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Health Services

TRICARE OPERATIONS AND PATIENT ADMINISTRATION

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This publication implements Air Force Policy Directive (AFPD) 41-2, *Medical Support*. It identifies and defines the requirements, policies, procedures, activities, and minimum expectations necessary to ensure a successful Air Force Medical Treatment Facility (MTF) TRICARE Operations and Patient Administration mission. This publication describes how to manage TRICARE Operations and Patient Administration 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 MTFs. This publication applies to all civilian employees and uniformed members of the Regular Air Force, Air Force Reserve and Air National Guard who perform TRICARE Operations and Patient Administration. Ensure all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual 33-363, *Management of Records*, and disposed of in accordance with the Air Force Records Disposition Schedule located in the Air Force Records Information Management System Records Disposition Schedule. Refer recommended changes and questions about this publication to Air Force Medical Readiness Agency (AFMRA)/SG3S using the Air Force Form (AF Form) 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of command. All field publications that either implement or supplement this publication must be submitted to AFMRA/SG3S for coordination prior to approval. **(T-2)**. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the

authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the requestor's commander for non-tiered compliance items. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force. This manual requires the collection and/or maintenance of information protected by Title 5 United States Code Section 552a, Privacy Act of 1974, authorized by 10 U.S.C. Chapter 55, Medical and Dental Care, and E.O. 9397 (SSN). The applicable SORN F044 AF SG D, Automated Medical/Dental Record System (August 29, 2003, 68 FR 51998) is available at **http://dpclo.defense.gov/Privacy/SORNs.aspx**.

SUMMARY OF CHANGES

This document has been substantially revised and should be completely reviewed. Major changes include: The publication text has been reduced significantly, removal of verbiage that pertains to the new stand-alone Air Force Instruction (AFI) 41-200, *Health Insurance Portability and Accountability Act (HIPAA)*, and tier waiver authorities have been added for wing-level, equivalent or below requirements in accordance with AFI 33-360. The Service Treatment Record suspense and outpatient medical record hand-carry policy has been updated. TRICARE Online has been removed and is included in AFI 44-176, *Access to Care Continuum*. References and verbiage related to Patient Squadron were changed to Airman Medical Transition Unit and references to Air Force Personnel Center (AFPC)/DPAMM were changed to AFPC/Medical Retention Standards Branch (DP2NP) throughout this publication. Further, the Unit Commander Notification of Disability Evaluation System Findings Process has been incorporated. Throughout this publication, references to Personnel Reliability Assurance Program include Personnel Reliability Program and Arming and Use of Force; whereas, references to Personnel Reliability Program refer to Personnel Reliability Program only.

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Chapter 1

OVERVIEW, ROLES AND RESPONSIBILITIES

Section 1A—TRICARE

1.1. TRICARE Overview. TRICARE is the Department of Defense's (DoD) managed healthcare program for active duty (AD) military and their families, Reserve Component (RC) members and their families, retirees and their families, and other beneficiaries. The TRICARE Program offers options for healthcare coverage including: TRICARE Prime, TRICARE Select, 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 **https://manuals.health.mil/**. Throughout this AFMAN, the TRICARE Operations and Patient Administration staff are responsible for the execution of the programs and processes outlined, unless explicitly stated.

1.2. TRICARE Operations Overview. The following activities are functions of TRICARE Operations: managed care support, beneficiary counseling and assistance, debt collection assistance, medical in/out-processing briefings, TRICARE plan marketing and education, health plan analysis, enrollment management, external resource sharing agreements, clinical support agreements, and the referral management center.

Section 1B—Patient Administration

1.3. Patient Administration Overview.

1.3.1. 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 Military Treatment Facility (MTF).

1.3.2. 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 duties, line of duty (LOD) determinations/coordination, outpatient records management, medical evaluation boards administration, physical evaluation board liaison officer, 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 administration.

