTPATIENT RECORD." See Figure 5.1. GSU Label.

5.15.4. Place a copy of the sponsor's PCS orders in Section I of the health record on top of most current DD Form 2766. Place a copy of the sponsor's PCS orders in Section I of all health records of family members identified on the PCS order to depart with the sponsor to the GSU. Active duty personnel and their family members preparing to PCS to a GSU may receive a complete copy of their health record from the MTF before the scheduled departure date. Place the copies in a new AF Form 2100 Series record jacket. The record jacket of the COPY should indicate the record is a copy and identify the MTF where the official record is being maintained. See Figure 5.2. GSU Record Copy.

5.15.5. EXCEPTION for Sensitive Duties Program Participants or Flight Status Personnel: The original Service Treatment Records (STR) of Service Members assigned to a GSU may be required to be maintained or stored at the unit to maintain sensitive duties program participation, flight status, or individual or overall program certification. If the original STR is required to be kept at the unit, the outpatient medical and dental records will be maintained by the unit commander, and secured in a locked container behind at least one locked door during non-duty hours. Access is restricted to the unit PRP, PSP, of flight status certification or program reporting official. A good example of this type of scenario would apply to Service Members assigned to remote Munitions Sites (MUNS) GSUs in USAFE. The nearest Air Force MTF Commander and Service Member's GSU commander will ensure mechanisms are in place to ensure all medical documentation generated from civilian medical facilities are added into the Service Member's STR and that all health records are maintained IAW this instruction.

5.15.6. When health record copies are provided, Air Force MTF records personnel will place a "Property of the U.S. Air Force" label containing the appropriate MTF address on the record jacket. See Figure 5.2. GSU Record Copy.

5.15.7. Miscellaneous or "loose" medical documents generated by an MTF for GSU members and/or their family members will be forwarded to the MTF or GSU that maintains the individual's health record.

5.15.8. Upon reassignment from the GSU to a military installation and subsequent MTF PCM assignment, the gaining MTF will send a DD Form 877, Request for Medical/Dental Records or Information or DD Form 2138, Request for Transfer of Outpatient Record, so that the member's original outpatient medical record(s) are forwarded to the new location. Upon receipt of the original health record, cover the GSU label with a blank label, create a new facility location label, and remove the PCS order to the previous GSU location. The gaining MTF/PCM should complete a release of information authorization for the patient to request copies of medical record documentation from their civilian provider to be added into the official medical record.

Figure 5.1. Sample GSU Label.

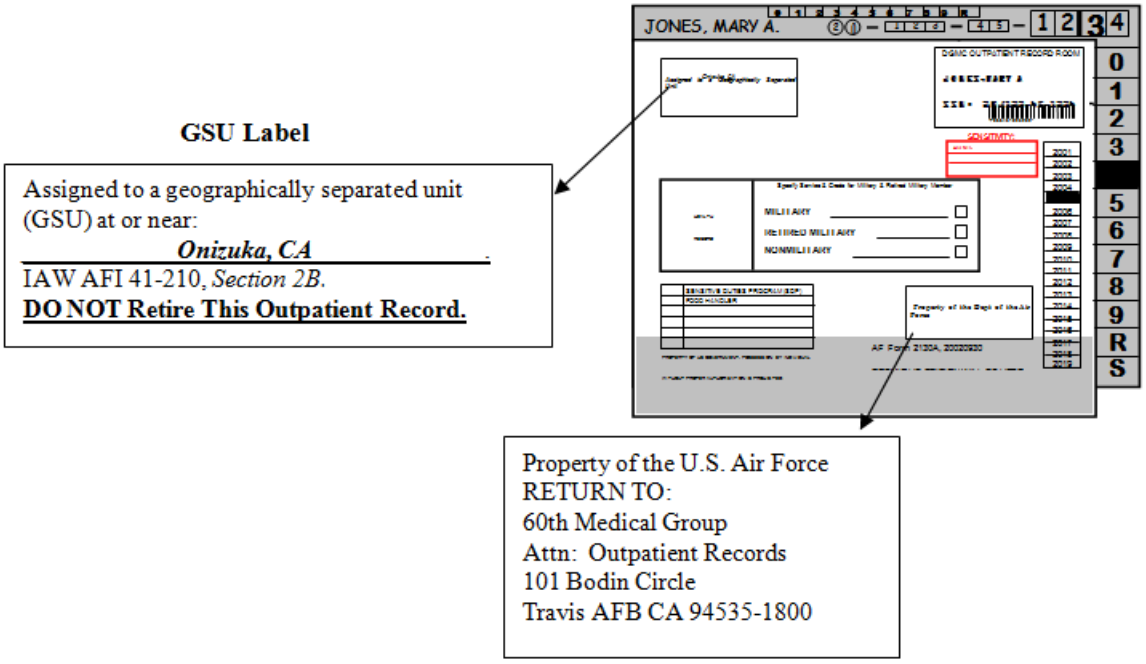
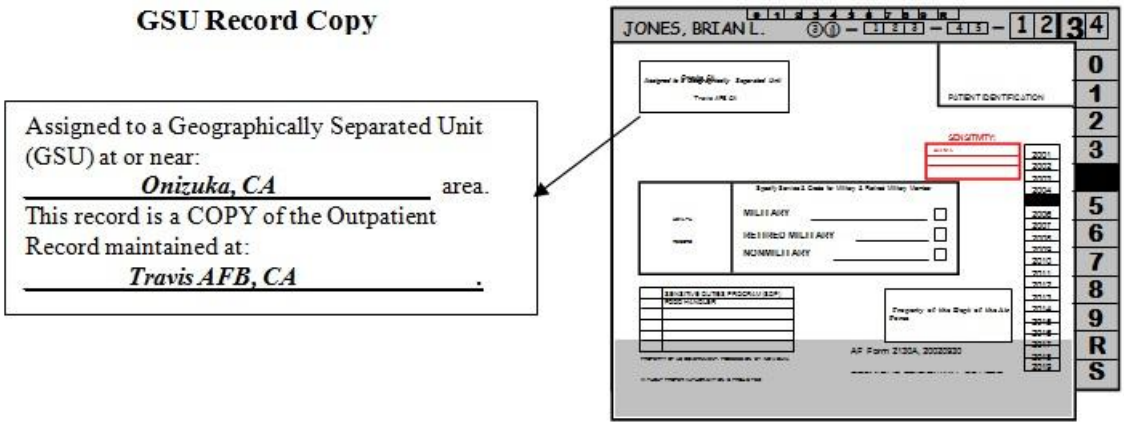


Figure 5.2. Sample GSU Record Copy.



5.16. Custody and Control of Health Records.

5.16.1. Beneficiary health records are the property of the United States Government. The information contained in the record belongs to the patient. IAW the Privacy Act of 1974 and HIPAA of 1996, the patient has the right to the information in the record. However, the maintenance of the record at the MTF is a legal requirement. Agency obligations mandate the health records be available for continuity of care purposes and to support national accreditation and OSD/HA (TMA) clinical coding auditing actions. The lack of medical records and documentation may adversely impact individual patient medical continuity of care as well as AAAHC and/or Joint Commission accreditation. Generally, beneficiaries are

not authorized to hand-carry their health records IAW DoDI 6040.43 and Air Force policy identified in this instruction. Local MTF records management policy must include measures to:

5.16.1.1. Establish a methodology to obtain beneficiary medical record(s) upon arrival on-station or upon initial enrollment.

5.16.1.2. Establish custody of the health record upon the patient's initial visit.

5.16.1.3. Ensure health records are available so that patients may obtain a copy of their complete medical record. Refer to paragraph 4.7. for instructions on responding to patient requests for copies of personal health records.

5.16.2. MTF personnel should not return an original medical or dental record to the patient's control after an outpatient visit unless authorized to do so by the MTF Commander e.g., the Records Custodian.

5.16.3. All miscellaneous, "loose or late-flowing" documents must contain sufficient patient identification information to allow for proper filing IAW paragraph 5.12. Additionally, these documents must identify the outpatient records location and the MTF where the record is maintained.

5.16.4. Generally, borrowed records will be returned to the MTF record section by the end of the day. However, records may be "charged out" or borrowed by an internal MTF requester for up to five days if the record is needed to accomplish an official task, audit, review, etc. The borrower must provide his/her rank (if applicable), first and last name, office symbol, name of duty or work location, and telephone contact number. The record must be returned to the records library as soon as possible. The records department supervisor may grant extensions to the 5-day rule on a case-by-case basis. While in the borrower's possession, the record(s) must be secured and immediately produced upon request if required for patient care. When an extension is granted, "RE-CHARGE" the record to the borrower.

5.16.5. Upon receipt of each new outpatient health record, not already maintained in the MTF records file system, outpatient records personnel will perform a quality assurance inspection of the medical record. Inspection checks shall include the following, but are not limited to: a) ensure the health record jacket is in satisfactory condition and labeled/documented properly, b) that medical documents are filed in their appropriate place, and c) remove any misfiled wrong-patient documents and forward the documents to the appropriate patient record or MTF.

5.16.6. As often as necessary, and whenever medical documents are filed into a health record, records personnel will correct any obvious misfiles or other noticeable errors in each health record. MTFs should establish local guidance to best facilitate this process.

5.16.7. Using Charge-Out Guides. Use AF Forms 885, 886, and 887, Medical Record Charge-Out Guides, and AF Form 250, to indicate the location of an outpatient record removed from the file. Use of the MRT module in CHCS is required as a tool to track movement of outpatient records. It also enhances the management of records accountability and availability.

5.16.8. Authorized Exceptions that Allow Service Members to Hand-Carry Their Health Records.

5.16.8.1. Every effort should be made to ensure patients do not leave the MTF with their records unless authorized to do so. However, there are at least two significant reasons where MTF records managers are allowed to provide health records to beneficiaries.

5.16.8.1.1. Exception #1. Applies to Service Members assigned to sensitive duties programs, including but not limited to: Personnel Reliability Program, Presidential Support Program, air traffic controllers, overseas U.S. embassy support, or any Airmen assigned to a current flight status (FLY) position or possessing an active aeronautical rating. Service Members who meet the aforementioned requirements or Service Members who [will be] assigned to a sensitive duties or active flight status position upon arrival to their next installation, are required to hand-carry their outpatient medical and dental treatment records (in a sealed envelope or package) from one MTF to another or from one official duty assignment location to another during a Permanent Change of Station, re-assignment, or extended Temporary Duty assignment. All inbound PRP personnel must hand-carry their medical records. If a TDY Airman is not expected to perform the duties normally associated with his or her sensitive duties program or aeronautical mission or if participation in said sensitive duties program, flight operations/status, operational program access or permission has been temporarily suspended during the TDY period, only the identified MTF competent medical authority, or home station medical facility Chief of Aerospace Medicine may authorize the individual to travel to the TDY location without his or her outpatient medical or dental treatment records. See paragraph 5.28. for additional PRP records transfer instructions.

5.16.8.1.2. Exception #2. The MTF Commander (Custodian of Records) or his/her delegate is authorized to grant exceptions (in writing) to this policy on a CASE-BY-CASE basis to satisfy unique individual situations where providing the original medical and/or dental records to the requesting beneficiary is in the patient's and/or the government's best interest. MTF Commanders may not issue general blanket orders or MTF policy that allows any beneficiary to hand-carry his or her medical or dental records without careful analysis of all of the circumstances surrounding the individual request. Additional exceptions may include circumstances in which a significant inconvenience to the patient may occur or where continuity of care may be negatively impacted if records were to be mailed. No sponsor is authorized to possess or hand-carry the original health records or copies of health records for any member of his family aged 18 years or older without written permission from the family member.

5.17. Filing Outpatient Computer Generated Clinical Diagnostic Results.

5.17.1. Daily filing of outpatient clinical diagnostic and/or test results is generally no longer required. Diagnostic results and tests are easily obtained using available automated computer system clinical diagnostic and test results retrieval mechanisms.

5.17.1.1. If a particular state law requires the maintenance of hard copy diagnostic test results or specifically prohibits the storage of these results in electronic media, then the MTF must comply. Otherwise, there is no requirement to print and file (into the paper outpatient medical record) a hardcopy diagnostic or clinical test result, however.

5.17.1.2. Prior to any PCS reassignment, personal geographic location move, MTF reassignment, or change to TRICARE enrollment location, MTF records personnel will identify and print all CHCS laboratory, radiology, and/or clinical diagnostic results that have accumulated from the departure or losing MTF for each departing beneficiary. This rule applies to Services Members, retirees, and family members alike. The losing MTF must still transfer the paper record to the gaining MTF. The gaining MTF will usually not be able to access or view clinical diagnostic reports and information completed and stored at another MTF or on a CHCS host computer server other than their own. These procedures are required to ensure the gaining MTF has access to the beneficiary's complete health record. While laboratory and radiology reports are usually available in AHLTA from any MTF location, printing all available laboratory and radiology reports prior to a beneficiary's MTF transfer will alleviate a portion of this burden prior to final record disposition.

5.18. Researching Appropriate Host MTF Record Locations.

5.18.1. File health record documents in the appropriate outpatient and/or dental record as soon as possible. Documents received after the record is "charged out" are temporarily placed in the pocket of the charge-out guide and will be filed into the health record upon return to the records library. The practice of "blindly" mailing medical documents or records to the MTF closest to where the beneficiary lives or works is prohibited. Confirmation of the exact MTF responsible for maintaining the beneficiary's health record(s) is required. If confirmation cannot be obtained, then contact the specific Uniformed Service personnel office according to the instructions in the following sections.

5.18.2. Active Duty Service Members: ADSMs may incur several permanent change of station (PCS) assignments; same station-permanent change of assignment (PCA) relocations; temporary duty assignments (TDY), deployments, and personal Leave absences that may include travel to various locations throughout the United States and abroad. Along the way, MTF medical records personnel may receive medical documents from internal facility clinics for active duty patients who have received transient medical care during these periods. Whatever the reason, the process of tracking down and locating current duty assignment stations is sometimes challenging. Several options for locating the primary record custody locations are listed below.

5.18.2.1. Active Duty Research Methods:

5.18.2.1.1. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the General Inquiry of DEERS (GIQD) Internet website. Defense Medical Information System (DMIS) ID location, military installation name, and current patient address are listed. Sponsor SSN is required to complete search. User ID and personal password are required to access this website application. Contact your Site Security Manager (SSM) to obtain necessary access. Contact AFMOA/SGAT if your SSM is not known.

5.18.2.1.2. Alternate Methods: When researching Air Force Service Member, access the Air Force Portal website's "White Pages" locator at **https://www.my.af.mil**/. User ID and personal password are required. Additionally, the Air Force "Global" e-mail directory may be used as another alternative reference method.

5.18.2.1.3. Although not a medical records or MTF locator, the DefenseLink Internet website at **http://www.defenselink.mil/faq/pis/PC04MLTR.html** may be of some limited use when researching an individual Service Member's duty address or duty contact information.

5.18.3. Family Members, Retired Military Members, and Other Non-Military Personnel: Health records of Air Force active duty family members are usually maintained at the MTF where the sponsor is assigned unless the sponsor is stationed at a remote or unaccompanied tour assignment. File medical documents for family members of active duty or retired military in the medical record at the MTF where the majority of care is provided or where the dependents are empanelled or enrolled in TRICARE. If the medical document(s) do not belong at the MTF where the research is accomplished, follow the instructions below.

5.18.3.1. Research Methods for Family Members, Retired Military Members, and Other Non-Military Personnel: Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the General Inquiry of DEERS (GIQD) Internet website. Defense Medical Information System (DMIS) ID location, military installation name, and current patient address are listed. Sponsor SSN is required to complete search. User ID and personal password are required to access this website application. Contact your Site Security Manager (SSM) to obtain necessary access. Contact AFMOA/SGAT if your SSM is not known.

5.18.3.2. In all other cases where the record cannot be located or if the patient's identification cannot be verified, file the "loose" documents in a charge-out guide. If the record is not located within 90-days, file the document(s) in either a new, properly labeled record jacket, or plain manila folder. Ensure the manila folder is labeled with the patient's full name, family member prefix, sponsor's SSN and year of last treatment. Create a label with the patient's ID and place the label on the left outside flap, in the upper right corner. Retire these medical documents IAW AFRIMS, Records Disposition Schedule, Series 41. **Note:** Card stock medical record jackets are often in short supply. Whenever practical use plain manila folders to document and store the miscellaneous "loose" documents.

5.18.4. If patient cannot be properly identified, return document(s) to the originating clinic for required ID data completion.

5.18.5. Develop local procedures between clinic and ancillary services personnel to correct errors and avoid omissions. Do not ask the patient to return an improperly completed form to the originator.

5.18.6. If the referring clinic cannot sufficiently identify the documents for filing, contact the Medical Records Review Committee chairperson or the Chief of the Medical Staff (SGH). If, after an extensive review the documents in questions cannot be identified by name, SSN, date of birth, or by any other available means, the Records Review Committee, with approval from the SGH, may destroy unidentifiable health documents.

5.19. Forwarding Loose Leaf, Orphaned, or Miscellaneous Medical Documents.

5.19.1. When forwarding health record documents, separated from the primary health record, to another MTF health records department, or similar authorized agency or location, follow the instructions listed below:

5.19.1.1. Active Duty Air Force Personnel. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the DEERS (GIQD) Internet website. Follow same instructions as listed in paragraph 5.18.2.1. If there is not enough patient data listed on the form(s) to properly identify the patient, then submit the documents to the MTF Health Records Committee. The committee is authorized to order the destruction of unidentifiable medical documents. Do not send loose or unidentifiable medical documents to the AFPC STR disposition center or to the AFPC world-wide personnel locator office.

5.19.1.2. Air Force Reserve Personnel. Although the CHCS-DEERS eligibility menu option or the DEERS (GIQD) Internet website may not identify the Service Member's RCMU location, it may identify the individual's home address, unit PAS Code, and/or last known Active Duty DMIS ID location (if the Service Member was activated at some point in the recent past). Follow same instructions as listed in paragraph 5.18.2.1. If unable to locate member's primary records custody location, or if there isn't enough patient data listed on the form(s) to properly identify the patient, and/or the Service Member's unit, contact the Air Force Reserve Command, Command Surgeon's Office (AFRC/SG), Robbins AFB, GA for additional guidance. Do not forward medical documents to AFRC without prior approval from an AFRC official. Furthermore, do not forward dependent or retiree health records or loose/orphaned documents to this headquarters command, nor to any Air Force Reserve unit as they DO NOT maintain records for retirees or dependents.

5.19.1.3. Air National Guard Personnel. Although the CHCS-DEERS eligibility menu option or the DEERS (GIQD) Internet website may not identify the Service Member's RCMU location, it may identify the individual's home address, unit PAS Code, and/or last known Active Duty DMIS ID location (if the Service Member was activated at some point in the recent past). Follow same instructions as listed in paragraph 5.18.2.1. If unable to locate member's primary records custody location, or if there isn't enough patient data listed on the form(s) to properly identify the patient and/or member's unit, contact Office of the Air Surgeon (NGB/SGP), National Guard Bureau, Joint Base Andrews, Maryland for additional guidance. Do not forward medical documents to NGB without prior approval from an NGB official. Furthermore, do not forward dependent or retiree health records or loose/orphaned documents to headquarters this command, nor to any Air National Guard Unit as they DO NOT maintain records for retirees or dependents.

5.19.1.4. USAF Individual Mobilization Augmentee (IMA) Personnel. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the DEERS (GIQD) Internet website. Follow the same instructions as listed in paragraph 5.18.2.1. If unable to locate member's primary records custody location, or if there isn't enough patient data listed on the form(s) to properly identify the patient, and/or IMA's unit of attachment, contact RMG/IRMS, Warner Robins AFB, GA for additional guidance. Do not forward medical documents to AFRC without prior approval from an AFRC official. Do not forward dependent family member or retiree Service Member health records to this command.

5.19.1.5. U.S. Army Personnel. Forward US Army health records or document(s) according to the instructions listed below:

5.19.1.5.1. Locate a patient's PCM and primary record location by referencing the General Inquiry of DEERS (GIQD) Internet website. Defense Medical Information System (DMIS) ID location, military installation name, and current patient address are listed. Follow same instructions as listed in paragraph 5.18.2.1. If unable to locate member's primary records custody location, forward AD officer, warrant officer, and enlisted health records to the: US Army Medical Command, ATTN: MCHO-CL-P, 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

5.19.1.6. U.S. Navy Personnel. Forward US Navy health records or document(s) according to the instructions listed below.

5.19.1.6.1. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the General Inquiry of DEERS (GIQD) Internet website. Defense Medical Information System (DMIS) ID location, military installation name, and current patient address are listed. Follow same instructions as listed in paragraph 5.18.2.1. If unable to locate member's primary records custody location, then draft and forward a generic letter with the name and SSN of the AD, Reserve, or retiree to the Department of the Navy, Navy Personnel Command (NPC), PERS-312, 5720 Integrity Drive, Millington, TN 38055-3120, commercial voice contact at (901) 874-3388, DSN Voice at 882-3388, or FAX to DSN 882-2766. The NPC should provide advice as to whether the document(s) and/or record(s) should be retired to NPRC or to the Department of Veterans Affairs (DVA) Records Management Center (RMC). For more information, visit the U.S. Navy Personnel Command website at **http://www.npc.navy.mil/default.htm**.

5.19.1.7. U.S. Marine Corps Personnel. Forward US Marine Corps health records or document(s) according to the instructions listed below.

5.19.1.7.1. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the DEERS (GIQD) Internet website @ **https://www.dmdc.osd.mil/appj/giqd/login.jsp**. Defense Medical Information System (DMIS) ID location, military installation name, and current patient address are listed. Follow same instructions as listed in paragraph 5.18.2.1. If unable to locate the member's primary records custody location, forward the medical record(s) or form(s) to the US Marine Corps (USMS) Worldwide Locator Service, Commandant of the Marine Corps, Headquarters USMC, Code MMSB-10, Quantico, VA 22134-5030.

5.19.1.8. U.S. Coast Guard. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the DEERS (GIQD) Internet website @ **https://www.dmdc.osd.mil/appj/giqd/login.jsp**. Defense Medical Information System (DMIS) ID location, military installation name, and current patient address are listed.

5.19.1.9. U.S. Public Health Service (USPHS) Commissioned Corps records or documents with a complete name and SSN, forward to Office of Commissioned Corps Support Services, Medical Branch, 5600 Fishers Lane, Parklawn Building, Room 4.35., Rockville, MD 20857-0435.

5.19.1.10. National Oceanic and Atmospheric Administration (NOAA) records or documents with a complete name and SSN, forward to Commissioned Personnel Center, NOAA (ATTN: CP01), 11400 Rockville Pike, Room 108, Rockville, MD 20852-3004.

5.19.1.11. Retired Military and Family Members. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the DEERS (GIQD) Internet Website @ **https://www.dmdc.osd.mil/appj/giqd/login.jsp**. Defense Medical Information System (DMIS) ID location, military installation name, and current sponsor/patient address are listed. Sponsor's SSN is required. If unable to locate the family member's PCM and/or primary records custody location, place the loose documents in a charge-out guide and follow instructions listed in paragraph 5.18.3.2.

5.19.1.12. Remember, to identify the primary health records custody location ID for all patient categories, in all services, first try the CHCS-DEERS eligibility menu option, then reference the DEERS (GIQD) Internet Website at: **https://www.dmdc.osd.mil/appj/giqd/login.jsp**. Finally, be sure to follow individual Uniformed Services forwarding instructions or contact the agency in question BEFORE you mail the documents via the US Postal System.

5.19.1.13. If the gaining/servicing MTF cannot be clearly identified, do not mail the medical documents or record. Mailing medical documents or records to the MTF closest to where the beneficiary lives or works is prohibited. Confirmation of the exact MTF responsible for maintaining the beneficiary's health record(s) is required. The losing MTF must maintain the record until it is requested or eligible for retirement to NPRC.

5.19.1.14. National Personnel Record Center (NPRC). Forward loose documents belonging in records stored at NPRC and those recalled from NPRC as follows:

5.19.1.14.1. When loose documents are identified but the original medical record has already been transferred to the NPRC, then:

5.19.1.14.1.1. Place documents in a folder (manila folder is acceptable).

5.19.1.14.1.2. Label the folder with the patient identifiers using a standard CHCS label to include at a minimum; last name and first name, sponsor SSN, patient date of birth, and record volume number (e.g., volume 2). **Note:** the label can be handwritten vs. CHCS output.

5.19.1.14.1.3. Add the record to the retirement index (via CHCS) for transfer to NPRC IAW the disposition rules in AFRIMS.

5.19.1.14.2. Guidelines for recalling records from NPRC:

5.19.1.14.2.1. NPRC technicians write the shelf location and transfer (accession) number on the record folders when charging out the record in response to record orders from MTFs. When the record is no longer required, return it to NPRC to be re-filed within the original shipment at the assigned NPRC shelf location.

5.19.1.14.2.2. Do not add the recalled record to subsequent record retirement shipments unless: a) the record was retained and updated for continued care and added back into CHCS, or b) NPRC cannot re-file the record due to insufficient room in the original storage box and has returned it the MTF for retirement in a future shipment.

5.20. Missing and Lost Health Records.

5.20.1. Health records, both in electronic and paper form are considered PHI and PII subject to the provisions of the Privacy Act (PA). Once a medical record is deemed "lost," specific steps must be taken in order to report the information and notify the affected beneficiary or party.

5.20.2. There are several instances when a health record may be considered "missing." Here are some of the most common examples:

5.20.2.1. A health record may be considered "missing" immediately following a record room supervisor's investigation of the circumstances surrounding the record's disappearance.

5.20.2.2. When a health record is discovered missing from the main Record File with no documented borrower location or date.

5.20.2.3. When a record is discovered missing from the main Record File (with a documented) borrower location and date, but the physical record has not returned to the Main File following a period of 30 calendar days or more - without a documented explanation.

5.20.3. MTFs must exhaust all reasonable means to locate a missing health record. When missing records are discovered, each MTF staff member is responsible for searching their immediate work area(s). MTF personnel will mobilize and help search for a missing record. The following procedures are required after discovering a record is missing.

5.20.3.1. Check to identify possible borrower charge-out locations in the automated MRT module; check for record misfiles in each record storage room; search provider offices and exam rooms; ensure the record has not been forwarded to a peer review or clinical review committee, meeting, or function; verify the record has not been sequestered from main file; verify the record has not been temporarily separated from the main file for any other official review function; if known, contact the previous MTF responsible for maintaining the beneficiary's health records. If the record still has not been located following the pre-ceding minimum search requirements, submit a record search request to the National Personnel Records Center and submit or add the missing record to the next quarterly AFMS "global" health records search request list.

5.20.4. AFMS "Global" Missing Health Records Search Requests.

5.20.4.1. If, after an extensive internal MTF search is completed, including contacting the patient's previous MTF, the investigation has not yielded the recovery of the missing record(s), MTF health records officials may request an Air Force Medical Service-wide search for the missing health records. This AFMOA/SGAT sponsored service provides MTF, RCMU, and GSU health records custodians, with an opportunity to broadcast their missing paper outpatient medical and/or dental records to other MTF records managers throughout the AFMS. Each quarter, AFMOA officials solicit all MTFs, RCMUs, and GSUs to submit their lists of missing medical and dental records to the San Antonio AFMOA office via secure, encrypted e-mail message. This quarterly missing record "data call" includes a pre-formatted data collection spreadsheet that each MTF completes when documenting their missing record(s). Before the missing record data/request is

submitted to AFMOA, the TOPA flight commander or patient administration flight commander will verify that all MTF records personnel have exhausted every possible research mechanism for every identified missing record. The TOPA flight commander or the patient administration flight commander will include the following statement in either the body of an encrypted e-mail message to AFMOA or typed and included in the faxed report: "I certify an extensive investigation has concluded the identified missing record(s) cannot be located within this MTF. All reasonable records research efforts have been exhausted. All necessary communications with records management officials at other potential MTF and/or record maintenance and storage sites have not contributed to the successful recovery of the missing record(s)."

5.20.4.2. The information listed below will be e-mailed or faxed to the AFMOA/SGAT, Health Benefits Office. Forwarding the missing record information via e-mail message is the preferred communication method. However, fax requests may be accepted but prior coordination with AFMOA is required. fax requests must also include the standard HIPAA warning advisory. E-mail messages will ONLY be forwarded to AFMOA using Common Access Card (CAC) digital signature and encryption protocols verified using registered Air Force Public Key Infrastructure (PKI) identification/security certificates. Simply assigning a document password and forwarding the information unencrypted to higher headquarters is not authorized. The message must be digitally signed and encrypted. No exceptions. Include the following information:

5.20.4.2.1. Patient's Last Name, Patient's First Name, Middle Initial.

5.20.4.2.2. Sponsor's Full Name (Last Name, First Name, Middle Initial).

5.20.4.2.3. Sponsor's SSN.

5.20.4.2.4. Patient FMP (20, 30, 01, 02, etc.).

5.20.4.2.5. Patient's PAT CAT.

5.20.4.2.6. Sponsor's Pay Grade and Rank.

5.20.4.2.7. Patient Status (AD/AF; Dep Son Ret/USN, Retired USA, etc.).

5.20.4.2.8. Location and date where record was last seen. **Note:** List MTF name only. Due to federal privacy laws, specific references to the name of the last known outpatient clinic or clinical work center will not be forwarded to the AFMS, e.g., do not include the Urology Clinic, 19 Sep 2010 as the last known record location.

5.20.4.2.9. Identify a POC for each missing record. Include name, rank, telephone number, and e-mail address.

5.20.5. If after all preceding research actions have completed, and still the missing record(s) has not been recovered, the squadron commander responsible for the records room reporting the loss is responsible for informing the MTF Commander. Only the MTF Commander may deem a missing health record as "lost."

5.20.5.1. After all efforts to find the lost health record(s) are exhausted, MTF personnel must follow the guidelines and procedures identified in DoD 5400.11-R in consultation with the installation Public Affairs Officer and available installation legal staff and/or the MLC. MTF personnel should be aware that Public Affairs reporting and notification

procedures often require disclosing the paper or electronic breech to the U.S. Computer Emergency Response Team (USCERT) within one hour of the "lost" determination.

5.21. Health Records Availability, Accountability, and "Tracking" Standards.

5.21.1. All MTFs and/or medical units with CHCS computer capabilities must utilize the CHCS MRT function to properly manage, track, and locate health records. Efficient use of associated MRT system tools like the records bar code scanner and electronic AF Form 250, Health Record Charge-Out Guide Request will save time and reduce misplaced paper health records. Any non-MTF organization authorized to maintain ADSM or RC health records without using the CHCS computer MRT module to identify and manage their record inventory, shall establish a manual tracking system.

5.21.2. The CHCS computer MRT function will be used to "charge in" and "charge out" records between the medical records department and every authorized requesting "borrower" location in the MTF or within the medical unit. Records managers should create or "build" borrowing locations within the MRT module for all locations/borrowers that regularly request health records. Contact your site CHCS systems office for assistance.

5.21.3. Monthly Outpatient Medical Record Accountability Review: Every 30 days, records managers in each MTF record room will review all of the medical records that have been loaned or "charged out" to borrowers for more than 30 days. Records personnel are required to identify each overdue record and contact the last known borrower to inquire about the status of the record. Establish a local process to retrieve records that have been loaned to borrowers for more than 30 days. Overdue records will be identified by viewing the CHCS Overdue Records List Report or similar CHCS records management reporting mechanism. Maintain monthly overdue/missing record statistics by documenting the overall records assigned to the individual record room (denominator) and comparing this number to the number of overall missing and/or overdue medical records (numerator). To obtain the percentage of missing and/or overdue records, divide the numerator by the denominator. Report findings monthly to the Health Records Review Committee (or similar records review function), and to the TOPA Flight Commander or Patient Administration Officer. The TOPA function is responsible for creating an aggregate MTF total of overdue or missing records. The TOPA Flight Commander or Patient Administration Officer will use the submitted information to identify duty locations and/or individuals who routinely borrow records without returning them to the main file. Refer to paragraph 5.14. for potential medical records availability exceptions for RCSMs on active duty orders. Refer to paragraph 5.20., Lost Medical Records, for additional information regarding obligations required when reporting missing or lost medical records.

5.21.4. Health Record Availability Standards: With the implementation of the DoD electronic health record, immediate reliance upon outpatient paper medical records should diminish, not cease. Eventually, the AFMS will completely transition from a paper-based to a comprehensive, all-inclusive, electronic health record system. However, to satisfy DoD, Joint Commission, and AAAHC functional and provider/point-of-service outpatient medical record availability, and various auditing requirements, paper outpatient paper medical records must still be maintained and accounted for at each MTF. Two basic medical records availability metrics measure an MTF's compliance with standards.

5.21.4.1. AFMS Provider/Point of Service Record Availability Standard. Unless an MTF has implemented a local policy to retrieve or "pull" outpatient paper medical records by exception, MTFs will continue to implement a system to meet the minimum 90% Air Force Medical Service (AFMS) provider/point-of-service availability standard. Air Force Medical Service Provider/Point of Service availability is defined as the physical presence of the paper record for use at the point-of-service or when needed for specific review or audit. This standard applies to MTF records rooms (whether centralized or decentralized).

5.21.4.1.1. Methodology. Outpatient records availability percentages are generated by tracking and maintaining the numbers of records that were retrieved and delivered to the point-of-service, then dividing by the number of record requests (manual entry AF Form 250 and electronic record requests) received. The overall monthly MTF records availability percentage is generated by combining the monthly number of records delivered to the point-of-service (for each individual records room) then dividing this total number by the total number of all MTF outpatient record room requests (manual and electronic). Report this data to the MTF Health Records Review Committee or function and to the AFMOA/SGAT Health Benefits office by the 10th duty day following the close of the previous reporting month. For patients with multiple appointments on the same day, count the record as being available for all of the appointments as long as the record(s) was delivered to the first scheduled appointment. However, records personnel should attach a note or locally created notice or "flag" to the record, before distribution to the first appointment location. The note should inform the record(s) borrower that the patient has multiple same-day appointments. The note or "flag" will alert clinic staff to forward the patient's record to the next clinic. Clinic personnel are required to forward the record to the next location.

5.21.4.2. DoD Minimum Functional Control Record Availability Standard. MTF records managers must ensure their outpatient records control process include procedures to ensure 95% percent availability of all outpatient medical records. "Availability" is defined as any outpatient medical record located within the MTF having functional responsibility for maintaining the record. DoD "availability" is not to be confused with "provider or point of service" availability as described in the previous paragraph.

5.21.4.2.1. Methodology. DoDI 6040.40, Military Health System Data Quality Management Control Procedures, Enclosure 1, paragraph C.6., identifies a minimum "on hand" records availability audit formula. From a random sample of CHCS outpatient appointments from the reporting month, medical record personnel will determine the percentage of available or "on hand" outpatient paper medical records that can be physically located in a record room file system. If an outpatient record is not immediately physically available in the record room file, but a properly documented AF Form 250 and plastic record charge-out guide are filed in place of the paper record, then count the record as available. If an MTF can prove record availability, according to this standard, by "pinpointing" the specific location of the record within an MTF medical records department(s) or MTF borrower location, using the CHCS computer MRT module or from a properly documented AF Form 250, then count the record as available. Records loaned to a borrower with a "check-

out" date older than 30 days, must be physically located and verified with the borrower.

5.21.4.3. Report monthly AFMS availability and OASD Health Affairs availability percentages to the MTF Health Records Review Committee. The committee chairperson will then report this information monthly to the Executive Committee of the Medical Staff (ECOMS) unless otherwise directed by the MTF Commander.

5.21.4.4. Refer to paragraph 5.14. for potential records availability exceptions for RCSMs placed on active duty.

5.21.5. Converting to a Paper Medical Records Retrieval or "Pull" by Exception Process: The Health Records Review Committee and the Executive Committee must support any decision to suspend or discontinue retrieving or "pulling" outpatient medical records for daily outpatient appointments.

5.21.5.1. The MTF SGH, in coordination with the unit commander(s) responsible for health records maintenance and management, must determine, based on program management analysis and input from the entire clinical staff that all providers who use AHLTA, are using the system the way it was designed to be used.

5.21.5.2. If the SGH and respective unit commander(s) support the decision to suspend daily paper outpatient medical records retrieval and distribution, the MTF Commander may approve the decision or determine another course of action. Approval may be for defined specialty groups, FHEs, clinics and/or entire facilities. Documentation of approval must include any sub-groups that will continue to require paper records on a regular basis.

5.21.5.3. Prior to approving any retrieve or "pull" records by exception policy, the MTF Commander must ensure that the requesting clinical work center(s) have created a process to verify patients have signed the HIPAA Notice of Privacy Practices for each empanelled patient. Refer to Section 6C for specific information and expectations regarding HIPAA (NoPP) requirements.

5.21.5.4. If the MTF Commander decides to suspend traditional daily paper outpatient medical records retrieval and distribution processes, an immediate six-month trial phase will be begin starting from the date of the decision or other designated implementation date.

5.21.5.5. During this period, the AFMS Provider or Point of Service records availability percentage, for patients with a) an established electronic medical record history, b) new patients with no previous outpatient paper medical record, and c) patient encounters for which the provider does not need to reference the traditional paper outpatient medical record, will be deemed to be 100%. Records room managers will meet with the CHCS site manager and/or information systems managers to suspend the automated function that produces the pre-printed AF Form 250, prior to each patient's appointment. Records personnel will inform clinic staff that individual records requests are still possible using CHCS.

5.21.5.6. During this period, if a provider(s) requests the traditional paper outpatient medical record prior to a patient encounter, and assuming there is an established

traditional paper record on file, records room personnel will retrieve and distribute the requested record(s). For all requested traditional outpatient paper medical records requested separately from the AHLTA system, records room supervisors will apply the same record availability methodology previously referenced in paragraph 5.21.5.1., and report this records availability statistic monthly to the Health Records Review Committee and to AFMOA/SGAT.

5.21.5.7. At the end of the six-month outpatient paper record suspension trial phase, the SGH, in coordination with the unit commander responsible for traditional health records maintenance and management, and based in part upon the input received from the Health Records Review Committee, the ECOMS, and input from the provider staff, will make a recommendation to the MTF Commander for one of the following options, a) permanently or temporarily cease MTF daily outpatient paper medical records retrieval and distribution processes, b) implement a limited cessation or selective cessation (based on MTF-unique circumstances) of paper medical records retrieval and distribution, c) institute another trial period, or d) determine some other appropriate action. Additionally, whatever process is chosen, paper documents from internal and external sources, scanned and uploaded into the EHR, must continue to be filed into the paper health record.

5.21.5.7.1. Exception 1: Until further policy guidance is provided, paper outpatient medical records will continue to be retrieved from the appropriate records file room and distributed to providers for daily outpatient encounters for members assigned to flight status or participating in the PRP, PSP, or other sensitive duties program. See paragraph 5.28. for more information regarding members assigned to the PRP or similar sensitive duties programs.

5.21.5.7.2. Exception 2: For official auditing purposes, the auditor must either be supplied with a paper copy of the applicable patient encounters or provided access to AHLTA to review the outpatient encounter documentation.

5.21.6. Using Charge-Out Guides. Use AF Forms 885, 886, and 887. Medical Record Charge-Out Guides, and AF Form 250, to indicate the location of an outpatient record removed from the file. Use of the MRT module in CHCS is required as a tool to track movement of outpatient records. It also enhances the management of records accountability and availability.

5.21.7. Loaning Records to Clinics/Units. MTFs must establish strict, but sensible, procedures to manage the loaning of records. The following instructions must be adhered to ensure sound health records management operations.