1.4. Patient Administration Officer, Director and Noncommissioned Officer (NCO).

1.4.1. The MTF commander or director will appoint a Patient Administration Officer, Director, Senior NCO (SNCO) or NCO, depending on the size of the MTF, to manage and provide oversight of all patient administration functions performed throughout the MTF. **(T-3).** The individual appointed by the MTF commander or director has primary authority to facilitate and/or enforce the policies, on behalf of the commander, identified in this manual.

1.4.2. Responsibilities: The Patient Administration Officer, Director, SNCO or NCO will manage functions listed in paragraph 1.3.2. **(T-1).**

1.5. HIPAA Privacy Officer. The duties and responsibilities of the MTF HIPAA privacy officer are discussed in AFI 41-200, *Health Insurance Portability and Accountability Act (HIPAA)*.

1.6. 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 must be credentialed by the American Health Information Management Association, and if a civilian, must be rated eligible by the Office of Personnel Management (OPM) Qualification Standard for the GS 669 or GS 675 series. **(T-1).**

1.6.2. The RHIA or RHIT will manage the inpatient records department, inpatient records coding, and inpatient professional service encounters (rounds), ambulatory procedure visits, medical transcription, outpatient record documentation, and coding oversight.

1.6.3. The RHIA or RHIT will work closely with the Information System Security Office and HIPAA privacy officer to ensure security of, and controlled access to, both the paper-based and automated medical records, and ensure release of information procedures conform to all legal requirements.

Section 1C—Medical Coding

1.7. Medical Coders. For recording diagnoses and procedures, MTFs will include in their position descriptions (PD) that coding staff will be required to complete the appropriate training and certification exam from the American Academy of Professional Coders or American Health Information Management Association within 18 months of placement under the PD indicated for their position in accordance with Defense Health Agency Interim Procedures Memorandum (DHA-IPM) 18-016, *Medical Coding of the DoD Health Records*.

1.7.1. Professional Services Coding: certified professional coder, American Academy of Professional Coders; or certified coding specialist-physician, American Health Information Management Association.

1.7.2. Institutional (Facility) Coding: certified outpatient coder (outpatient facility only), certified inpatient coder (inpatient facility only), American Academy of Professional Coders; or certified coding specialist, American Health Information Management Association.

1.7.3. An American Health Information Management Association RHIT or RHIA credential may be counted in lieu of the certified coding specialist or certified coding specialist – physician credential.

1.8. Air Force Medical Operations Agency (AFMOA) Coding Program Office. The AFMOA Coding Program Office will be the office of primary responsibility for all Air Force Medical Service (AFMS) coding related issues, composed of the Coding Manager and the AFMOA Coding Consultants.

1.8.1. Responsibilities:

1.8.1.1. Represent the AFMS in tri-Service meetings and discussions involving coding policy and guidance.

1.8.1.2. Provide program management oversight, expertise, and technical support to AFMS coding operations.

1.8.1.3. Define coder qualifications and provide AFMS coder manning and funding recommendations.

Section 1D—Unit Commanders

1.9. Unit Commanders. The responsibilities of the unit commander are discussed throughout this AFMAN. In particular commander authorizations, notifications and coordination with MTF staff may occur. See paragraphs 2.9, 2.18.4, 2.20.2, 4.11.2, 4.23.10, 4.24, 4.50.4, 4.65.8, 4.68.5, 5.4.5, 5.7.2.4, 5.15.6, 5.21.5.7.

Section 1E—Administrative Assistant to the Secretary of the Air Force (SAF/AA)

1.10. SAF/AA. The responsibilities of SAF/AA include delegated authority of the Air Force Secretarial Designee Program. See paragraphs 4.13, 4.14, 4.15.

Chapter 2

HEALTHCARE BENEFITS AND REQUIREMENTS

Section 2A—Healthcare Entitlements for Current and Former Uniformed Services Personnel and Foreign Forces Members

2.1. General Administration of Healthcare Benefits. MTFs will administer healthcare benefits to uniformed service members, family members, retirees, and other eligible persons in accordance with Department of Defense Directive (DoDD) 6010.04, *Healthcare for Uniformed Services Members and Beneficiaries*, and Health Affairs Policy 11-005, *TRICARE Policy for Access to Care*. **(T-0).**

2.1.1. MTFs will provide care without regard to the sponsor's Service affiliation, rank or grade. **(T-0).**

2.1.2. Active Duty (AD) service members must be enrolled to TRICARE Prime. **(T-0).** Reference Health Affairs Policy 05-014, *Policy Guidance for Active Duty Service Member Enrollment to TRICARE Prime* and 32 CFR Part 199.17, *TRICARE program*.

2.1.3. Eligibility Verification. MTFs will require that all persons, including members in uniform, show satisfactory evidence of their beneficiary status before receiving MTF care. **(T-0).** MTFs will not provide routine care to patients whose eligibility cannot be verified unless a competent medical authority determines a delay in care would create an unreasonable risk to the patient's health. **(T-0).** In such cases, the MTF will require the patient to sign a statement of eligibility that indicates the patient's requirement to provide proof of eligibility within 30 days or be held responsible for the costs associated with the care provided. **(T-0).** After the 30th day, if the individual has not produced evidence that satisfactorily verifies eligibility, the TRICARE Operations and Patient Administration Flight will forward the patient's information to the Resource Management Flight to initiate the billing process. **(T-1).** This process applies to outpatient care, inpatient care, and ancillary care; however, for emergency cases, MTFs will always provide care first and verify eligibility after treatment. **(T-0).** The Military Personnel Section (MPS) establishes eligibility, whereas the MTFs verify eligibility. Reference: 10 USC Chapter 55, "Medical and Dental Care;" DoDI 1341.02, *Defense Enrollment Eligibility Reporting System (DEERS) Program and Procedures* and AFI 36-3026_IPV1, *Identification Cards for Members of the Uniformed Services, Their Eligible Family Members, and Other Eligible Personnel*.

2.1.3.1. MTFs will require that all patients requesting care present a valid government identification card that satisfactorily establishes the identity of the patient except when the patient is aged 10 or under. **(T-0).** Beneficiaries aged 10 and under may receive MTF care without providing a valid government identification when the child passes a Defense Enrollment Eligibility Reporting System (DEERS) check and a legally authorized representative with a military identification validates the child's identity. Legally authorized representatives who lack a military identification may not validate the child's identity. In cases where the legally authorized representative lacks military identification, the child must show government identification that satisfactorily confirms the child's identity. **(T-0).**

2.1.3.2. MTFs will perform DEERS checks for eligibility on all patients requesting care. **(T-0).** Eligible beneficiaries enrolled in a Uniformed Services Family Health Plan are not eligible for routine care at MTFs; however, all other patients reflecting eligibility in DEERS are authorized care within MTFs. RC service members and their family members who present a government, state or country photo identification card and pass a DEERS check should not be asked for a copy of AD orders.

2.1.3.2.1. If a patient fails a DEERS check, MTFs may still provide routine care within the direct care system in the following circumstances and as otherwise authorized in this manual, or by statute:

2.1.3.2.1.1. The patient is a member of the RC on active or inactive duty for less than 30 days and presents a copy of their orders or other administrative documentation.

2.1.3.2.1.2. The patient is a member of the RC on active or inactive duty status, and is seeking healthcare related to an in line of duty (LOD) medical or dental condition or a condition which is currently under LOD investigation in accordance with AFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON) and Incapacitation (INCAP) Pay*.

2.1.3.2.1.3. If a RC service member is issued delayed-effective-date AD 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 latter of either: (a) the date their orders were issued or (b) 90 days before the service member reports for duty or is activated to AD.