5.21.7.1. Limit access to all outpatient medical records areas to only authorized personnel. MTF personnel should not be granted access based solely on the proximity of their clinic or work center to the secure records area.

5.21.7.2. When a paper medical record is requested or removed from file by an authorized borrower, records room personnel will ensure the borrower uses a charge-out guide and completes the AF Form 250 with accurate, adequate, and legible, information or requests the record through the CHCS MRT module. Whenever possible, automated CHCS AF Form 250s should be used to place inside the charge-out guide.

5.21.7.3. The outpatient records department and clinic personnel will ensure the outpatient record is available prior to the patient's appointment.

5.21.7.4. Medical records staff must notify the requesting clinic or clinical work center when the medical record is not available. If the record is not available at the clinic or borrower's location before the patient arrives the clinic staff should access the MRT module to ascertain the location of the health record(s) or contact the medical records department if an explanation has not been provided. If the record is not available, the provider should make an entry on the form used to document care that the record was not available for review.

5.21.7.5. Generally, health records are only to be loaned to internal work centers. However, there may be very unique instances when the original health record(s) may be released to an outside agency, MTF, civilian medical facility, or even the patient. The MTF Commander is the only official authorized to release original health record(s) to external MTF requestors. **Note:** If a health record(s) is involved in a potential Medical Affirmative (MAC) Claim, or other potential claim either for or against the US Government, or for potential litigation, or for use as evidence in a court of law, do not give the original record to the patient. All parties with legitimate and legal authorization to receive either the health record(s) or copies will be provided the information once all security validation and/or authorization requirements have been met. Refer to the HIPAA disclosure and information release section of this instruction for further guidance.

5.21.7.5.1. The Medical Cost Reimbursement Program (MCRP) replaced the Hospital Recovery (HR) claims program administered by base legal offices and is now administered through 8 regional offices. MCRP recoveries are made pursuant to the Federal Medical Care Recovery Act and the Coordination of Benefits statute, as well as any applicable state laws allowing for recovery. All money recovered will be returned to the MTFs or TMA. MCRP legal personnel may require access to health records and MTFs should coordinate the appropriate access to needed health information. For more information on MCRP, contact the Air Force Legal Operations Agency, Claims and Tort Litigation Division (AFLOA/JACC).

5.21.7.6. Health records for military retired Service Members and the records of a retired Service Member's family members must be maintained at an MTF.

5.21.8. Medical Records Custody Responsibility and Records Borrower Training.

5.21.8.1. TRICARE Operations and/or Patient Administration officials will brief newly assigned staff members during initial "in-processing" or MTF newcomer's orientation and again annually thereafter, about their responsibilities regarding expected health records custody management. Training should provide, but not be limited to, how to request a paper medical record, information regarding appropriate records control, release, availability, accountability of health records, and the transition from paper-based to electronic health records. Training may be informal, formal, or computer-based. This records "awareness" training is separate from initial and annual HIPAA training requirements.

5.21.8.2. Training will be documented in the Career Field Education and Training Plan or other official record of personnel training accomplishments.

5.21.8.3. Just as important as the availability of health records so is the completeness of the documentation for the same. MTFs will establish procedures to ensure that records contain accurate and complete documentation of outpatient visits.

5.21.8.4. MTFs should inform beneficiaries of DoD and AFMS health records custody rules whenever and wherever possible (e.g., at town hall meetings, via patient newsletters, time of MTF registration, etc).

5.21.9. Obtaining Government Owned Medical Record(s) from Patients: When it is known that a patient has custody of their record(s), initiate the following procedures to retrieve the record from the patient:

5.21.9.1. Contact the patient and/or the sponsor and inform the party(s) the record(s) is the property of the United States Government and must be returned immediately. Inform the patient they may receive a free copy of the record but the original must be maintained at the MTF.

5.21.9.2. If the patient does not return the record after contact, take the following actions:

5.21.9.2.1. Active Duty and their Family Members: Contact the sponsor's first sergeant or unit commander for assistance in retrieving the health record(s). Inform the sponsor's unit commander or first sergeant of your previous attempts to collect the record(s) in accordance with instruction. If, after contacting the sponsor's chain of command, the patient still has not returned the record(s), send a certified letter to the sponsor's and/or patient's home address notifying him/her that the record(s) are the property of the United States Government. Inform the sponsor or patient that a complete copy may be provided at no charge. The sponsor must provide a signed authorization however for any dependent over the age of 18. Reference any known previous attempts or actions to collect the record(s) and instances (if any) of refusals to cooperate. Request the record(s) be returned to the MTF within 10 calendar days from receipt of the letter. Inform the sponsor that failure to comply will result in an additional notification to his/her first sergeant or unit commander which may result in potential administrative or corrective personnel action.

5.21.9.2.2. For all other beneficiaries enrolled to your MTF: If, after requesting the record(s) in accordance with the directions found in this instruction, the patient(s) still has not returned the record(s), send a certified letter to the sponsor's and/or patient's home address notifying him/her that the record(s) are the property of the United States Government. Inform the sponsor or patient, that a complete copy may be provided (at no charge) to the sponsor and/or patient. Reference any known previous attempts or actions to collect the record(s) and instances (if any) of refusals to cooperate. Request the record(s) be returned to the MTF within 10 calendar days from receipt of the letter. Inform the patient and/or sponsor that failure to comply will result in notification to local law enforcement or installation Security Forces which may result in a criminal investigation for theft of United States Government property.

5.21.10. Clinic Personnel Record Accountability and Tracking Responsibilities:

5.21.10.1. Clinic personnel must keep outpatient record entries up-to-date and use the following disposition rules:

5.21.10.1.1. As a general rule, records are to be returned to the Outpatient Records location at the end of the duty day associated with each episode of care. Any provider requiring extended use of a record to complete necessary healthcare documentation requirements should re-charge the health record to their clinic every three-days using the CHCS Medical Records Tracking module.

5.21.10.1.2. Admission to Hospital. Send the outpatient record to the designated inpatient nursing unit. Clinic personnel will update the CHCS MRT module to document that the record has been transferred to the appropriate inpatient nursing unit

5.21.10.1.3. Transfer of Patient to Another Military Facility for Treatment. Outpatient medical records may be transferred to another MTF without obtaining a patient's permission. MTF personnel are required to document the record transfer using the CHCS MRT module.

5.22. Medical Documentation Requirements for Partial Hospitalization.

5.22.1. Partial hospitalization is defined as a facility or unit that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility. Patients would spend a portion or majority of a day (less than 24-hour daily care) in a hospital setting and then return to their homes or places of residence in the evening. They would then return to the facility on the following day.

5.22.1.1. Partial hospitalizations are characterized by structured, daily supervised, outpatient activities over a prolonged period (usually 2-6 weeks) tailored to treat or rehabilitate individuals with generic-like illnesses, dependencies or psychological profiles. Partial hospitalization may be used for crisis stabilization, treatment of partially stabilized mental health disorders for adults and adolescents, chemical dependency treatment programs, or as a transition from an inpatient program when medically necessary.

5.22.1.2. All documentation for partial hospitalization must comply with the current Joint Commission documentation standards. Standard Forms (SF), or other forms, as noted, are recommended for use in the partial hospitalization records. At a minimum, the documentation in the medical record will include:

5.22.1.2.1. SF 504, Parts I and II.

5.22.1.2.2. SF 505, Parts II and III.

5.22.1.2.3. SF 506 .

5.22.1.2.4. Nursing assessments and interventions.

5.22.1.2.5. SF 509, written daily, which reflects a brief summary of the therapeutic activity, observation of the patient's status and responses in the course of the therapeutic contact and the therapist's plans for any subsequent therapeutic contact.

5.22.1.2.6. AF Form 3066 or 3066-1.

5.22.1.2.7. AF Form 3069, as applicable.

5.22.1.2.8. Supporting documentation such as case management notes, treatment team notes, weekly progress summaries, and physician summaries including physician supervision, evaluation, and certification.

5.22.1.2.9. Patient education, release instructions, and plans for follow-up care.

5.22.1.3. All documentation related to a partial hospitalization stay will be filed as a package in the mental health record IAW AFI 44-172 or in Section III of the outpatient medical record, as applicable. Illnesses related to mental health will be filed in the mental health record.

5.23. Supplemental Documentation Guidance.

5.23.1. Inpatients Seen in Outpatient Clinics. Occasionally, inpatients may have appointments in an outpatient clinic during their admission. After the appointment, the outpatient clinic staff will forward the outpatient appointment document(s) to the inpatient's nursing unit or place into the inpatient medical record.

5.23.2. Withdrawing Documents. When documents in an outpatient record are relevant to further treatment as an inpatient, the documents may be withdrawn and inserted in the inpatient record. Note the withdrawal on SF 600. Other than this exception, original medical document(s) will not be removed from a medical record after filing.

5.23.3. Dead on Arrival (DOA) and Emergency Room Death (ERD). All MTF DOA and ERD encounters will be reported in the automated ambulatory data collection system or other ambulatory data collection and coding system. Appropriate clinical coding and MEPRS code assignment is required. Any documents created for these patients will be filed in an Extended Ambulatory Record (EAR) and maintained in a secure, limited access area, separate from inpatient/outpatient health records.

5.23.4. Variations in the disposition and maintenance of records in clinics are not authorized. The MTF Commander ensures that the health records are maintained as required by current Air Force directives.

5.23.5. Request for Ancillary Services. Clinic personnel will ensure the appropriate ancillary request form is properly completed and lists all patient identification and other data required by directives. Develop local procedures between clinic and ancillary services to correct errors and avoid omissions.

5.23.6. When health record documents are received without adequate identification, records personnel may return the documents to the point of origin. The originating clinical work center must add the missing information for each incomplete entry and then return the document(s) to the appropriate health record section.

5.24. Mental Health Records Documentation Requirements.

5.24.1. Mental health records are a separate category of records that contain detailed psychiatric notations of evaluations, consultations, tests, and treatment provided on an outpatient or inpatient status. Do not use AF Form 2100 or 2100A series for records kept in the mental health clinic. These records must be kept in properly secured files in the mental health clinic. See AFI 44-109 and AFI 44-172, Chapter 4, for details on mental health records and records management.

5.25. Prenatal Records Documentation Requirements.

5.25.1. Prenatal records may be maintained separately by the prenatal clinic and then must be incorporated, as a package, into the inpatient record at the time of delivery, see Attachment 16 for filing instructions. For exceptions, see the following:

5.25.1.1. If a patient is transferred or relocates before delivery, the prenatal record should be given to the patient to hand-carry to the next MTF. If the patient does not expect to deliver in an MTF, copies of the prenatal record should be given to the patient and the original documents filed in the patient's outpatient record.

5.25.1.2. Prenatal records should be screened quarterly. When the expected date of delivery has passed or there is no indication that the patient is being followed, the prenatal record should be withdrawn from the prenatal file and forwarded to the outpatient records department for inclusion in the patient's outpatient record. If no outpatient record is available, prepare one.

5.26. Family Advocacy Program (FAP) Documentation Requirements.

5.26.1. The Family Advocacy clinic or office maintains the original FAP patient record. The FAP record contains detailed, confidential information regarding alleged or verified family maltreatment. For every patient visit to the Family Advocacy clinic, an abbreviated continuity of care entry must be documented in AHLTA. Treatment entries, documenting only minimal information, are inserted into AHLTA by FAP providers. The continuity of care AHLTA entry most commonly used indicates: "Patient was seen in Family Advocacy for assessment due to allegations of family maltreatment." Other abbreviated or minimally documented statements or references to one's suicidal/homicidal assessment and/or a maltreatment risk assessment will also be included in an AHLTA entry. The initial FAP Clinical Case Staffing (CCS) recommendations will be placed in AHLTA, as well as the transfer/closure summary for each patient treated in FAP.

5.26.2. When patients are seen in FAP for prevention services, there is only a requirement for an AHLTA note when there is a clinically significant finding, requiring documentation for continuity of care or a referral to a medical provider.

5.27. Documentation Requirements to Support Graduate Medical Examination (GME) Programs. Documentation requirements will be as outlined by the Accreditation Council for Graduate Medical Education (ACGME) in their common and specific program requirements.

5.28. Managing Service Treatment Records (STR) for Service Members Assigned to the Personnel Reliability Program (PRP), Sensitive Duties Programs, and for Personnel Assigned to Flight Status.

5.28.1. Medical Notification Process: The Service Treatment Record (medical and dental records) for Service Members assigned to the PRP, Presidential Support Program, active flying programs/status, or other highly sensitive, national security operations, require special handling to maintain program reliability and integrity. Overall PRP program requirements are located in DoD 5210.42-R, Nuclear Weapons Personnel Reliability Program, June 30, 2006 and AFMAN 10-3902, same title. MTF records managers are required to print the Electronic Health Record (EHR) patient encounter document(s) for every episode of care for each Service Member assigned to a sensitive duties (e.g., PRP, PSP, etc…) position. EHR patient

encounters must be printed to document each individual's operational status, unit notification stamp, notifier's name/initials, and time and date of the notification. File the printed encounters in the Service Member's outpatient medical record. Until further policy instructions are released, and/or the Military Health System (MHS) EHR system is enhanced to support automated individual operational capability/status notifications for Service Members assigned to any sensitive duties program or Airmen assigned to active flight status, the use of the EHR alone is not enough to ensure program assurance for these unique mission-critical programs. Printing of every encounter is not required for Service Members on FLY status who are not also on a sensitive duty status. Aeromedical dispositions on FLY status may be performed electronically, with unit notifications for changes in status being managed via the PIMR program.

5.28.2. Transferring STRs During PCS, PCA, or Permanent Duty Location Reassignment for Service Members Assigned to a Sensitive Duties Program or Flight Status.

5.28.2.1. This section applies to any Service Member or Airman currently assigned or who will be assigned upon arrival at their next installation or organization, to a sensitive duties or active flight status position, including but not limited to: Personnel Reliability Program, Presidential Support Program, air traffic controllers, overseas U.S. embassy support, or any Airmen on active Flight Status (FLY) or a Service Member assigned to a Flight position or those who maintain an active aeronautical rating. Airmen meeting these requirements, or any other Service Member authorized by the MTF Commander, are required to hand-carry their outpatient medical and dental treatment records (in a sealed envelope or package) from the losing or departure MTF to the arrival or gaining MTF; from the departure RCMU to the arrival or gaining RCMU; or from any official location responsible for maintaining health records to the arrival or gaining MTF, RCMU, or official duty assignment during a Permanent Change of Station, Permanent Change of Assignment, duty location re-assignment or extended Temporary Duty (TDY) assignment (excluding deployment). Inbound PRP and active flight crew personnel must hand-carry their medical records. If an Airman is not expected to perform the duties normally associated with his or her sensitive duties program, flight, or aeronautical mission or position, or if sensitive duties program, flight status, operational program access or permission(s) has been suspended or is expected to be suspended during, or at the next installation or duty assignment, or during an extended TDY period, only the identified MTF Competent Medical Authority, or MTF Chief of Aerospace Medicine (SGP) may authorize an individual to travel to the gaining installation or TDY location without his or her outpatient medical and dental treatment records in hand.

5.28.3. Physical Separation, from the Main File, for STRs of Service Members on Active Flight Status or Those Service Members Assigned to a Sensitive Duties Program. Outpatient medical and dental treatment records for active flight personnel or Airmen assigned to the PRP, PSP, or any other sensitive duty program, shall be maintained in a separate, secured location. Access to these physical STRs must be restricted to only those medical personnel with an official need.

5.28.4. Airmen meeting the personnel status conditions identified above are required to hand-carry their health treatment records (in a sealed envelope) from the losing MTF or RCMU to the gaining MTF or to the medical unit responsible for maintaining health records. Upon arrival to the gaining MTF or to the medical unit, the health records must be

surrendered to the MTF clinic or office responsible for the daily maintenance of these special records.

5.28.5. Before health records are provided to the Service Member, outpatient and/or dental records medical and dental record personnel will seal the record(s) in an appropriately sized envelope, then write or place a pre-worded ink stamp that indicates, "During Transport, Open Only for Medical Emergencies," across the envelope sealed flap seam. Then place one strip of clear or transparent ½ inch adhesive tape down the entire length of the envelope along the sealed flap seam. Finally, the records management official that seals the envelope must write his/her initials along the sealed flap seam and legibly write or place a pre-worded ink stamp that identifies the losing MTF or installation DTF unit name, office symbol, address, installation name, zip code, POC name and contact telephone number.

5.29. Transferring Health Records Between MTFs or Medical Units.

5.29.1. Transferring STRs During PCS, PCA or Permanent Duty Location Reassignment for Airmen Not Assigned to Sensitive Duties or Active Flight Status.

5.29.1.1. Custody and Control of Outpatient Medical and Dental Records: Historically, Airmen have been allowed to hand-carry their outpatient medical and dental records in a sealed envelope during a PCS or PCA reassignment. This practice is now prohibited for all Airmen, with the exception of Airmen assigned, or who will likely be assigned, to active Flight status, a sensitive duties position, or for those Service Members attending special operations courses identified later in this section.

5.29.1.2. MTF and RCMU records managers at the departure or losing MTF or RCMU are required to forward the health records (outpatient medical and dental records) for departing Service Members, to the gaining MTF or RCMU responsible for maintaining the Service Member's health records. Health records will be mailed NLT five duty days following the Service Member's PCS/PCA departure or date of separation/transition to the Reserve Component. Mail the records via standard First Class U.S. mail with immediate delivery confirmation/acknowledgment, certified mail, or other commercially available option, e.g., FedEx, that offers package tracking and/or arrival confirmation. Use of standard First Class U.S. Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment or certified mail receipt, is prohibited. Return receipt confirmation must not be dependent upon the timeliness or willingness of the destination MTF to complete a DD Form 2825, Internal Receipt, or other manual delivery confirmation receipt option.

5.29.1.3. The Service Member is required to present military PCS orders or duty location reassignment orders to the departure or losing MTF or to the RCMU prior to final departure from the installation or organization. Records managers at the losing MTF or RCMU will include a copy of the Service Member's PCS orders in the same mailing shipment package bound for the gaining MTF or destination medical unit.

5.29.1.4. MTF and DTF In/Out-Processing PCS Customer Service Locations: Ideally, each MTF and DTF should provide one central in-processing and out-processing customer service location for health records respective to each facility. For the installation DTF, this location is usually the front clinic reception desk. However, some MTFs have decentralized outpatient medical record rooms. Although one central MTF

outpatient medical records customer service and/or reception area is recommended, MTF Commanders may choose instead to align multiple outpatient medical customer service locations alongside or co-located with PCM or PCMH clinic operations.

5.29.1.5. Airmen PCS Departure Out-Processing Procedures: All Service Members empanelled to the MTF and scheduled for reassignment to another station are required to "out-process" through the MTF and DTF before final installation departure. The purpose of the out-processing visit is to ensure MTF and DTF records managers know to remove the Service Member's outpatient medical and dental records from the main file and prepare the record(s) for shipment to the gaining MTF.

5.29.1.6. Airmen projected for installation departure related to a PCS reassignment are required to clear the DTF and MTF no earlier than the 5th duty day BEFORE their final installation out-processing MPS appointment. This time period restriction ensures outpatient medical and dental records will be readily available to medical and dental providers up until the time the member leaves the base.

5.29.1.7. During each respective out-processing appointment, Airmen are required to provide four copies of their orders (two copies for the DTF, two copies for the MTF). Again, some MTFs have decentralized MTF records rooms. Depending on local operating policy, Service Member's may be required to visit a centrally located MTF records customer service office or out-process through their PCM records room location. MTF & DTF records personnel will ensure local installation out-processing checklists include MTF & DTF records out-processing requirements.

5.29.1.8. DTF Record Processing: No later than the close of business each duty day, DTF records managers will ensure two copies of each departing Airman's PCS reassignment orders are filed properly. One copy will be placed on top of all other documents in Section II of the AF Form 2100b series, Dental Treatment Record. The second copy will be placed in a plastic AF Form 885-887 series, Medical Record Charge-Out Guide.

5.29.1.8.1. Complete an AF Form 250, Health Record Charge-Out Guide Request and insert into the upper right identification slot on the charge-out-guide. File the charge-out guide into the main file according to terminal-digit order - just like the original dental record. The charge-out guide will remain for 90 calendar days. At the end of this period, if any loose, late-flowing dental documents are discovered, then place the documents and the copy of the PCS reassignment order in an envelope and mail directly from the DTF to the member's gaining DTF. Do not forward these late, loose flowing documents to the MTF outpatient records office.

5.29.1.8.2. No later than the close of business on the duty day following the member's out-processing visit, DTF records managers will forward the dental treatment record(s) to either a central MTF records room or to the PCM records room where the Service Member is empanelled. After receiving the dental treatment record(s), MTF records managers may temporarily stage the records in a separate location, away from the main outpatient medical file. Local MTF policy must be established to identify the best method for transferring the dental treatment records from the dental clinic to the MTF.

5.29.1.8.3. Dental record managers will document the date and forwarding location of each dental treatment record removed from the dental records main file using the current local or standard dental records tracking mechanism.

5.29.1.9. MTF Record Processing: No later than the close of business each duty day, MTF records managers will ensure two copies of each departing Airman's PCS reassignment orders are filed properly. One copy will be placed on top of all other documents in Section II of the AF Form 2100A series, Outpatient Treatment Record. The second copy will be placed in a plastic AF Form 885-887 series, Medical Record Charge-Out Guide.

5.29.1.9.1. Complete an AF Form 250, Health Record Charge-Out Guide Request and insert into the upper right identification slot on the charge-out-guide. File the charge-out guide into the main file according to terminal-digit order - just like the original outpatient medical record. The charge-out guide will remain for 90 calendar days. At the end of this period, if any loose, late-flowing dental documents are discovered, then place the documents and the copy of the PCS reassignment order in an envelope and mail directly from the MTF to the member's gaining MTF.

5.29.1.9.2. MTF records managers are required to mail the medical and dental records bundled together, to the gaining MTF, RCMU, or to the gaining medical unit responsible for the daily maintenance of the record, NLT five duty days following the Service Member's installation departure date. Ensure a copy of the Service Member's PCS reassignment or service component transition orders have been placed inside the dental treatment and outpatient medical records. Mail the records via standard First Class U.S. mail with immediate delivery confirmation/acknowledgment, certified mail, or other commercially available option, e.g., FedEx, that offers package tracking and/or arrival confirmation. Use of standard First Class U.S. Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment or certified mail receipt, is prohibited. Return receipt confirmation must not be dependent upon the timeliness or willingness of the destination MTF to complete a DD Form 2825, Internal Receipt, or other manual delivery confirmation receipt option.

5.29.1.9.3. Select and enter the appropriate transfer code in the CHCS MRT module and enter the name of gaining MTF in the "MTF Location Remarks Section."

5.29.1.9.4. Keep and maintain a copy of the member's PCS orders and place into a plastic Medical Record Charge-Out Guide. File the charge-out guide in the main file, according to member's SSN, and remove after 90 days.

5.29.1.9.5. After 90 days, retrieve the charge-out guide from the main file and forward any "loose" or late flowing documents that may have collected in the charge-out guide to the gaining MTF, RCMU, or to the gaining medical unit responsible for the daily maintenance of the record. Place loose documents in an envelope and mail to the gaining MTF or RCMU. Mail the loose medical documents via standard First Class U.S. mail with immediate delivery confirmation/acknowledgment, certified mail, or other commercially available option, e.g., FedEx, that offers package tracking and/or arrival confirmation. Use of standard First Class U.S. Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment or

certified mail receipt, is prohibited. Return receipt confirmation must not be dependent upon the timeliness or willingness of the destination MTF to complete a DD Form 2825, Internal Receipt, or other manual delivery confirmation receipt option.

5.29.2. Transferring Service Member STRs During PCS, PCA or Duty Location Reassignment to Forward or Foreign Combat/Combat Support Theater of Operations Locations, or Other Overseas Deployment Locations for Airmen Not Assigned to Sensitive Duties or Active Flight Status.

5.29.2.1. For 365-day PCS and/or extended deployments to the Area of Responsibility (AOR), overseas combat/campaign theater of operations, combat zones, or combat support locations, the Service Member's original STR will remain at the MTF for which he or she was recently enrolled until the Service Member either returns from deployment or receives a "follow-on" PCS assignment to another installation. Obtain two copies of the PCS orders and place one copy of each inside the original outpatient medical and dental treatment records in Section I or attach to the left side folder flap on top of most current DD Form 2766, Adult Preventive and Chronic Care Flowsheet, dental treatment encounter form, service transition order, or AF Form 1288, Application for Ready Reserve Assignment.

5.29.2.2. Following the AD or RCSM's deployment medical clearance, established during the MTF pre-deployment screening, and before the Service Member finishes departure PCS out-processing, print the most current version of the Preventive Health Assessment and Individual Medical Readiness (PIMR) DD Form 2766 and DD Form 2766C (Immunization History Continuation Form) and place them into the cardstock DD Form 2766 (secured with the metal prongs). Include paper copies of any medical information that documents chronic medical conditions or any documents ordered to be copied and placed into the Service Member's DD Form 2766. The Service Member (or a deployment chalk commander or deployment team leader) is responsible for transporting the original DD Form 2766 along with the documents listed above, leaving the original outpatient medical and dental treatment record and a copy of the DD Form 2766 behind at the Service Member's home MTF.

5.29.2.3. When the Service Member returns to his/her home installation, the DD Form 2766 and any documents generated in theater are removed from the DD Form 2766 and filed in their respective sections inside the original outpatient medical and/or dental treatment record. If the Service Member has received an order to proceed to a follow-on PCS re-assignment installation, the gaining MTF will request the Service Member's original outpatient medical and dental treatment records from the departure or losing home installation MTF.

5.29.2.4. Exception: When a Service Member receives a 365-day PCS order to proceed to the 386 EMDG/EMEDS (Ali Al Salem), the Service Member will hand-carry his/her original outpatient medical and dental treatment records (in a sealed package – secured by the departure MTF). Upon arrival, the Service Member is required to relinquish their health records to the EMEDS facility or to the installation MTF. (**Note:** As additional AOR, theater or combat and combat support sites are adequately resourced to manage

medical records, these facilities will be identified and added to the exception list maintained by AFMOA/SGAT).

5.29.3. Transferring Service Member STRs During PCS, PCA or Duty Location Reassignment for Air Force Members Empanelled to Sister-Service MTFs: The fact that some Airmen are enrolled to non-Air Force MTFs may pose a noteworthy challenge, but this scenario does not prohibit the accurate and timely health records transfer process. Health records for Service Members are normally maintained at the MTF where the member obtains his/her primary care, regardless of service affiliation. To facilitate appropriate health records transfer procedures for Air Force Service Members, health records management officials at Air Force MTFs located nearest to the Service Member's sister-service PCM/MTF location must establish a local memorandum of agreement or support agreement with the sister-service MTF and the Service Member's servicing MPS to ensure all final out-processing documents, checklist requirements, MPS-generated PCS notices, and PCS orders are completed and/or forwarded between and/or to each appropriate agency for necessary processing action. The agreement must identify how the health records of Air Force personnel will transfer to the MTF at the next duty location. Transfer options may include, but are not limited to instructions that specify health records be, a) mailed to the requesting Air Force MTF by the sister-service MTF, b) forwarded to the MTF at the Airman's next duty location or, c) provided to the Service Member (if the Airman is assigned to a sensitive duties program or active flight status) in a sealed envelope by the sister-service MTF according to written local instructions that clearly define the minimum records custody rules, requirements, and prohibitions (IAW DoDI 6040.43. and this instruction) regarding record hand-carrying allowances or case-by-case MTF Commander waiver authority.

5.29.3.1. **Note:** If an agreement between the sister-service PCM/MTF, the local installation MPS and the MTF nearest to the Service Member's GSU cannot be reached, the local MPS and the nearest MTF may have to initiate local procedures that are fair and equitable to both organizations to ensure the health records located at non-Air Force MTFs are properly forwarded and delivered to the Airman's next duty station support MTF.

5.29.4. Active Duty Virtual MPS Checklist Confirmation. Historically, only the MTF Force Health Management (FHM) staff had access to the Virtual MPS. In May 2010, AFPC directed all MPSs to authorize MTF and DTF Records Rooms access. MTF health records offices have been added as mandatory out-processing checklist destinations for each outbound Service Member. Although the FHM may have additional medical out-processing checklist approval authority or obligations, they should not "sign off" or approve any outpatient medical or dental treatment record out-processing tasks on a Service Member's Virtual MPS out-processing checklist. Outpatient medical and dental records managers and FHM officials will work together to ensure each outbound Airmen has fulfilled all of his or her MTF out-processing responsibilities.

5.29.4.1. Checklist Operation: Multiple (at least two) staff members assigned to MTF and DTF records departments be granted Virtual MPS Checklist access to ensure each departing Service Member is informed of the requirement to provide the MTF and DTF with copies of his/her orders at the time of MTF/DTF out-processing. Access will also allow MTF records managers to obtain and print individual retirement/separation orders when necessary.

5.29.5. Transferring Outpatient Medical and Dental Records between MTFs for Family Members, Retired Military Service Members, or Any Other Category of Beneficiary Not Specifically Captured in this Section.

5.29.5.1. According to DoDI 6040.43, MHS beneficiaries are prohibited from hand-carrying their medical records. The practice of mailing family member hard-copy, paper-based, outpatient medical and dental treatment records from one MTF to another during a PCS/PCA reassignment, personal relocation move, or PCM reassignment is now standard procedure throughout the AFMS. Only the MTF Commander can make a case-by-case exception to deviate from this process.

5.29.5.2. Upon notification from the sponsor that he or she is being re-assigned to another installation, MTF outpatient medical records personnel will check the Service Member's typed PCS/PCA orders to determine if the reassignment is to be "ACCOMPANIED" (with family members) or "UNACCOMPANIED" (without family members). If the Service Member's reassignment orders indicate family members will accompany the Service Member to his or her next destination, then MTF records personnel will ask the Service Member if all of the family members are expected to accompany him or her. If all family members are accompanying the Service member, then MTF records personnel will verify the departure date with the sponsor, obtain any available dental treatment records, and then combine all of the family member health records into one package (if reasonably able to do so without weakening the mailing envelope or package). MTF records personnel may also add the sponsor's STR into the same package. If the package is too big or it becomes impractical to combine all of the family's records together, then separate the Service Member's record from the package and mail separately. Enclose a copy of the sponsor's typed PCS/PCA reassignment orders in each package. Mail the health records package(s) to the destination MTF NLT five calendar days following the sponsor's departure date.

5.29.5.3. If the Active Duty sponsor indicates that one or more family members are NOT accompanying him or her to the next installation or if the sponsor's PCS/PCA reassignment orders indicate UNACCOMPANIED, MTF records personnel must verify, with the sponsor, if the remaining family member health record(s) should stay behind at the current MTF or whether the remaining health records should be forwarded to another facility where MTF TRICARE enrollment is expected. Inform the sponsor that if family members are expected to receive direct healthcare at another MTF, apart from where the sponsor will be enrolled, then upon arrival and/or TRICARE re-enrollment at the new MTF, the sponsor, spouse, or legally-aged family member must contact the outpatient medical records department to complete the necessary records request paperwork. Only after receiving a properly completed DD Form 2138, Request for Transfer of Outpatient Record or a DD Form 877, Request for Medical/Dental Records, or another suitable request form, from the requesting MTF, will the Air Force MTF (where health records are currently maintained) release and forward the requested records.

5.29.5.4. For retired Service Members, their family members, and active duty family members who wish to change their MTF PCM and/or MTF TRICARE enrollment location, without associated sponsor PCS/PCA or duty location reassignment, whether the move be across the country or within a multi-market service location (e.g., changing MTF/PCM location within the San Antonio, TX; Washington, DC; or Hampton

Roads/Norfolk/Portsmouth, VA - Tidewater area), inform the sponsor that upon arrival and/or TRICARE re-enrollment at the new MTF, the sponsor, spouse, or legally-aged family member must contact the outpatient medical records department to complete the necessary records request paperwork. Only after receiving a properly completed DD Form 2138, Request for Transfer of Outpatient Record or a DD Form 877, Request for Medical/Dental Records, or another suitable request form (from the requesting MTF) will the Air Force MTF (where health records are currently maintained) release and forward the requested records. If the sponsor contacts the departure or losing MTF before the anticipated MTH change, provide the sponsor with a DD Form 2138. Instruct the sponsor to complete Sections I and II of form and deliver the form to the MTF records department at the gaining MTF where TRICARE re-enrollment is expected.

5.29.5.5. Under all circumstances when mailing health records or when mailing loose, late flowing medical documents, MTF records personnel will use standard First Class U.S. mail with immediate delivery confirmation/acknowledgment, certified mail, or other commercially available option, e.g., FedEx, that offers package tracking and/or arrival confirmation. Use of standard First Class U.S. Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment or certified mail receipt, is prohibited. Return receipt confirmation must not be dependent upon the timeliness or willingness of the destination MTF to complete a DD Form 2825, Internal Receipt, or other manual delivery confirmation receipt option.

5.29.5.6. MTF Commanders (Custodians of Record or their delegates) may make exceptions to the hand-carrying policy on a CASE-BY-CASE basis if extenuating circumstances warrant it. No sponsor is authorized to possess or hand-carry the original health records or copies of health records for any member of his/her family aged 18 years or older without written permission from the family member.

5.29.5.7. Forward health records critical to potential, pending, or active litigation using ONLY Certified Mail via official military mail or U.S. Postal System. Packages will be mailed with an immediate delivery confirmation/acknowledgment feature, or other commercially available option, e.g., FedEx, that offers package tracking and/or arrival confirmation. Use of standard First Class U.S. Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment, is prohibited.

5.29.6. Disposition of Family Member Outpatient Medical and Dental Records When the Sponsor has a 365-day PCS to an Overseas Location in Support of Contingency Operations.

5.29.6.1. If the Service Member's PCS is identified as ACCOMPANIED on the sponsor's orders, the outpatient medical and dental records for all family members will remain at the losing or "home base" facility until the Service Member either returns from deployment or receives a follow-on PCS assignment to another location. Only upon request, provide copies of family member medical records (including AHLTA patient encounters) to the sponsor and/or any legally-aged family member.

5.29.6.2. If requested by the sponsor or any legally-aged Upon return from a 365-day PCS overseas location, if the sponsor receives a follow-on assignment to a different installation he or she will contact the gaining MTF upon arrival (at the new installation) and initiate a formal request to obtain his or her family-member dependent medical records from the losing MTF.

5.29.6.3. If the Service member's PCS is identified as UNACCOMPANIED on the orders, determine where the family member's MTF TRICARE enrollment is expected and mail records package accordingly or leave the records at the losing MTF if the family member remains enrolled there.

5.29.6.4. Insert a charge out guide with a copy of PCS orders, DD Form 877, or DD Form 2138. File all loose medical documents in the appropriate charge out guide. Maintain loose, late-flowing documents no more than 90 days. If, after 90 days have expired and one or more loose, late-flowing documents has been placed inside the charge-out guide, remove the document(s), place in a sealed envelope, and mail to the gaining MTF. Packages will be mailed with an immediate delivery confirmation/acknowledgment feature, or other commercially available option, e.g., FedEx, that offers package tracking and/or arrival confirmation. Use of standard First Class U.S. Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment, is prohibited.

5.29.6.5. When individuals who are not attached to the base are receiving medical care on base (for example, AFIT students), identify their records by entering their status on the record folder, in pencil. Do not forward these records except at the patient's specific request.

5.29.6.6. When mailing records pertinent to litigation cases, medical records and claims files will be mailed via certified mail/return receipt.

5.29.7. Transferring Mental Health Records.

5.29.7.1. See AFI 44-172 for procedures detailing the transfer of Mental Health Records.

5.30. Providing Health Records to Active Duty Members During TDY Periods.

5.30.1. With the enterprise-wide use of the EHR, there are very few situations where an Airman would be required to bring his or her paper outpatient and/or dental records to a TDY location. Most Professional Military Education (PME) and technical training schools no longer require students to bring their original medical record or copies of recent encounters. As a general rule, MTF outpatient records departments should only provide the original outpatient medical record to the member if, a) specifically required per formal training requirements (TDY orders must include this requirement in writing on the orders), b) if the member has a chronic medical condition where reference of the medical record could be useful during treatment at the TDY location, or c) in any situation that a provider deems medically necessary for the member to hand-carry his/her record while TDY. Ensure all pertinent EHR documents are printed and filed into the record prior to the Service Member's departure. If an original health record is to be provided, the record(s) must be enclosed in a strong envelope or package and sealed.

5.30.2. Exceptions.

5.30.2.1. Specialty Combat Rescue and Survival and Evasion Schools: The Air Force Survival, Evasion, Resistance and Escape (SERE) School and the Combat Rescue Officer Selection Course (CROSC) Course VS0V94-C. Often the remote location of these unique training environments does not allow EHR access. Students bound for SERE or CROSC training may be required to bring their paper (hard copy) outpatient medical record or

copies of their most recent patient encounters. Ideally, students approved and scheduled for these training courses will contact the MTF outpatient records department to either obtain their original outpatient medical records or copies of the most pertinent portions of the medical record well in advance of their class start date. If faced with the task of providing last-minute‖ records or copies, MTF records personnel will expedite the student's request. If the specialty school requires the original paper medical record, obtain one copy of the student's TDY orders and place inside a plastic AF Form 885-887 series, Medical Record Charge-Out Guide. Place the Charge-Out Guide in the main file where the original medical record was located for the duration of the TDY period. If providing copies, include the cardstock DD Form 2766, a current copy of the DD Form 2766C, and the last six months worth of printed EHR encounters. The record(s) must be enclosed in a strong envelope or package and sealed. If either SERE or CROSC course officials require only copies instead of original outpatient medical records, MTF personnel are required to provide the original DD Form 2766, a current copy of the DD Form 2766C, and the last 6 months of printed EHR historical encounters. These documents should be placed in an envelope and handed directly to the Service Member. Advise the member that he must return the DD Form 2766 to the MTF upon return from the TDY.

5.30.2.2. Airmen who will be assigned to, perform, or fill an active Flight status job or position or active sensitive duties program (PRP, PSP, etc.) job or position while at the TDY location shall hand-carry their STR to the TDY location. Flyers traveling to another military installation (to fulfill professional or continuing military or professional education requirements, when not assigned to an operational flight position), who remain for no more than six months, usually do not need to bring their paper STR. Instead, a current copy of the AF Form 1042, Medical Recommendation for Flying or Special Operational Duty should be enough to satisfy training program acceptance requirements. Flyers should obtain this form (or a copy) from their flight medicine physician before leaving for their TDY assignment.

5.30.2.2.1. The competent medical authority, Senior Flight Medicine Physician, and/or sensitive duties program integrity manager at the MTF at the TDY location will continue to perform all standard patient evaluations and duty capability/limitation unit notifications (following a patient encounter) between the MTF and unit commanders or operational unit sensitive duties program officials to maintain continued program integrity for Airmen traveling to or temporarily assigned to another military installation.

5.30.2.2.1.1. Each documented automated patient encounter for active flyers and sensitive duty participants will be printed from the EHR and filed into the Service Member's STR so that required hand written/stamped individual medical duty capability/limitation unit commander notifications may be permanently documented. Following the completion of all official TDY duties, local MTF records personnel will provide the original Service Member with his or her original STR to hand-carry back to their home installation. The STR must be enclosed in a strong envelope or package and sealed. In those instances where the original STR was not carried to the TDY location, it is the responsibility of the TDY MTF Flight to mail the printed AHLTA encounters back to the Airman's

host MTF. Use standard First Class U.S. mail with immediate delivery confirmation/acknowledgment, certified mail, or other commercially available option, e.g., FedEx, that offers package tracking and/or arrival confirmation. Use of standard First Class U.S. Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment or certified mail receipt, is prohibited. Return receipt confirmation must not be dependent upon the timeliness or willingness of the destination MTF to complete a DD Form 2825, Internal Receipt, or other manual delivery confirmation receipt option.