2.1.3.2.1.4. The patient has a Secretarial Designee letter that authorizes the care. Ensure the patient only receives care limited to the specific dates and diagnosis annotated in the approval letter. **(T-0).**

2.2. RC Members. MTFs will administer health benefits to RC service members on AD tours, on AD orders, and under circumstances directed in Department of Defense Instruction (DoDI) 1241.01, *Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements* and AFI 36-2910. **(T-0).**

2.2.1. When not in an Extended Active Duty military status (orders for greater than 30 days), TRICARE Early Mobilization or Transitional Assistance Management Program status; RC member military healthcare is limited. Refer to DoDI 1241.01 for entitlements.

2.2.2. RC service members placed on orders for more than 30 days for non-contingency related operations are authorized TRICARE benefits equal to the AD component. Additionally, TRICARE benefits are extended to the RC service member's authorized family members during the same period.

2.2.2.1. Officer direct accessions: Members commissioned as reserve officers in the uniformed services may be entitled to full medical and dental benefits prior to commencing AD service on Extended AD orders when: Extended AD orders will be issued but have not been issued yet, or the orders have been issued but the member has not yet entered AD; and the member does not have healthcare insurance and is not covered by any other health plan. Reference 10 USC § 1074.

2.2.3. RC service members ordered to Federal AD 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 RC service member's authorized family members. Additionally, if the RC service member is issued delayed-effective-date AD orders for more than 30 days in support of a contingency operation, the member and sponsored family members are eligible for early TRICARE medical and dental benefits beginning on the latter of either: (a) the date orders were issued or (b) 180 days before the member reports for duty or is activated to AD.

2.2.4. Air Reserve Component (ARC) members do not have to be in a duty status to make an appointment. However, the member must show they are on duty status (active, inactive or points only) at the time of any treatment/care (i.e. any annual military requirement exam, immunization, or deployment-related exam). **(T-1)**. MTFs verify ARC members are in a duty status (active, inactive, or points only) for annual military requirements such as Periodic Health Assessment, flight physicals and immunizations with the AF Form 40A, *Record of Individual Inactive Duty Training*, or a copy of the member's orders.

2.3. Foreign Forces and Their Dependents. MTFs will provide healthcare to foreign forces, and their eligible dependents when applicable, in accordance with DoDI 6025.23, *Health Care Eligibility Under the Secretarial Designee (SECDES) Program and Related Special Authorities*, DoDI 6015.23, *Foreign Military Personnel Care and Uniform Business Offices in Military Treatment Facilities (MTFs);* DoDI 1000.13, *Identification (ID) Cards for Members of the Uniformed Services, their Dependents, and other Eligible Individuals.* **(T-0).**

2.3.1. MTFs will provide authorized care for the categories of foreign nationals listed below, and seek reimbursements that are consistent with international agreements (i.e. Status of Forces Agreement or Reciprocal Health Care Agreement). **(T-0).** If a Reciprocal Health Care Agreement exists that establishes different benefits or charges from those associated with a training program, then the Reciprocal Health Care Agreement takes precedence. Foreign nationals and their family members must present approved identification and/or Invitational Travel Orders as appropriate when requesting care. **(T-0).** Treatment of foreign nationals and their family members is subject to the provisions of approved international agreements.

2.3.1.1. North Atlantic Treaty Organization (NATO) and Partnership for Peace Status of Forces Agreement personnel and their authorized family members eligibility is determined by DoDI 6015.23.

2.3.1.2. Foreign diplomatic or other senior foreign officials and the dependents of such officials may be provided inpatient or outpatient services in MTFs only in compelling circumstances, including both medical circumstances and mission interests, and through case-by-case approval. Refer to DoDI 6025.23.

2.3.1.3. Foreign military personnel assigned or attached to United States military units for duty and their family members eligibility is determined by DoDI 6015.23.

2.3.1.4. International students assigned or attached to United States military units for training and their authorized family members eligibility is determined by DoDI 6015.23.

2.3.1.5. Detainees, Enemy Prisoners of War, refugees, and other displaced personnel will be provided medical care equal to that of United States Service Members. See for example, Article 91 of Geneva Convention Relative to the Protection of Civilian Persons in Time of War of August 12, 1949: 75 U.N.T.S. 287 (1950) which can be located at

https://ogc.osd.mil/LoW_Treaties.html. Consult with Staff Judge Advocate regarding Law of War compliance."