5.30.3. For all TDY Airmen normally assigned to a sensitive duties program (PRP, PSP, etc.) who are not expected to perform or fill an active operational sensitive duties position or job at the TDY location, are not required to hand-carry their STR to the TDY. Following each episode of care at the TDY location, personnel assigned to the sensitive duties program support office, flight medicine clinic or any official(s) responsible for managing the integrity of the MTF portion of the sensitive duties program notification system, will print out a copy of the EHR note and mail a copy (via Certified military or U.S. Mail with immediate delivery confirmation/package tracking) to the MTF at the Airman's home station. MTF personnel at the TDY location will also provide a copy of the printed EHR note to the Service Member. The Service Member is required to bring the printed EHR note to his or her provider at his/her home station. The returning Airman's provider is required to review the EHR document (either the mailed copy or the copy provided by the Service Member) to identify any potential medical issues that could jeopardize overall program integrity or reliability based upon the patient's capabilities/limitations (if any) documented or identified at the TDY location.

5.30.4. Before health records are provided to the member, outpatient and/or dental records personnel shall seal the record(s) in an appropriately sized envelope, then write or place a pre-worded ink stamp that indicates, "During Transport, Open Only for Medical Emergencies," across the envelope sealed flap seam. Then place one strip of clear or transparent ½ inch adhesive tape down the entire length of the envelope along the sealed flap seam. The records management official that seals the envelope must write his/her initials along the sealed flap seam and write or place a pre-worded ink stamp that identifies the losing MTF or installation DTF unit name, office symbol, address, installation name, zip code, POC name and contact telephone number.

5.30.5. Inform the member that the original medical record must be returned to the MTF records department within 24 hours upon returning from school or the first available duty day. Have the member sign the record out using the AF Form 1942, Clinic Index. This form acts as a receipt allowing the member to hand-carry their record to TDY location and they are responsible for returning the government property.

Section 5C—Inpatient Records Administration

5.31. Creating Inpatient Records.

5.31.1. Develop and maintain inpatient records using guidelines from this chapter and from Joint Commission standards. Records are to be completed within 30 days after the patient's discharge IAW Joint Commission standards. Prepare an inpatient record for the following episodes:

5.31.1.1. Patients admitted to an inpatient unit of an Air Force MTF, including patients admitted and discharged before midnight on the day of admission regardless of the type of discharge.

5.31.1.1.1. Reactivate the record of hospitalization if the patient is readmitted before midnight on the same day as discharged for the same reason as the first admission. The attending provider annotates the reason for readmission and the hospitalization is considered as one continuous period.

5.31.1.1.2. If the patient is readmitted after midnight, or the reason for readmission is different from that of the previous admission, create a new record.

5.31.1.2. Live births occurring in an Air Force MTF. **Note:** Do not create a separate record for stillbirth infants. All paperwork, including the autopsy (if performed), will be filed in the mother's inpatient record.

5.31.1.3. Patients who die in transit. The MTF receiving the remains processes the records and completes the AF Form 565 as if the patient had transferred in.

5.31.1.4. All patients admitted to an EMEDS facility or fixed contingency hospital during deployment. See Section 5D, Deployed Assignment Medical Record Management for further instructions.

5.31.2. A "canceled admission" may be appropriate in some instances. Annotate the admission worksheet with the reason for cancellation and place all paperwork generated by the admission (e.g., history and physical, progress notes, laboratory and x-ray reports, etc…) in the patient's outpatient record folder. Record and code the episode as an outpatient encounter.

5.32. Creation of the Master Patient Index (MPI).

5.32.1. The MPI serves as an alphabetical index of all hospital patients and patients for whom administrative responsibility is assumed (e.g., active duty military in non-federal MTFs). **Note:** Do not destroy - maintain for 50 years.

5.32.2. The MPI is created by and stored in the current automated system.

5.32.3. MTFs without automated A&D functions will maintain either "hard-copy" paper index cards or easily accessible and properly maintained DD Forms 739, Register of Patients as a source for locating prior admission data.

5.33. Preparing Inpatient Record Folders.

5.33.1. Number folders according to the sponsor's social security number (SSN). Place an automated bar code patient identification label in the upper right corner of the record jacket cover in the Patient Identification block. Document the record jacket cover according to the following table:

Table 5.3. Preparing Inpatient Record Folders.

If the patient is:	Use SSN of:
Active Duty/Reserve Component	Service Member
Family Member	Sponsor
Civilian Employee	Employee
Retired military	Member
Civilian Emergency	Patient
Foreign national, allied or other military member without SSN	Construct a SSN

5.33.2. See paragraph 5.10.6. for guidance regarding the creation of a "pseudo" SSN when a patient's own SSN is not known or does not exist.

5.33.3. Select an AF Form in the 788A-788J series, as appropriate, according to the last two digits of the applicable SSN. Enter patient identification information on the front of the folder.

5.33.3.1. Print the first name, middle initial, and last name of the patient in the space provided with a black pen, felt-tip marker, or embossed card. Address labels prepared by the Personnel Data System may be used to provide names of military personnel. DO NOT use pencil for any entry. Always place information in the upper right-hand corner of the jacket cover in the patient ID area.

5.33.3.2. Enter the sponsor's SSN in the preprinted blocks in the upper right-hand corner of the record.

5.33.3.3. Enter the family member prefix in the two circles next to the SSN.

5.33.3.4. Fill in the ½-inch square block, along the right edge of the back leaf of the folder, containing the same digit as the last digit of the SSN, with a black ink pen, felt-tip marker, or black tape.

5.33.3.5. On the outside, front cover of the inpatient record jacket, in the pre-printed or labeled treatment year grid section, fill-in the current treatment year that corresponds to the patient's most recent inpatient treatment. Use a black felt-tip marker or black pen.

5.33.3.6. Indicate the patient's status in the appropriate block on the front.

5.33.3.7. Attach the CHCS MRT bar code label to the inpatient record folder. See the MRTR2 User Guide for instructions on label requirements.

5.33.3.8. Stamping or labeling the front cover of the medical record with any large-letter identifiers other than "CROSS-REFERENCE," or with infant-adoption related notifications is discouraged. See paragraph 4.3.10. for detailed information regarding infant-adoption medical information release instructions.

5.33.4. Documents placed in the folder may be held together with a 3-inch fastener or fastened into the folder. When records are retired to the NPRC, documents are permanently affixed to the folder.

5.34. Contents of the Inpatient Record.

5.34.1. Upon the patient's disposition, arrange paper copies of forms in the order listed below as applicable to the case. **Note:** As MTFs increase their use of Essentris or other automated systems to create a computer-based patient record, the style and arrangement of data in the electronic record may vary from the guidance provided here. Records printed from automated systems should be assembled as closely as possible to the traditional inpatient record until more detailed instructions are published. An asterisk "*" denotes that the form may not be filed in the order listed. See instruction column for proper filing location. Command and locally developed medical forms should be filed in the appropriate order as according to purpose. See Attachment 16 for arrangement of forms in the inpatient record.

5.34.2. Problem Oriented Medical Record (POMR). If an MTF elects to use the POMR format, develop local directives to prescribe which cases will use this format, the method by which the forms are used and the manner in which the forms will be filed.

5.34.3. Self-Determination Act (Advance Directive) Documents. When provided by the patient (at each admission), the documents (which may include the living will, durable power of attorney, and/organ donation paperwork) will be filed with the other administrative documents in the record. After discharge, the patient may take the original documents home with them and bring them back if admitted again at some future date. At the time of discharge, the MTF inpatient nursing ward clerk will make a copy of the Advance Directive document(s) and replace into the health record for reference.

5.35. Inpatient Record Documents, Forms, and Patient Identification.

5.35.1. Inpatient records consist of the original copy of the forms listed in Attachment 16 as applicable to the case. Each form filed in the inpatient record must contain, at a minimum: Patient name (last, first, middle name or initial), Register Number, patient's FMP, patient's and sponsor's SSN, and MTF organization and/or treatment name.

5.35.2. Standard Forms Available on Internet. Many (SF) Standard Forms are now available at the GSA Forms Library website. Most forms are in ".pdf" format and must be downloaded with the Adobe Reader, available on the website. Forms not available on the website must be ordered from:

GSA-FSS

General Products Commodities Center

ATTN: 7FSM

819 Taylor Street

Fort Worth, TX 76102

5.35.3. See Section 5A for guidance on overprinted and electronically generated forms.

5.35.4. Dictated and Transcribed Medical Forms. Providers, at the time of dictation, will indicate the date and time of the dictation, their clinical occupational specialty, and their AFSC, if applicable. Transcriptionists, will include the aforementioned data, the transcribed clinical content, and the date of transcription on all transcribed reports, such as SFs 502, 504-506, 516, etc.

5.36. Filing Inpatient Records.

5.36.1. Preparation of folders, arrangement of content, and record filing methodology is consistent throughout Air Force MTFs.

5.36.2. File records in terminal digit format by SSN.

5.36.3. For discharges in Calendar Year 2003 and earlier, records of previous admissions may be brought forward and filed, as a separate entity, in the folder of the current admission record.

5.36.4. Beginning with discharges as of 1 Jan 04, file each admission in a separate folder. There is no requirement to re-file admissions in a separate folder for discharges occurring prior to 1 Jan 04.

5.36.5. Only authorized personnel at the MTF may access inpatient records. Substitute an AF Form 614, Charge-Out Record, for the inpatient record when removed from the file and charge out record in the MRT module of CHCS.

5.36.6. Fetal Monitoring Strip (FMS) Filing Procedures. Maintain the FMS on the obstetrical unit with the prenatal record until delivery.

5.36.6.1. After discharge of the infant, send the FMS to the inpatient records department for maintenance until retirement to the NPRC. Annotate the envelope with the name and register number of the infant, sponsor's name and SSN, name of the MTF, and date of infant's birth.

5.36.6.2. Place strips in envelopes that will be filed in record folders when retired to NPRC. **Note:** Digitized, or other format, FMS which can be printed out on an 8 1/2" X 11" document are filed in the infant's inpatient record or the mother's if the infant is stillborn. Attach the CHCS MRT bar code label to the folder.

5.36.6.3. When an undelivered patient is transferred, send all FMS prepared with the copy of inpatient records to the receiving MTF.

5.36.6.4. Send the FMS with the patient, when a newborn is transferred to another MTF during initial hospitalization.

5.36.6.5. File FMS for stillborn infants, those under 22 weeks gestation, under the register number of the mother.

5.36.6.6. In cases where the case outcome is, for some reason, unclear, send the outpatient fetal monitoring strips to the inpatient record department. File the FMS in a record created under the mother's name, FMP and sponsor's SSN.

5.36.6.7. All FMS will be retired to NPRC in the same shipment as the inpatient records and the Extended Ambulatory Records (EAR).

5.37. Coding and Documenting Inpatient Records.

5.37.1. Coding of Inpatient Records.

5.37.1.1. All diagnoses and procedures are to be written in full, without symbols or abbreviations, in acceptable provider terminology.

5.37.1.2. Sequence and code diagnoses and procedures according to the current version of the International Classification of Diseases or other government approved coding classification system.

5.37.1.3. Signatures are not required on all documentation before the record is coded.

5.37.1.4. After coding the record, prepare and print the final cover sheet (AF Form 565 or automated equivalent).

5.37.1.5. At the end of each month, create the Standard Inpatient Data Record (SIDR) and transmit it by the 5th working day.

5.37.2. The provider's Social Security Number will not appear anywhere in the patient's inpatient record.

5.37.3. AF Form 560 - Use this form as a worksheet for admitting the patient and for recording final diagnoses and procedures.

5.37.3.1. Demographic information can be entered directly into the current automated system, without duplicate entry of the same information on AF Form 560. It is not necessary that the AF Form 560 be an exact copy of the final automated coversheet.

5.37.3.2. The appropriate healthcare provider completes AF Form 560 at discharge and authenticates the entry and identifies himself or herself by signature, initials and use of a signature block/name stamp.

5.37.3.3. Upon receipt of the inpatient record, inpatient records personnel review the entire record to ensure completeness and accuracy of diagnostic and procedure information on the AF Form 560. If a question arises, consult the provider for clarification. The provider completing the form makes the final decision regarding additions and deletions of diagnoses and procedures.

5.37.3.4. Sequence and code the diagnoses and procedures using the current version of the International Classification of Disease. Prepare the final cover sheet (AF Form 565 or automated equivalent) after all information has been checked and completed.

5.37.3.5. Disposition of the AF Form 560.

5.37.3.5.1. The original worksheet is filed in the inpatient record.

5.37.3.5.2. A copy of the AF Form 560 is placed in the outpatient record when used in lieu of an AF Form 565.

5.37.4. AF Form 565. Use this form or automated equivalent as the final cover sheet of each record to provide an administrative and clinical summary of each admission.

5.37.4.1. The appropriate healthcare provider will sign the provider's attestation statement on the final cover sheet. This statement is used to verify the provider agreed with the identification of the principal diagnosis and procedure, any co-morbidities or

complications, and the sequencing of the diagnoses and procedures. Provider terminology will be used for diagnoses and procedures.

5.37.4.2. A locally designated healthcare provider will sign the AF Form 565, in an administrative capacity only, for a military member hospitalized in a nonfederal hospital. (The current automated system requires the name of a healthcare provider in order for the record to be entered.) At local MTF option, in addition to the provider's signature, a stamp indicating that the record was created for administrative purposes only may also be used.

5.37.4.3. Use AF Form 565 in death cases for persons who are inpatients at the time of death.

5.37.4.4. Disposition of AF Forms 565.

5.37.4.4.1. Insert the original AF Form 565 in the inpatient record.

5.37.4.4.2. Insert a copy of AF Form 565 in the outpatient record after final disposition of the case.

5.37.4.4.3. File a copy of the AF Form 565 in the outpatient record of patients being transferred to another facility.

5.37.5. The Joint Commission mandates that "a concise discharge summary providing information to other caregivers facilitating continuity of care includes the following: the reason for hospitalization; significant findings; procedures performed and care, treatment, and services provided; patient's condition at discharge; and instructions to the patient and family as appropriate." Consideration should be given to instructions relating to physical activity, medication, diet and follow-up activity. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved." When preprinted instructions are given to the patient or family, the record should so indicate and a sample of the instruction sheet in use at the time should be on file in the medical record department.

5.37.5.1. The healthcare provider dictates a concise clinical resume (narrative summary) which is transcribed on the SF 502 for:

5.37.5.1.1. Patients hospitalized 8 days or longer.

5.37.5.1.2. Patients received by transfer from another MTF for further medical treatment regardless of the length of stay.

5.37.5.1.3. Patients who die after admission.

5.37.5.2. The narrative summary may be handwritten on the SF 502 if the patient has been hospitalized less than 8 days.

5.37.5.3. When a patient is transferred to another medical facility for further care, a handwritten summary will be completed. If, for expediency's sake, a quick transfer note is written, a written or dictated summary will follow.

5.37.5.4. Final progress notes on SF 509 may be substituted for narrative summaries on patients with minor problems requiring less than a 48-hour stay, normal newborn infants

or uncomplicated obstetrical deliveries. Include any instructions given to the patient or family in the final progress note. Insert a copy in the patient's outpatient record.

5.37.5.5. Disposition of SF 502:

5.37.5.5.1. File the original in the patient's inpatient record.

5.37.5.5.2. File a copy in the patient's outpatient record.

5.37.5.5.3. Send one copy to the Commandant (G-KMA), US Coast Guard, Washington DC 20590, when US Coast Guard members on active duty are discharged.

5.37.5.5.4. Upon disposition of a uniformed services member who is already on the TDRL when admitted, send a copy of the AF Form 565 and SF 502 to the parent service as indicated below:

Air Force:

HQ AFPC/DPSD

550 C Street West

Randolph AFB TX 78150

Navy:

Department of the Navy

Bureau of Medicine and Surgery (MED-25)

2300 E St., NW

Washington DC 20372-5300

Public Health Service and National Oceanic Atmospheric Administration

Medical Affairs Branch

ATTN: Dr. David Hooper

Department of Health and Human Services

5600 Fishers Lane, Rm 4C-06

Rockville, MD 20857

5.37.6. For an active duty patient pending final disposition of Permanent Change of Station (PCS) to home or transfer to a VA hospital, place all additional copies of the AF Form 565 (or AF Form 560 when used in lieu of) and SF 502 in a suspense file. Keep the patient in a change-of-status category until final disposition of the case. Upon disposition, patient administration personnel complete the administrative data on the final cover sheet (i.e., regarding type of disposition, etc...) and file the forms as specified in Attachment 16.

5.37.7. SF 504, SF 505, and SF 506.

5.37.7.1. Healthcare providers complete the history and physical examination records within 24 hours after admission.

5.37.7.1.1. Completion of any part of the history or physical examination by a medical student/physician's assistant student does not relieve the attending healthcare provider of the responsibility to ensure that an adequate history and physical examination is performed and documented. (See AFI 44-102 for procedures concerning histories and physicals conducted by medical/physician's assistant students.)

5.37.7.1.2. The certified nurse mid-wife completes the history and physical examination on obstetrical patients for whom he/she is responsible.

5.37.7.1.3. A properly credentialed oral surgeon completes the physical examination for patients admitted for dental services.

5.37.7.1.4. Podiatrists complete the history and physical as applicable to the podiatry problem.

5.37.7.2. If an adequate history and physical examination is sent with transfer-in patients, the provider may document an interval note on SF 509 stating no changes. The provider will document any important changes.

5.37.7.3. Enter a note in the SF 509 referring to the previous history and physical examination for patients readmitted within one month to the same MTF for the same condition. Document any changes. If desired, place a copy of the previous history and physical in the current record.

5.37.7.4. If a history and physical examination was performed within 30 days before admission, such as in the physician's office, place a durable, legible copy in the inpatient record and document any changes in the SF 509.

5.37.8. DD Form 2770, may be used for the following:

5.37.8.1. Hospitalizations of five days or less for minor medical conditions normally treated on an ambulatory basis when care in the patient's residence is inadequate.

5.37.8.2. Hospitalizations of two days or less for minor surgical procedures performed under local or peripheral nerve block anesthesia. This includes stable anesthesia Class III or IV with minor procedure under local or regional anesthesia with or without IV sedation.

5.37.8.3. Hospitalizations of five days or less for delivering obstetric patients whose intra-partum and postpartum course is uncomplicated, provided that a complete prenatal record is included in the inpatient record.

5.37.8.4. Hospitalizations of 48 hours or less for surgeries when the patient is clearly anesthesia Class I or II, regardless of type of anesthesia used.

5.37.9. Prepare SF 535 in duplicate for all newborn infants. Include the original in the newborn's inpatient record. File a copy in the newborn's outpatient record.

5.37.10. Record the patient's diagnosis, treatment and care on the SF 509 to chronologically describe the clinical course of the patient.

5.37.10.1. Determine the frequency of the notes based on the patient's condition. Make daily notations for the following: the first five days after a patient has undergone a major operation; if the patient is seriously ill.

5.37.10.2. Record the postoperative note on the SF 509. The form may be overprinted locally to provide a format.

5.37.10.3. Document the informed consent on the SF 509. See AFI 44-102 for instructions.

5.37.11. Report surgical operations, including those performed in the ambulatory surgery unit, on SF 516.

5.37.11.1. According to Joint Commission requirements, providers/surgeons will dictate the report immediately following surgery.

5.37.11.1.1. If immediate dictation is not feasible, dictate the report no later than 24 hours following the end of the surgical procedure.

5.37.11.1.2. If the operative report is not placed in the medical record immediately after surgery, then prior to the patient's release from the Recovery Room, the provider will draft and enter an operative note into the inpatient or ambulatory procedure record indicating pertinent clinical information to ensure continuity of care.

5.37.11.2. Providers, at the time of dictation, will indicate the date and time of the dictation, their clinical occupational specialty, and their AFSC, if applicable. Transcriptionists, will include the aforementioned data, the transcribed clinical content, and the date of transcription on all transcribed reports, including operative reports, Standard Forms: 502, 504-506, 516, etc.

5.37.11.3. Include in the report a description of the findings, the technique used, the tissue removed or altered, estimated blood loss, as indicated, the postoperative diagnosis, the condition of the patient at the end of the operation, and the name of the primary surgeon and assistants.

5.37.12. Laboratory and Radiology reports. When a computerized or automated summary of all laboratory and radiology report results compiled during the patient's hospitalization is provided, file only the cumulative final report with the exception of preadmission labs and x-rays. Destroy all previous duplicated computerized/automated report results. For inpatient records unlike outpatient, all laboratory and radiology results must be filed in the record upon discharge from the hospital.

5.37.13. AF Form 3066 or 3066-1. A provider signs and dates orders on the AF Form 3066 or 3066-1, or enters the information into the current automated system.

5.37.13.1. When a hardcopy AF Form 3066 or 3066-1 is utilized, maintain the original with the patient's inpatient record.

5.37.13.2. When medications are ordered, send a copy to the Pharmacy. The provider's Drug Enforcement Agency (DEA) number is required in the provider's signature block/name stamp for any hand written prescriptions for controlled substances. Non-US

physicians and dentists assigned to overseas facilities use their medical or dental license number instead of a DEA number. (See AFI 44-102).

5.37.13.3. A verbal or telephone order may be given to a registered nurse. Each verbal order is dated by the individual taking the order and identifies the names of the individuals who gave and received it. In such cases, the provider confirms the order, signs, dates, and stamps it within 48 hours.

5.37.14. Reverse of AF Forms 3068 and 3069.

5.37.14.1. The reverse of these forms contain a section for the initials and signatures of nursing staff administering the medications. Instead of signing the reverse of these forms, utilize a separate sheet that contains the names, signatures and initials of the nursing staff.

5.37.14.2. When there is a separate sheet with the names, signatures and initials, the nursing staff is only required to initial the reverse of the AF Form 3068 and 3069 when administering medications.

5.37.14.3. File the sheet after the AF Form 3068 or 3069.

5.37.15. Maintain inpatient records received with a transfer-in patient as a component part of, and attach to, the current inpatient record. Do not break up the transfer record and interfile its forms among the forms of the current record. **Note:** If the original record was sent, copy and maintain the pertinent portions, returning the original record to the transferring MTF.

5.38. Prenatal Records. Prenatal documentation is maintained in the OB/GYN clinic until the mother delivers.

5.38.1. If delivery is in your MTF, maintain the documents, as a package, with the inpatient documentation and file in the mother's inpatient record.

5.38.2. If the delivery was not performed in your MTF, file the prenatal package (as a whole package with prenatal treatment documents filed chronologically between the SF 533 and AF Form 3915) in the mother's outpatient record in Section III.

5.39. The Extended Ambulatory Record (EAR).

5.39.1. The EAR is a folder that contains information on treatment received during an Ambulatory Procedure Visit (APV), an observation stay, Emergency Room Death (ERD), Dead on Arrival (DOA), or other similar status.

5.39.1.1. Maintain each occasion of treatment, prior to 1 Jan 04, as a separate episode within the same EAR similar to the way multiple admissions are maintained within a single inpatient record folder. Starting 1 Jan 04 create a separate folder for each episode. **Note:** There is no requirement to re-folder episodes created before 1 Jan 04.

5.39.1.2. Maintain the EAR folder in a method similar to the inpatient record, using the inpatient record folder (AF Form 788A-J). Annotate the folder with the patient's name, Family Member Prefix (FMP), and sponsor's Social Security Number (SSN). Attach the CHCS MRT bar code label to the folder. The EAR will be filed by the sponsor's SSN (same as the outpatient and inpatient records).

5.39.1.3. The EAR will be maintained in a limited access area.

5.39.1.4. Although the paperwork for these cases is filed in the EAR folder, these episodes are coded as an outpatient episode in the appropriate ambulatory data collection system.

5.40. Creating, Coding, and Documenting, Ambulatory Procedure Visit (APV) Records.

5.40.1. File original documentation on a patient seen during an APV episode in the EAR folder.

5.40.2. Create an APV record for those cases when a patient is seen in the Emergency Room or specialty procedure room, an APV procedure is performed, and the patient is discharged within 23 hours and 59 minutes of the time the patient was checked in by the nurse for preliminary work-up for the procedure.

5.40.3. Maintain the record in a limited access area (preferably in the inpatient records department). The APV record will be filed by the sponsor's Social Security Number, (same as the outpatient and inpatient records).

5.40.4. Clinical Application of APV Records.

5.40.4.1. The medical record documentation for the APV must meet the standards of documentation similar to the short-term stay (abbreviated medical record). The record documentation must comply with Joint Commission standards. At a minimum, the record must include an abbreviated history and physical, progress notes, doctor's orders, patient's informed consent, operative report, tissue report (if any), anesthesia record, summary of care, to include discharge instructions and any Advance Directive. Copies of the summary, operative report, and any tissue reports are forwarded to the outpatient record.

5.40.4.2. Physicians will sign and stamp an automated cover sheet or ambulatory encounter summary form for the APV records. All diagnoses and procedures are to be written in full, without symbols or abbreviations, and in acceptable provider terminology.

5.40.4.3. The following forms are recommended for use in APV records:

5.40.4.3.1. AF Form 560 or automated coversheet.

5.40.4.3.2. DD Form 2770.

5.40.4.3.3. SF 509.

5.40.4.3.4. SF 516.

5.40.4.3.5. OF 522, or locally produced form.

5.40.4.3.6. OF 517.

5.40.4.3.7. AF Form 3066 or 3066-1.

5.40.4.3.8. AF Form 3069.

5.40.4.3.9. AF Form 3068.

5.40.4.3.10. AF Form 3067.

5.40.4.4. Until Standard, Air Force or DD Forms (for APV records) are developed, each MTF may elect to develop local forms, as an alternative to the established forms listed in paragraph 5.40.4.3. to integrate documentation requirements into the comprehensive records. The MTF Medical Records Function approves all requests for locally developed forms before use in the health record. The MTF may utilize an ambulatory encounter summary form.

5.40.5. Coding of APVs.

5.40.5.1. Code diagnoses according to current version of the International Classification of Diseases (ICD) or current government approved coding classification system.

5.40.5.2. Code procedures/operations according to Current Procedure Terminology (CPT) coding references or current government approved coding classification system.

5.40.5.3. Utilize the Ambulatory Data Module (ADM) in CHCS to capture the coded information on each APV.

5.40.5.4. Utilize the ADM Patient Encounter Forms or the automated APV form used for coding in the APV record for auditing and quality assurance purposes.

5.40.6. Admission of APV Patients.

5.40.6.1. Admit as an inpatient an APV patient that stays beyond the time limit of 23 hours and 59 minutes. Time commences when the patient is checked in for preliminary work-up for the procedure.

5.40.6.2. Do not backdate or change the time of the admission date and time to the point when the patient's APV episode began. Use the date and time when the admission to the hospital occurs. Enter the following statement in the administrative section of the cover sheet "Patient admitted from APU. Information on the APV procedure is maintained in the APV record."

5.40.6.3. Do not combine the original APV documentation with the inpatient record but maintain it separately in the EAR folder.

5.40.6.4. Include copies of the ADM Patient Encounter Form or automated cover sheet, the abbreviated history and physical, operative report, and any other pertinent documentation in the inpatient record, as applicable.

5.40.6.5. Code the inpatient record with the reason that caused the admission.

5.41. Creating, Coding, and Documenting Observation Records.

5.41.1. Observation patients are outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition. The decision to place a patient in observation status is based upon the complexity, intensity, and duration of care required.

5.41.2. Outpatient observation stays generally should not exceed 23 hours and 59 minutes. However, up to 48 hours may be authorized when medical necessity has been clearly demonstrated.

5.41.3. Observation patients may be cared for in either dedicated observation units or in any designated bed space. Appropriate Joint Commission and/or AAAHC standards will apply.

5.41.4. Documentation of Observation Records.

5.41.4.1. Documentation for an observation patient must meet the standards for a short-term stay (abbreviated medical record) and must comply with the current Joint Commission and/or AAAHC documentation standards.

5.41.4.2. Standard Forms (SF), or other forms as noted, are recommended for use in observation records. At a minimum, the documentation in the medical record will include:

5.41.4.2.1. Summary of pertinent diagnostic findings.

5.41.4.2.2. A plan of care to include reasons for observation, diagnoses, and risks of complication, patient education, release instructions, medication orders, and plans for follow-up care.

5.41.4.2.3. SF 558.

5.41.4.2.4. SF 509.

5.41.4.2.5. All diagnostic reports (e.g., laboratory, radiology, or electrocardiogram) as applicable.

5.41.4.2.6. AF Form 3066 or 3066-1.

5.41.4.2.7. AF Form 3069 as applicable.

5.41.4.2.8. AF Form 3068 as applicable.

5.41.4.2.9. AF Form 3067 as applicable.

5.41.4.2.10. Advance Directive (if previously accomplished by the patient).

5.41.4.3. File all documentation related to an observation stay in the EAR folder.

5.41.4.4. Forward the following documents to the outpatient treatment record: release note with summary of pertinent diagnostic findings, status of patient upon release, and release instructions with plans for follow-up care.

5.41.5. Coding of Observation Records.

5.41.5.1. Code diagnoses according to the current version of the International Classification of Diseases (ICD) coding references or current government approved coding classification system.

5.41.5.2. Code procedures/operations according to the Current Procedure Terminology (CPT) coding references or current government approved coding classification system.

5.41.5.3. Utilize the Ambulatory Data Module (ADM) in CHCS to capture the coded information on each observation episode, except when an observation patient is admitted.

5.41.6. Admission of Observation Patients. When a patient is admitted from an observation status, file the observation documentation in the EAR folder. Place copies of pertinent documentation in the inpatient record.

5.42. Patients Discharged Without Definitive Diagnosis. The inpatient records department maintains in a suspense file, records that the provider has indicated should be held pending pathology reports, laboratory test results, or other confirmations. Never maintain the records in

suspense longer than one month after the month of disposition. Process the record with whatever information is available. The record may be corrected at a later date if information, which alters the final diagnosis, is received.

5.43. Disposition of Inpatient Records.

5.43.1. When transferring patients to another MTF, send a complete and legible copy of the current inpatient record, original outpatient record, and copies of any previous admissions pertinent to the patient's current condition. If complete and legible copies cannot be made in time for the patient's transfer, send the original current inpatient record. **Note:** The receiving MTF returns original records to the transferring MTF when they have served their purpose. Also, send any x-ray films and duplicate slides or surgical specimens when the findings have a direct bearing on the diagnosis and treatment.

5.43.2. The admitting facility notifies the originating MTF of patients admitted while on directed convalescence, PCS home, or AWOL from another medical facility while in patient status. If the patient will remain at the new MTF, the initial facility transfers the individual to the new MTF and forwards the patient's records.

5.43.3. When transferring patients to non-military MTFs, a transcript or copy of pertinent pages may accompany the patient. Never release the original records; however, pertinent x-ray films are furnished to the receiving non-military MTF as required.

5.43.4. Send a copy of the current inpatient record and any x-ray films when an active duty patient is transferred to a VA hospital pending separation or retirement from the uniformed services.

5.43.5. Forward original records of North Atlantic Treaty Organization (NATO) military personnel and their family members (including x-ray film and medical examination reports) in a sealed envelope with the individual concerned upon transfer to another MTF. When the individual is discharged, return the record to the parent country. Retain copies of pertinent records necessary for quality assurance review.

5.43.6. Handle inpatient records of non-NATO military personnel and their family members the same as any other inpatient record.

5.43.7. When mailing records pertinent to litigation cases, mail medical records and claims files via certified mail/return receipt.

5.44. Medical Transcription.

5.44.1. Responsibilities of Medical Transcription: Medical transcription services provide timely and accurate transcription of provider dictation dealing with inpatient and ambulatory patient care. It is a patient administration responsibility and is usually managed by the inpatient medical records department supervisor in cooperation with the transcription quality assurance evaluator (QAE) and/or contracting officer's technical representative (COTR).

5.44.2. Production Goals: Each medical transcription center should produce an acceptable quantity and quality of medical transcription in a timely manner. Normally, these services are employed to generate transcription services for inpatient episodes of care. If transcription staffing and inpatient workload allow, transcription services can be expanded to ambulatory and outpatient clinic services. Inpatient and Ambulatory Procedure Visit (APVs) dictated operative reports must be transcribed and filed in the medical record immediately following

surgery. MTFs need to generate clear policy/guidance to all providers in their facility regarding the scope of medical transcription services they intend to offer in accordance with the Joint Commission.

5.44.2.1. Quantity: Suggested production goals for medical transcriptionist are 800 lines per day per transcriptionist. The senior transcriptionist or supervisor, in a smaller medical transcription center, contributes to the work center output, however, their goals are lower than those established for other medical transcriptionists and decrease as the size of the medical transcription center and supervisory responsibilities increase. Personnel in training should be able to achieve the production goals within a reasonable period of time, not to exceed 1 year.

5.44.2.2. Counting and Reporting: Medical transcriptionists count and record their output according to the following suggested instructions. (Output is reported daily to the senior transcriber or supervisor.)

5.44.2.2.1. Margins should be adjusted to ensure full lines that average 80 strokes. Narrative lines of 80 strokes should average 13 words. Count each typed line with six words or more as a line; any narrative line with five words or less is not counted.

5.44.2.2.2. Form-style typing:

5.44.2.2.2.1. Count each line with two or more names, dates or words as one line.

5.44.2.2.2.2. Physician signature elements are counted as two lines when a two-line signature element is used, and counted as one line when a one-line signature element is used.

5.44.2.2.2.3. Patient identification data is counted as two lines.

5.44.2.2.3. The senior transcriptionist or supervisor reports individual production to the supervisor or QAE/COTR of inpatient records.

5.44.2.3. The supervisor or QAE/COTR of inpatient records, through the senior transcriptionist or supervisor, monitors the quality of all medical transcription. When medical transcriptionists are required to retype work which does not meet quality standards, do not include lines retyped in production counts.

5.44.2.4. Work should normally be completed within 24 hours of receipt of dictation. Transcribed narrative summaries and operative reports should be filed in the medical record prior to inpatient/APV coding to provide complete documentation and ensure accurate coding.

Section 5D—Deployed Assignment Medical Record Management

5.45. Minimum Deployed Medical Documentation and Record Management Requirements.

5.45.1. The DD Form 2766, Adult Preventive and Chronic Care Flowsheet is the principle folder used to document primary medical and dental care for active duty, Air Force Reserve, Air National Guard, and deployable federal civilian employees while in a deployed environment. Inpatient documents generated from a theater MTF will likely be maintained and documented separately from the medical information stored in the DD Form 2766.

5.45.2. Health records located at deployed combat theater locations are maintained by unit medical personnel. Deployed medical Commanders will ensure effective re-deployment medical out-processing procedures are in place, and will work with deployed unit commanders to ensure required actions are completed for all re-deploying personnel, to include all DoD uniformed members, civilians, and contractors IAW DoDI 6490.03.

5.45.3. Deployed medical unit records managers will use the cardstock DD Form 2766 to document primary medical and dental care. The DD Form 2766 typically contains the same types of outpatient medical and dental forms that would normally be generated back at the Service Member's host MTF/DTF. Deployed records personnel are required to file all primary local, Service-specific, Standard, and Optional forms generated from primary care provider-patient encounters, into the cardstock DD Form 2766. File documents inside the cardstock DD Form 2766 in chronological order, with the most recent encounter filed on top of older documents.

5.45.4. Theater Electronic Health Record(s) and/or Applications: Although advances in electronic medical record technology support comprehensive regional healthcare operations in the deployment environment, unless the medical information maintained in these systems can provide reliable, secure, and timely medical record data transfer from the deployed medical unit to the DoD's Central Data Repository, deployed medical records personnel are required to print each primary care patient encounter and file the printed form into the cardstock DD Form 2766.

5.45.5. Documenting Patient Care: Proper documentation of medical/surgical care is accomplished on all patients treated at the EMEDS/Air Force Theater Hospital. Utilization of the SF 600, Chronological Record of Medical Care, is the primary form used to document most ambulatory care. AF Form 3909, Critical Care Flow Sheet is used to record critical care patients' treatment/progress. All ambulatory care healthcare forms and documents must be filed into the DD Form 2766. The outpatient healthcare information collected on these forms must return to the member's host MTF.

5.45.5.1. For patients entering the aeromedical evacuation system, the AF Form 3830, Patient Manifest (5 copies minimum) should be completed for each AE mission. If not available, substitute this form with the DD Form 601, Patient Evacuation Manifest. The AF Form 3899, AE Patient Record, accompanies the patient to ensure appropriate care during transport. This document is primarily used to direct and record en route care. If AF Form 3899 is not available, use DD Form 602, Patient Evacuation Tag. Medical orders should be clearly written on either the AF Form 3899 or the DD Form 1380, U.S. Field Medical Tag. The DD Form 1380 normally is used by the originating facility during contingencies. The information on the DD Form 1380 is transcribed to the AF Form 3899/DD Form 602 upon entry into the AE System. Information should include both primary and secondary diagnoses, correct patient classification, and orders for all enroute medications, care, and special diets. A concise, pertinent nursing note from the referral MTF should be written on the form as a transfer note. At a minimum, the note should include the dates and times of last medications, vital signs, and treatment rendered. The employment of the CHCS or other electronic medical record systems is desired for inpatient management.

5.45.5.2. Required deployed healthcare minimum documentation forms include: SF Form 600, Chronological Record of Medical Care; DD Form 1380, US Field Medical Tag; AF Form 1042, Medical Recommendation for Flying or Special Operational Duty; Post-deployment Survey; AF Form 422, Physical Profile Serial Report; AF Form 579, Controlled Substances Register; SF 516, Operative Report, Optional Form 517, Anesthesia Medical Record; and DD Form 590, Patient Storage Tag.

5.45.6. Deployed MTF medical staff will:

5.45.6.1. Work with the deployed MPS and unit commanders to ensure all returning or re-deploying personnel are identified in a timely manner and have completed medical re-deployment screening and/or out-processing no earlier than 30 days prior to scheduled/projected departure.

5.45.6.2. Interview returning or re-deploying members, and for each:

5.45.6.2.1. Ensure Service Members complete the automated DD Form 2796, Post-Deployment Health Assessment, via electronic process using Aeromedical Services Information Management System (ASIMS) Web (hard copies will not be accepted). Following the member's completion of the electronic DD 2796, a MTF provider must interview the member face-to-face and electronically sign the DD 2796 in ASIMS Web. Once the DD 2796 has been electronically signed by the provider and closed in ASIMS Web, it will be automatically transmitted via the Defense Medical Surveillance System.

5.45.6.2.2. After the patient and MTF provider have completed the electronic DD 2796 in ASIMS Web, MTF medical personnel are required to print a hard copy of the electronic DD 2796 and place it in the member's deployment medical record (DD 2766). The form must contain a provider's signature, date and time stamp. If the Service Member is unable to complete the form electronically due to computer failure, network interruption, or the unavailability of an automated process, deployed medical staff must prominently place the following notice in the DD 2766,; "Member unable to Electronically Complete DD 2796 in Theater. Member must report to Public Health within 5 duty days of returning to home unit to complete the electronic DD 2796."

5.45.7. The deployed healthcare provider will:

5.45.7.1. Reviews the completed DD 2796 and deployed health record with member during a face-to-face encounter, and in so doing:

5.45.7.1.1. Address all positive responses entered by member on the DD 2796. Discuss any member concerns relating to mental health issues, potential environmental/occupational exposures, or special medications taken during the deployment.

5.45.7.1.2. Document any Force Health Protection Prescription Products (i.e., anti-malarial, P-tabs, Atropine, 2-PAM Chloride or CANA) that the member ingested or introduced into his/her body during the deployment. The provider must annotate any related adverse events, and advises member on required follow-up actions.

5.45.7.1.3. Arrange for further medical evaluation or follow-up in theater (within existing capabilities) or annotate the need for evaluation on return to home station.

5.45.7.1.4. The healthcare provider shall also sign and stamp (signature block/name) each departing member's hard copy DD Form 2796.

5.45.8. Deployed MTF support (records) staff will:

5.45.8.1. File the signed/stamped hard copy DD Form 2796 into the DD Form 2766, Deployed Health Record, for later placement in the permanent medical record by host station MTF personnel.

5.45.8.2. Package and seal the medical records for each returning Service Member. Individual records may be bundled together (but not inter-filed) and sealed together in a bulk courier package. Identify the troop commander for each returning or re-deploying group and transfer the sealed medical records to him or her. If no troop commander exists, identify the senior ranking member in the group and transfer the records to him/her, or his/her authorized delegate. Obtain a chain of custody receipt before completing the transfer. If records are to be packaged and sealed for a single returning or re-deploying Service Member, first check with a mental health provider to ensure the Service Member should not be physically or mentally harmed if he or she were to open the sealed package and read the documents inside. If the mental health provider decides the sealed medical documents for a returning or re-deploying Service Member could potentially cause the member harm if he or she were to read the documents, contact the Service Member's host MTF and arrange for the records to be mailed back to the medical unit. If the mailing option is used, ensure the package is mailed with a package-tracking or return-receipt confirmation service (if available).

5.45.8.3. Each DD Form 2766 should contain all primary care medical documents generated during the length of the deployment. The minimum number and name of documents to be filed into each DD Form 2766 include:

5.45.8.3.1. Smallpox vaccination screening forms (SF 600 Overprint).

5.45.8.3.2. All primary care patient documents (if no automated data transfer mechanism exists that guarantees reliable, secure, and timely medical record data transfer from the deployed location to DoD's Central Data Repository, print each primary care patient encounter and file the printed form into the cardstock DD Form 2766).

5.45.8.3.3. Environmental/Occupational Health Exposure Data (SF 600 Overprint).

5.45.8.3.4. Physical therapy and dental visit records.

5.45.8.3.5. Mental health provider documentation: (**Note:** If a mental health provider decides that sealed medical documents for a returning or re-deploying Service Member could potentially cause the member harm if he or she were to read the documents, contact the Service Member's host MTF and arrange for the records to be mailed back to the medical unit).

5.45.8.3.6. Provider signed, dated, and ID stamped DD Form 2796.

5.45.8.3.7. Insert a shipping roster of names and ranks for each corresponding DD Form 2766 placed inside each bulk courier package. Label individual sealed envelopes with the returning or re-deploying member's name, rank, home unit, and assignment installation. For bulk courier and individual medical record packages, address the outside envelope or package with the following pre-printed or stamped message, "PROTECTED HEALTH INFORMATION ENCLOSED. THIS ENVELOPE MUST BE DELIVERED TO THE FORCE HEALTH MANAGEMENT OFFICE AT YOUR HOME DUTY STATION."

5.46. Expeditionary Electronic Health Record Management Platforms and Systems.

5.46.1. Joint-Theater Trauma Registry (JTTR). The JTTR system is a data repository that captures the information pertinent to the personal circumstances, clinical care and short and long-term outcomes of individuals subject to traumatic injury in the deployed environment.

5.46.1.1. The JTTR application is used to capture data from non-integrated clinical and administrative systems within the DoD Military Health System. The Trauma Registry Coordinators ensure that critical clinical data is collected in theater and incorporated into the JTTR to provide a comprehensive picture of trauma patients from point of injury through rehabilitation. Data should reflect all care given to victims of trauma at all levels of care. Referrals at all levels and for all purposes should be captured by the system.

5.46.1.2. Since its implementation, the JTTR has created and maintained thousands of electronic health records of battle and non-battle injuries of US, Allied and enemy combatants. The system also provides a full-range of critical data regarding personal protective equipment effectiveness and durability to engineer better protective equipment to safeguard service members from explosions. As the Theater Trauma System matures, JTTR data will be used to improve the overall quality of care provided to injured Airmen, Soldiers, Sailors, and Marines.

5.46.2. TRANSCOM (Transportation Command) Regulating and Command & Control Evacuation System (TRAC2ES). TRAC2ES is a medical regulating, medical asset tracking, and in-transit visibility (ITV) patient movement system. It combines transportation, logistics, and clinical decision elements into a seamless information system that prioritizes requirements, assigns proper resources, and distributes relevant data to efficiently deliver patients. TRAC2ES is sponsored and maintained by the United States Transportation Command. It is a Joint, unclassified and classified system that is also used by the Department of Veterans Affairs (VA) and Coalition military members to coordinate and track the movement of patients and their attendants throughout the entire patient movement process, during war, peace, and contingency operations worldwide. For deployed sites with limited or no web access, TRAC2ES has a "store and forward" client-based application. Information captured by the system also provides DoD with critical data used for medical and disease trending and operational planning. TRAC2ES provides support for multi-modal, military and commercial patient transportation. See AFI 41-301 and DoDI 6000.11, Patient Movement for instruction on AE operations.

5.46.3. Theater Medical Information Program (TMIP). The TMIP is a family of systems that includes a variety of modular and scalable information management and information technology solutions, which together extend the military's home-based electronic health record capabilities to the Theater of Operations. TMIP enables complete clinical care

documentation, medical supply and equipment tracking, patient movement visibility and health surveillance in Theater environments.

5.46.4. Theater Medical Data Store (TMDS). TMDS is part of TMIP's integrated suite of deployed solutions and serves as the authoritative Theater database for collecting, distributing and viewing Service Members' pertinent medical information. It provides one central location for healthcare providers to view Theater medical data. TMDS views and tracks ill or injured patients as they move through the Theater levels of care, Sustaining Base MTFs and those shared with the VA. TMDS updates the AHLTA CDR, where all Service Members' Electronic Health Records reside. This information is also made available to the VA through an interface known as Bidirectional Health Information Exchange-Theater (BHIE-T). Using TMDS, medical staff can view an airlifted critically injured patient's history, progress notes, laboratory, drug and radiological history before arrival at their next location. TMDS supports the collection of information from first responder, battalion aid station and Theater hospitals and makes the information readable in Theater and back to OCONUS and CONUS hospitals and ultimately to the CDR and to the VA.

5.46.5. Medical Communications for Combat Casualty Care (MC4). Deployable medical forces use the MC4 system to gain quick, accurate access to patient histories and forward casualty resuscitation information. The system also provides units with automated tools facilitating patient tracking, medical reporting and medical logistical support. Combatant commanders use the MC4 system to access medical surveillance information, resulting in enhanced medical situational awareness.

Chapter 6

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Section 6A—Air Force Program Overview

6.1. HIPAA within the Air Force Medical Service. The purpose of the Health Insurance Portability and Accountability Act is to improve the portability and continuity of health insurance coverage, improve access to long term care services and coverage, and to simplify the administration of healthcare. A primary component of HIPAA administrative simplification provisions is the protection and privacy of individually identifiable health information. The HIPAA Privacy Rule governs this component, and DoD 6025.18-R, DoD Health Information Privacy Regulation implements the requirements of the HIPAA Privacy Rule throughout the MHS.

6.1.1. Department of Defense Regulation, 8580.02-R, DoD Health Information Security, implements the requirements of the HIPAA Security Rule throughout the MHS. The Air Force Medical Service furthers implements the HIPAA Security Rule through AFI 41-217, Health Information Assurance For Military Treatment Facilities. These instructions should be referenced as necessary to ensure full integration of HIPAA Privacy and Security activities.

6.2. Interaction Between HIPAA Privacy and Patient Administration Functions. Many of the HIPAA Privacy implementation requirements set forth by DoD 6025.18-R are functions inherently conducted by TRICARE Operations and Patient Administration (TOPA) personnel within the MTF. As such, guidance regarding HIPAA matters can be found throughout various sections of AFI 41-210; the purpose of this chapter is to address topics not otherwise referenced in this instruction, or requiring additional emphasis.

Section 6B—HIPAA Administration

6.3. Organizational Structure and Functional Responsibilities.

6.3.1. The Air Force Medical Support Agency (AFMSA). AFMSA will appoint an Air Force Medical Service (AFMS) HIPAA Privacy Officer (HPO). The primary responsibility of the AFMS HPO is to oversee policy development and interpretation as necessary to ensure AFMS compliance with applicable federal guidelines, Department of Health and Human Services (HHS) rules, Department of Defense (DoD) directives and instructions, and Air Force (AF) policies and procedures pertaining to the confidentiality, integrity and availability of individual's health information subject to the HIPAA Privacy Rule. Additionally, the AFMS HPO provides HIPAA privacy support and subject matter expertise to all AF/SG directorates assigned to the National Capitol Region (NCR).

6.3.1.1. Communicates and coordinates with the TRICARE Management Activity (TMA), external federal agencies, Secretary of the Air Force (SECAF) agencies, and other DoD organizations as necessary to implement, clarify and execute HIPAA privacy activities throughout the Air Force Medical Service.

6.3.1.2. Provides policy guidance to Air Force Medical Ooperations Agency (AFMOA), Health Benefits Support Branch on a regular and as needed basis to ensure MTFs are receiving current and accurate information regarding HIPAA privacy policy, procedures and operational changes.

6.3.1.3. The Air Force HPO, in collaboration with AFMOA, will create and distribute Privacy Officer training for MTF Privacy Officers. The AF HPO will ensure AF/SG and directorate personnel assigned to the NCR receive initial and annual HIPAA training in accordance with AFMS and HIPAA policy and procedures.

6.3.2. Air Force Medical Operations Agency (AFMOA). Will provide centralized capability and lead the AFMS in executing all HIPAA and Privacy Act (PA) policies and prepare for, respond to, and mitigate the effects of breaches of PHI. AFMOA will provide privacy and security consultation to support the AF medical infrastructure. The Chief, Health Benefits Support will ensure AFMOA and MAJCOM/SG personnel are trained in accordance with AFMS and HIPAA policy and procedures.

6.3.2.1. HIPAA and Privacy Act execution functions will be centralized at AFMOA within the SGA Directorate, Health Benefits Support. AFMOA will appoint an individual to serve as the single point of contact to funnel privacy and security information between AFMSA and the field. This branch will oversee HIPAA privacy and security functions and will be responsible to monitor AFMS HIPAA compliance, provide centralized technical expertise, conduct site visits, and provide consultative assistance to MAJCOM Surgeons and MTFs.

6.3.3. Medical Group Commander. The Medical Group Commander (Medical Treatment Facility (MTF) Commander) will maintain overall responsibility for the implementation and administration of local MTF HIPAA privacy and security programs designed to ensure compliance with established federal, DoD, and Air Force privacy and confidentiality rules.

6.3.3.1. Ensures comprehensive Medical Group Instructions (MDGIs) are developed to integrate all documentation requirements and implementation specifications of DoD 6025.18-R and this instruction into local business practices.

6.3.3.2. Designates, in writing, a HIPAA Privacy Officer (HPO) to implement and manage HIPAA Privacy compliance activities throughout the MTF's facilities, and to receive and investigate complaints and allegations of non-compliance with the HIPAA Privacy Rule.

6.4. MTF HIPAA Privacy Officer (HPO).

6.4.1. Oversees all ongoing activities related to the development, implementation, and maintenance of MTF policies and procedures covering the access to [and privacy of] patient health information. The HPO ensures adherence to the MHS policies and procedures covering these same areas. The HPO ensures MTF compliance with federal laws and regulations, and with the healthcare organization's information privacy practices. He or she leads initiatives to strengthen patient information privacy protections. Many activities required by HIPAA privacy overlap with patient administration duties and require interaction with senior level personnel and coordination with external agencies. Therefore, it is appropriate to appoint the TOPA Flight Chief, Patient Administration Officer, TOPA or Patient Administration Director, Flight Superintendent or NCOIC or other individual with

commensurate rank and experience as the HPO. The duties of the HPO will not be delegated or appointed to an entry-level employee.

6.4.2. Develops policies and procedures for local implementation of the DoD HIPAA Privacy regulation as described in paragraph 6.3.3.1. **Note:** many implementation requirements required by DoD 6025.18-R may already be addressed in other MDGIs such as Patient Administration Functions, Medical Record Administration, and Information Assurance guidelines. In these cases the HPO should coordinate with the appropriate office to validate existing instructions adequately address DoD 6025.18-R requirements, and may then simply cross-reference the policy rather than duplicate policies in a separate HIPAA instruction.

6.4.3. Ensures the delivery of initial and refresher privacy training to all members of the MTF workforce, including volunteers, medical and professional staff, physician residents and interns, contractor employees, and visiting personnel such as clinical students who have access to PHI.

6.4.4. Serves as a member of the MTF Medical Information Security Readiness Team (MISRT).

6.4.5. Maintains current knowledge of applicable federal and DoD privacy laws, accreditation standards, DoD and AFMS regulations and policies. Monitor advancements of emerging privacy technologies to ensure that the MTF is positioned to adapt and comply with these advancements.

6.4.6. Ensures continuous assessment, implementation, monitoring, and revision of the MTF HIPAA Privacy programs in light of changing circumstances in its organizational, security, and/or regulatory environment. Coordinates on the review process for applicable MDG policies and procedures to ensure alignment with current HIPAA practices.

6.4.7. Establishes, recognizes and shares best practices relative to the management of the privacy of health information.

6.4.8. Ensures a mechanism is in place at the MTF for receiving, documenting, tracking, investigating, and taking action on all complaints concerning the organization's privacy policies and procedures in coordination and collaboration with other similar functions, and when necessary, legal counsel.

6.4.9. Liaisons with Medical Logistics and other MTF activities to ensure Business Associate Agreements (BAAs) are incorporated into appropriate MTF contracts and Memorandum of Agreements (MOAs) as necessary. In addition, contact the AFMOA HIPAA representative to ensure the MTF is utilizing the most current and appropriate BAA.

6.4.10. Makes decisions on a case-by-case basis to balance patient needs and the organization's requirements when making decisions related to the use and release of PHI in situations which may deviate from normal Treatment, Payment and Healthcare Operations (TPO). The TRICARE Management Activity (TMA) HIPAA website at **http://www.tricare.osd.mil/hipaa**/ is a useful reference for the latest information regarding HIPAA rules, regulations, and requirements.

6.4.11. Serves as the liaison between the MTF and host wing Privacy Act Official to report, resolve and mitigate breaches of identifiable health information. Refer to Attachment 20 for detailed information on this process.

6.4.12. Provides the following MTF Integration Activities:

6.4.12.1. Understands the content of health information in its clinical, research, and business context.

6.4.12.2. Understands the decision-making processes throughout the MTF that rely on all forms of health information. Identify and monitor the flow of information within the MTF and throughout the local healthcare network.

6.4.12.3. Serves as privacy liaison for users of clinical and administrative systems.

6.4.12.4. Coordinates with HIPAA Security Officer to review all system-related information security plans throughout the MTF network to ensure alignment between security and privacy practices and act as a liaison to the information systems department.

6.4.12.5. Collaborates with HIPAA Security Officer to ensure appropriate security measures are in place to safeguard PHI.

6.4.12.6. Conducts an initial compliance assessment within 60 days of assignment and documents findings in the AFMS approved compliance monitoring tool. Conducts periodic compliance monitoring per AFMS policy guidance, identifies shortfalls in compliance and implements corrective action(s) as necessary; documents results using the AFMS approved compliance monitoring tool.

6.4.12.7. Provides a briefing on patient rights and provides the MHS Notice of Privacy Practices (NoPP) at all Wing Newcomer's Orientations briefings as part of the TOPA Flight briefing.

Section 6C—Providing Notice of Privacy Practices (NoPP)

6.5. NoPP Requirements. The AFMS utilizes the Military Health System (MHS) Notice of Privacy Practices (NoPP), which explains how the patient's PHI may be used and disclosed. It also describes the patient's rights regarding the use of PHI and contact information for complaints or issues. Each MTF must have procedures established to meet all the administrative elements found in the Notice of Privacy Practices (NoPP).

6.5.1. In instances where the MTF has a Direct Treatment Relationship with a patient, the MTF must make a good faith attempt to ensure the patient has received the MHS Notice of Privacy Practices and obtain a written acknowledgement of receipt. The patient, parent, or guardian must be asked to sign the acknowledgement of their receipt of a copy of the NoPP located on the back-side (exterior) of the outpatient medical or dental record. **Note:** Acknowledgement was previously required on both the medical and dental record. Redundant acknowledgement is not required if local procedures are in place allowing MTF personnel to validate an acknowledgement is on file. If the NoPP acknowledgement is not found, then affix a NoPP label with the required information to the back-side (exterior) of the outpatient medical or dental medical record. The label should be centered and placed near the bottom of the exterior of the record jacket. If an individual refuses to sign the NoPP label, then the refusal must be annotated by MTF staff on the NoPP label.

6.5.1.1. MTFs that retrieve or "pull" records only by exception for outpatient visits must have a process in place to ensure the beneficiary has acknowledged receipt of the MHS NoPP.

6.5.1.2. Future technological updates to AHLTA may automate the NoPP process and afford the capability of capturing a patient's signature electronically. Once deployed, facilities with this ability may use this system to obtain beneficiary acknowledgement of the MHS NoPP in lieu of obtaining a hard-copy acknowledgement. Use of electronic NoPP capture is not mandatory; facilities may determine the most efficient method of NoPP acknowledgement as appropriate to local business practices.

6.5.2. Ensure copies of the MHS NoPP pamphlet are readily available throughout MTF points of service for beneficiaries to review and take with them. Additionally, the MHS NoPP poster must be prominently displayed in locations where it is reasonable to expect patients to be able to read the notice. Ensure the MTF HIPAA Privacy Officer contact information is provided on the poster in the lower right corner.

6.5.3. MTFs that maintain an official website describing customer services or benefits must prominently post the MHS Notice of Privacy Practices (NoPP) on the website's home page.

Section 6D—Accounting for Disclosures of Health Information

6.6. Accounting of Disclosures. A patient may request an accounting of every disclosure for the previous 6-year period. This does not currently include uses of PHI for treatment, payment or healthcare operations. These disclosure categories include: information about Decedents, As Required by Law, To Avert Serious Threats to Health or Safety, Cadaver Organ, eye, or Tissue Donation Purposes, Health Oversight Activities, Inmates in Correctional Institutions or in Custody, Judicial and Administrative Proceedings, Law enforcement Purposes, Medical Facility Patient Directories, Public Health Activities, Research Purposes, Specialized Government Functions, Victims of Abuse, Neglect or Domestic Violence, Workman's Compensation. For more detailed guidance, refer to DoD 6025.18-R, Chapter 7. Refer to DoD 6025.18-R Chapter 13 for a listing of exceptions to accounting.

6.6.1. Disclosure Accounting Procedures: The HPO will establish a mechanism that tracks disclosures of PHI within the purview of organizational policy as required by law and allows qualified individuals to review or receive a report on such activity. IAW DoD 6025.18-R, all MTFs will use a standardized tracking mechanism for accountable HIPAA disclosures. The Protected Health Information Management Tool (PHIMT) is the preferred method to document all accountable disclosures. If the MTF elects to use an alternative tool, it must be coordinated through the AFMOA HIPAA team and approved by the Air Force HIPAA Privacy Officer (AFMSA) prior to implementation to ensure compliance with statutory requirements. At a minimum, this data must be centralized and the tool able to account for all disclosures made throughout the MTF, and conform to all privacy and security safeguards. All accountable disclosures must be kept for a minimum of 6 years IAW DoD 6025.18-R. Refer to Chapter 13 in DoD 6025.18-R for further guidance on the various categories of disclosures which must be documented.

Section 6E—Access to Armed Forces Personnel Health Records by Commander or Designee

6.7. Authorized Access. HIPAA allows for a specific military exception as governed by DoD 6025.18-R, C7.11 to "assure the proper execution of the military mission."

6.7.1. Access, however, must be balanced with the recognized sensitivity of medical records, which often contain information of a very private nature. Therefore, before a commander or his/her designee gains access to an individual's PHI, he or she must establish the information is required for mission-related purposes IAW DoD 6025.18-R, C7.11. In instances where the MTF is uncertain if the commander or designee has established a need for the information the HPO shall seek the advice of the SJA or in-house MLC, who in turn will consult with the appropriate MLC. Disclosure of PHI should be released IAW the Minimum Necessary Rule as defined in DoD 6025.18-R.

6.7.1.1. The MTF Commander or their designee may provide a summary of the pertinent health information to the requesting Commander or designee IAW the Minimum Necessary Rule. Consent of the individual concerned in the review is not required.

6.7.1.2. Access to the original record will be provided only if specifically requested for clarification purposes or other clear need. For records release in this section, the requester shall document in writing to the MTF Commander the need for the record and why a summary per paragraph 6.7.1.1. is not sufficient. The review of said records, by command authority, shall be conducted with the assistance of a provider who can advise on medical record data that might otherwise be misinterpreted.

6.7.2. Protected Health Information properly disclosed to command authorities under the provisions of DoD 6025.18-R, Chapter 7, remains subject to the Privacy Act as it is derived from a Privacy Act system of records. The information in the commander's possession is no longer HIPAA-protected, as HIPAA only applies to covered entities.

6.7.3. For release of information for PRP purposes, refer to the MTF Commander's role as described in DoD Regulation 5210.42, Nuclear Weapons Personnel Reliability Program (PRP) and AFMAN 10-3902, same title. Each disclosure of the patient's medical information for PRP purposes must be accounted for.

6.8. Commander Designee Process. Verification of identity is required before releasing PHI to commanders or their respective designee under the provisions of DoD 6025.18-R. The MTF must ensure the individual to whom the PHI pertains is under the command authority of the requestor, and that the information requested pertains to the military mission, fitness for duty, or other permissible disclosure. The following safeguards will be observed to ensure these requirements are met:

6.8.1. A commander is defined as an officer that has command authority over the individual as determined by the "G-series" orders process. Personnel permanently assigned to the position of deputy/vice commander and first sergeant are designated as commander designees by virtue of their position and do not require an appointment letter. Individuals filling these positions on a temporary or interim basis must be appointed in writing. Commanders will designate by name, in writing any additional personnel that are authorized to act on their behalf to receive PHI for assigned squadron personnel. Designees should be

limited in number, and designee letters must be for a specified period of time and for a specified and directed purpose.

6.8.2. The MTF HPO will establish procedures for communicating with local units supported by the MTF to obtain and maintain current designee listings from each unit. The HPO will provide MTF work centers with a current listing of designees for use in verifying the identity of commanders and their respective representatives.

6.8.3. The MTF HPO will establish procedures to ensure routine disclosures of PHI such as appointment rosters, PIMR reports, and quarters notifications are released only to authorized commanders or their respective designees and accounted for accordingly.

Section 6F—Training

6.9. HIPAA Privacy Officer Oversight. The HIPAA Privacy Officer oversees, directs, and ensures delivery of HIPAA privacy/security training and orientation to all MTF employees and volunteers. Upon in-processing to the organization, employees that can provide proof of completion of Air Force approved "core" HIPAA training within the previous 12 months, need only receive local facility training. Employees that cannot offer proof of completion must complete both Air Force approved core HIPAA training and local facility training within 30 days of assignment or arrival. Document results in compliance with Air Force approved training documentation policies. Ensure annual refresher training is conducted in order to maintain workforce awareness and to introduce any changes to privacy policies.

6.9.1. Delivery. MHS-Learn is the preferred Air Force method of delivering initial and annual core HIPAA training. MTFs may request use of alternative delivery methods in instances where MHS-Learn is determined to be unusable due to connectivity issues which cannot be resolved. Use of alternative delivery methods must be coordinated through the AFMOA HIPAA team and approved by the Air Force HIPAA Privacy Officer at AFMSA, prior to implementation to ensure compliance with core training content and documentation requirements. AFMSA/SG3SA will provide standardized training content for use in delivering core training content to those facilities that are approved for alternative delivery methods. Use of commercially available or locally produced training content is not authorized to meet core HIPAA training requirements. Organizations approved for use of alternative delivery methods must maintain current and accurate records of initial and annual training of all workforce members and provide training statistics to AFMOA/SGAT as requested. MTFs requesting waiver consideration must submit the following information to AFMOA/SGAT in letter format, endorsed by the MTF Administrator (SGA) or medical support squadron commander:

6.9.1.1. Identify the nature of the technical difficulties that prevent the MTF from using the MHS-Learn Platform.

6.9.1.2. Identify the specific actions that have been taken to correct problem (e.g., contacting Base Communications or the MHS-Learn Help Desk, and/or user computer configuration attempts).

6.9.1.3. Provide contact information for MTF MHS- Learn Administrator.

6.9.2. Ensure MTF specific HIPAA information (e.g., training on local policies, procedures, and awareness training) is briefed at MTF in-processing sessions, commander's calls and

other venues in order to maintain workforce awareness and to introduce any changes to privacy policies. Ensure that MTF staffers, including ADSMs, RCSMs, civil service employees, contractors, residents, students, and volunteers receive HIPAA training.

6.9.3. Initiate, facilitate and promote activities to foster information privacy awareness within the organization and related entities.

6.9.4. Other audiences. HIPAA Privacy Officer or medical group leadership will provide general HIPAA overview training to new commanders and first sergeants within 90 days of assignment using the standardized AFMS briefing template. Additional briefings may be provided as needed or upon request of wing leadership.

Section 6G—Complaints

6.10. Intake. MTFs must establish a standard procedure to receive and investigate HIPAA-related complaints and allegations of non-compliance. The MTF may elect to use existing Patient Advocate services as a focal point for receiving complaints, or refer individuals directly to the MTF HPO.

6.11. Investigation. In cases where the MTF Commander appoints an investigating officer, the MTF HPO will serve as an SME to the investigator; otherwise, the MTF HPO will investigate all HIPAA-related complaints and prepare a written report of the investigation. For complaints involving e-PHI, the HPO will collaborate with the HIPAA Security Officer (HSO) to ensure an integrated review of the concern. If the findings of the investigation confirm a violation occurred, the HPO will recommend corrective actions to the MTF Commander. The HPO will also recommend actions to mitigate, to the extent possible, any harmful effect of a confirmed violation. At a minimum, the report should contain the following information:

6.11.1. Name of the Complainant.

6.11.2. Date the complaint was filed.

6.11.3. Date, time, and location of the incident.

6.11.4. Name(s) and duty location(s) of any staff members who were involved.

6.11.5. Synopsis of the complaint.

6.11.6. Results of the investigation.

6.11.7. Actions taken to resolve the complaint.

6.12. Reporting. The HPO will respond to the complainant in writing regarding resolution of the complaint in accordance with local Patient Advocate guidance, but not later than 30 days from receipt of the complaint. Complainants will also be advised if the investigation determines that personally identifiable information was, or is reasonably believed to have been acquired by an unauthorized person for fraudulent purposes. Refer to DoD 5400.11-R and Attachment 20 for further guidance on patient notification in these instances.

6.13. Department of Health and Human Services (HHS) inquiries. These are high-visibility, time sensitive issues. Complaints received at HHS are forwarded to the TMA Privacy and Civil Liberties Office for dissemination to the appropriate service-level Privacy Officer. See paragraph 6.13.2. for guidance in situations where HHS sends the inquiry directly to the MTF.

6.13.1. Procedures for processing HHS inquiries.

6.13.1.1. Upon receiving a notification of inquiry the AFMS HIPAA Privacy Officer will prepare a cover letter to inform the appropriate MTF Commander of the inquiry; the letter will include guidance regarding investigation and documentation requirements, and establish a suspense date for returning the completed investigation to AFMSA/SG3SA. The cover letter will be packaged with the HHS inquiry and forwarded to the AFMOA/SGAT HIPAA Team for processing. AFMSA/SG3SA will maintain a log of all HHS inquiry actions and responses.

6.13.1.2. The AFMOA Health Benefits (AFMOA/SGAT) HIPAA team will forward the cover letter and inquiry documentation to the appropriate MTF Commander. Additionally, the team will provide SME assistance to MTF personnel as necessary in conducting the investigation and in ensuring a comprehensive response is prepared for submission to HHS.

6.13.1.3. Once completed, the MTF response to the inquiry and all required documentation will be submitted to the AFMOA/SGAT HIPAA team for quality review and submission to the AFMS HIPAA Privacy Officer. The Privacy Officer will review and approve the report, then submit to the TMA Privacy and Civil Liberties Office for review and final processing.

6.13.2. The MTF HIPAA Privacy Officer must immediately notify AFMOA/SGAT in the event an HHS inquiry bypasses the normal routing chain and is received directly at MTF-level. The AFMOA/SGAT HIPAA team will ensure appropriate tracking and response procedures are initiated as described above; MTFs must not coordinate response submissions directly with HHS Field Representatives.

Section 6H—Potential or Documented Compromise of Personally Identifiable Information (PII)

6.14. Public Law 111-5. The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law on February 17, 2009. Title XIII of the act, also known as Health Information Technology for Economic and Clinical Health Act (HITECH), implements several changes to the existing HIPAA Privacy and Security Rules. Among these changes is the requirement to notify individuals, the Department of Health and Human Services (HHS), and the media of certain breaches of unsecured PHI.

6.14.1. As an entity within the Federal Government, the Air Force Medical Service is required to comply with the Privacy Act of 1974 as implemented by AFI 33-332 as pertains to safeguarding and reporting breaches of PII. Identifiable medical information is by definition PII, and therefore subject to the safeguards and reporting requirements identified in DoD 5400.11-R. Additionally, as a Covered Entity (CE) subject to the requirements of HIPAA, AFMS medical organizations must also comply with DoD 6025.18-R and DoD 8580.02-R.

6.14.2. Compliance with HHS reporting requirements does not negate current DoD reporting requirements. As such, AFMS organizations at all levels must ensure policies and procedures are in place to adhere to the evaluation and reporting criteria of both DoD and HHS requirements when reporting potential or verifiable breaches of PHI.

6.15. Response Action Procedures. Refer to Attachment 20 for detailed policy guidance and action steps all MTFs and other AFMS organizations must adhere to in ensuring the AFMS promotes a standardized and comprehensive approach to reporting breaches of information under our control.

Section 6I—Use of e-mail to communicate Protected Health Information

6.16. Use of Electronic Mail. All communications of PII, which includes identifiable health information, must be properly safeguarded in accordance with HIPAA and Air Force Messaging guidelines. Use of e-mail to transmit PHI is only authorized For Official Use Only (FOUO) purposes and must comply with encryption and digital signature requirements of AFI 33-119, Air Force Messaging and permissible uses/disclosures as described in AFI 33-332 and the HIPAA privacy rule.

6.16.1. Patient communications. The Corporate Dental Application (CDA), MiCare secure messaging, and other AFMS approved secure messaging programs are authorized. The use of clinical e-mail between MTF personnel and a beneficiary is not authorized at this time. Common examples of clinical e-mails include, but are not limited to:

6.16.1.1. Communications of health information.

6.16.1.2. Discussion of services and treatment options.

6.16.1.3. Providing healthcare consultation or advice.

6.16.1.4. Coordinating prescription refills.

6.16.1.5. Scheduling appointments and referrals.

6.16.2. Treatment, Payment, and Healthcare Operations (TPO). Use of e-mail between MTF personnel for treatment, payment and healthcare operations functions is permissible within the ".mil" domain. Under no circumstances will e-mail containing PHI be transmitted to an address outside the ".mil" domain or to any address within the ".mil" domain that is unable to receive PKI encrypted messages. This includes e-mail messages transmitted via the PIMR system to appropriate command authorities; all messages must be properly encrypted prior to transmission.

6.16.3. Safeguards for transmitting FOUO e-mail include:

6.16.3.1. Ensuring there is an official need to send the information before transmitting.

6.16.3.2. Confirming all recipients are authorized to receive the information under the Privacy Act and HIPAA.

6.16.3.3. Protecting the message from unauthorized disclosure, loss, or alteration through use of DoD PKI-based encryption.

6.16.3.4. Adding "FOUO" to the beginning of the subject line, followed by the subject. Do NOT annotate any PHI in the subject line.

6.16.3.5. Inserting the following statement at the BEGINNING of the e-mail message: "FOR OFFICIAL USE ONLY. This electronic transmission contains For Official Use Only (FOUO) information which must be protected by the Privacy Act and AFI 33-332 and the Health Insurance Portability and Accountability Act and DoD 6025.18-R. The

information may be exempt from mandatory disclosure under the Freedom of Information Act, 5 U.S.C. § 552. If you have received this message in error, please notify the sender by reply e-mail and delete all copies of this message."

6.16.3.6. Double-checking all recipients' e-mail addresses before transmitting.

6.16.3.7. Do not indiscriminately use FOUO disclaimers or encryption on messages not warranting it.

6.16.4. E-mails containing PHI may be sent to organization/office symbol e-mail addresses (e.g., AFMOA/SGAT, AFMSA/SG3SA) and must comply with encryption and digital signature requirements of AFI 33-119 and permissible uses/disclosures as described in AFI 33-332 and HIPAA Privacy and Security Rules. Individuals with access to the organization/office symbol e-mailboxes must have a need for the information as the proper recipients of the PHI. As a general precaution, remove any personally identifiable information (e.g., SSNs, names, addresses, dates of birth, etc…) whenever possible. The use of "de-identified" or purposeful unidentifiable information should always be used if the intent of the issue can be conveyed without including PHI in the e-mail message.

Section 6J—AHLTA Patient Record Auditing Roles, Capabilities, and Audit Request Processing

6.17. AHLTA Audit Program Overview.

6.17.1. Program Overview: As a result of recent AHLTA technical advances, the process of submitting an audit request to the Military Health System (MHS) Service Desk to determine whether or not an identified AHLTA user may have inappropriately accessed a patient's "sensitive" electronic health record data by invoking a "break the glass" patient encounter audit function is no longer required. Instead, this unique audit capability is now delegated to two individuals at every Air Force MTF. Each MTF Commander is responsible for appointing (in writing) a primary and alternate auditor and granting the necessary computer security access keys to each individual.

6.17.2. This delegated audit capability will benefit HIPAA Privacy and Security Officers when determining whether an AHLTA user has impermissibly accessed an electronic health record. Because this new capability allows MTFs to perform their own audits locally, strict compliance with two OASD/HA policy and guidance memorandums titled, Patient Record Auditing Roles and Capabilities, dated 19 May 2010 and Guidance for Assigning AHLTA Auditors and Requesting an AHLTA Audit, dated 21 Oct 2010, is required. Because this delegated responsibility allows each MTF to perform their own audits locally, it is essential that strict oversight and control of access be maintained. Identified primary and alternate auditors will be required to complete "Just-in-time" training before initiating an audit.

6.17.3. Prior to version 3.3.3.2, AHLTA did not have the capability to return audit results for "Read-Only" access unless the user had invoked the "Break the Glass" function on patient encounters marked "Sensitive." Additionally, MTFs requesting an audit had to submit a "trouble" ticket to the MHS Service Help Desk for all audit requests. AHLTA version 3.3 and higher now provides the ability at the local level to initiate and complete an audit report on encounters created in version 3.3. for "Read-Only" and "Break the Glass" access. This

new localized audit report functionality, once exercised, will provide information on a specific user's access to a patient's electronic medical record during a specific time period.

6.17.4. Submission of a trouble ticket to the MHS Service Help Desk is no longer required for incidents that have occurred while accessing patient data using an AHLTA 3.3 client (or higher). However, if the requested audit time period included incidents or actions occurring on an earlier AHLTA 838 client, the MTF must submit a trouble ticket to the DHIMS Tier 3 support office via the MHS Service Help Desk.

6.17.5. If there is any question as to whether a patient's electronic AHLTA medical record was accessed using the earlier 838 or later 3.3 version, or if there are multiple MTFs involved in any one investigation, a trouble ticket must be opened with the MHS service help desk.

6.18. Appointing Auditors.

6.18.1. MTF Commanders are required to appoint (in writing) two AHLTA auditors per site, one primary and one alternate for whom each MTF systems administrator will assign the AHLTA patient electronic record auditing capability or security access "keys." Only these two individuals are authorized to have the Patient and User Audit Report role added to their user account profile. No one else in the MTF is authorized to perform user access audits of patient electronic medical record encounters. Ensure each individual is fully qualified for the duties for which they will be entrusted. Ensure each auditor has completed all available or required annual information assurance, information protection, resource protection, ethics, HIPAA and/or Privacy Act awareness training.

6.18.2. Both primary and alternate auditors will be identified on the same appointment letter. Once the MTF Commander signs the letter, the original document is maintained in the MTF HIPAA Privacy Officer's office. Each auditor is provided a copy. The HIPAA Privacy Officer will review the letter annually ensuring the names of the identified auditors are accurate and correct.

6.18.3. The DHIMS Tier 3 support office will perform regular reviews to see which users have been assigned as auditors. Auditor access keys for any AHLTA user for which the help desk cannot identify as either a primary or alternate auditor, will be removed.

6.19. Auditor Training.

6.19.1. Prior to each approved audit, each auditor will complete "Just-in-time" training. The training is computer-based and is provided via the MHS Learn website. Before an MTF auditor begins an AHLTA audit of a patient's electronic medical record, he or she is required to contact officials at the below location to obtain the necessary "Just-in-time" training. If any of the contact information changes, contact the AFMOA HIPAA Privacy Team for assistance with obtaining training.

The Office of the Deputy Director of Clinical Documentation

Defense Information Management System

Arlington, VA

(703) 681-7147

6.20. Requesting and Documenting a User Access Audit.

6.20.1. The TOPA Flight Commander, the Patient Administration Flight Commander, the MTF Patient Administration Officer, the MTF Information Systems or Information Management Flight Commander, the MTF Chief of the Medical Staff, and the MTF HIPAA Privacy and/or Security Officers are the only MTF officials authorized to request AHLTA user access audits. This group is henceforward identified as the Electronic Health Record (EHR) User Access Audit Review Group.

6.20.2. Before an audit may begin, an audit request letter must be coordinated with the members of the EHR User Access Audit Review Group, then reviewed and approved in writing by the MTF Commander or designee. The only two authorized designees are the MTF Chief of the Medical Staff (SGH) and the MTF HIPAA Privacy Officer. If audit approval authority is delegated, the designee authority must be documented in writing on official unit letterhead and maintained in the MTF Commander's office. No more than one delegated reviewing/approving authority may be appointed at any given time. The designee is provided a copy of the approval letter. If an AHLTA user access audit request is submitted by the MTF HIPAA Privacy Officer or MTF SGH, and if the MTF Commander has delegated reviewing/approval authority to either official, then delegation approval authority is temporarily suspended and the MTF Commander is required to review, approve, or disapprove the request. Each written audit request letter must include the following information:

6.20.2.1. Patient Internal Entry Number (IEN).

6.20.2.2. Provider IEN.

6.20.2.3. User IEN.

6.20.2.4. Date range of suspected violation.

6.20.2.5. Specific AHLTA electronic medical record area of concern (if applicable or if known).

6.20.2.6. The contact information for the HIPAA Privacy Officer expected to receive the audit results.

6.20.2.7. Justification or reason for the request.

6.20.3. Once the information contained in the request letter is validated, the audit request should be approved and then forwarded to one of the AHLTA auditors authorized to perform user access audits. The results of the audit are forwarded to the MTF HIPAA Privacy Officer for analysis. If an audit requires Tier 3 intervention or analysis, an MHS Service Help Desk trouble ticket should be submitted with the same information identified above. Forward the MHS trouble ticket number and case summary to the AFMS HIPAA Privacy Program Manager. Maintain all approved and denied AHLTA user access audit requests and audit results for six years in a locked container in the MTF HIPAA Privacy Officer's office.