2.4. Cadets and Midshipmen. MTFs will administer health benefits to cadets enrolled at the United States Air Force Academy, the United States Military Academy at West Point, the United States Coast Guard Academy, and midshipmen enrolled at the United States Naval Academy. **(T-0).** Enrollment into TRICARE is authorized. Reference 10 USC § 1074b.

2.5. Senior College or University Reserve Officer Training Corps (ROTC) Cadets; ROTC Membership Applicants; Uniformed Service Applicants; and Service Academy Applicants. MTFs will provide limited healthcare to ROTC Cadets and applicants to the Service Academies, ROTC and the Uniformed Services. **(T-0).** Reference 10 USC § 1074b.

2.5.1. MTFs will provide cadets medical and 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. **(T-0)**

2.5.2. If a ROTC cadet's college, university, or institution does not have the ability to perform a physical exam, the cadet will be provided an examination(s) at a MTF, per Health Affairs Policy 99-003, *Physical Examination for ROTC Applicants*, including admission if required to satisfy clinical diagnostic requirements. **(T-0).** Uniformed Service or Service Academy applicants may receive initial service eligibility examination(s) at a MTF. For remedial ROTC commissioning, Uniformed Service, or Service Academy entrance examinations that require additional diagnostic care beyond a MTFs capabilities, refer the cadet or applicant to the closest MTF (with the required capabilities) for required medical testing.

2.5.3. Cadets requiring additional follow-up medical care after hospitalization and/or after completing summer training, military exercise training, practical military training, etc., are authorized Department of Defense (DoD) MTF care only, regardless of the cadet's distance from a MTF.

2.6. Medal of Honor Recipients. MTFs will administer medical and dental benefits to otherwise non-eligible Medal of Honor recipients and their immediate dependents as if the Medal of Honor recipient is a retiree entitled to retired pay. **(T-0).** Reference 10 USC § 1074h.

Section 2B—Healthcare for Current and Former Uniformed Service Family Members

2.7. Un-remarried Former Spouses. MTFs will administer healthcare benefits to certain un-remarried former spouses of Uniformed Service Members. **(T-0).** Reference 10 USC § 1072 and 1086a.

2.8. Abused Family Members and Dependents. MTFs will administer health benefits to abused family members and dependents in accordance with 32 CFR Part 199.3, DoDI 1342.24, *Transitional Compensation for Abused Dependents*, and in accordance with 10 USC § 1076, 1408(h), 1059. **(T-0).**

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

2.9. Federal Civilian Employees. MTFs will provide limited health care to Federal civilian employees in accordance with DoDI 1400.32, *DoD Civilian Work Force Contingency and*

Emergency Planning Guidelines and Procedures; DoDI 6490.03, *Deployment Health*; and Health Affairs Policy 08-002, *Policy for Billing Care Furnished by Military Treatment Facilities to Federal Employees for On-the-Job Injuries and for Occupational Health* to support DoD civilian personnel deployment and occupation health. **(T-0)**.

2.9.1. Conditional Employment/Annual Occupational Exam Requirements. MTFs will provide occupational exams when they have the capability. **(T-3).** Reference 5 Code of Federal Regulations 339.301, *Authority to Require an Examination*.

2.9.1.1. When the local MTF does not have the capability to provide a medical examination (or a portion of the exam) required for Air Force civilian employment, then the MTF may arrange to have the examination (lab tests, etc.) completed in the civilian sector (non-DoD) healthcare community after receiving payment authorization from the employee's unit commander.

2.9.1.2. The employee's unit commander must authorize payment for all civilian sector (non-DoD) examinations in advance of the MTF making the arrangements. **(T-1).** Payment is made from the same appropriation that funds the employee's salary. The Defense Health Program appropriation will not be used for the examinations, unless the employee's salary is Defense Health Program-funded (e.g., a MTF employee). **(T-0).**

2.9.1.3. The Installation Occupational and Environmental Medicine Consultant will provide clinical oversight of referrals/consults to ensure they are appropriate and justified. **(T-3).**

2.9.1.4. The MTF provider's support staff will notify 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 or test). **(T-3).**

2.9.1.5. The RMO will send a request for unit commander's Authorization of Payment for Civilian Medical Exam packet to the employee's unit commander. **(T-3).** The packet contains two attachments: (1) Commander's Authorization of Payment for Civilian Medical Exam, and (2) Instructions for the unit resource advisor.

2.9.1.6. 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 unit commander's acknowledgement that unit funds will be used for payment of the exam. **(T-3).**

2.9.1.7. Instructions to unit resource advisor: This information sheet explains to the employee's unit resource advisor the steps the advisor must take in order for payment to be made to the civilian healthcare provider. **(T-3).** Payment will not be made until exam results are received by the MTF. **(T-3).**

2.9.1.8. Once the RMO receives the unit 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. **(T-3).**

2.9.1.9. The MTF clinic that schedules the employee's exam should 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. **(T-3). Note:** MTF must provide the address, fax, and point of contact information. **(T-3).**

2.9.1.10. The Referral Management Center will: (1) Forward the exam results to the MTF provider that requested the exam, and (2) Forward the invoice for the exam to RMO. **(T-3).**

2.9.1.11. 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 should 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. The RMO should not proceed with payment until exam results are received by the MTF. **(T-3).**

2.9.2. Workers' Compensation Eligibility for Medical Services. Under the Federal Employee's Compensation Act, an employee injured while in the performance of duty is entitled to compensation. This compensation may include services, appliances, and supplies prescribed or recommended by a qualified physician. The Secretary of Labor must consider the compensation likely to cure, give relief, and reduce the degree or period of disability or aid in lessening the amount of monthly compensation. Reference 5 USC § 8103. Said services, appliances, and/or supplies may be furnished by MTFs, Veterans Affairs (VA), or, United States Public Health facilities; however, this instruction does not guarantee that the required service(s) or supplies will be available at any one particular MTF, VA, or, United States Public Health facility. When the local MTF has the capacity and supplies to provide this care, the employee may choose to seek care through either the MTF or the civilian sector.

2.9.2.1. Direct MTF medical care, also known as in-house care, for job related injuries or illnesses require: (1) Presentation of a completed Department of Labor Form LS-1, *Request for Examination and/or Treatment*, LS-201, *Notice of Employee's Injury or Death*, or LS-202, *Employer's First Report of Injury or Occupational Illness* along with Form Compensation Act (CA)-16, *Authorization for Examination and/or Treatment*. A separate Form CA-16 is not required for each episode of follow-up care if a Form CA-16 was provided on the initial visit. If follow-up care is required beyond 60 days of the initial issuance of the Form CA-16, the supervisor contacts the United States Department of Labor (DOL) for authorization to issue another Form CA-16; (2) the care being provided is for the same illness or injury as on the initial visit; and (3) the MTF has the capability to provide the care.

2.9.2.1.1. A Form CA-16 authorizes an injured employee to obtain a medical examination and/or treatment for up to 60 days. The Form CA-16 is used to authorize payment for medical care of injuries only and cannot be used for illnesses. The Form CA-16 is required for MTF care and prior to referring the patient outside of the MTF for a consult or special study.

2.9.2.2. If the patient is referred/transferred to a specialist, the worker's supervisor will complete the Form CA-16 to authorize payment to the specialist (again, only for the first 60 days following injury). **(T-1).** 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. **(T-1).** In an emergency, the supervisor prepares the form within 48 hours after treatment is rendered. If a Form CA-16 is created, a copy is scanned/uploaded into the individual's Air Force electronic health record. The MTF Patient Administration function does not provide

advice to employees or supervisors regarding form completion. Refer to the United States Department of Labor, Office of Worker's Compensation Programs.