CHARLES B. GREEN
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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Abbreviations and Acronyms

AAC—Assignment Availability Code

A&D—Admissions & Dispositions Office

AAAHC—Accreditation Association for Ambulatory Healthcare

ACS—American College of Surgeons

ADSM—Active Duty Service Member

ADT—Active Duty of Training

AFCITA—Air Force Complete Immunization Tracking Application

AFMOA—Air Force Medical Operations Agency

AFMSA—Air Force Medical Support Agency

AFRIMS—Air Force Records Information Management System

AFSAT—Air Force Security Assistance Training

AFSC—Air Force Specialty Code

AGR—Active Guard/Reserve

AHLTA—Armed Forces Health Longitudinal Technology Application

AIDS—Acquired Immunodeficiency Syndrome

AIM—Alternate Input Method

ALC—Assignment Limitation Code

ALC—R—Assignment Limitation Code-Request Program aka Assignment Limitation Code "Fast Track" Program

AMA—Against Medical Advice

AMC—Annual Medical Certificate

ANG—Air National Guard

APV—Ambulatory Procedure Visit

ARC—Air Reserve Component

ART—Air Reserve Technician or Assistance Reporting Tool

ASD—Assistant, Secretary of Defense

ASF—Aeromedical Staging Flight

AT—Annual Tour

AWOL—Absent Without Leave

BA—Business Associate

BAA—Business Associate Agreements

BCAC—Beneficiary Counseling and Assistance Coordinator

BIMAA—Base Individual Mobilization Augmentee Administrator

C&CS—Communications & Customer Service (@ TMA)

CAL—Casualty Affairs Liaison

CAP—Civil Air Patrol

CFR—Code of Federal Regulations

CHCS—Composite Healthcare System

COCOM—Combatant Command

COMPASS—Clinical Optimization Military Provider AHLTA Satisfaction Strategy

CONUS—Continental United States

CPO—Civilian Personnel Office

CPT—Current Procedural Terminology

COTR—Contracting Officer's Technical Representative

CRO—Carded for Record Only

DAC—Deployment Availability Code

DAWG—Deployment Availability Working Group

DCSA—Defense Communications Services Agency

DDMS—Duty Determination Management System (DDMS)

DEERS—Defense Enrollment Eligibility System

DES—Disability Evaluation System

DHIMS—Defense Health Information Management System

DES—Disability Evaluation System

DLC—Duty Limiting Code

DMDC—Defense Manpower Data Center

DOA—Dead on Arrival

DODDS—The Department of Defense Dependents Schools

DODMERB—Department of Defense Medical Examination Review Board

DSG—Deputy Surgeon General

DTF—Dental Treatment Facility

DVA—Department of Veterans Affairs

EAD—Extended Active Duty

EAR—Extended Ambulatory Record

ECHO—Extended Care Health Option

EFMT—Emergency Family Member Travel Program

EFMP—Exceptional Family Member Program

EHHC—ECHO Home Healthcare

EHR—Electronic Health Record

EMEDS—Expeditionary Medical Support

EMF—Employee Medical Folder

EPTS—Existed Prior To Service

ER—Emergency Room

ERD—Emergency Room Death

ETS—Expiration of Term of Service

FAP—Family Advocacy Program

FDI—Facility Determination Inquiry

FECA—Federal Employees Compensation Act

FHM—Force Health Management

FIN—Foreign Identification Number

FMCMT—Family Maltreatment Case Management Team

FMP—Family Member Prefix

FMRC—Family Member Relocation Clearance

FMS—Fetal Monitor Strip

FMS—Foreign Military Sales

FMS—Foreign Military Service

FOPR—Full Reimbursement Outpatient Rate

FPC—Family Practice Clinic

FRC—Federal Recovery Coordinator

FRR—Full Reimbursement Rate

FOIA—Freedom of Information Act

GAF—Global Assessment of Function

GPMRC—Global Patient Movement Requirements Center

GSU—Geographically Separated Unit

HBA—Health Benefits Advisor

HA—Health Affairs

HHS—Department of Health and Human Services

HIPAA—Health Insurance Portability and Accountability Act

HIV—Human Immunodeficiency Virus

NoPP—Notice of Privacy Practices

HPO—HIPAA Privacy Officer

IAOPR—Inter-Agency Outpatient Rate

IADT—Initial Active Duty Training Date

IAR—Inter-Agency Rate

IAW—In Accordance With

IG—Inspector General

ICD—CM—International Classification of Diseases – Clinical Modification

IDES—Integrated Disability Evaluation System

IDT—Inactive Duty Training

IMA—Individual Mobilization Augmentee

IMR—Individual Medical Readiness

IPR—Inpatient Record

ITIN—Individual Taxpayer Identification Number

ITO—Invitational Travel Order

JC—Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations or JCAHO)

JFTR—Joint Federal Travel Regulation

JTR—Joint Travel Regulation

LOD—Line of Duty

MAJCOM—Major Command

MC4—Medical Communications for Combat Casualty Care

MCSC—Managed Care Support Contractor

MEB—Medical Evaluation Board

MEPRS—Medical Expense and Performance Reporting System

MHS—Military Health System

MHSS—Military Health Services System

MISRT—Medical Information Security Readiness Team

MLC—Medical Law Consultant

MMSO—Military Medical Support Office

MOOTW—Military Operations Other Than War

MPI—Master Patient Index

MPS—Military Personnel Section

MRTR2—Medical Record Tracking, Retirement and Retrieval

MSA—Medical Service Account

MSC—Medical Service Corps

MSME—Medical Standards Management Element

MTF—Medical Treatment Facility

NAF—Non-Appropriated Fund

NATO—North Atlantic Treaty Organization

NDAA—National Defense Authorization Act

NGB—National Guard Bureau

NOAA—National Oceanographic and Atmospheric Administration

NOK—Next of Kin

NOPP—Notice of Privacy Practices

NSI—Not Seriously Injured

NPRC—National Personnel Records Center

NSTR—Non-Service Treatment Record

OAFME—Office of the Armed Forces Medical Examiner

OASD(HA)—Office of the Assistant Secretary of Defense for Health Affairs aka TRICARE Management Activity

OF—Optional Form

OPAC—Open Access

OPM—Office of Personnel Management

OPR—Outpatient Record or Office of Primary Responsibility

OSD—Office of the Secretary of Defense

OSD/HA—Office of the Assistant Secretary of Defense for Health Affairs

OSI—Office of Special Investigation

OWCP—Office of Workers' Compensation Program

PA—Privacy Act

PAD—Patient Administration

PCA—Permanent Change of Assignment

PCMH—Patient Centered Medical Home

PCS—Permanent Change of Station

PDS—Permanent Duty Station

PEB—Physical Evaluation Board

PEBLO—Physical Evaluation Board Liaison Officer

PHA—Preventive Health Assessment

PHI—Protected Health Information

PHIMPT—Protected Health Information Management Tool

PHO—Public Health Officer

PII—Personally Identifiable Information

PIMR—Preventive Health Assessment and Individual Medical Readiness

PKI—Public Key Infrastructure

PL—Public Law

PME—Professional Military Education

PMRC—Patient Movement Requirements Center

PO—HIPAA Privacy Officer (aka HPO)

POC—Personally Owned Conveyance

POC—Point of Contact

POMR—Problem Oriented Medical Record

POV—Personally Owned Vehicle

PRP—Personnel Reliability Program

PSP—Presidential Support Program

PSDA—Patient Self Determination Act

QAE—Quality Assurance Evaluator

RC—Reserve Component

RCC—Recovery Care Coordinator

RCMU—Reserve Component Medical Unit

RCPHA—Reserve Component Preventive Health Assessment

RCSM—Reserve Component Service Member

RSM—Recovering Service Member

RD—Reinforcement Designees

RHIA—Registered Health Information Administrator

RHIT—Registered Health Information Technician

RILO—Review-In-Lieu-Of [Medical Evaluation Board]

RMO—Resource Management Office

ROTC—Reserve Officer Training Corps

SADR—Standard Ambulatory Data Record

SECAF—Secretary of the Air Force

SF—Standard Form

SI—Seriously Ill

SIDR—Standard Inpatient Data Record

SJA—Staff Judge Advocate

SOFA—Status of Forces Agreement

SPO—Senior Profile Officer

SSN—Social Security Number

STR—Service Treatment Record

TAMP—Transitional Assistance Management Program

TDRL—Temporary Disability Retired List

TDY—Temporary Duty

TIN—Temporary Identification Number

TMA—TRICARE Management Activity

TMDS—Theater Medical Data Store

TMO—Traffic Management Office

TOL—TRICARE Online

TOPA—TRICARE Operations and Patient Administration

TPO—Treatment, Payment, or Healthcare Operations

TPR—TRICARE Prime Remote

TRAC2ES—TRANSCOM Regulating Command and Control and Evacuation System

TRO—TRICARE Regional Office

TRS—TRICARE Reserve Select

TSC—TRICARE Service Center

TTAD—Temporary Tour of Active Duty

TYA—TRICARE Young Adult

ULN—Unit Line Number

USHBP—Uniformed Services Health Benefits Program

USINS—US Immigration and Naturalization Service

USTF—Uniformed Services Treatment Facility

USUHS—Uniformed Services University of Health Sciences

UTA—Unit Training Assembly

VSI—Very Seriously Ill

VA—Veterans Affairs

VARO—Veterans Affairs Regional Office

WW—Wounded Warrior

WWL—Worldwide Locator

WWR—Worldwide Workload Report

Terms

Active Duty—Applies to members serving full-time duty in the active military service of the United States. It includes members of the Reserve Component serving on active duty or full-time training duty, but does not include full-time National Guard duty. The term Inactive Duty for Training (IDT) does not apply to this definition when considering healthcare eligibility. See AFI 36-2115, for more details.

Active Duty Training or Active Duty for Training—A tour of active duty which is used for training members of the Reserve components to provide trained units and qualified persons to fill the needs of the Armed Forces in war or national emergency and such other times as the national security requires. The member is under orders that provide for return to non-active status when the period of active duty training is completed. It includes annual training, special tours of active duty for training, school tours, and the initial duty for training performed by non-prior service enlistees.

Active Guard/Reserve—Members of the Air National Guard or Air Force Reserves who are on extended active duty tours.

Adjunct Dental Care—Dental care that in the professional judgment of the attending physician and dentist are judge to be both:

- Necessary for the treatment or management of a medical or surgical condition other than dental, and;

- Greatly beneficial to the patient's primary medical or surgical condition or its after-effects.

The primary diagnosis must be specific so that the relationship between the primary condition and the requirement for dental care in the treatment of the primary condition is known. Dental care to improve the general health of the patient is not necessarily adjunctive dental care.

Air Reserve Component (ARC)—Units, organizations, and members of the Air National Guard (ANG) and the Air Force Reserve (USAFR).

Appropriate ARC/SG—HQ AFRC/SGP for unit assigned reservists, DSN 497-0603. HQ ARPC for Individual Mobilization Augmentees (IMA), DSN 926-7237. NGB/SGP for Air National Guard, DSN 278-8550.

Attending Physician—The physician who has the primary responsibility for the medical diagnosis and treatment of the patient.

Beneficiary—Persons entitled to benefits under the USHBP and this instruction.

Child—The natural or adopted child of a sponsor, or in some cases for purposes of determining eligibility for military health benefits, the unadopted step-child of a sponsor, or the legal ward of a sponsor. To determine whether a minor child may consent to certain classes of healthcare, refer to applicable state law, or for overseas locations local Medical Group Operating Instructions (see AFI 36-3001).

Chronic Medical Condition—A medical condition that active medical treatment cannot cure or control. Chronic conditions may involve periodic acute episodes and may require intermittent inpatient care. Sometimes medical treatment may control a chronic medical condition sufficiently to permit continuation of daily living activities such as work, or school.

Civilian Health and Medical Program of the Uniformed Services—That part of the USHBP under which the Government pays a portion of the specific health service that eligible individuals receive from civilian healthcare providers. Authority for the TRICARE Program is 32.C.F.R. pt. 199.

Commander—The principle commissioned officer responsible for all activities, operations, and resources under his/her control. Synonymous with commanding officer and commanding officer in charge.

Comprehensive Medical Information—Patient's name, rank, age, status (e.g., AD, RC) unit of assignment or government occupational position, date of admission and/or date of treatment, diagnosis, current medical status, whether the admission was routine or happened under emergent circumstances, and the projected length of stay.

Consent to Release Medical Information—Written authorization by a patient or an individual authorized by law to so act on behalf of the patient to release medical information not otherwise lawfully releasable absent such authorization. **Note:** A routine, general authorization for the release of information is not adequate for disclosing information from records containing drug/alcohol abuse, treatment, or rehabilitation information.

Convalescent Leave—An authorized leave status granted to active duty uniformed service members while under medical or dental care that is a part of the care and treatment prescribed for a member's recuperation or convalescence.

Continental United States (CONUS)—United States territory, including the adjacent territorial waters, located within North America between Canada and Mexico (Alaska and Hawaii are not part of CONUS).

Custodial Care—Healthcare for a patient who:

- Is mentally or physically disabled and expected to continue as such for prolonged period.

- Requires a protected, monitored, or controlled environment in an institution or home.

- Requires assistance to support the essentials of daily living.

- Is not under active and special medical, surgical, or psychiatric treatment that reduces the disability to the extent necessary to enable the patient to function outside a protected, monitored, or controlled environment.

Deceased Member—A person who was, at the time of death, a uniformed service active duty member or retired; or a retired member of a Reserve Component who elected to participate in the Survivor Benefit Plan (for information on this plan, contact the Personal Affairs department at the local MPS), but died before reaching age 60.

Defense Health Information Management System (DHIMS)—The DHIMS information management/technology (IM/IT) system helps capture, manage and share health data across the DoD enterprise. As a component of the Military Health System (MHS) Chief Information Office, DHIMS applications are built upon the functional, technical and operational perspectives of theater and clinical medical professionals. This new program office, created as a result of the merger between the Clinical Information Technology Program Office (CITPO), Resources Information Technology Program Office (RITPO), and the Theater Medical Information Medical Program – Joint (TMIP-J), manages the development, deployment, and maintenance of the systems that make up AHLTA – the military's electronic health record.

Deferred Non-Emergency Care—Medical, surgical, or dental care that, in the opinion of medical authority, could be performed at another time or place without risk of the patient's life, limb, health, or wellbeing. Examples are surgery for cosmetic purposes, vitamins without a therapeutic basis, sterilization procedures, therapeutic abortions, procedures for dental prosthesis, and prosthetic appliances.

Definitive Diagnosis—For purposes of an MEB evaluation, any condition that significantly interferes with performance of duties appropriate to a Service Member's office, grade, rank, or rating.

Department of Defense Line of Duty WEB Application Database (DoD LOD WEB APP)—Designed to operate in tandem with DEERS and display medical care eligibility information for RCSMs who are not on active duty orders, yet are entitled to medical care at government expense because of a medical condition which is either pending an administrative, informal, or formal LOD investigation or has been determined to be "In Line of Duty" following an LOD investigation. At the time of this instruction publication, this system was not authorized for use at AD MTFs. However, this system may become a viable resource in the near future.

Dependency Determination—A determination by the Air Force Accounting and Finance Center, that individuals may retain their status as dependents of an active duty or retired member of the uniformed services. A favorable dependency determination does not in itself establish an entitlement to medical care. The dependency determination must also provide specifically for medical care.

Dependent—A term that has generally been replaced with "family member." An immediate family member of an active duty or retired Uniformed Services member. See AFI 36-3002 for a detailed explanation.

Direct Care System—The system of military hospitals and clinics around the world.

Disability Evaluation System (DES)—A process maintained by the military Services to ensure a fit and vital force by determining a Service Member's fitness for continued military service. The DES should include a medical evaluation board (MEB), a physical evaluation board (PEB), an appellate review process, and a final disposition.

Disposition—The removal of a patient from a MTF because of a return to duty or to home, transfer to another MTF, death, or other termination of medical care. The term may also refer to change from inpatient to outpatient status (for example, inpatient to subsisting elsewhere or convalescent leave).

Domiciliary Care—See also "Custodial Care"—Inpatient institutional care provided to a patient beneficiary whereby the patient's family members can or will not provide the care, not because it is medically necessary, but because care in a home setting is either not available or is unsuitable. Although there may be a clinical difference between Domiciliary and Custodial Care, for the purpose of determining entitlements, they are the same.

Durable Medical Equipment—Equipment that can withstand repeated use and generally is not useful to a person in the absence of illness or injury, for example, respirators, nebulizers, IPP machines, oxygen tents, wheelchairs, hospital type beds, and ambulation devices such as walkers.

Elective Healthcare—Non-emergent, optional healthcare, also defined as healthcare that is not medically necessary to provide relief from undue suffering or relief from symptoms that could cause potential health problems.

Emergency Care—The immediate medical or dental care necessary to save a person's life, limb, or sight, or to prevent undue suffering or loss of body tissue.

Extended Active Duty—A tour of active duty, normally for more than 90 days, that members of the Reserve Component perform. Strength accountability changes from the Reserve Component to the active duty force. Active duty for training is not creditable as EAD.

Foreign Military Sales—That portion of United States security assistance authorized by the Foreign Assistance Act of 1961, as amended, and the Arms Export Control Act of 1976, as amended. This assistance differs from the Military Assistance Program and the International Military Education and Training Program in that the recipient provides reimbursement for defense articles and services transferred. Also called FMS.

Former Spouse—An individual who was married to an active duty member for a sufficient length of time to become eligible for healthcare.

Highly Sensitive Records—Health records, correspondence (including working papers), and laboratory results, which may have an adverse effect on the morale or character of the patient or other person(s). Highly sensitive records include but are not limited to alleged or confirmed information relating to the treatment of patients for sexual assault, criminal actions (including child or spouse abuse), psychiatric or social conditions, or venereal disease. Claims against the government (including malpractice) are also considered highly sensitive.

Inactive Duty Training—Authorized training performed by a member of a Reserve Component not on published active orders and consisting of regularly scheduled unit training assemblies, additional training assemblies, periods of appropriate duty of equivalent training, and any special additional duties for Reserve Component personnel that an authority designated by the Secretary

concerned, and performed by them in connection with the prescribed activities of the organization in which they are assigned with or without pay. Does not include work or study associated with correspondence courses. Refer to AFI 36-2115 for more definitive information.

Inpatient Records Library—The library provides resources for clinical reference and research, supports specialty training and post-graduate programs, provides the means for accomplishing analysis and establishing trends, etc.

Integrated Disability Evaluation System (IDES)—The IDES integrates the DES with the Veterans Administration (VA), and delivers the advantage of single-sourced disability ratings that are accepted by both the DoD and the VA, so the member will receive a VA benefits decision shortly after separation or retirement.

International Military Education and Training— Formal or informal instruction provided to foreign military students, and forces on a non-reimbursable (grant) basis by offices or employees of the United States, contract technicians, and contractors. Instruction may include correspondence courses; technical, educational or informational publications; and media of all kinds.

Maternity (obstetrical) and Infant Care—Medical and surgical care incident to pregnancy, including prenatal care, delivery, postnatal care, treatment of complications of pregnancy, and inpatient newborn care.

Maximum or Optimum Health Benefit—The point during hospitalization when the patient's progress appears stable, and medical authorities can reasonably determine that further hospitalization or medical care will not result in a full or complete recovery, or when it appears that any likely recovery will prohibit the Service Member from meeting medical retention standards, or if the Service Member is most likely not capable of performing the duties of his office, grade, rank or rating.

Medical Care—Inpatient, outpatient, dental care, and related professional services.

Military Patient—A patient who is a member of the Uniformed Services of the United States on active duty, or Reserve Component status eligible for military care, or an active duty member of a foreign government eligible for military care.

Medical Treatment Facility—A military medical facility established for the purpose of furnishing medical and/or dental care to eligible individuals (applies to both hospitals and clinics). It does not include aid stations or contract facilities.

Medical Treatment Facility Commander—The person appointed on orders as the commanding officer of the medical treatment facility.

NATO Countries—See NATO member.

NATO Member—A military member of a NATO country who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. NATO nations are: Albania, Belgium, Bulgaria, Canada, Croatia, Czech Republic, Denmark, Estonia, France, Germany, Greece, Hungary, Iceland, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Turkey, the United Kingdom, and the United States.

Non-appropriated Fund (NAF) Employee—A Government employee whose pay comes from other than appropriated funds (for example, bowling alley and Base Exchange employees).

Office of Worker's Compensation Program (OWCP) Beneficiary—A civilian employee of the US Government who is injured or contracts a disease in the performance of duty and whom the OWCP has designated as a beneficiary.

Power of Attorney—A legal document authorizing an individual to act as the attorney or agent of the grantor. General rules and individual state laws specify when a power of attorney is required. Refer any questions pertaining to powers of attorney to the legal office.

Reserve Components—Reserve components of the Armed Forces of the United States are: The Air National Guard of the United States, The Air Force Reserve, The Army National Guard of the United States, The Army Reserve, The Naval Reserve, The Marine Corps Reserve, The Coast Guard Reserve. For the purpose of this instruction, the term also includes the reserve members of the commissioned corps of the United States Public Health Service and National Oceanic and Atmospheric Administration.

Retiree—A former member of a uniformed service who is entitled to retired, retainer, or equivalent pay, based on duty in a uniformed service.

Sanitized Healthcare Information—A patient's name, rank, age, military status (AD, RC), unit of assignment or government occupational position, date of admission and/or treatment date, and whether the admission was routine or happened under emergent circumstances, as this information applies to reporting an ADSM's status to the authorized ADSM's commander or the commander's properly appointed designee.

Security Assistance Training Program—The umbrella program for International Military Education and Training Program and Foreign Military Sales.

Sensitive Medical Information—Information that may affect the patient's morale, character, medical progress, or mental health. This includes the specific location or description of illness or injury, which may prove embarrassing to the patient or reflect poor taste. If the patient consents, information relating to the description of disease or injury and general factual circumstances may be released. **Note:** To protect the sensitive nature of the information, records or documents will be sent directly through medical channels when considered advisable by the healthcare provider or MTF Commander.

Supplemental Care—A non-elective specialized inpatient and/or outpatient treatment, procedures, consultation, tests, supplies, or equipment in a non-MTF while an inpatient or outpatient of a military facility. This care is required to augment the course of care being provided by the MTF. As outlined in 32CFR pt. 199, Supplemental Care applies to Active Duty and other non-TRICARE eligible beneficiaries.

Transitional Assistance Management Program (TAMP)—Offers transitional healthcare coverage under TRICARE Prime where offered, TRICARE Extra, and TRICARE Standard to certain separating active duty members and their eligible family members. Care is available for a limited time. Sponsors may verify eligibility for themselves and their family members by visiting or contacting the nearest uniformed services ID card facility or contacting the Defense Manpower Data Center Support Office toll free at (800) 538-9552. To locate the nearest ID card facility, visit **www.dmdc.osd.mil/rsl**/. Refer to paragraph 2.48. for additional information.

Treatment—A procedure or medical service that medical persons expect to lead to or assist in the patient's recovery.

TRICARE—The military's managed healthcare program, overseen by the Department of Defense in cooperation with regional civilian contractors. TRICARE uses the Military Health System as the main delivery system augmented by a civilian network of providers and facilities serving our active duty (including Reservists/National Guard), their families and retired military/families and survivors world-wide.

TRICARE Prime Remote (TPR)—TPR provides healthcare coverage through civilian providers for those U.S. Uniformed Service Members and their families who are on remote assignment. It applies to members of the Army, Navy, Marine Corps, Air Force, Coast Guard, U.S. Public Health Service, and National Oceanic and Atmospheric Administration. Eligible beneficiaries must live and work more than 50 miles or approximately one hour's drive time from the nearest MTF. TPR is offered in the 50 United States only.

TRICARE Reserve Select (TRS)—TRS is a premium-based TRICARE health plan offered for purchase by certain members and former members of the Reserve Component (RC) and their families, if specific eligibility requirements are met. TRS coverage is available to eligible RCSMs who were called or ordered to active duty, under Title 10, in support of a contingency operation. Enrollment usually requires the RCSM to serve in the RC for one entire year or more to qualify. TRS coverage must be purchased. TRS members pay a monthly premium for healthcare coverage (for self-only or for self and family). TRS premiums are adjusted 1 January each year.

Unified Combatant Command—A Unified Combatant Command is composed of forces from two or more services, has a broad and continuing mission and is normally organized on a geographical basis. The number of unified combatant commands is not fixed by law or regulation and may vary from time to time.

Uniformed Services—The Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanic and Atmospheric Administration (NOAA), and US Public Health Service (USPHS).

Uniformed Services Medical Treatment Facilities—Medical treatment facilities that belong to the Air Force, Army, Navy, and Coast Guard, but not former Public Health Service medical facilities that the Congress has designated as part of the USFHP.

Uniformed Services Family Health Plan—US Family Health Plan is a TRICARE Prime option There is a TRICARE Prime option available to eligible persons - including those who are age 65 and over - who live near selected civilian medical facilities around the country. These facilities are called "designated providers" (DPs) - formerly known as Uniformed Services Treatment Facilities.

United States—The 50 states and the District of Columbia, Puerto Rico, the US Virgin Islands, and Guam.

Veteran—A person who served in the active military, Army, Navy, Coast Guard or Air Force. A person who originally enlisted in a regular component of the Armed Forces after 7 September 1980, or who entered active duty after 16 October 1981, is not eligible for benefits from the Department of Veterans Affairs unless he or she completes the lesser of 24 continuous months of active duty or the full period for which the person was called or ordered to duty. This

provision does not apply to veterans who have a compensable service-connected disability or who were discharged close to the end of an enlistment term because of hardship, or a disability incurred or aggravated in line of duty.

Veterans Medical Benefits—Medical benefits authorized under Title 38, U.S.C. Chapter 17, available to veterans with honorable and general discharges. Discharges issued by general court-martial are a bar to Department of Veterans Affairs benefits.

Wounded Warrior—Any Service Member who has sustained a combat or hostile-related injury or illness requiring long-term care that will require a Medical Evaluation Board or Physical Evaluation Board to determine fitness for duty.

Written Authorization—Written consent from the patient or authorized representative allowing release or disclosure of information.

Attachment 2

SAMPLE PROOF OF ELIGIBILITY LETTER

Figure A2.1. Sample Proof of Eligibility Letter.

MEMORANDUM FOR_____Date

FROM: MDG/CC

SUBJECT: Proof of Eligibility

1. Per AFI 41-210, Patient Administration, paragraph 2.41., all MTFs must verify a patient's eligibility status when they present for care. This verification is accomplished by the patient presenting a valid ID card and the MTF staff performing a DEERS check.

2. When presenting for care today, your eligibility could not be verified through this process. Verification of your eligibility must be received by _____. (no later than 30 days from date care is rendered) If verification is not received by this date, you may be held liable for the cost of your care.

3. If you have any questions regarding this policy, please contact the Medical Service Account office at XXX-XXXX. Thank you.

MDG Commander Signature Block

Attachment 3

QUARTERS AUTHORIZATION FORM EXAMPLE

Figure A3.1. Sample Quarters Authorization Form. This is not an official form.

QUARTERS AUTHORIZATION/SICK SLIP

SECTION I: DURATION OF QUARTERS

DURATION: (circle one)

24 Hrs or Less 48 Hrs 72 Hrs OB Patient DATE: _____

Date & Time Patient is Expected to Return to Work: _____ Return Appointment (if necessary): _____

SECTION II: GENERAL CHARACTERIZATION OF QUARTERS CONDITION

(circle all that apply)

ILLNESS NON-BATTLE INJURY BATTLE CASUALTY RELATED INJURY

AIRCRAFT RELATED MOTOR VEHICLE RELATED OTHER

SECTION III: PATIENT IDENTIFICATION

LAST NAME: _____ FIRST NAME: _____

RANK: _____ Last 4 (SSN): _____ Service Branch: _____

Organization/Unit: _____ Station of Assignment: _____

SECTION IV: UNIT NOTIFICATION:

DATE & TIME: _____ PERSON CONTACTED: _____

SECTION V: MEMBER ACKNOWLEDGEMENT

My provider has explained the "quarters" process to me and I understand that my excusal from duty is temporary and I am to return to work in accordance with the time indicated above. I further understand that my excusal from duty is to rest and recover from an injury or illness, in my own home. I have been instructed to contact my immediate supervisor and inform him/her of my status. I will take this form to my immediate commander or commander's support staff before proceeding home. I also understand that failure to follow the instructions listed in this agreement may result in negative administrative action.

_____

Signature of Patient

Example AFB Form XX-XX

This document may contain information covered under the Privacy Act, 5 USC 552, Health Insurance Portability and Accountability Act, Public Law 104-191, and DoD 6025.18-R. It must be protected in accordance with those provisions.

Attachment 4

MEDICAL SUFFICIENCY STATEMENT FORMAT

Figure A4.1. Sample Medical Sufficiency Statement

Date:

To:DFAS-IN/JFLTBA

ATTN: Air Force Dependency

8899 E 56th St

Indianapolis IN 46249-1200

From: Name of USAF Medical Treatment Facility or civilian provider's office

Subject: Medical Sufficiency Statement

1. In accordance with AFI 41-210, TRICARE Operations and Patient Administration Functions, this medical sufficiency statement is being submitted to determine the eligibility for (insert applicants name and SSN or DoD ID number, and sponsor's name and SSN or DoD ID number).

2. The MTF Commander or civilian provider checks √ one of the four statements below as prescribed from AFI 41-210, paragraph 2.42.4:

__Approved: Medical sufficiency is established based on the patient's medical condition. This individual is incapable of self-support because of a mental or physical incapacity that has existed on a continuous basis and originated before the individual's 21st birthday (or 23rd birthday if enrolled as a full-time student when incapacitation occurred) and may be resolved within ( ) years, or will not be resolved in the foreseeable future.

Patient cannot dress him/herself.

Patient cannot feed him/herself.

Patient cannot cook meals on his/her own.

Patient cannot bathe him/herself.

__Disapproved: The patient's condition is such that it does not establish medical sufficiency.

__Disapproved: This individual is incapable of self-support because of a mental or physical incapacity that exists at this time. It is my opinion that this incapacity did not exist before the individual's 21st birthday (or 23rd birthday if enrolled as a full-time student when incapacitation occurred).

__No Determination Made: Medical sufficiency of patient's medical condition or supporting

documentation is lacking; therefore, no determination of incapacity and dependency can be made at this time. **Note:** If at a later date the dependent meets the eligibility criteria as listed in AFI 41-210, or if there are other facts for consideration, a new application may be submitted.

3. The attending physician's statement summarizing the patient's incapacitation is filed in the patient's medical record. Should you have any questions or require additional information, please contact the MTF's TOPA office or civilian provider commercially at (xxx) xxx-xxxx.

Commander or Civilian Provider's Signature Block and Signature.

Attachment 5

EXAMPLE OF SECDES APPROVAL LETTER

Figure A5.1. Sample SECDES Approval Letter.

MEMORANDUM FOR AFMOA/SGAT

FROM: SAF/AA

1720 Air Force Pentagon

Washington DC 20330-1720

SUBJECT: Air Force Secretary Designee Request - Mr. John Doe

Per your request, Mr. John Doe is granted Secretarial Designee Status IAW AFI 41-210, Chapter 4, under the Teaching Case criteria. Designation is effective for the period of 10 Jan 2010 - 9 Jan 2011. Treatment is limited to medical care associated with <INSERT SPECIFIC MEDICAL CARE>.

Designation is limited to care at the XXth Medical Group, Fly Straight AFB, TX. Charges are at the Family Member Rate and will be recouped from the third party insurance carrier (**Note:** Insert this statement only if patient has third party insurance) Transportation aboard military aeromedical evacuation (is or is not - only one will be identified) authorized.

BY DIRECTION OF THE SECRETARY OF THE AIR FORCE.

Signed

Mr. or Ms. Senior Executive

Administrative Assistant

cc:

AF/SG

Attachment 6

SECRETARY OF THE AIR FORCE DESIGNEE EXAMPLE REQUEST

Figure A6.1. Sample SECDES Request.

Date

MEMORANDUM FOR (MAJCOM NAME AND ADDRESS)

FROM: (MTF NAME AND ADDRESS)

SUBJECT: Secretary of the Air Force Designee Program Application

1. The following information must be provided when requesting Secretarial Designee status, in accordance with AFI 41-210, Chapter 4.

a. The patient's full name.

b. The patient’s date of birth.

c. The patient’s relationship to sponsor.

d. Sponsor's full name.

e. Sponsor’s rank.

f. Sponsor’s branch of service.

g. Last four numbers of the Sponsor’s SSN.

h. Sponsor’s military status (active duty retired, deceased) and reason for discharge or separation.

i. The exact date Designee status should begin.

j. The recommended length of Designation.

k. Transportation aboard an aeromedical evacuation aircraft is/is not requested. Identify whether the patient requesting Designee status might require transportation on aeromedical evacuation. If so, include patient's home address.

l. Reason for Designation: for example, age (specify date of birth), marriage status, sponsor leaving the service.

m. Justification: Identify both the primary program category/criteria best suited for the situation and a supporting narrative.

n. Diagnosis: The application should include diagnosis in both clinical and layman's terms.

o. Brief Case History: The application needs a brief (one or two paragraph) case history. For complex cases, attach a separate letter with additional details. Include a long-term prognosis, the

patient's age when medical providers first diagnosed the problem, and when and where DoD sponsored care began. Histories must be understandable to non-medical personnel.

p. Name of attending physician.

q. Medical specialty required: Application should specify the type of medical specialist (orthopedics, pediatrics, etc.) who would provide care for the patient.

r. Name, rank, and duty phone (DSN and commercial) of the Secretarial Designee caseworker.

s. Third Party Insurance Carrier: Identify if the sponsor, and or, applicant has Third Party Insurance.

t. Third Party Insurance Carrier Policy Number.

u. Space Availability: Indicate if the MTF has the capacity to treat the applicant.

v. Like-care TRICARE Prime patients are/are not being deferred to the network. Indicate if other TRICARE Prime beneficiaries with the same diagnosis are being deferred to the network.

w. Right of First Refusal (ROFR) status: Indicate if your MTF accepts/does not accept ROFRs.

2. For additional information please call the caseworker at the above phone number.

JAMES M. PHYSICIAN, LtCol, USAF, MC

Chief of the Medical Staff

Attachment 7

SECRETARY OF THE AIR FORCE DESIGNEE LOG FORMAT

Figure A7.1. SECDES Log Format.

Annual Designee Log

MAJCOM: _____ Year Covered by List: _____.

Name of person submitting list: _____.

Phone number (DSN): _____.

Category refers to the reason for designation, for example, Continuity of Care, Best Interest of the Air Force, etc.

a. Overseas MAJCOMs and all MTFs' logs should include all categories of Designees except those designated through the SAF/AA.

b. HQ PACAF and HQ USAFE should include contractors who had access to care under the provisions of AFI 41-210.

c. Detail: (Sample format):

Patient's Name Criteria Category Designation Date(s) Approval Date Remarks

Doe, John A Best Interest Newborn 1 Apr 12 20 Mar 12

of the USAF of Dep Dau

Green, Mary Teaching ECMO 30 Aug 12 15 Jul 12

Johnson, Buddy Teaching Bone 15 Sep 12 5 Sep 12

Marrow Pgm

Smith, Ken Continuity Hyperbaric 10 Dec 12 1 Dec 12

of Care O2 Therapy

(Mandatory statement to include at the bottom of each report page)

This document may include information protected under the Privacy Act, 5 U.S.C. § 552, Health Insurance Portability and Accountability Act, Public Law 104-191, and DoD Directive 6025.18. This document must be protected in accordance with the aforementioned provisions.

Attachment 8

EXPIRED PATIENT CHECKLIST (EXAMPLE ONLY)

Figure A8.1. Sample Expired Patient Checklist.

Use this checklist when notified of the death of a patient.

Name of Patient: _____Ward: _____Notified by Whom: _____

Date/Time: _____Family Members Present:_____A&D Clerk's Initials: ___

MAKE ENTRY ON THE QUALITY CONTROL CHECKLIST ON DEATH FOLDER AT THIS TIME!

COMPLETE THE FOLLOWING ACTIONS "BEFORE" GOING TO THE WARD:

1. Retrieve the expired patient's suspense file from the file cabinet.
2. From the computer or patient's file get information needed to fill out the following forms:

_____ AF Form 146 - Death Tag- Fill in all blocks (except blocks 5 and 8) Must have 3 tags.

_____ AF Form 570 - Notification of Patients Medical Status - All data in Block I.

_____ Bring the local MTF Death Certificate Worksheet or copy of state death certificate - (Handwrite information into pre-selected information blocks - block locations & numbers vary per state).

_____ Release of Remains - Date and Name of Deceased.

3. Print a Blue Stamp Plate.

WITH THE ABOVE FORMS, GO TO THE WARD AND TALK TO (1) THE DOCTOR (2) CHAPLAIN (3) NURSING STAFF (4) THE FAMILY.

1. The doctor will fill in the following information and provide SIGNATURES:

_____ AF Form 146 - Death Tag - All 3 tags, blocks 5 and 8. Give to the ward.

_____ AF Form 570 - Notification of Patient Medical Status - Sections III and IV (STAMP NAME OF PHYSICIAN).

_____ SF 523 - Authorization for Autopsy- Must Use patient's blue plate to stamp information under patient's identification.

_____ Request for Postmortem Examination.

DEATH CERTIFICATE WORKSHEET (Enter - Blocks 1,2,3,7,8,107,108,109,110,111,112,113, and 118. **Note:** Again block locations and numbers vary by state).

(STAMP BLOCK #118 AND DOCTOR'S PAGER NUMBER).

_____ Higher HQ FAX NOTIFICATION (may not be necessary for every patient. If higher HQ notification is required, the physician identified on the certificate needs to complete the bottom of the form).

_____ Complete AF Form 1122 - Personal Property Inventory - Complete ONLY if family members are NOT present and secure property until family arrives in the patient valuables locker.

2. Obtain the following information from the family:

_____ Confiscate patient's ID card.

_____ Release of Remains: (1) Sign the release (2) Name of Funeral Home.

_____ Authorization for Autopsy: Be sure to obtain NOK signature in presence of physician and yourself.

_____ Patient Belongings - maintained in secure patient valuables locker or safe.

UPON RETURNING TO THE OFFICE COMPLETE THE FOLLOWING ACTIONS:

Make ALL necessary notifications:

_____ AF Form 570, Block V.

_____ Computer/Box/File.

_____ Fax (HQ MAJCOM).

_____ Command Post.

_____ CTDN (All deaths--inform of patient's wish to/not to donate organ and/or tissue).

_____ If patient died within 24hrs of admission or arrival at the hospital call XXX-XXXX. Leave message if no answer.

_____ Autopsy: If one is required, after obtaining signatures and filling out both forms completely, turn into Pathology on the next duty day (unless an Emergency Autopsy is requested).

_____ Type Death Certificate – Obtain doctor's signature, make 3 copies (Original: To Funeral Home, 1st copy: For A&D File, 2nd copy: In the Risk /Quality Management Box, 3rd copy: To Inpatient Records Section.