2.9.3. Non-Deployment, non-work related illness/injury MTF Healthcare. Federal civilian employees may be provided limited MTF medical treatment at the discretion of the MTF commander or director for non-work related conditions on an outpatient basis for the purpose of preventing excessive loss of duty time, or when immediate occupational requirements dictate. Outpatient MTF medical care provided to federal civilian employees must be limited to urgent relief of minor illnesses (e.g., sunburn, insect bite/stings, etc.) during the duty period when care from a private medical provider would require a disproportionate amount of time lost from the job. **(T-1).** The MTF commander or director must limit treatment to what is needed to complete the work shift. **(T-3).** Surgical procedures, intravenous fluids and prolonged course of care should not be provided. Controlled substances must not be administered. **(T-1).** If simple outpatient medical care is approved by the MTF commander or director and care is provided, the MTF should not assume responsibility for continued treatment for any condition that could not be reasonably resolved during the initial episode of treatment.

2.9.4. Federal Civilian employees employed outside the United States. Federal civilian employees employed outside the United States who require treatment for conditions not covered by the Office of Workers' Compensation Program, who are not beneficiaries of any other federal agency listed in this chapter, and dependents of such employees may receive space available care in MTFs outside the United States. Charges will be collected locally in accordance with DoD 6010.15-M, *MTF Uniformed Business Office Manual*, from the individual at the interagency rate, except that no charge will be made for immunizations authorized by AR 40-562/BUMEDINST 6230.15B /AFI 48-110/CG COMDTINST M6230.4G, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases,*, or for occupational health services as authorized elsewhere in this chapter. **(T-0).**

2.9.5. Non-Appropriated Fund employees. Non-Appropriated Fund employees are generally not considered to be United States Government employees for most benefits, but may receive occupational health services such as pre-employment, pre-deployment, and annual physicals at MTFs in accordance with Health Affairs Policy 08-002. Such services are billed to the Non-Appropriated Fund instrumentality.

2.9.6. Armed Forces Retirement Home. Title 24 United States Code Section 411 establishes the Armed Forces Retirement Home as an independent federal organization. The purpose of the Armed Forces Retirement Home is to provide residences and related services to certain retired and former members of the Armed Forces in two locations—the Washington, D.C. area and the Gulfport, MS area. Title 24 United States Code Section 413 authorizes the DoD to provide secondary and tertiary hospital care, to the extent available, for both retiree and non-retiree residents that is not available at the Armed Forces Retirement Home itself. As such, Armed Forces Retirement Home residents do not require Secretarial Designation and are eligible for secondary and tertiary hospital care at those MTFs that have been identified by the DoD to provide these services (currently the Walter Reed National Military Medical Center and Keesler Air Force Base). Armed Forces Retirement Home leadership is responsible for transportation to and from these MTFs.

2.10. Family Members (Dependents) of Federal Civilian Employees. When available, MTFs will provide limited care to dependents who reside overseas under applicable laws and directives. **(T-0).** Reference AFI 36-3026_IPV1; 24 USC § 34; DoDI 6000.11, *Patient Movement;* DoDI 6025.23. When their civil service sponsor is stationed overseas, family members are eligible to receive space available healthcare and space available routine dental at MTFs at the Interagency Outpatient Rate or Interagency Rate. Family members of civilians stationed in the United States are not eligible for any routine healthcare or dental at MTFs.

2.11. Secretarial Designees. MTFs will administer medical and dental care to secretarial designees, when applicable, in accordance with DoDI 6025.23. **(T-0).**

2.12. Members of Uniformed Services Auxiliaries. MTFs will provide limited healthcare to senior adult and cadet members of the Uniformed Services Auxiliaries, who are injured while on official government business. **(T-0).**

2.13. Emergency Care. 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.

2.14. Contractors.

2.14.1. MTFs will provide care in accordance with contract terms and applicable laws and policies to support contractor deployments and occupational health requirements. **(T-0).** Elective care is not authorized, and in most instances, routine care is not authorized. Always check the contract for specific terms. Reference DoDI 3020.41, *Operational Contract Support.*

2.14.2. MTF Contractor Occupational Health. Exams, evaluations, and immunizations necessary to comply with MTF occupational health requirements are authorized at MTFs, except when the provision of these occupational health services are designated as a contractor responsibility under the terms of the contract.