_____ Call Funeral Home when death certificate is signed and autopsy are completed.

_____ Release of Remains: Have the funeral home complete their portion and make a copy for them. The original release form is filed in the death folder.

Attachment 9

ARRANGEMENT OF FORMS IN THE AF FORM 2100A SERIES, HEALTH RECORD OUTPATIENT SECTION 1

Figure A9.1. Arrangement of the Health Record Outpatient Section 1.

Form Number and Title	Special Instructions
DD Form 2766, Adult Preventive and Chronic Care Flowsheet , and/or, AF Form 1480a, Adult Preventive and Chronic Care Flowsheet	**Note:** AF Form 1480A, and the AF Form 4320 have been replaced by DD forms, same title. Whichever form is used, (DD Form 2766, AF Form 1480, or AF Form 4320), this form is always the top form filed in section I. Transcribe pertinent information from older forms to each subsequent new form(s) and file the old form(s) underneath the newer form in section I. DO NOT remove/discard the old forms. File old forms underneath the current version.
DD Form 2882, Pediatric & Adolescent Preventive and Chronic Care Flowsheet, and/or, AF Form 4320, Pediatric & Adolescent Preventive and Chronic Care Flowsheet	
DD Form 2766C or AF Form 1480B, Adult Preventive and Chronic Care Flowsheet – Continuation Sheet	File after/behind the DD Form 2766, AF Form 1480A, or AF Form 4320. This form is used as a continuation form for documenting information that cannot fit on DD Form 2766 or AF Form 1480A, or for local requirements. The Air Force Complete Immunization Tracking Application (AFCITA) also utilizes an automated version of the form. Each time a member receives an updated immunization, the AFCITA system may generate an updated paper form. If an updated form is generated, discard the previous form ONLY after ensuring the latest form contains BOTH historical and current immunization data, then file the new form in its place.
DD Form 2795, Pre-Deployment Health Assessment Questionnaire	File the DD Form 2796, DD Form 2844, and DD Form 2900 (post deployment assessment forms) after the corresponding DD Form 2795 that each form is associated with.
DD Form 2796, Post-Deployment Health Assessment	
DD Form 2844, Medical Assessment Post-Deployment	

DD Form 2900, Post-Deployment Health RE-Assessment	
AF Form 1480, Summary of Care	Information will be transcribed from the AF Form 1480 onto the DD Form 2766 or AF Form 1480A. Do not discard old forms. File under the oldest DD Form 2766.
AF Form 3922, Adult Preventive Care – Flowsheet	Transcribe the AF Form 3922 information in the same way as the AF Form 1480 and file it after the AF Form 1480.
AF Form 3923, Child Preventive Care – Flowsheet	Transcribe the AF Form 3923 information onto the AF Form 4320.
Form Number and Title	Special Instructions

DD Form 2569, Third Party Collection Program (TPCP) – Record of Other Health Insurance	1. File here unless MTF policy is to maintain the form in the resource management (business) office or in an authorized electronic format and stored in an enterprise-wide electronic clinical documentation database. File the most current form. Remove older, out-dated forms. This form must be updated annually or upon change of patient information. The form must be validated at every encounter as being current and correct. This form contains PII and must be safeguarded if maintained apart from the outpatient medical record. 2. Filing Options: a. Continue with current process of maintaining a hardcopy of this form filed in the outpatient medical record. b. Capture and store the form electronically. The stored e-file must be saved with the following naming convention: Last Name (or first 8 characters), First Initial, FMP, Last 4 of Sponsor's SSN, Month/Year of patient or adult family member signature with dashes separating each data entry, e.g., (Jones, D-20-4567-0910). Stored electronic forms will not be available to anyone without authorized, need to know, TPCP or clinic staff member access. MTF Data Quality auditors and TPCP contract support personnel must have access to the electronic forms database. Obsolete or outdated electronic forms may be deleted/destroyed IAW applicable records management rules. c. Maintain the original hardcopy form in the MTF RMO, business office, or TPCP office. The form should be filed by signature date/month and alphabetically thereafter. During non-business hours, store in a secure location, which offers at least one locked door between the filed documents and the outside hallway or office entrance. Destroy form/file one year after date of signature of the form, or when

	replaced by an updated signed form. d. File this form for non-enrolled/non-empanelled patients who otherwise do not receive regular direct care from the MTF and/or there is no paper medical record already on file, in either the MTF outpatient records department or in the RMO/business office, TPCP office. File forms by signature date/month and alphabetically thereafter. During non-business hours, store in a secure location, which offers at least one locked door between the filed documents and the outside hallway or office entrance. Destroy form/file one year after date of signature of the form, or when replaced by an updated signed form. 3. Each MTF will choose one option for filing the form. If not already accomplished, the MTF must communicate the option of choice to their TPCP contract partner. Regardless of the filing option choice, the TPCP contractor must receive the original or copy of all DD Forms 2569 before final filing.
AF Form 565, Record of Inpatient Treatment (or approved CHCS computer generated form)	Copy of original, or similar document used by the US Army, US Navy, or Department of Veterans Affairs medical facilities.
AF Form 560, Authorization and Treatment Statement	Original – Only necessary if admission was cancelled. Previously filed AF Forms 560 will not be removed.
SF 502, Medical Record - Narrative Summary	Copy of original.
SF 509, Medical Record – Progress Notes	File a copy of original, when used as a final discharge note or discharge instruction.
SF 515, Medical Record – Tissue Examination	File a copy of original report if the procedure relates to inpatient care; file the

	original report if the procedure relates to outpatient care if not already filed in an EAR.
SF 516, Medical Record – Operation Report	File a copy of original report if the procedure relates to inpatient care; file the original report if the procedure relates to outpatient care if not already filed in the EAR.
OF 517, Clinical Record – Anesthesia	File a copy of the original document if episode of care relates to inpatient report (if there was an anesthetic incident); file the original document if the care relates to an outpatient episode.
Form Number and Title	Special Instructions
OF 522, Medical Record – Request for Administration of Anesthesia and for Performance of Operations and Other Procedures	Copy of all documentation relating to ambulatory surgery.

Attachment 10

ARRANGEMENT OF FORMS IN THE AF FORM 2100A SERIES, HEATLH RECORD OUTPATIENT SECTION 2

Figure A10.1. Arrangement of the Health Record Outpatient Section 2.

Form Number and Title	Special Instructions
AF Form 745, Sensitive Duties Program Record Identifier	Always the top form in this section when used.
AF Form 966, Registry Record	Filed after AF Form 745, if used.
SF 600, Health Record – Chronological Record of Medical Care	SF 600s from single-visit encounters (e.g. Health Assessment Overprints), with no other associated supporting paperwork, should be filed in chronological order, most current form filed on top of the other single-visit SF 600s.
OF 558, Medical Record – Emergency Care and Treatment	Interfile OF 588 with applicable SF 600s in date order. Forward original to the inpatient unit and file with the inpatient record if the patient is admitted.
DD Form 2161, Referral for Civilian Medical Care	File these forms on top of the SF 600 to which it belongs.
SF 513, Consultation Report	
AF Form 1535, Physical Therapy Consult	
AF Form 1352, Hyperbaric Patient Information and Therapy Record	Original if treatment was on an outpatient basis. File the most recent form on top of all others.
AF Form 1446, Medical Examination – Flying Personnel	Signed original.
DD Form 2697, Report of Medical Assessment	
SF 78, Certificate of Medical Examination	Applies to civilian employees only.
SF 88, Report of Medical Examination or DD Form 2808, Report of Medical Examination	Signed copy of each report. When DD Form 2161 or any other form is prepared in conjunction with the SF 88/DD Form 2808, it is filed with the SF 88/DD Form 2808.
SF 93, Report of Medical History, DD Form 2807-1, Report of Medical History or DD Form 2807-2, Medical Prescreen of Report of Medical History	Signed copy of each report. File civilian employee's SF 93/DD Form 2807-1/DD Form 2807-2 in his/her health record.

Notes:

Careful attention must be paid to ensure inter-related documents for the same episode of care or subsequent referral care documents are filed on top of the initial encounter document. For example, place subsequent DD Form 2161, Referral for Civilian Medical Care, SF 513, Consultation Report, or AF 1535, Physical Therapy Consult, on top of the SF 600 that documented the initial encounter.

Attachment 11

ARRANGEMENT OF FORMS IN THE AF FORM 2100A SERIES, HEALTH RECORD OUTPATIENT SECTION 3

Figure A11.1. Arrangement of the Health Record Outpatient Section 3.

Form Number and Title	Special Instructions
AF Form 348, Line of Duty Determination	
AF Form 422, Physical Profile Serial Report	Filed chronologically with most recent report on top.
AF Form 469, Duty Limiting Condition Report	Most recent
Prenatal Forms	Prenatal forms will be maintained in the OB-GYN clinic until the mother delivers. If the mother delivers in a civilian facility the forms will be filed in the outpatient record.
SF 533, Medical Record – Prenatal and Pregnancy	If the mother did not deliver in the hospital, the prenatal record is filed as a whole package with all forms pertaining to prenatal treatment filed chronologically between the SF 533 and AF Form 3915.
AF Form 618, Medical Board Report	Signed copy of original and associated documents.
AF Form 1042, Medical Recommendation for Flying or Special Operational Duty	File a copy of the most current recommendation for or against (either temporary or permanent suspension) flying status or special operational duty. File the AF Form 1418 with the AF Form 1042, the SF 88, or any other form prepared in conjunction with AF Form 1042. Keep all supporting documents even though the AF Form 1042 may be destroyed. Remove the AF Form 1042, specifically prepared for annual or incoming clearance, from the record and destroy when it expires. Remove and destroy any AF Form 1042 excusing, grounding, or disqualifying an individual for flying or special operational duty after the new AF Form 1042 returning the individual to medically approved/cleared status is filed.
AF Form 1418, Recommendation for Flying or Special Operational Duty – Dental	

AF Form 137, Footprint Record	AF Form 137 is filed on top of DD Form 2005. **Note:** The September 1988 edition of AF Form 2100A series has the Privacy Act Statement printed on the folder. It is not required to place DD Form 2005 in these folders.
All other forms not listed in Section 1, 2, and 4	File all other forms in chronological order by date, including letters and copies of reports of care from civilian sources (reviewed by the military healthcare provider) and locally generated forms.
DD Form 2005	For records that do not have a privacy act statement preprinted on the record folder.
Disclosure Accounting Record	The purpose of the document is to maintain a record of patient information released. This document will contain the following information: individual's name (e.g., patient); requestor's name and address; nature of disclosure; individual's consent with a block for annotating "Yes" or "No, not required;" and date of
Form Number and Title	Special Instructions
Disclosure Accounting Record (continued)	disclosure. Until such time as this form is printed on the AF Form 2100A series folder, each MTF will develop a local form containing space for the requested information with space for entry of multiple requests.

Attachment 12

ARRANGEMENT OF FORMS IN THE AF FORM 2100A SERIES, HEALTH RECORD OUTPATIENT SECTION 4

Figure A12.1. Arrangement of the Health Record Outpatient Section 4.

Form Number and Title	Special Instructions
Laboratory Forms	File in chronological order with most current laboratory results/report filed on top.
SF 601, Health Record – Immunization Record	Used by US Army, US Navy, Air National Guard, and US Air Force Reserve.
SF 602, Health Record – Serology Record	
SF 519B, Medical Record – Radiological Consultation Request Report	Filed in chronological order by date with the most recent on top.
OF 520, Medical Record-Electrocardiographic Record, (or automated EKG report)	Filed together in chronological order by date (the most recent on top), except when OFs 520 attached as documentation to reports, are filed with other reports. Filing a copy of the inpatient electrocardiograms (EKGs) in the outpatient record is optional. Facilities with computer generated EKG reports may destroy OF 520 after the test has been ordered and if all patient identification is on the automated report.
AF Form 1721, Spectacle Prescription	
DD Form 2215, Reference Audiogram	
DD Form 2216, Hearing Conservation Data	
AF Form 1671, Detailed Hearing Conservation Data Follow-up	
AF Form 190, Occupational Illness/Injury Report	
AF Form 1527, History of Occupational Exposure to Ionizing Radiation	
AF Form 1527-1	
AF Form 1527-2	
AF From 1753, Hearing Conservation Examination	
AF Form 2755, Master Workplace Exposure Data	

Summary	
AF Form 2769, Supplemental Data Sheet	
AF Form 895, Annual Medical Certificate	
Form Number and Title	Special Instructions
OTHER DIAGNOSTIC TEST RESULTS and/or flat disc digital MEDIA not already stored in the patient's electronic health record or specifically mentioned in this attachment.	**Note:** Some MTFs may receive referral results from civilian providers in the form of CD-ROM digital media. If no capability exists to transfer/convert this information into AHLTA, print the information from the CD-ROM and file in the appropriate outpatient record s department.
Advance Directives (Self Determination Act forms), durable Power of Attorney forms, organ donor forms	

Attachment 13

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Attachment 14

SAMPLE LETTER – MISSING ORDERS REQUIRED FOR STR SHIPMENT

Figure A14.1. Sample Missing Orders Letter.

(Sample letter provided for MTFs to use when they cannot obtain a copy of the Service Member's separation, retirement, or discharge orders)

Service Agency Letterhead

(Date)

MEMORANDUM FOR HQ AFPC/DPSSR

MEDICAL RECORDS DISPOSITIONS

550 C STREET W SUITE 21

RANDOLPH AFB TX 78150

FROM: XXth Medical Support Squadron (XX MDSS/CC)

110 General Arnold Street

Any Air Force Base, Any Town/State 12345-4321

SUBJECT: Missing Orders

1. The XXth Medical Group Outpatient Records Department could not obtain orders for the following Service Member:

Full Name:

Rank:

SSN:

Date of Birth:

Final Service Obligation Date:

2. We exhausted all available options and search mechanisms within our means, but could not locate the orders for one or more of the following reasons (check all that apply):

____ Service Member did not out-process with the MTF,

____ Military Personnel Staff (identify POC) could not provide due to (provide reason),

____ Other (provide detailed reason and POC) _____

3. Please contact Rank, First Name, Last Name at DSN 555-1234 or commercial (999) 555-1234 for questions.

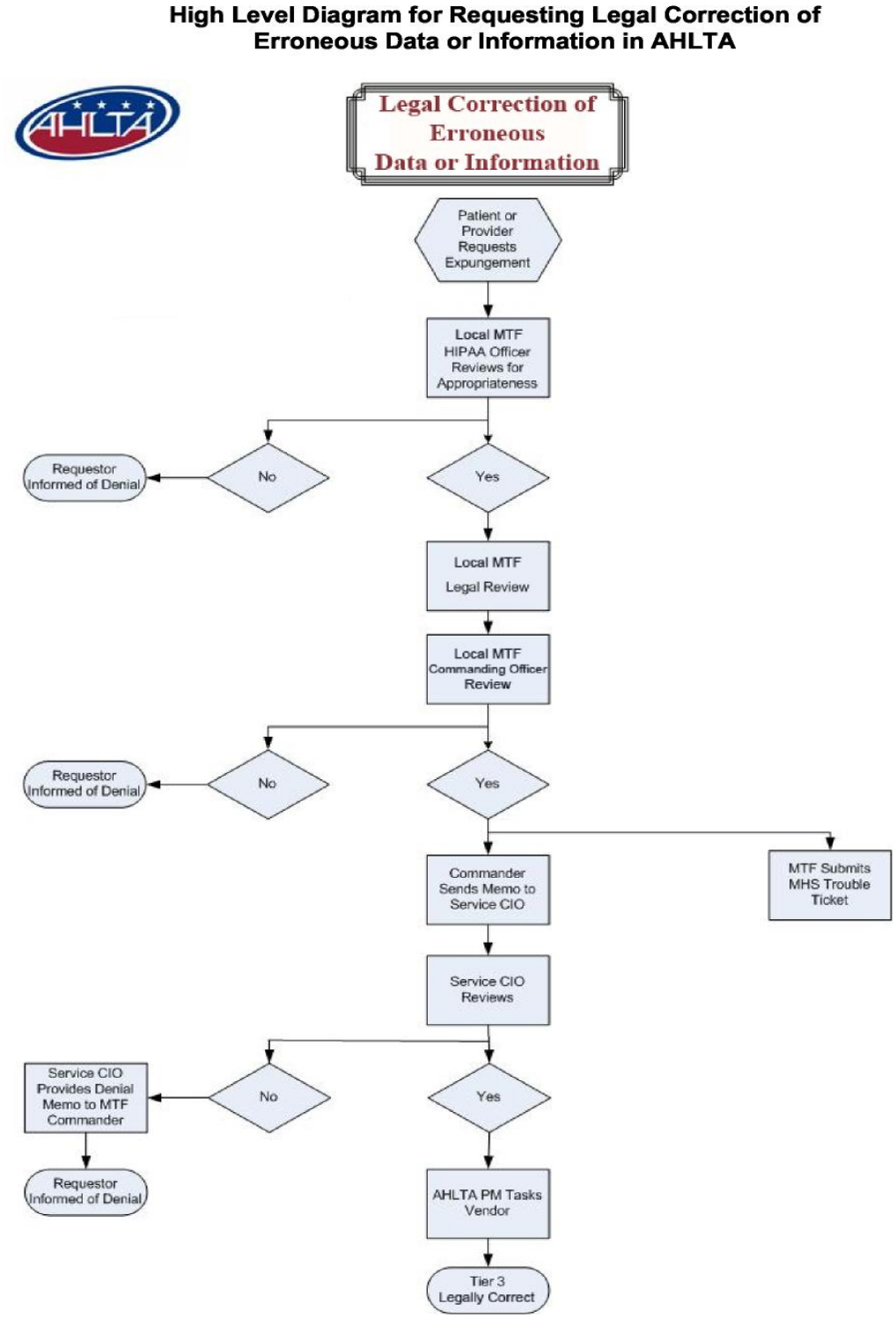
JOHN A. COMMANDER, Lt Col, USAF, MSC

Commander, XXth Medical Support Squadron

Attachment 15

CORRECTIONS OF AHLTA ERRONEOUS DATA OR INFORMATION

Figure A15.1. Corrections of AHLTA Diagram.



High Level Diagram for Requesting Legal Correction of

Erroneous Data or Information in AHLTA

Legal Correction of Erroneous Data Process Summary

Process for Requesting Legal Correction of Erroneous Data or Information within AHLTA

A legal correction of erroneous data is the removal of erroneous PHI information entered into the wrong patient's AHLTA encounter. Legal correction of erroneous data should not be requested unless erroneous PHI is visible in the wrong patient encounter. The procedure for removing erroneous information not containing PHI is defined later in this document.

Detailed steps for requesting legal correction of erroneous data:

1. The patient or provider requests legal correction of erroneous data.

2. The HIPAA Officer reviews the request for appropriateness. **Note:** If the HIPAA Officer denies the request, the requester is notified.

3. The request receives a legal review.

4. The MTF Commander reviews the request. **Note:** If the Commander denies the request, the requester is notified.

5. The MTF submits trouble ticket to begin a tracking process.

6. The MTF Commander or designee (e.g., Deputy Commander for Clinical Services (DCCS) or HIPAA Privacy Officer) signs a memorandum requesting the legal correction of erroneous data or erroneous PHI and sends the memorandum to the appropriate Chief Clinical Information Officer (CIO) within each Service. **Note:** The MTF Commander's memorandum will contain the MHS trouble ticket number and the MTF Point of Contact (POC). No other personal information is needed. A sample letter is attached.

7. The CIO or the Clinical Information Services personnel within each Service will review requests and may contact the MTF POC for clarification as needed. If the request is approved, the Chief Clinical Information Services Division within each Service will forward the request to Defense Health Information Management System (DHIMS) Program Office for action as needed.

Note: If the request is denied the CIO will send a denial memorandum to the MTF Commander.

8. DHIMS Program Office tasks the AHLTA Vendor.

9. Tier 3 corrects the information in the AHLTA record as directed.

Figure A15.2. Sample Letter to Correct AHLTA.

Service Agency Letterhead

MEMORANDUM FOR THE CHIEF, INFORMATION OFFICER

SUBJECT: Request for AHLTA Legal Correction of Erroneous Data or Erroneous Protected Health Information (PHI)

1. The purpose of this memorandum is to request an AHLTA Legal correction of erroneous data.

a. The MHS Help Desk ticket number is xxxxxxxxxx.

b. Patient IEN.

c. Provider IEN.

d. User IEN.

e. Specific Encounter.

f. Reason for information removal "Information entered on an incorrect patient."

2. Please address any questions and send the results to:

a. HIPAA Privacy Officer (Primary POC)
Maj John Doe
john.doe@amedd.army.mil
DSN 772-1234 or commercial (000) 234-1234.

b. MDG/SGH (alternate POC)
LTC John Smith
john.smith@amedd.army.mil
DSN 777-5588 or commercial (001) 234-5678.

John D. Sample Colonel, USAF, MC
Commander

Attachment 16

ARRANGEMENT OF FORMS IN THE INPATIENT RECORD

Figure A16.1. Arrangement of the Inpatient Record.

Form Number and Title	Special Instructions
AF Form 565, Record of Inpatient Treatment	Original, typed, or electronic. Filed on top of all other applicable forms. File all other forms (listed below) for the same episode of care beneath this form in listed order.
AF Form 560, Authorization and Treatment Statement	Original with physician's signature, or initials, and signature stamp at bottom.
SF 569, Patient's Absence Record	
*AF Form 618, Medical Board Report	With attachments as a complete package when prepared.
SF 502, Medical Record-Narrative Summary (Clinical Resume)	Unless included in Medical Board package.
SF 503, Medical Record-Autopsy Protocol	
DD Form 1322, Aircraft Accident Autopsy Report	When used instead of SF 503 for reporting autopsies performed on aircraft accident fatalities.
SF 504, Clinical Record-History Parts I and II	
SF 505, Clinical Record-History Parts II&III	
SF 506, Clinical Record-Physical Examination	
SF 539 (or DD Form 2770), Medical Record-Abbreviated Medical Record	When used instead of, or in addition to SF 504-506.
SF 558, Medical Record-Emergency Care and Treatment	When patient is admitted through the Emergency Room; Original.
*SF 507, Clinical Record Report On ____ or Continuation of SF Report_____	Always file as an attachment to the form to which it pertains. Do not separate from that form.
*OF 275, Medical Record Report	When used in lieu of a SF, AF or DD form, file in place of that form.
SF 535, Clinical Record-Newborn	
SF 509, Medical Record-Progress Notes	When appropriate place preadmission SF 600s in front of SF 509
SF 513, Consultation Report	

DD Form 2161, Referral for Civilian Medical Care	
SF 515, Medical Record-Tissues Examination	If an AFIP report is prepared, file it beneath the SF 515 to which it pertains
SF 516, Clinical Record-Operation Report	
OF 517, Medical Record-Anesthesia Recovery Room Record	
AF Form 1864, Preoperative Nursing Record	
OF 522, Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures	Or locally approved form (check with State Requirements).
SF 533, Medical Record – Prenatal and Pregnancy	Prenatal record is filed as a whole package with all forms pertaining to prenatal treatment filed chronologically between the SF 533 and AF Form 3915.
AF Form 3915, Labor and Delivery Flow Sheet	Prenatal record is filed as a whole package with all forms pertaining to prenatal treatment filed chronologically between the SF 533 and AF Form 3915.
AF Form 1302, Request and Consent for Sterilization	
AF Form 1225, Informed Consent for Blood Transfusion	
SF 523, Medical Record-Authorization for Autopsy	
OF 523B, Medical Record-Authorization for Tissue Donation	
Form Number and Title	Special Instructions
SF 518, Medical Record-Blood or Blood Component	
SF 519B, Medical Record – Radiological Consultation Request Report	
OF 520, Medical Record-Electrocardiographic Record or automated electrocardiograph (EKG) report	Facilities with computer generated EKG reports may destroy the OF 520 after the test is ordered and all patient identification is on the automated report.
SF 546, Chemistry I	

SF 541, Medical Record-Gynecologic Cytology	
SF 547, Chemistry II	
SF 548, Chemistry III (urine)	
SF 549, Hematology	Facilities having Coulter Counter Model S, Use AF Form 1976-Hematology instead of SF 549.
SF 550, Urinalysis	
SF 551, Serology	
SF 552, Parasitology	
SF 553, Microbiology I	
SF 554, Microbiology II	
SF 555, Spinal Fluid	
SF 557, Miscellaneous (**Note:** Laboratory Reports may be computerized)	
DD Form 741, Eye Consultation	
AF Form 1412, Occupational Therapy Treatment Record	
AF Form 1535, Physical Therapy Consultation	
AF Form 1536, Physical Therapy Consultation Continuation Sheet Record	
SF 521, Medical Record-Dental	
SF 524, Medical Record-Radiation Therapy	
SF 525, Medical Record-Radiation Therapy Summary	
SF 526, Medical Record-Interstitial/Intercavitary Therapy	
SF 527, Medical Record-Group Muscle Strength, Joint R.O.M., Girth and Length Measurements	
SF 528, Medical Record-Muscle Function by Nerve Distribution: Face, Neck and Upper Extremity	
SF 529, Medical Record-Muscle Function by Nerve Distribution: Trunk and Lower Extremity	
SF 530, Medical Record-Neurological	

Examination	
SF 531, Medical Record-Anatomical Figure	
AF Form 3066 (or 3066-1), Doctor's Orders	
AF Form 3069, Medication Administration Record	
AF 3068, PRN Medication Administration Record	
AF 3067, Intravenous Record	
AF Form 3241, Adult Admission Note	
AF Form 3242, Adult Patient Care Plan	
AF Form 3244, Pediatric Admission Note	
AF Form 3245, Pediatric Patient Care Plan	
AF Form 3247, Neonatal Admission Note	
AF Form 3248, Neonatal Patient Care Plan	
Form Number and Title	**Special Instructions**
AF Form 3250, Obstetric Patient Care Plan	
AF Form 3252A, Mental Health Patient Care Plan	
AF Form 3254, Patient Care Plan	
AF Form 3256, Patient/Family Teaching Flow Sheet	
SF 511, Medical Record-Vital Signs Record	
SF 512, Medical Record-Plotting Chart	
SF 512A, Medical Record-Plotting Chart-Blood Pressures	
DD Form 792, Twenty-Four Hour Patient Intake and Output Worksheet (if local requirements to file)	
Other prescribed nursing forms	
AF Form 570, Notification of Patient's Medical Status	
AF Form 1122, Personal Property Inventory	
AF Form 1122A, Personal Property Inventory (Continuation Sheet)	

Birth Certificate and Worksheet	
Death Certificate	
AF Form 438, Medical Care - Third Party Liability Notification	
DD Form 2569, Third Party Collection Program – Other Health Information	File the most up-to-date form signed by the patient or guardian. Admitted patients or guardian will sign this form prior to or at the time of admission.
Other command and local administrative forms	
Other release of information forms	
Correspondence Records received with transferred patients	
*DD Form 602, Patient Evacuation Tag	File beneath the SF 502 from the transferring MTF.

Attachment 17

ASSIGNMENT LIMITATION CODE C STRATIFICATION LEVELS AND MEMBER APPROVAL AUTHORITY

Table A17.1. Assignment Limitation Code C Stratification Levels and Approval Authority.

Stratification Level	Forward Deployability	Gaining Approval Authority	Generally Approved for
ALC-C1	Deployable/Assignable to Global DoD fixed facilities with intrinsic Medical Treatment Facilities Deployable/Assignable to non-permanent installations or installations without intrinsic MTF with approval of gaining installation SGP or SGH (MAJCOM equivalent if none at installation)	MTF COMMANDER or MAJCOM/SG if no MTF COMMANDER present or COCOM/SG if SM is deploying	This ALC-C is used to identify SMs with medical conditions for which specialist medical care and referral within one year is likely but who could deploy or be reassigned OCONUS or to non-fixed environments if appropriate specialty care is available, or for short periods of time.
ALC-C2	Deployable/Assignable to CONUS installations with intrinsic fixed MTFs (TRICARE Network availability assumed) Deployable/Assignable to OCONUS installations with approval of gaining COCOM/SG or MAJCOM SG (or delegate)	MAJCOM/SG or COCOM/SG if SM is deploying	This ALC-C is used to identify SMs with medical conditions for which specialist medical care and referral within one year is likely but who could be deploy or be reassigned OCONUS or to non-fixed environments if appropriate specialty care is available, or for short periods of time.

ALC-C3	Non-Deployable/Assignment limited to specific installations based on medical need and availability of care.	AFPC/DPAMM	This ALC-C stratification designates SMs who should not deployed or be assigned away from specialty medical capability required to manage their unique medical condition.

Attachment 18

PATIENT SQUADRON ASSIGNMENT ORDER

Figure A18.1. Sample Patient Squadron Assignment Order.

UNCLASSIFIED.

ACTION PREC: ROUTINE.

INFO PREC: ROUTINE.

SPECAT: NONE.

THIS MESSAGE IS SENT ON BEHALF OF (Gaining MTF COMMANDER)

THIS MESSAGE IS INTENDED FOR: (Losing Base Outbound Assignments Section)

(Losing Base CPTS)

INFO: HQ AFPC/DPAMM

SUBJ: PATIENT ASSIGNMENT – (Rank, Last Name, First Name, Middle Initial, SSN).

RNLTD Date: (Date member needs to report to gaining MTF).

SUSPENSE MSG REPLY: (Date a reply is required).

REQUEST IMMEDIATE COMPLIANCE. USE THIS MESSAGE AS AUTHORITY TO REASSIGN MEMBER PCS TO PATIENT SQ SECTION (Gaining MTF Unit and Address).

GPAS: (Gaining Base PAS code).

FORWARD MEMBER'S UPRG, EDUCATION, AND OJT RECORDS TO GAINING FSS/MPS: (Gaining Force Support Squadron or MPS and Address).

PLEASE E-MAIL A COPY OF THE COMPLETED ORDERS TO: (Contact Name and DSN).

ENSURE MEMBER IS NOT RETRICTED BY AFI 36-2110 FOR PCS. ADVISE BY PRIORTY MESSAGE IF MEMBER IS PENDING INVOLUNTARY DISCHARGE (REFERENCE AFI 36-3206 AND AFI 36-3208).

IF PENDING DISCHARGE, MAIL DENTAL RECORDS, UPRG, SPECIAL ORDERS, AND UIF (IF ANY) TO (Gaining Base FSS/MPS) MARK FOR ATTENTION OF: RETIREMENTS/SEPARATIONS, REPEAT, MARK FOR ATTENTION OF RETIREMENTS/SEPARATIONS. REQUEST MESSAGE PROVIDING THIS OFFICE WITH DATE DENTAL RECORDS, SPECIAL ORDERS UPRG, AND UIF ARE TO BE DATED. INCLUDE SPECIAL ORDER NUMBER, DATE OF SPECIAL ORDERS, AND FUNDING CITATION TO EXPEDITE PROCESSING. AMEND TDY ORDERS TO COVER PERIOD FROM DATE DEPARTED YOUR STATION TO RNLTD SPECIFIED ABOVE.

FOR UNIT COMMANDER: PATIENT WILL NOT BE RETURNING TO YOUR UNIT. ADVISE BY PRIORITY MESSAGE OF ANY PROBLEMS RELATING TO MEMBER'S PCS TO THIS STATION.

FOR A1PS: UIF (IF ANY) WILL BE PROCESSED IAW AFI 36-2907, TABLE 2.2, RULE 4. A TR WILL NOT BE RECEIVED. USE AF FORM 330.

FOR FMF: FORWARD DOD TRAVEL CARD TO ACCOUNTING AND FINANCE OFFICE THIS STATION IMMEDIATELY.

FOR CAREER ENHANCEMENTS SECTION: FORWARD COPY OF LAST PERFORMANCE REPORT IF NOT ON FILE IN PATIENT'S UPRG. ENSURE LAST REPORT IS UPDATED IN PDS.

FOR (Gaining MTF Patient Squadron Section): USE THIS MESSAGE TO ADVISE THE PATIENT OF REASSIGNMENT (PCS) TO (Gaining MTF Unit) WITH A RNLTD (Date) AS INDICATED ABOVE. ADVISE PATIENT THAT MOVEMENT OF DEPENDENTS (IF ANY) TO THE LOCAL AREA IS NOT AUTHORIZED UNTIL PCS ORDERS ARE PUBLISHED. REIMBURSEMENT IS NOT WARRANTED IF DEPENDENTS TRAVEL WITHOUT AUTHORITY. UPON ARRIVAL OF DEPENDENTS IN THE AREA, PATIENT SHOULD CLEAR THE HOUSING REFERRAL OFFICE. ALSO ADVISE THE PATIENT THAT, PENDING RECEIPT OF PCS ORDERS, THIS MESSAGE WILL BE USED TO OBTAIN PERMANENT PARTY BILLETING IF REQUIRED (E.G., THE PATIENT IS BEING TREATED OR WILL BE TREATED AS AN "OUTPATIENT" AND IS SUBSISTING ELSEWHERE). ENSURE THE PATIENT UNDERSTANDS THAT CONTINUED BILLETING AT THE TEMPORARY LODGING FACILITY OR OFF-BASE HOUSING (IF EITHER IS BEING USED) WILL NOW BE AT THE PATIENT'S OWN EXPENSE. FURTHER, UNDER THE PROVISIONS OF AFI 65-103, CHAPTER 1, THIS MESSAGE WILL ALSO BE USED TO NOTIFY THE PATIENT'S ATTENDANT (IF ANY) THAT THE ATTENDANT'S ENTITLEMENTS TO ACTUAL EXPENSES WILL TERMINATE AT 2400 HOURS THE DAY FOLLOWING THE "REPORT NOT LATER THAN DATE" (RNLTD) STATED ABOVE. ENSURE THAT BOTH THE PATIENT AND THE PATIENT'S ATTENDANT (IF ANY) ARE IMMEDIATELY FURNISHED A COPY OF THIS MESSAGE.

POC: (Patient Squadron Section-Name, Rank, Address, Commercial/DSN, & E-mail).

Attachment 19

MILPDS PROCEDURES FOR ASSIGNMENT TO A PATIENT SQUADRON

A19.1. Losing Personnel Relocations Element: Upon receipt of the message from the gaining MTF Commander the Losing Personnel Relocations Element must take the action and update 2 transactions: An Unprojected Departure upon receipt of the message and a Projected Departure upon the member's departure.

A19.2. Update Unprojected Departures: Navigation in MilPDS: Relocations and Employment> Outbound Assignments> Assignment Actions> F7, SSN, F8> Click Assignment> Extra Information> Unprojected Departures Update the following IAW the message:

a. Req PAS - Gaining PAS code.

b. Do not populate position number field. The gaining MPS

will update prior to arrival confirmation.

c. PDD - Projected Departure Date (Must be future date).

d. AAN – Assignment Action Number (Required to

complete the update, MPS can currently populate with "1111111111").

e. AAR – Assignment Action Reason (use AP).

f. PCS Tour ID (J, if crossing the Atlantic or Pacific ocean)

(E, all others).

g. Remarks – Type appropriate comments.

h. Click ok and save.

A19.3. Update Projected Departure: Navigation in MilPDS: Relocations and Employment> Personnel Relocations> Outbound Assignments> Assignment Actions> Select Special from Tool Bar> Alter effective date (just as you would to update an 801)> Enter 08-AUG-3888 in Effective Date box> Select OK> F7, Type SSN in National Identifier box, F8> Click Assignment Tool Bar> Click Extra Information Tool Bar> Select PCS Departure Actions> Click on Details>.

a. Reason: 803 -- NOT an 801.

b. Effective Date (member's departure date).

c. Source Document (CX – WRITTEN COMMUNICATION FROM MEDICAL FACILITY).

d. **Note:** Do Not update the Duty Status directly; the 803 action will automatically update the Duty Status from 00 to 10.

A19.4. Gaining Personnel Employment Element: Must assign the member a patient bypass position number, save, then update the arrival confirmation as they would for any other arrival action (IAW AFCSM 36-699, Vol 1, Ch 5). After the arrival confirmation is complete, take action to process a Duty Information Update as indicated below.

Note: Be sure you have a Bypass position (built correctly) for the member. Once the arrival confirmation is completed, update member's DAFSC and Duty Title to Patient.

A19.4.1. Bypass Position Number Update: Navigation in MilPDS: Relocations and Employment> Employment> Position Information> Position Window will appear.

a. Delete the "FROM" date field and replace with DD-MMM-YY (1 day

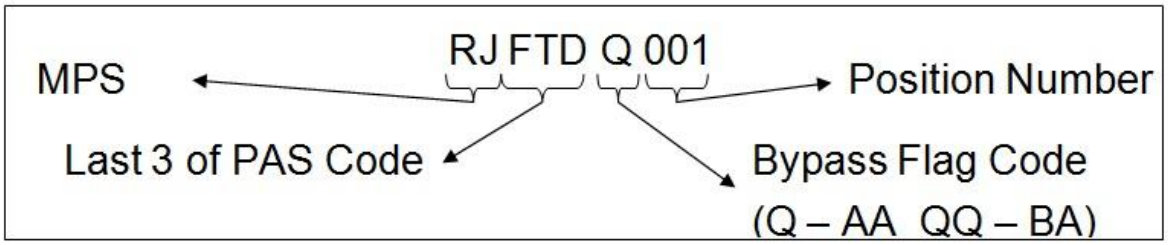
prior to Date Arrived Station).

b. Tab twice to open the Position Structure window.

c. Update Position Type – Use Patient (PAT 1 – AA or PAT 2 – BA).

d. Update the Position Code: MPS ID, last 3 characters of gaining PAS code, bypass flag code, and position number (001, 002, 003, etc.).

Figure A19.1. Sample Position Structure.



e. Update Sequence Number: Corresponds to the position number – start with 1 and sequentially number (1 character) and click OK.

f. In the Organization field, click the LOV> the Enter Reduction Criteria for Long-List window will appear.

g. Type either a percent sign (%) and locate or type the specific PAS Code the position is being built for and click OK.

h. Select the PAS Code and click OK.

i. Move to Jobs field and click the LOV> the Enter Reduction Criteria for Long-List window will appear.

j. Type either a percent sign (%) and locate or type the appropriate AFSC (AA - 9P000 and BA – 93P0) and click OK.

k. Move to the Status field and click the LOV, Double click on Valid.

l. Save the updates by clicking the Save Button (on Menu Bar) and exit the application.

A19.4.2. Arrival Confirmation Update: Navigation in MilPDS: Relocations and Employment> Personnel Employment> Employment> Projected Gain Duty Info> Projected Gain Duty Info window will appear> F7, SSN, F8>

a. Click Confirm Arrival Button.

b. In the Extra Assignment Information window, click in the Details field to be updated.

c. In the Further Assignment Information window, update all required fields and click OK.

d. Save the update by clicking the Save Button (on Menu Bar) and exit the application.

A19.4.3. **Duty Information Update:** Navigation in MilPDS: Relocations and Employment> Personnel Employment> Employment> Duty Information> F7> SSN> F8> Click Duty Information> Assignment window will appear.

a. Ensure Member is assigned to the appropriate Job AFSC (AA –

9P000 and BA – 93P0). If not, alter effective date to one day after the current Assignment effective date. Click in Job AFSC and input the above AFSC.

b. Click the "Correction" option.

c. Click position field and update the Bypass position number built.

d. Save the update by clicking the Save Button (on the Menu Bar).

e. Click Duty Info (at bottom of screen).

f. Highlight Assignment Duty and click in the first empty detail field.

g. Update Duty Start date (Date must equal Date Arrived Station).

h. Click Duty AFSC field and update appropriate AFSC (AA - 9P000

and BA – 93P0).

i. Click Duty Command Level field, Click LOV and update applicable

Command Level.

j. Click in Duty Title Filed and update "Patient" as duty title.

k. Click MCT Bypass field and update Bypass Indicator "QQ".

l. Click ok and Save the update by clicking the Save Button (on

Menu Bar) and exit the application.

Note: Upon completion of the Duty information update, members Duty Status will automatically flip to 13 – Hospitalized, assigned to patient SQ or HQSP.

Attachment 20

BREACH REPORTING PROCEDURES

A20.1. Overview

A20.1.1. Requirement. DoD 5400.11-R, Department of Defense Privacy Program, AFI 33-332, Air Force Privacy Program, DoD 6025.18-R DoD Health Information Privacy Regulation, and the Health Insurance Portability and Accountability Act of 1996, require our facilities to properly safeguard the confidentiality of PII and PHI within our control. Organizational leadership must ensure a prompt and coordinated response is initiated when PII or PHI is lost, stolen or compromised within an AFMS organization. Response procedures must limit or prevent further damage, assess the risk of harm to the individuals involved, mitigate those risks to the extent possible, and ensure all mandatory reporting and notification requirements are accomplished to Air Force, DoD, TRICARE Management Activity (TMA) Privacy Officer, and Department of Health and Human Services (HHS) offices as appropriate. These procedures, to include breaches, specifically apply to contractors under DoD 5400-11R and the contracting officer should be engaged ASAP for contract compliance issues.

A20.1.1.1. Applicability. The requirements and procedures outlined in this attachment pertain only to Individually Identifiable Health Information as defined in paragraph 1.2.3. below. Breaches involving non-medical PII (e.g., a unit alpha roster or information from an individual's personnel file) must be properly reported through the Host Wing Privacy Act Office, but do not require coordination through the AFMS HIPAA team or the TMA Privacy and Civil Liberties Office.

A20.1.2. Definitions. It is important to be familiar with, and appropriately apply the following terms when evaluating potential or actual breaches of information within Air Force medical facilities. There is no differentiation made between paper and electronic documents when considering whether a potential or actual compromise has occurred.

A20.1.2.1. Personal Information (DoD 5400.11-R, DL1.14). Information about an individual that identifies, links, relates, or is unique to, or describes him or her, e.g., SSN; age; military rank; civilian grade; marital status; race; salary; home/office phone numbers; other demographic, biometric, personnel, medical, and financial information, etc. Such information is also known as personally identifiable information (i.e., information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, including any other personal information which is linked or linkable to a specified individual).

A20.1.2.2. Health Information (DoD 6025.18-R, DL1.1.15). Any information, in any form or medium, that is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, or school or university; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual.

A20.1.2.3. Individually Identifiable Health Information (DoD 6025.18-R, DL1.1.20). Information that is a subset of health information, including demographic information collected from an individual, and is created or received by a healthcare provider, health plan, or employer; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual; and that identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

A20.1.2.4. Lost, Stolen, or Compromised Information (DoD 5400.11-R. DL1.10). Actual or possible loss of control, unauthorized disclosure, or unauthorized access of personal information where persons other than authorized users gain access or potential access to such information for an other than authorized purposes where one or more individuals will be adversely affected. Such incidents also are known as breaches.

A20.1.2.5. Breach (HHS Interim Final Rule, 24 Aug 2009). Breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted under subpart E of this section (aka the Privacy Rule) which compromises PHI security or privacy. For purpose of this definition, "acquisition, access, use, or disclosure of PHI in a manner not permitted under the Privacy Rule" is presumed to be a breach unless the covered entity or business associate, as applicable, can demonstrate that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

A20.1.2.6. Protected Health Information (DoD 6025.18-R, DL1.1.28). Individually identifiable health information that is transmitted or maintained by electronic or any other form or medium. EXCEPTION: Protected health information excludes individually identifiable health information in employment records held by a covered entity in its role as employer.

A20.1.2.7. Unsecured Protected Health Information (HHS). Protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under section13402(h)(2) of Pub. L.111-5 on the HHS website.

A20.2. Roles and Responsibilities

A20.2.1. Organizational Leadership. Leadership at all Medical Groups, Medical Wings, Direct Reporting Units, MAJCOM Command Surgeons, AFMOA, and AFMSA must:

A20.2.1.1. Develop local policies and procedures to ensure compliance with all DoD Privacy Programs, Information Assurance requirements, and Department of Health and Human Services requirements as pertains to the reporting and mitigation of compromised information (paper or electronic) and incident response procedures outlined in this guidance.

A20.2.1.2. Identify a primary and alternate Breach Response Coordinator within the organization to act as a single point of contact for coordinating organizational activities associated with the breach notification and reporting process. This individual must be empowered to convene the organization's Medical Information Security Readiness Team (MISRT) and coordinate personnel and resources throughout the organization as necessary to ensure the prompt investigation and mitigation of the incident.

A20.2.1.3. Ensure workforce members are trained on local policies and procedures for the safeguarding of PII and PHI. Personnel must also be trained on action steps for securing unprotected PII and PHI and internal reporting procedures in the event of a suspected or actual breach of information.

A20.2.2. HIPAA Privacy Officer. The organization's HIPAA Privacy Officer serves as the Subject Matter Expert (SME) to the Breach Response Coordinator and MISRT for HIPAA privacy related matters. In addition to general guidance and assistance, the HIPAA Privacy Officer will:

A20.2.2.1. Document any unauthorized disclosures of PHI resulting from the incident in the Protected Health Information Management Tool (PHIMT) or other approved disclosure accounting tool.

A20.2.2.2. Provide the Breach Response Coordinator with any necessary documentation such as HIPAA training records of individuals involved with the incident, local policies and procedures relevant to the incident, and any other documentation/assistance as requested.

A20.2.3. HIPAA Security Officer. The organization's HIPAA Security Officer serves as the Subject Matter Expertise (SME) to the Breach Response Coordinator and MISRT for information systems and security. In addition to general guidance and assistance, the HIPAA Security Officer will:

A20.2.3.1. Coordinate with the organization's Information System Security Officer to perform an initial evaluation of the vulnerability or incident when the incident involves electronic information, information systems or network systems.

A20.2.3.2. When indicated, coordinate/assist with activities required by AFSSI 5021, Time Compliance Network Order (TCNO) Management and Vulnerability and Incident Reporting.

A20.2.3.3. Provide the Breach Response Coordinator with any necessary documentation such as systems audit logs, summary activity reports and information systems user agreements of individuals involved in the incident, local policies and procedures relevant to the incident, and any other documentation/assistance requested.

A20.2.4. Breach Response Coordinator. Any individual within the organization may be appointed to this position, but individuals such as the organization's Privacy Act Monitor, HIPAA Privacy Officer, and HIPAA Security Officer are particularly well-suited based on their functional responsibilities and expertise. General responsibilities of the Breach Response Coordinator include:

A20.2.4.1. Acts as the single point of contact within the organization with overall responsibility for coordinating information flow and response actions to breaches of PII or PHI under the organization's control.

A20.2.4.1.1. Keeps organizational leadership informed of evolving events and response activities through periodic updates and executive summaries, as requested.

A20.2.4.1.2. Coordinates with the AFMOA/SGAT HIPAA team as necessary to ensure all reporting requirements and status updates are up-channeled to AFMS leadership.

A20.2.4.1.3. Coordinates with the organization's Chief Information Officer for all incidents involving information systems and e-PHI.

A20.2.4.2. Develops a plan of action to ensure compliance with all reporting requirements and action steps as required by this appendix.

A20.2.5. AFMOA/SGAT HIPAA Team. The AFMOA/SGAT HIPAA team provides Subject Matter Expertise (SME) and assistance to AFMS organizations in the reporting, documentation and mitigation of breaches of PII involving health information under AFMS control.

A20.2.5.1. Provides, as appropriate to the breach, initial notification to the AFMSA/SG3SA HIPAA Privacy Officer, AF/SG6 HIPAA Security Officer, AFMOA/SGAI Information Services, and appropriate MAJCOM/SGA of the incident; provides status updates as required until the incident is closed.

A20.2.5.1.1. Ensures the AFMOA/CC is informed of all breaches involving 500 or more beneficiaries as well as all other high-visibility breaches, regardless of the affected number of beneficiaries.

A20.2.5.2. Ensures a copy of the initial Defense Privacy Office (DPO) Breach Report is transmitted to AFMSA/SG3SA within 24 hours of the time the breach was reported.

A20.2.5.3. Controls flow of information between involved (affected) organization and higher headquarters/external agencies.

A20.2.5.4. Requests/coordinates external SME input and assistance as necessary to assist the affected organization in reporting, mitigating, documenting and resolving the incident.

A20.2.5.5. Coordinates with AFMSA/SG3SA to implement, monitor and document actions associated with Department of Health and Human Services (HHS) breach reporting requirements as described in paragraph 4.0 of this guidance.

A20.2.6. AFMOA/SGAI. The Information Services Team at AFMOA/SGAI will assist the AFMOA HIPAA team as necessary by providing Subject Matter Expertise (SME) and assistance in the reporting, documentation, and mitigation of breaches involving electronic PHI and PII.

A20.2.7. AFMSA/SG3SA and AF/SG6. The AFMS HIPAA Privacy and Security Officers develop, update, and interpret policy as necessary to ensure AFMS compliance with Air Force, DoD, HHS and other Federal requirements associated with the safeguarding of PII/PHI and responding to breaches of the same.

A20.2.7.1. AFMSA/SG3SA notifies the TRICARE Management Activity Privacy and Civil Liberties Office of all breaches of PII involving MHS beneficiaries by providing a copy of the initial Defense Privacy Office (DPO) Breach Report by unencrypted e-mail message to **PrivacyOfficerMail@tma.osd.mil** within 24 hours of the time the breach was reported.

A20.2.7.2. Provides interim status reports and facilitates communications with the Air Force Privacy Act Office, TRICARE Management Activity Privacy and Civil Liberties

Office, DoD Privacy Office and Department of Health and Human Services as may be necessary throughout the course of incident resolution.

A20.2.7.3. Ensures AFMSA/SG3 is informed of all breaches involving 500 or more beneficiaries as well as all other high-visibility breaches, regardless of the affected number of beneficiaries.

A20.2.7.4. Tracks and trends reported breaches; provides "lessons learned" and other applicable feedback to AFMS leadership and organizations as appropriate.

A20.3. Reporting and Mitigating Breaches

A20.3.1. Actions taken immediately upon identifying a potential or actual breach. Workforce members that become aware of an actual or possible loss of control, unauthorized disclosure, or unauthorized access to PII or PHI, in either paper or electronic form, must immediately report the circumstances of the event to the organization's Breach Response Coordinator.

A20.3.1.1. Upon being notified of a potential or actual breach, the Breach Response Coordinator will evaluate the preliminary facts to determine if an actual or possible loss of control, unauthorized disclosure, or unauthorized access to PII or PHI has occurred. Based on this assessment, the Breach Response Coordinator will either document the basis for determining no breach has occurred and take no further action, or initiate breach response procedures as outlined in paragraph A20.3.2.

A20.3.1.2. When an organization identifies a potential or actual compromise caused by another organization, the Breach Response Coordinator of the facility that identified the incident will initiate the following actions:

A20.3.1.2.1. Notify the Installation Privacy Act Official.

A20.3.1.2.2. Initiate a US-CERT unless directed otherwise by the Installation Privacy Act Official. Maintain a copy of the US-CERT and provide it to the responsible (accountable) organization.

A20.3.1.2.3. Notify leadership of the responsible (accountable) organization. Once notified, the accountable organization must assume full responsibility for resolution of the incident.

A20.3.2. Actions within one hour of identifying a potential or actual breach. Initial notification actions and associated reporting activities occur in rapid sequence, and in some circumstances may occur simultaneously. Upon determining an actual or possible breach has occurred, the Breach Response Coordinator will:

A20.3.2.1. Initiate a local events log and maintain comprehensive documentation of dates, times and significant communications and events throughout the duration of the incident resolution. Retain hard copies of all documentation and communications pertinent to the investigation, mitigation and resolution of the incident.

A20.3.2.2. Initiate internal notifications to organizational leadership IAW local policies and procedures.

A20.3.2.3. Notify the organization's Information Systems Security Officer for incidents involving electronic PHI or information systems. Information Assurance personnel will

initiate simultaneous incident response procedures while the Breach Response Coordinator continues with breach reporting activities.

A20.3.2.4. Initiate and coordinate initial activities to contain the exposure of information and limit the magnitude of the incident. This could be as simple as securing loose documentation or as complex as securing electronic information systems and networks. Other actions include securing physical evidence and evaluating associated information systems and activities for collateral risks and vulnerabilities.

A20.3.2.5. Contact the Installation Privacy Act Official upon learning of a breach to provide them with preliminary facts surrounding the incident and to receive guidance on completing reporting and documentation requirements. In cases where the Privacy Act Official determines reporting is not required, fully document the decision and maintain the documentation with the case file. In cases where reporting is required, initiate a US-CERT notification at **https://forms.us-cert.gov/report**. Print a copy of the completed US-CERT notification and document the US-CERT confirmation number. Maintain a copy of the US-CERT notification with the events log. Notification must be completed within one hour of receiving notification of lost, stolen or compromised information.

A20.3.2.6. The Breach Response Coordinator must work closely with the Installation Privacy Act Official throughout the course of incident to ensure all reporting and individual notification actions are accomplished.

A20.3.3. Actions Immediately Following US-CERT Notification. The Breach Response Coordinator will initiate secondary notifications and mitigation activities as quickly as practical following notification to US-CERT and the Installation Privacy Official. Secondary notifications and actions include, but may not necessarily be limited to:

A20.3.3.1. If not already aware, ensure the Information Systems Security Officer is notified of the incident. The security team will notify the servicing Network Control Center (NCC) and submit follow-up reports as necessary to meet established timelines based on the category of incident.

A20.3.3.1.1. The security team may be required to submit additional reports depending on the type of system involved and whether the incident involved a confirmed network/system intrusion or changes to Information Operations Condition (INFOCON).

A20.3.3.2. Notify the organization's appropriate representative(s) for incidents involving the loss or suspected loss of a government authorized credit card or financial data associated with the card.

A20.3.3.3. Upon direction of organizational leadership, notify the local Security Forces or Office of Special Investigations (OSI) if the commission of a crime is known or suspected.

A20.3.3.3.1. These procedures, to include breaches, specifically apply to contractors under DoD 5400-11R, Department of Defense Privacy Program, and the contracting officer should be engaged as soon as possible for contract compliance issues.

A20.3.3.4. Conduct a preliminary assessment of the incident and complete a Defense Privacy Office (DPO) Breach Report. The DPO Breach Report must be submitted to the

Installation Privacy Act Official as quickly as possible to ensure sufficient lead time for review and routing to the Air Force Privacy Office (SAF/A6PP). All DPO Breach Reports must be received by SAF/A6PP within 24 hours of the breach becoming known.

A20.3.3.4.1. The Defense Privacy Office (DPO) Breach Report may be updated and re-submitted as additional information and follow-up actions become known throughout the course of the investigation. Do not delay submission of the initial report while gathering additional information.

A20.3.3.4.2. A template for the DPO Breach Report may be obtained from the Installation Privacy Act Official or from the TRICARE Management Activity Privacy Office website at: **http://www.tricare.mil/tma/privacy/downloads/TMA%20Breach%20Reporting%20Form.doc**. (Web link subject to change).

A20.3.3.4.3. For the most part, completing the DPO Breach Report is a matter of filling in blank data fields and checking appropriate boxes. There are however certain areas such as Item Number 8 (description of the breach) and Item Number 9 (actions taken in response to the breach) that require narrative input. It is very important that these two items provide as many relevant facts as possible. Specifically, Item Number 8 should paint a clear picture of the circumstances involved in the incident, e.g., the "who, what, when, where and why," and Item Number 9 should describe exactly what steps or action(s) are being (or will be) implemented to correct and mitigate the incident and prevent similar recurrences.

A20.3.3.5. Notify the AFMOA/SGAT HIPAA team at **AFMOAHIPAATRAINING@US.AF.MIL** or respective AFMOA HIPAA representative in an unencrypted e-mail message, marked FOUO, that a US-CERT has been initiated. Place "FOUO: US-CERT Notification" in the subject line. Include the following information with the message:

A20.3.3.5.1. Name of organization and POC (Breach Response Coordinator).

A20.3.3.5.2. A completed copy of the preliminary Defense Privacy Office (DPO) Breach Report.

A20.3.4. Investigation and Risk Assessment. All incidents involving the compromise of PII and PHI must be thoroughly investigated to determine the circumstances which lead to the incident, and assess the level of risk associated with the incident. Minor incidents may be easily investigated and resolved by the Breach Response Coordinator alone, whereas more complex or sensitive incidents may necessitate the activation of the organization's MISRT or appointment of an investigating officer. Guidance from SMEs such as the SJA and Public Affairs should be solicited as necessary.

A20.3.4.1. Information gathered during the investigation of the incident should be thoroughly documented. When circumstances warrant, complete and submit a supplemental Defense Privacy Office (DPO) Breach Report to the Installation Privacy Act Official and AFMOA/SGAT HIPAA team following the procedures described in paragraph 3.3.5. Ensure updated information within supplemental reports is documented in red font and that item #3 and #3a of the report are updated accordingly.

A20.3.4.2. With the facts of the incident known, the Breach Response Coordinator will assess the risk of harm to affected individuals as a result of the breach and make a recommendation to organizational leadership regarding the need to notify affected individuals of the compromise. The risk assessment will be conducted using the OSD and HHS Risk Assessment criteria as shown in Table 1 of this attachment. The Breach Response Coordinator will consult with the Installation Privacy Act Official, AFMOA/SGAT HIPAA team, and legal counsel as necessary for questions pertaining to the risk assessment and recommended findings.

A20.3.4.2.1. Organizational leadership will assess the results of the risk assessment and recommendations of the Installation Privacy Act Official in determining whether affected individuals should be notified of the breach. When assessing risk level, leadership should bear in mind that notification when there is little or no risk of harm might create unnecessary concern or confusion. The Breach Response Coordinator must thoroughly document the circumstances of all breaches and the decisions made relative to each of the factors identified in the risk assessment table; the documentation must clearly demonstrate the rationale behind the notification determination.

A20.3.5. Notification Procedures to Affected Individuals.

A20.3.5.1. Notification required. When notification is deemed appropriate, the Breach Response Coordinator will ensure notification letters are prepared in accordance with the template provided in DoD 5400.11-R, paragraph C1.5.1.5 and DoD 5400.11-R, Appendix 2.

A20.3.5.1.1. Forward a final draft of the proposed letter to the Installation Privacy Act Official for review and approval before mailing to affected individuals.

A20.3.5.1.2. Notification letters must be mailed within ten (10) days of identifying the affected individuals. Letters will be endorsed by the Group Commander/organizational equivalent or above, and delivered by first class mail. Refer to DoD 5400.11-R, paragraph C1.5.1.2.3 for alternative means of notification when use of mail is impractical.

A20.3.5.1.3. Additional reporting requirements are necessary in instances when notification letters are required, but not delivered within the ten (10) day time requirement. In these cases the Breach Response Coordinator will prepare a memorandum signed by the organization's Group Commander/organizational equivalent or above, addressed to the Deputy Secretary of Defense explaining the circumstances of the delay. Forward the signed memorandum to the Installation Privacy Act Official for submission SAF/A6PP and DoD.

A20.3.5.2. Notification not required. In cases where notification to affected individuals is determined to be unnecessary, the Breach Response Coordinator must fully document the rationale for not providing notification to affected individuals; the burden of proof for not notifying affected individuals rests with the organization.

A20.3.5.3. Law Enforcement may request a delay in notification in situations where making notification would impede a criminal investigation. Follow procedures in DoD 5400.11-R C1.5.1.4.1. for responding to law enforcement requests to delay notification.

A20.4. Special Considerations Regarding HHA Breach Reporting

A20.4.1. Process Overview. The TMA Privacy and Civil Liberties Office is the AFMS central point of contact for evaluating and assisting in the reporting of breaches of unprotected health information to the Department of Health and Human Services (HHS). TMA receives initial notification of a potential or actual breach via the DoD breach reporting guidelines as described in paragraph 2.7.1.

A20.4.1.1. The TMA Privacy and Civil Liberties Office will review the Defense Privacy Office Breach Report submitted by AFMSA/SG3SA and make a determination regarding whether the incident qualifies as a breach for purposes of notification to HHS. When required, TMA will make necessary notifications to HHS and inform AFMSA/SG3SA that the notification was made.

A20.4.2. Notification Required. The Breach Response Coordinator will ensure notification letters are prepared. DoD breach notification requirements are more stringent than HHS requirements, therefore, in cases where notification is deemed appropriate under HHS guidelines, the notification will have also been required under DoD requirements. The content of the DoD notification template is generally sufficient for HHS purposes, provided the following two additional elements are incorporated into the letter:

A20.4.2.1. The date of the breach and the date of the discovery of the breach, if known.

A20.4.2.2. The contact procedures for the recipient to ask questions or learn additional information. This information must include a toll free telephone number, an e-mail address, Web site, or postal address.

A20.4.3. Delivery of Notification Letters. Letters are required to be delivered to individuals within 60 days by HHS standards for HIPAA related incidents, but the more stringent DoD notification requirement of 10 days for Privacy Act incidents takes precedence. Letters will be endorsed by the organization's Group Commander/organizational equivalent or above, and delivered by first class mail. In cases where the individual is deceased, deliver notification to the Next of Kin (NOK) or personal representative if their address is known.

A20.4.4. Alternative Procedures When Letters Cannot Be Sent. When insufficient or out-of-date contact information precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual may be used.

A20.4.4.1. When the number of individuals that cannot be contacted is fewer than ten, the substitute notice may be provided by an alternative form of written notice, telephone, or other means.

A20.4.4.2. When the number of individuals that cannot be contacted is ten or more, the substitute notice must be in the form of either a conspicuous posting for a period of 90 days on the home page of the website of the organization involved, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside. The substitute notice must also include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual's unsecured PHI may be included in the breach.

A20.4.4.2.1. Activation of a toll-free number and associated costs are the responsibility of the affected organization.

A20.4.4.2.2. The AFMOA/SGAT HIPAA Team will coordinate with the affected organization as necessary to ensure reporting and notification requirements are fully implemented.

A20.4.5. Health and Human Services Reporting and Documentation Requirements.

A20.4.5.1. For breaches involving fewer than 500 individuals, the AFMOA/SGAT HIPAA Team will ensure AFMSA/SG3SA receives all necessary information for completion of the HHS reporting log. Table 2 of this attachment provides a list of required information which will be reported to and maintained by AFMSA/SG3SA. AFMSA/SG3SA will forward breach information to the TMA Privacy and Civil Liberties Office for review and submission to HHS on an annual and as-needed basis.

A20.4.5.2. For breaches involving 500 or more individuals, AFMOA/SGAT HIPAA team will:

A20.4.5.2.1. Coordinate with AFMSA/SG3SA to ensure the TMA Privacy and Civil Liberties Office has all the necessary information for making immediate notification to the Department of Health and Human Services.

A20.4.5.2.2. Assist the affected organization and MAJCOM leadership to implement required notifications to prominent media outlets serving the State or jurisdiction in which the breach occurred.

A20.4.5.2.3. Coordinate with AFMSA/SG3SA to ensure all TMA and HHS reporting requirements as accomplished.

A20.5. Incident Closure

A20.5.1. Close-out actions. The Breach Response Coordinator has oversight and responsibility for ensuring all mitigation and reporting activities are completed. The following actions should be accomplished prior to closing the incident:

A20.5.1.1. If initially consulted, re-convene the MISRT to validate all mitigation and restoration actions have been accomplished.

A20.5.1.1.1. Initiate and complete a Risk Assessment if applicable under guidance found in AFI 41-217, paragraph 3.1.1.2.

A20.5.1.2. Develop “Lessons-Learned” and convey information to organizational and AFMS leadership as appropriate.

A20.5.1.3. Update local breach response procedures as necessary based on “lessons learned.”

A20.5.1.4. Construct a case file and ensure all activity logs, documentation and miscellaneous support materials associated with the incident are properly filed and retained.

A20.6. Process Summary

A20.6.1. Timeline. The time requirements for breach reporting and mitigation begin at the time the breach is discovered or becomes known. Although it is possible various processes and follow-on reporting actions will extend beyond ten (10) days, most breaches are

concluded within the ten (10) day notification requirement established by DoD 5400.11-R. The ten (10) day timeline can be viewed as follows:

A20.6.1.1. Figure 1 graphically demonstrates the activities that occur between the time of discovery through the first hour.

A20.6.1.2. Figure 2 graphically demonstrates the activities that occur between the first hour and the end of the first day.

A20.6.1.3. Figure 3 graphically demonstrates the activities that occur between the second and tenth day following discovery of the breach.

A20.6.1.4. Figure 4 graphically represents the decision matrix for media notifications

Table A20.1. OSD-HHS Risk Assessment Criteria.

#	OSD FACTOR	HHS FACTOR	RISK	EXAMPLES - CONSIDERATIONS
1	Evaluate the nature of the data elements breached and the type of PII involved	Evaluate the nature and extent of the PHI involved; the types of identifiers, and the likelihood of re-identification.		
	a. Name only		Low	Consideration needs to be given to unique names; those where one or only a few in the population may have or those that could readily identify an individual (such as a public figure)
	b. Name plus one or more personal identifiers such as demographic information (not SSN, medical or financial data)		Moderate	Additional identifiers include date and place of birth, mother's maiden name, biometric record and any other information that can be linked or is linkable to an individual
	c. SSN		High	SSN includes truncated or partially masked
	d. Name plus SSN		High	
	e. Name plus medical or financial data		High	
2	Number of individuals affected		NA	The number of individuals affected is a determining factor in how notifications are made, not whether they are made
3	What is the likelihood the	Whether the PHI was actually		

	information is accessible and usable? What level of protection applied to the information?	acquired or viewed		
	a. Encryption Used DOD: (FIPS 140-2) HHS: (Applicable NIST)		Low	Data at rest or in motion is properly encrypted and unable to be viewed or used
	b. Password only		Moderate to High	The level of risk must be determined in context to the type of data in factor #1
	c. No protection		High	Loose paperwork or unencrypted data
4	Likelihood the breach may lead to harm	Status of the unauthorized user or recipient	Low Moderate High	The determination is made in consideration of the type of breach and the type(s) of data involved For HHS purposes, consider whether the unauthorized recipient has an obligation to protect the information (PA, HIPAA, etc)
5	Ability of the Agency (organization) to mitigate the risk of harm	The extent to which the risk to the PHI has been mitigated		
	a. Loss		High	Evidence exists that PII has been lost and is no longer under DOD control
	b. Theft		High	Evidence shows that PII has been stolen and could possibly be used to commit ID theft
	c. Compromise within DOD control		Low High	Low: No evidence of malicious intent High: Evidence or possibility of malicious intent
	d. Compromise beyond DOD control		High	Possibility that PII could be used with malicious intent or to commit ID theft

Table A20.2. HHS Breach Notification Log.

ITEM	REQUIRED INFORMATION
1	COVERED ENTITY INFORMATION

	Name of Covered Entity: Physical Address (No overseas APOs): Type of Covered Entity: Name of Contact at Covered Entity: Contact's Phone Number: Contact's E-Mail:
2	BUSINESS ASSOCIATE INFORMATION (if breach occurred by a business associate)
	Name of Business Associate: Address: Name of Contact at Business Associate: Contact's Phone Number: Contact's E-Mail:
3	BREACH INFORMATION
	Date of Breach: Date Breach was Discovered: Approximate Number of Individuals Affected: Type of Breach [ ] Theft [ ] Unauthorized Access [ ] Hacking/IT Incident [ ] Loss [ ] Improper Disposal [ ] unknown [ ] Other (explain) Location of Breached Information [ ] Laptop [ ] Desktop [ ] Network [ ] E-mail [ ] Other Portable Device [ ] Electronic Medical Record [ ] paper [ ] Other (explain) Type of PHI Involved [ ] Demographic Information [ ] Financial Information [ ] Clinical Information [ ] Other (explain) Safeguards in Place Prior to Breach [ ] Firewalls [ ] Packet Filtering [ ] Secure Browser Sessions

	[ ] Strong Authentication [ ] Encrypted Wireless [ ] Physical Security [ ] Logical Access Control [ ] Antivirus Software Narrative Description of the Breach:
4	Notice of Breach and Action Taken
	Date Individual Notice Provided: Was Substitute Notice Required? [ ] Yes [ ] No Was Media Notice Required? [ ] Yes [ ] No Actions Taken in Response to Breach: [ ] Mitigation [ ] Sanctions [ ] Security and/or Privacy Safeguards [ ] Policies and Procedures [ ] Other (explain) Narrative Description of Other Actions Taken:

Figure A20.1. Breach Timeline; Discovery – 1 hour.

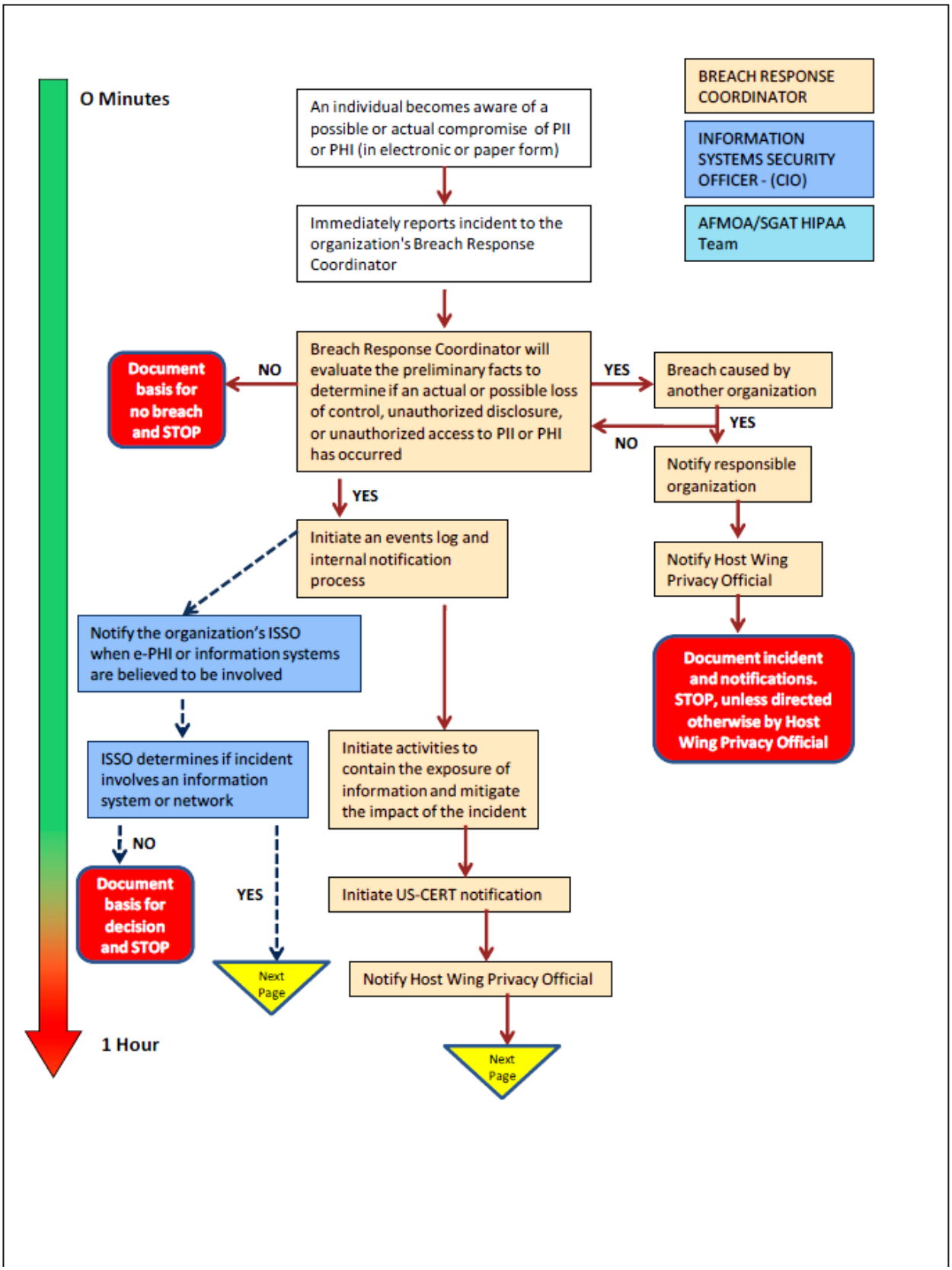


Figure A20.2. Breach Timeline; 1 hour – Day One.

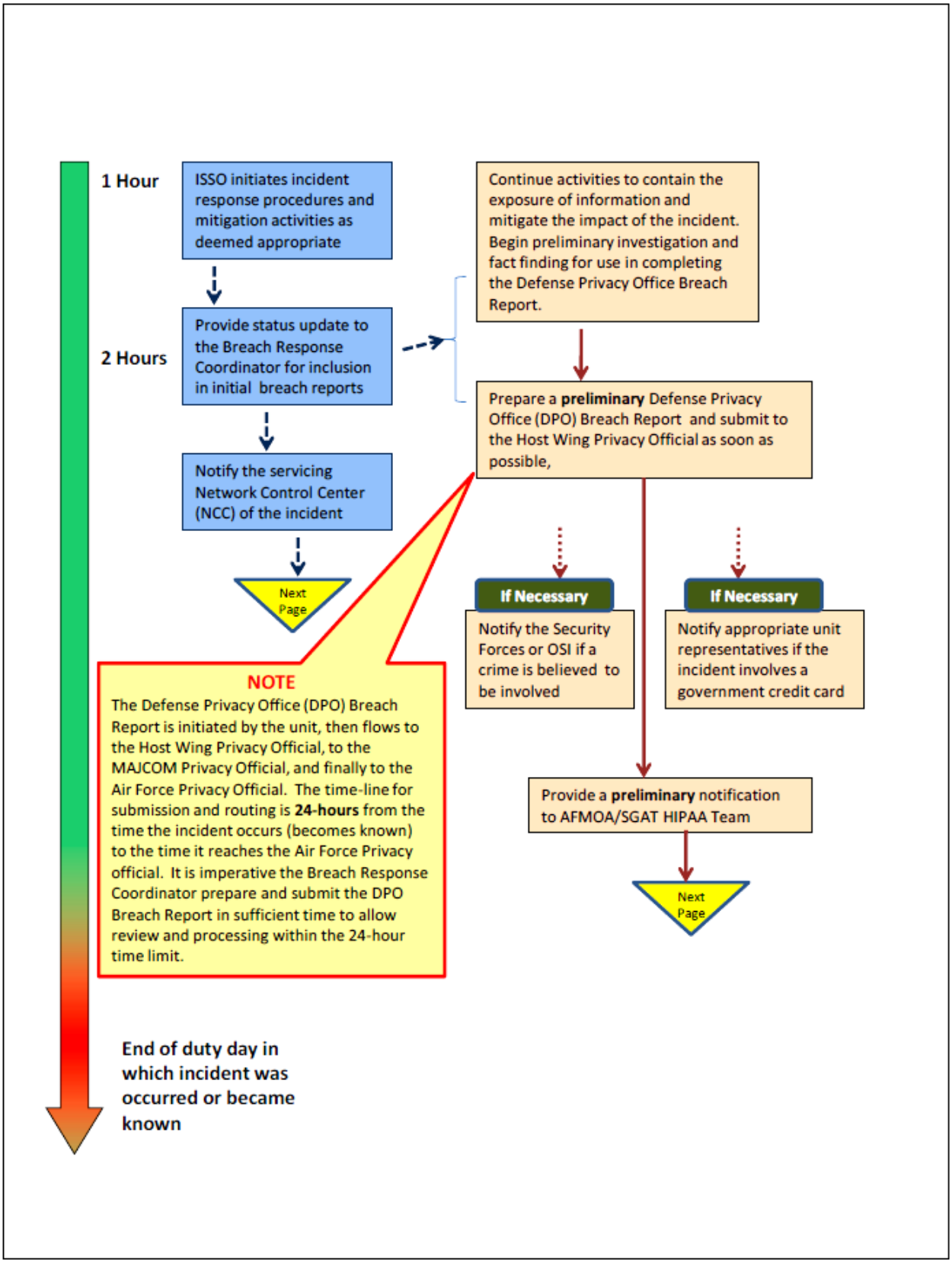


Figure A20.3. Breach Timeline; Day 2 – Day 10.

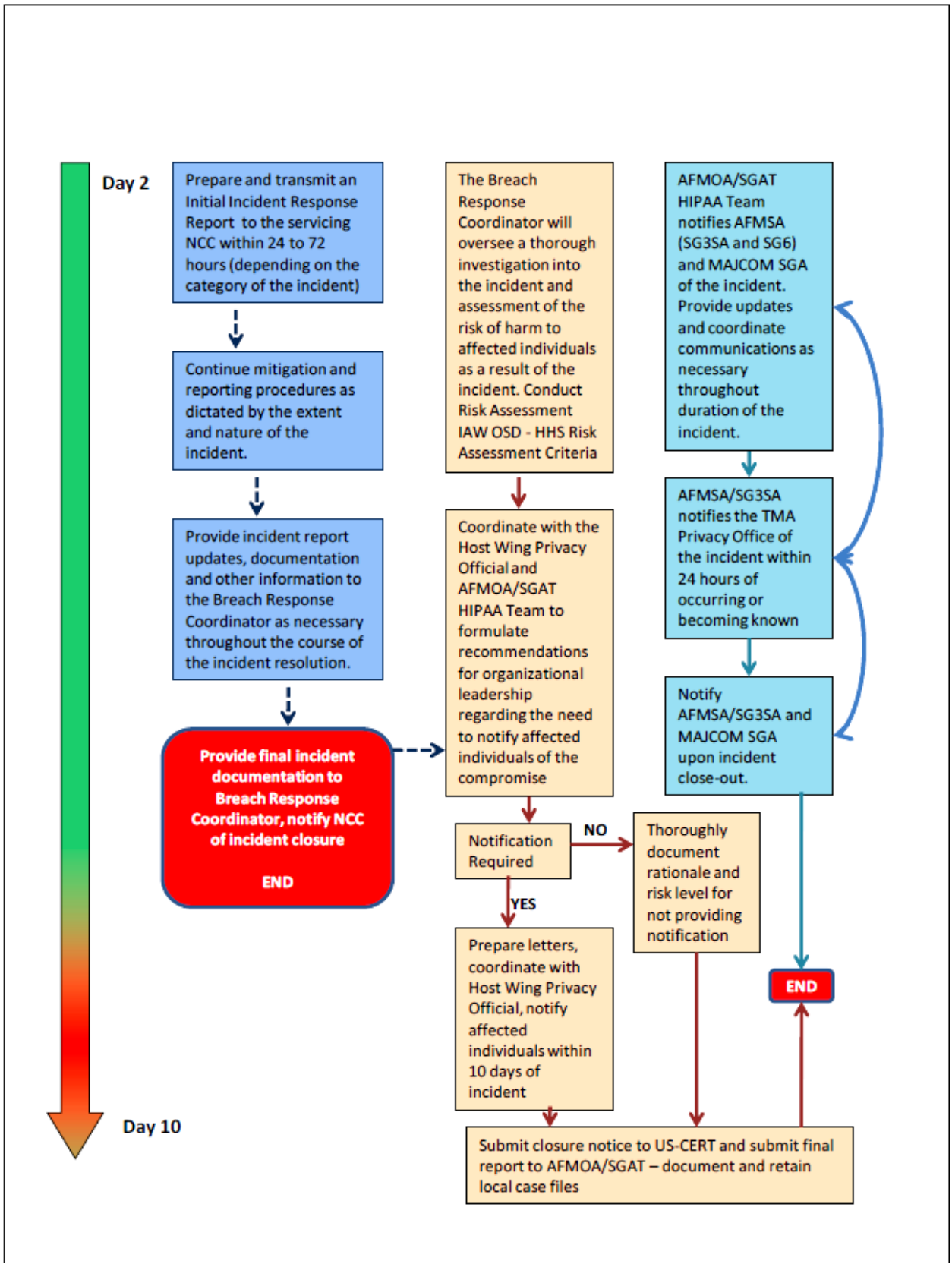
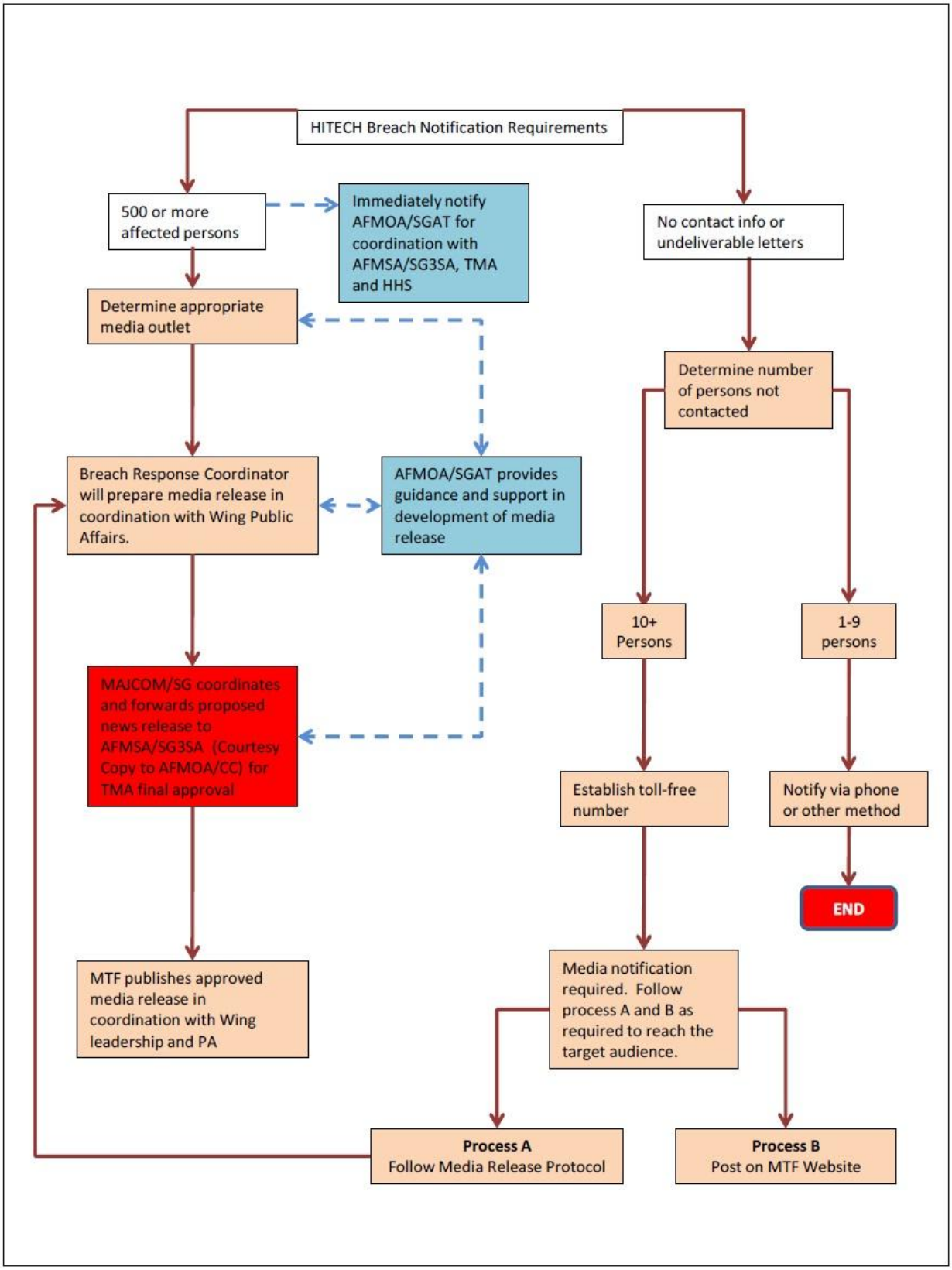


Figure A20.4. Breach Notification – Media Flowchart.



Attachment 21

INSTRUCTIONS FOR AF FORM 618, MEDICAL BOARD REPORT

Figure A21.1. Instructions for AF Form 618, Medical Board Report.

FIELD	Special Instructions
Field 1. Installation at Which Convened	Identify the MTF where the MEB was convened.
Field 2. Date Convened	Enter exact date the MEB convened and not the date the AF Form 618 is typed.
Field 3. Name	Give last name, first name, and middle name or middle initial of the evaluee.
Field 4. Grade	For USAF and USN members, abbreviate the proper grade (E5, 03, etc.). For USA members add the member's corps (SSgt, Ord; Capt, Inf etc.).
Field 5. SSN	Enter social security number. If not otherwise available, it may be obtained from the evaluee's servicing MPS.
Field 6. Component	Enter Reg AF, ANG, or AFRC for Air Force Regular, Air National Guard, or Reserve Components, and similar abbreviations for US Army and Navy counterparts.
Field 7. Department of Service	Enter USAF, USA, USN, USMC, NOAA, USPHS or USCG. For members of a foreign military service, the nation is listed. For example, French AF, etc.
Field 8. Organization	Enter the military organization to which the evaluee is assigned and its location, e.g., 347th CRS, Moody AFB GA. Avoid nonstandard abbreviations.
Field 9. Sex	Enter "M" for male or "F" for female.
Field 10. Date of Birth	Enter year, month, and day of birth. For example, 2000 Jan 25.
Field 11. Age	Enter age at last birthday in years only.
Field 12. Separation and Retirement Date	Enter the evaluee's established non-disability separation or retirement date. Secure it from the evaluee's services MPS. Enter "NA" or "none" if none has been established.
Field 13. Hospital Initially Admitted	Enter the name and location of the hospital to which the evaluee was first admitted due to the condition for which he or she is being evaluated by the MEB. If the same as Item 1, enter "NA."
Field 14. Transferred From	If transferred as an inpatient or outpatient from another hospital, enter the name and location of that hospital. If that hospital is the one identified in Item 13, enter "Same as Item 13." If not transferred, enter "NA."

Field 15. Home A2.39.ddress	This is the permanent address and should not be confused with current military organization or current mailing address. For RCSMs, include the home, military duty location, and civilian work section phone numbers here also.
Field 16. Military Occupational Specialties	Enter title and number for primary and secondary Air Force Specialty Codes (AFSC) or equivalent other Service code. If not otherwise available, obtain from the servicing MPS. If no secondary AFSC, list primary only.
Field 17. Total Years' Military Service	Separate active service from inactive service. Indicate in years and in fractions of years. For example: 3 years 5 months will be shown as 3 5/12.
Field 18. Date Entered Active Duty Current Tour	This is the date from which the member has been on continuous duty without a break in service, or the date a member of a Reserve Component entered the current period of active duty orders.
Field 19. Aeronautical Rating	Do not abbreviate. Enter "NA" if none.
Field 20. On Flying Status on Admission	This item is to indicate if an evaluee with an aeronautical rating or designation was on flying status when admitted to the hospital. Temporary removal from flying duty (DNIF, or duty not involving flying) is not removal from flying status. If temporary removal from flying status led to permanent removal from flying status, will be certified by the proper authority.
Field 21. Date Relieved from Flying Status	If the evaluee has an aeronautical rating (Item 19) and is now on flying status (Item 20), enter the date relieved from flying status. If no aeronautical rating, enter "NA."
FIELD	Special Instructions
Field 22. Applicable Directives and Purpose	Column A. Directives: AFI 48-123 and this instruction are specified for all cases. The Manual for Courts Martial is utilized for sanity cases. DFAS-DSM 177-373 is specified for mentally incompetent members. Column B. Purpose: Check "Continued Active Duty" for members on active duty when separation, discharge, or retirement for non-disability reasons is not pending. Check "EPTS" when a defect existed prior to service and is the principal reason for the MEB. Check "Other" and enter "Sanity" or "Competency" for a sanity or competency case. Enter "ANG Duty" or "AFRES Duty" if the evaluee is a member of one of these components and is not eligible for disability processing under this instruction.
Field 23. Diagnosis and Findings	These appear in Column A of Item 23. List all diagnoses that contribute or may contribute to disqualification for worldwide duty. Use terminology in the International Classification of Diseases, Clinical Modification (lCD-CM), the current Diagnostic

	and Statistical Manual of Mental Disorder (DSM). Administrative LOD.
Field 24. Sanity Determination	Complete for sanity cases only.
Field 25. Actions Recommended by Board	Enter only “Return to Duty,” “Refer to PEB.”
Field 26. Board Members	Each member of the MEB signs the original AF Form 618. In sanity or competency cases, place a check mark after the signature of the board member(s) who is/are a psychiatrist(s).
Field 27. Minority Report	If the board recommendation is not unanimous, “Yes” is checked and the minority report with substantiating rationale is entered on the reverse side of AF Form 618 or on an attachment sheet. For unanimous recommendation, check “No.”
Field 28. MTF Commander or Designee	Self-Explanatory. Commander leaves the approve and disapprove boxes blank.
Field 29.	Except in mentally incompetent or deleterious cases, the findings and recommendations of the medical board, after administrative review and signature by the Convening Authority, are explained to the evaluee. The evaluee is also advised that if exception is taken to the narrative summary, findings, or recommendation of the medical board, three work days will be allowed to prepare a letter of exception, which will be attached to the board report forwarded to AFPC/DPPAM or AFPC/DPSDS. By completing A, B and C of Item 29, the evaluee acknowledges that he/she has been informed of the findings and recommendation of the board and of the option to submit a letter of exception. The MEB recorder signs opposite the footnote below Item 29 to indicate that he/she has thoroughly briefed the evaluee on the findings, recommendation, and options referenced above. If the evaluee is unable, refuses, or is not available to sign AF Form 618, enter “Signature Unavailable” or “Refuses to Sign” in Item 29B and explain circumstances on the reverse of AF Form 618 with signatures of two additional witnesses to the evaluee’s briefing and refusal to sign.

Attachment 22

ATTACHMENT AND ASSIGNMENT OF PATIENTS TO HOSPITAL

Figure A22.1. Attachment and Assignment of Patients to Hospital.

Rule	If the member is:	Then the member is:
1	Admitted to an MTF and is expected to stay less than 90 calendar days and is expected to be returned to the parent unit.	Attached to the MTF (see notes 1 and 2).
2	Likely to be hospitalized for 90 calendar days or more.	Assigned to the MTF (see notes 1, 2, 3, and 4).
3	Unlikely to return to the unit.	Assigned to the MTF (see notes 1,2,3, and 4).
4	Hospitalized as a result of injury in a combat area.	Attached to the MTF (see notes 1 and 2).
5	Hospitalized while PCS en route or otherwise separated from the unit and assignment to the MTF is necessary to ensure efficient personnel management.	Assigned to the MTF (see notes 1,2,3, and 4).
6	Undergoing physical evaluation for retention, retirement, or separation.	Attached to the MTF as determined by the gaining MTF Commander or as directed by HQ AFPC/DPAMM (see notes 1, 2, 3, and 4).
7	Overseas and must be evacuated to CONUS hospital.	Attached to the MTF as determined by the gaining MTF Commander or as directed by AFPC/DPAMM (see notes 1,2, 3, and 4).
8	At or en route to CONUS port for PCS overseas and expected to be disqualified for worldwide duty for more than 30 calendar days (time in hospital PLUS convalescence).	Attached to the MTF (see note 5).

Notes:

1. If an established length of service date of separation or retirement is within 60 calendar days, the MPS notifies the MTF who then requests Medical Hold, if appropriate, from HQ AFPC/DPAMM. If Medical Hold is approved, the MPS immediately notifies HQ AFPC retirement or separations management office so that retirement or separation orders may be rescinded before the effective Service departure date.

2. If a Prior to Expiration of Term of Service (PETS) separation is pending, the MPS notifies the MTF which then informs the discharge authority about the patient's medical status. The discharge authority may determine whether discharge should be delayed.

3. If an officer is the subject of a judicial or adverse administrative action he or she will

remain assigned to the unit initiating the action and will be attached to the medical facility.

4. If a patient is moved to a non-Air Force hospital by the GPMRC and assignment to Patient Squadron is indicated, patient is attached to the non-Air Force hospital but assigned to the nearest Air Force hospital.

5. The MTF TOPA function notifies the servicing MPS and provides a brief medical statement from the attending physician in addition to the physician's name and telephone number. The MTF informs the assignment authority and requests assignment instructions.

Attachment 23

ADMINISTRATIVE DETERMINATION TO TEMPORARILY OR PERMANENTLY REASSIGN MEMBER PATIENTS FROM OVERSEAS LOCATIONS

Table A23.1. Administrative Determination to Reassign Patients from Overseas Locations.

Rule	If the member:	And	Then:
1	Has served any length of time.	Cannot be treated in overseas (see note 1).	TDY to CONUS hospital for final PCS determination and disposition (see note 3).
2	Is likely to be hospitalized in excess of 90 calendar days (see note 1).	Is not expected to be retained on active duty.	Assign to CONUS hospital.
3	Can be treated in overseas area and hospitalization is expected to be less than 90 calendar days (see note 1).	Is expected to remain on active duty.	TDY to overseas hospital for treatment (see note 4).
4	Within two calendar days of DEROS (see note 1).	Can be treated in overseas area and return to duty is expected before DEROS (see note 1).	PCS to gaining unit.
5	Can be treated in overseas area (see note 1).	Return to duty is expected after DEROS (see note 2).	PCS to gaining unit with TDY en route to CONUS hospital (see note 3).
6	Cannot be treated in overseas area (see note 1).	Hospitalization is expected to be less than 60 calendar days and is expected to remain on active duty.	TDY to CONUS hospital.

Notes:

1. Overseas MTF determines.

2. Servicing MPS provides assistance.

3. Air Force MPS servicing medical facility designated by Armed Service Medical Regulating Office provides Personnel support.

4. May result in further TDY or CONUS medical facility for final PCS or separation determination.

Attachment 24

RECOMMENDED USAGE OF AF FORM 330

Figure A24.1. Recommended Usage of AF Form 330.

RECORDS TRANSMITTAL / REQUEST

DATE PREPARED: 10NOV08

SUSPENSE DATE:

TO: HQ AFPC/STRCC, MEDICAL RECORDS DISPOSITIONS, 550 C STREET W SUITE 21, RANDOLPH AFB TX 78150

FROM: 60 MDSS/SGSMO, 101 Bodin Circle, Travis AFB CA 94535

NAME (Last, First, Middle Initial): SEE ATTACHED INVENTORY ROSTER

GRADE: N/A

SSN:

SECTION I - REQUESTOR COMPLETES

	MEMBER IS ASSIGNED TO A UNIT SERVICED BY YOUR ACTIVITY		MEMBER WAS SEPARATED BY YOUR ACTIVITY
	ACTION INDICATED MUST BE TAKEN AND CONFIRMATION FORWARDED AS AN ATTACHMENT TO THE FORM OR AN INTERIM REPLY FURNISHED NOT LATER THAN SUSPENSE DATE SHOWN ABOVE. IF INDIVIDUAL HAS BEEN REASSIGNED, FORWARD TO GAINING CBPO AND FURNISH COPY OF YOUR ACTION TO REQUESTOR.		
X	OTHER STATUS (Specify): Service Treatment Records (STR) - One (1) Box 14 Totals STRs (including outpatient medical and dental records)		

BASE LEVEL RECORDS/DOCUMENTS (LEGEND: (U = Updated) (T = Transmitted) (R = Requested) (NA = To be used when the record/document does not apply)

	EPR		OPR		TNG RPT		LOE		AF 522 GROUND WPNS TRNG DATA & FIRE ARMS QUALIFICATION
DATE REPORTING PERIOD BEGAN			DATE REPORTING PERIOD ENDED						AF 538 PERSONNEL CLOTHING AND EQUIPMENT RECORD OR CERTIFICATE IN LIEU OF
									AF 623 OJT RECORD
	REPORT BEING PROCESSED - WILL FORWARD ON								AF 976 TRAFFIC SAFETY EDUCATION RECORD (AD personnel)
	REPORT NOT REQUIRED - INDIVIDUAL'S INITIALS								DD 1360 MOTOR VEHICLE OPERATOR QUALIFICATIONS & RECORD OF LICENSING, EXAMINATION, AND PERFORMANCE
TOTAL NUMBER OF REPORTS IN (AMN)									AF 1568 WAPS TEST VERIFICATION
	AF 10 AMN/OFF UPRG								AF 991 ANCILLARY TRAINING RECORD OR AUTOMATED PRODUCT
T	AF 2100 THRU 2190 TREATMENT RECORD (Medical)								AF 899 INDORSED PCS SPECIAL ORDER
T	AF 2100 THRU 2190 TREATMENT RECORD (Dental)								AF 63181 ACTIVE DUTY SERVICE COMMITMENT
	AF 173 RECORD OF RETENTION INTERVIEWS (1st/2nd Term Airm)								(ADSC) STATEMENT OF UNDERSTANDING
	AF 185 INDIVIDUAL RECORD EDUCATION SERVICES PROGRAM								MILITARY PAY RECORDS ENVELOPE
	AF 298 PERSONNEL RELIABILITY CERTIFICATE								FLIGHT RECORDS/EVALUATION FOLDER/FILE
	AF 375 INDIVIDUAL PHYS FITNESS & WEIGHT EVAL RECORD								

RECEIPT AND CERTIFICATION FOR HANDCARRIED RECORDS: I acknowledge receipt of records checked "R" and understand that I am to turn these records over to the appropriate activity upon arrival at my new station, and that I am not authorized to open the sealed envelope in which these records are being transmitted, and that I am responsible for safeguarding these records enroute.

DATE: SIGNATURE:

REMARKS: 1 - CBPO ADDITIONAL SPACE 2. HAF AND MAJCOM RECORDS REQUEST, TRANSMITTALS, AND REMARKS

Please acknowledge receipt by returning this form to the address listed above or email at john.smith@travis.af.mil.
Names: Atkins - Reyes

DATE	TYPED OR PRINTED NAME AND GRADE	TELEPHONE	SIGNATURE
10NOV08	JOHN SMITH, TSgt, USAF NCOIC, Outpatient Records	DSN 555-1212	John Smith

SECTION II - ACTION OFFICER COMPLETES

TO: FROM:

	FORM(S)/ DOCUMENT(S) IDENTIFIED ABOVE BY "R" ARE ATTACHED.
	FORM(S)/ DOCUMENT(S) IDENTIFIED ABOVE BY "R" WILL BE FORWARDED TO YOUR OFFICE NO LATER THAN
	FORM(S)/ DOCUMENT(S) IDENTIFIED ABOVE BY "R" WERE HANDCARRIED BY MEMBER'S COPY OF AF FORM 330 ATTACHED
	FORM(S)/ DOCUMENT(S) IDENTIFIED ABOVE ARE NOT AVAILABLE AT THIS OFFICE, SEE REMARKS BELOW

REMARKS

DATE	TYPED OR PRINTED NAME AND GRADE	TELEPHONE	SIGNATURE

AF IMT 330, 19900101, V1 PREVIOUS EDITION WILL BE USED

Attachment 25

RESERVE HEALTHCARE ELIGIBILITY MATRIX (NON-CONTINGENCY OPERATIONS)

Table A25.1. Reserve Healthcare Eligibility Matrix (Non-Contingency Operations).

COVERAGE CATEGORY	Military Duty 30 Days or Less	Pre-Activation (180 days early eligibility)	Active Duty Benefits	De-Activation (upon leaving active duty)
Healthcare: Sponsor:	Line of Duty Care	N/A. (Applies when sponsor is called or ordered to Active Duty in support of a contingency operation for more than 30 consecutive days).	Full TRICARE coverage as Active Duty service members.	CHCBP
Healthcare: Family Members	None	N/A. (Applies when sponsor is called or ordered to Active Duty in support of a contingency operation for more than 30 consecutive days).	Full TRICARE coverage as Active Duty family members.	CHCBP
Dental: Sponsor	TRICARE Dental Program	TRICARE Dental Program	Active Duty dental benefits	TRICARE Dental Program
Dental: Family Members	TRICARE Dental Program (Reserve component family member rates).	TRICARE Dental Program (Reserve component family member rates).	TRICARE Dental Program (Active Duty family member rates).	TRICARE Dental Program (Reserve component family member rates).

Note:

This information is subject to change in accordance with Federal Law and DoD directives.

Source: DoD TRICARE Management Activity (TMA) Internet Website: http://www.tricare.osd.mil/.

Attachment 26

RESERVE HEALTHCARE MATRIX CONTINGENCY OPERATIONS

Table A26.1. Reserve Healthcare Eligibility Matrix (Contingency Operations)

COVERAGE CATEGORY	Military Duty 30 Days or Less	Pre-Activation (180 days early eligibility)	Active Duty Benefits	De-Activation (upon leaving active duty)
Healthcare: Sponsor:	Line of Duty care only	Full TRICARE coverage as Active Duty service members	Full TRICARE coverage as Active Duty service members	TAMP followed by CHCBP or TRS*
Healthcare: Family Members	None	Full TRICARE coverage as Active Duty family members	Full TRICARE coverage as Active Duty family members	TAMP followed by CHCBP or TRS*
Dental: Sponsor	TRICARE Dental Program	Active Duty dental benefits	Active Duty dental benefits	TRICARE Dental Program
Dental: Family Members	TRICARE Dental Program (Reserve component family member rates).	TRICARE Dental Program (Active Duty family member rates)	TRICARE Dental Program (Active Duty family member rates).	TRICARE Dental Program (Reserve component family member rates).

Notes:

1. Specific eligibility requirements must be met to qualify for TRICARE Reserve Select. TRS is a new premium-based TRICARE health plan offered for purchase by certain members and former members of the Reserve Component* (RC) and their families, if specific eligibility requirements are met.

2. TRS coverage is available to eligible RCSMs who were called or ordered to active duty, under Title 10, in support of a contingency operation on or after September 11, 2001. To qualify, RCSMs must serve in the Select Reserve for one entire year or more. The RCSM's unit must agree to the employment/assignment terms.

3. TRS coverage must be purchased. TRS members pay a monthly premium for healthcare coverage (for self-only or for self and family). TRS premiums are adjusted Jan 1st each year. Source: DoD TRICARE Management Activity (TMA) Internet Website: http://www.tricare.osd.mil/.

Attachment 27

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Attachment 28

MEMORANDUM FOR RETIRING/SEPARATING MEMBERS INTENT TO FILE DVA CLAIM

Figure A28.1. Memorandum for Retiring/Separating Members Intent to File DVA Claim.

MEMORANDUM FOR AFPC/DPSIR Central Cell

FROM: SEPARATING/RETIRING MEMBER

SUBJECT: Notice of Intent to File Disability Claim

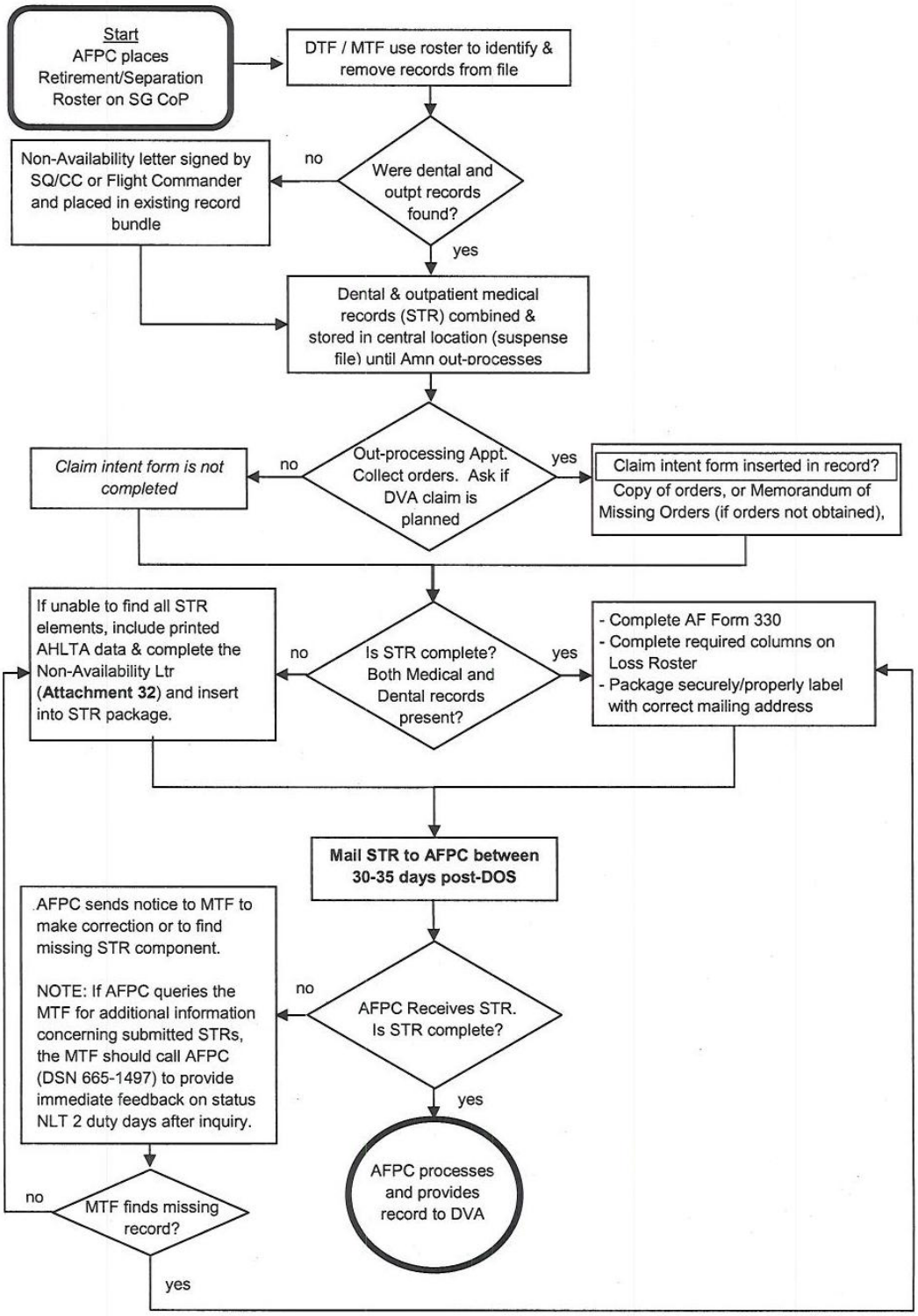
I, _____, SSN _____ plan to file a disability claim with the Department of Veterans Affairs. I authorize XX MDG to forward my service treatment record (including outpatient medical and dental records) to the DVA regional claims office in (city and state) _____.

_____
Signature of Member/Grade/Date

Attachment 29

AIR FORCE SERVICE MEMBER STR DISPOSITION FLOWCHART

Figure A29.1. Air Force Service Member STR Disposition Flowchart.



Attachment 30

CHECKLIST FOR MAILING STRS TO AFPC

Obtain 2 copies of the member's orders.

If orders cannot be obtained, accomplish a Memorandum of Missing Orders.

Have the member fill out the VA Claim Intent form if they plan to file a claim.

Obtain roster (downloaded monthly from AF/SG CoP).

Locate & retrieve the member's outpatient medical record.

Print applicable AHLTA patient encounters and CHCS ancillary report data and file into the paper record.

Place 1st copy of orders in a charge-out in place of the record.

Place 2nd copy of orders inside record with VA Claim Intent form on top of Section II.

Place record (with orders & VA Claim Intent form inside) in suspense file.

If either the original paper dental or outpatient medical record is missing, accomplish Letter of Non-Availability and place it in the available record.

If both the original paper dental and outpatient medical records are missing, annotate record locations on roster if known. Print applicable AHLTA patient encounters and CHCS ancillary report data and file into an appropriate record jacket; label the record as Volume II, or applicable volume number; insert the Letter of Non-Availability for the missing volume into the created volume.

If the original outpatient medical record is missing, create a new AF Form 2100A series record and insert printed AHLTA/CHCS encounters and reports. Label the record as Volume II, or applicable volume number; insert the Letter of Non-Availability for the missing volume into the created volume.

If the original dental treatment record is missing and if AHLTA Dental Module is operational, print all dental encounters and file inside a new AF Form 2100B Series record. Label the record as Volume II, or applicable volume number; insert the Letter of Non-Availability for the missing volume into the created volume.

File complete STRs in suspense file in order of projected retirement/separation date.

Check suspense files daily for upcoming mailing dates.

Prepare record(s) for shipment.

Retrieve STR from suspense file.

Retrieve any additional loose documents from record shelf and file them in record.

Bundle or place dental treatment record inside medical record (between Section I and II).

Ensure 2nd copy of orders & VA Claim Intent form are located inside outpatient medical record (on top of Section II). If the orders cannot be obtained, file a Memorandum for Missing Orders inside the outpatient medical and dental treatment records.

TRANSFER medical records in CHCS Medical Records Tracking menu.

Place STRs in shipping boxes or envelopes.

Prepare, complete, and sign AF Form 330 (1 per shipping envelope/box).

Print copy of roster with records included in package.

Annotate “SEE ATTACHED ROSTER” in name block of AF 330.

Staple roster and AF 330 together.

Keep a copy of the AF 330 and roster.

Mail to AFPC with return receipt or commercial tracking number (e.g., FedEx tracking number) no earlier than 30 calendar days and no later than 35 calendar days following the Service Member’s date of separation/retirement.

Attachment 31

CHECKLIST TO MAIL STRS TO GAINING GUARD/RESERVE MEDICAL UNITS

Obtain 2 copies of the member's orders or AF Form 1288

Obtain roster (downloaded monthly from SG CoP)

Locate & retrieve the member's outpatient medical record

Place 1st copy of orders or AF Form 1288 in a charge-out in place of the record

Place 2nd copy of orders or AF Form 1288 inside record on top of Section II

Place record (with orders inside) in suspense file

Locate & retrieve dental treatment record – place in suspense file bundled inside outpatient medical record

If both the original paper dental and outpatient medical records are missing, annotate record locations on roster if known. Print applicable AHLTA patient encounters and CHCS ancillary report data and file into an appropriate record jacket; label the record as Volume II, or applicable volume number; insert the Letter of Non-Availability for the missing volume into the created volume.

If the original outpatient medical record is missing, create a new AF Form 2100A series record and insert printed AHLTA/CHCS encounters and reports. Label the record as Volume II, or applicable volume number; insert the Letter of Non-Availability for the missing volume into the created volume.

If the original dental treatment record is missing and if AHLTA Dental Module is operational, print all dental encounters and file inside a new AF Form 2100B Series record. Label the record as Volume II, or applicable volume number; insert the Letter of Non-Availability for the missing volume into the created volume.

File complete STRs in suspense file in order of projected separation date

Check suspense files daily for upcoming mailing dates

Prepare record(s) for shipment

Retrieve STR from suspense file

Retrieve any additional loose documents from record shelf and file them in record

Bundle or place dental treatment record inside medical record (between Section I and II)

Ensure 2nd copy of orders or AF Form 1288 is inside outpatient medical record (on top of Section II)

TRANSFER medical records in CHCS Medical Records Tracking menu

Place STRs in shipping boxes or envelopes

Prepare, complete, and sign AF Form 330 (1 per shipping envelope/box)

Print copy of roster with records included in package

Annotate "SEE ATTACHED ROSTER" in name block of AF 330

Staple roster and AF 330 together

Keep a copy of the AF 330 and roster

Mail the STR to the gaining Guard or Reserve Medical Unit with return receipt or commercial tracking number (e.g., FedEx tracking number) within or NLT FIVE duty days following the Service Member's date of transition.

Attachment 32

LETTER OF STR NON-AVAILABILITY (FORMAT)

Figure A32.1. Letter of STR Non-Availability Format.

Using Unit Letterhead

Sample Template

AFPC/DPSIR

ATTENTION: Medical Records Central Cell

550 C STREET W SUITE 21

RANDOLPH AFB TX 78150

SUBJECT: Missing Health Record Information

The Service Treatment Record for this patient is not complete. The original dental or outpatient medical record(s) for the following patient is/are missing:

Full Name:

Rank:

SSN:

Date of Birth:

Final Service Obligation Date:

Missing Record Description:

An extensive search of the entire facility was conducted. We utilized and reviewed all automated patient tracking and registration mechanisms available within our means, but still could not locate the record(s). The record(s) have been identified as missing.

If located, the record(s) will be immediately mailed to the AFPC Records Disposition Center. Please contact (insert POC name and contact numbers, both commercial and DSN).

Squadron CC or Flight CC Signature Block

Attachment 33

EXAMPLE OF MEMORANDUM OF UNDERSTANDING WITH SISTER-SERVICE MTFS

Figure A33.1. Sample Memorandum of Understanding with Sister-Service MTFs.

MEMORANDUM OF UNDERSTANDING

between

The XXth Medical Group (Air Force MTF or Installation Name)

and

The Army / Navy / Community Hospital concerning

A PARTNERSHIP TO ENSURE CORRECT SERVICE TREATMENT RECORD (STR) DISOSITION FOR SEPARATING AND RETIRING AIRMEN

I. PURPOSE

This Memorandum of Understanding (MOU) defines a partnership agreement between the XXth Medical Group, Any Air Force Base, Any Town and the XXd Battalion Army Community Hospital, or the Naval Health Clinic, Any Army or Navy Post or Installation, Any Town, to ensure that STRs (outpatient medical and dental records) for retiring or separating Soldiers, Sailors, Airmen, Marines, and Coast Guardsmen are properly dispositioned.

This document identifies and delineates the roles and responsibilities of each organization to ensure that the STR for any retiring or separating Soldier, Sailor, Airman, Marine, or Coast Guardsmen enrolled or empanelled to one of the Other-Service MTFs identified above, is properly dispositioned according to each individual Service's own STR disposition rules.

II. BACKGROUND

Historical processes to recover STRs for Service Members enrolled or empanelled to Other-Service MTFs has been difficult, especially in multi-market service areas, this agreement is enacted to clarify the process for each Military Service to ensure that STRs are returned to their respective agencies where the best possibility for accurate records disposition can be assured.

III. OBJECTIVES AND RESPONSIBILITIES

The XXth Medical Group and the XXd Battalion Army Community Hospital, or the Naval Health Clinic agree to cooperate and collaborate, in the best interest of the Service Member, to obtain, in the most reasonable and efficient manner possible, the STRs for retiring or separating Service Member's enrolled to MTFs not of their own Service affiliation. Under this MOU, both parties agree to:

Contact the Other-Service MTF that maintains the Service Member's STR, no later than 30 calendar days prior to the member's date of separation with notice of the member's impending service separation or service retirement date.

Provide written notice/documentation of said date of separation either through US Postal Service, equivalent commercial mailing mechanism, or personal delivery.

Establish an agreed upon method of transferring STRs to the requesting Other-Service MTF that includes either:

a) A method of mailing the STR from MTF to MTF (to include a return receipt confirmation or package tracking option), or

b) A schedule that identifies available STR pick-up times and location so that the requesting MTF may physically visit the Other-Service MTF and obtain the STRs in person.

When requested by the Service Member, the MTF to which the member is enrolled will provide the retiring or separating member with a copy of their STR prior to forwarding the original record.

IV. AGENCY CONTACT INFORMATION

For the XXth Medical Group:

Major James Smith

james.smith@anybase.af.mil

TRICARE Operations and Patient Administration Flight Commander

XX MDG/SGXX

123 Any Road

Any Base, Any State 12345

(202) 123-4567 DSN 555

For the XXd Battalion Army Community Hospital:

Capt David Manager
david.manager@us.army.mil
Patient Administration Director
XXd Battalion, XXd Regiment Medical
Any Name Army Community Hospital
Any Fort, Any State 54321
(202) 987-6543 DSN 444

V. CHANGES TO MOU

Any participant in this agreement may propose changes to this MOU at any time. The proposed change(s), along with the supporting rationale, will be submitted to both signatories for review and consideration. If changes are approved by both signatories (in the form of an amendment) both signatories are required to sign (a new signature page), indicating their agency's agreement with the change(s).

VI. EFFECTIVE DATE, PERIODIC REVIEW, WITHDRAWAL AND TERMINATION

This MOU shall take effect upon the date of the last signature. This agreement will be reviewed (by both parties) every TWO years for relevancy. This MOU may be terminated at any time by mutual written agreement of the two signatories. A participant MTF may withdraw from this MOU with 180 days written notice to the remaining signatory.

FOR THE XXth MEDICAL GROUP

____Signature_____ Date 1 Nov 2012

Name & Rank Here

Commander, XXth Medical Group

FOR THE XXd BATTALION ARMY COMMUNITY HOSPITAL

____ Signature_____ Date 12 Dec 2012

Name & Rank Here

Commander, XXd Army Community Hospital

Attachment 34

SERVICE TREATMENT RECORDS MAILING ADDRESSES FOR OTHER SERVICES

U.S. Army:
Department of VA Records Management Center
ATTN: MEDCOM STR Processing Cell
4300 Goodfellow Blvd
St. Louis, MO 63120

U.S. Navy:
Nearest Naval Personnel Support Detachment (PSD).
(See the AF/SG CoP for a current list of addresses of Naval PSD locations)

U.S. Marine Corps:
Headquarters US Marine Corps
Manpower Information Division
James Wesley Marsh Center
3280 Russell Road
Quantico, VA 22134 - 5103

U.S. Coast Guard:
Commander
U. S. Coast Guard
Maintenance and Logistics Command Atlantic 3
00 East Main Street, Suite 1065
Norfolk, VA 23510

USAF Reserve Component (RC):
See SG CoP for list/addresses of Reserve and Guard medical units

Attachment 35

SAMPLE INVENTORY ROSTER FOR ALL STRS DISPOSITIONED ON 1 JAN 09 AND AFTER

Figure A35.1. Sample Inventory Roster for All STRs Dispositioned on 1 Jan 09 and After.

Required columns to retain on the AFPC LOSS Roster for the inventory:

NAME (Last, First):

SSN:

Date of Separation:

MEDICAL RECORD (YES/NO):

DENTAL RECORD (YES/NO):

DATE RECORD MAILED:

REMARKS:

After all names are identified, then sign.

SIGNATURE BLOCK

Flight Commander, NCOIC, or Records Dept Supervisor

Attachment 36

SAMPLE INVENTORY ROSTER FOR ALL STRS DISPOSITIONED BEFORE 1 JAN 09

Figure A36.1. Sample Inventory Roster for All STRs Dispositioned before 1 Jan 09.

Required data elements:

NAME (Last, First):
SSN:
MEDICAL RECORD (YES/NO/LETTER OF NON-AVAILABILITY):
DENTAL RECORD (YES/NO/LETTER OF NON-AVAILABILITY):
ORDERS (YES/NO):
COMMENTS:

After all names are identified, then sign.

SIGNATURE BLOCK
Flight Commander, NCOIC, or Records Dept Supervisor
INSTRUCTION END