2.15. Family Members (Dependents) of Contractors. Contractors may request approval from the overseas Major Command (MAJCOM) Commander for medical care for their family members beyond emergency care when specified requirements are met. Agreements reached under this paragraph are annotated in the annual report for Secretarial Designees. Elective care is not authorized. **(T-1).**

2.16. Expanded Medical Care for Caregivers. MTFs will inform individuals designated as caregivers for seriously ill/very seriously ill service members of their authorization for space-available inpatient/outpatient medical care at MTFs. **(T-0).** Reference 38 USC 1720G, *Assistance and support for caregivers*.

2.17. Volunteers. MTFs will treat DoD volunteers, who are not TRICARE eligible, as federal employees for volunteer-related injury or stabilization for illness. **(T-0).** Reference 10 USC § 1588, 5 USC § 8103, 5 USC § 8141 and DoDI 1100.21, *American Red Cross* (ARC)-DoD MOU. If a DoD 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, volunteers may be authorized outpatient and inpatient direct MTF healthcare for volunteer-related injury or illness for stabilization.

Section 2D—Other Services and Authorizations

2.18. Additional MTF Requirements.

2.18.1. Healthcare at Department of VA and Other Government Agencies. MTF commanders or directors may authorize active duty and other DoD beneficiaries to receive space available care at other federal agencies through resource sharing agreements. MTF commanders or directors may also authorize beneficiaries from other federal agencies to purchase care from MTFs when an appropriate agency official requests the services in writing from the MTF, and the request will not interfere with medical care for persons entitled to MTF care. Reference AFI 41-126, *Department of Defense/Veterans Affairs Health Care Resource Sharing Program*.

2.18.2. Dependency Determinations for Incapacitated Children. MTFs will process dependency determinations for incapacitated children to assist in applying for continued benefits for a child who becomes incapacitated before losing eligibility. **(T-1).** MTFs will provide a medical sufficiency statement and follow process and eligibility guidance in AFI 36-3026_IPV1. **(T-1).** Children enrolled in TRICARE Young Adult do not fall under the provisions of this paragraph.

2.18.2.1. The Defense Finance and Accounting Service-Indianapolis Center is the final approving authority for dependency determinations. The Military Personnel Section and Base Finance Office will review the DD Form 137-5, *Dependency Statement*, and other documentation to determine if the initial eligibility criteria warrant further processing and forwarding to Defense Finance and Accounting Service-Indianapolis Center.

2.18.2.2. A medical statement in narrative format from the attending physician, or primary care manager, including a medical sufficiency statement must be included in the dependency determination application package provided from the MTF. **(T-1).** The MTF commander or director is responsible for completing the Medical Sufficiency Statement; however, the MTF commander or director may delegate the responsibility to the Chief of the Medical Staff.

2.18.2.3. The patient and/or sponsor is responsible for obtaining and providing any supporting medical documentation required for the application package. The TRICARE Operations and Patient Administration Office will coordinate all requests for dependency determinations with the Chief of Medical Staff. **(T-3).** Final medical sufficiency review rests with the MTF commander or director, or Chief of Medical Staff if delegated. If the MTF commander or director has delegated endorsement authority to the MTF/Chief of Medical Staff, the application package does not need the MTF commander's or director's signature before it is forwarded to officials at the installation personnel/finance office.

2.18.2.4. 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 a MTF, a civilian provider may complete the medical sufficiency statement and submit it to the nearest Air Force MTF for endorsement.

2.18.2.5. In order to establish medical incapacity, the patient's illness must be substantial and truly disabling. **(T-1).** 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). **(T-1).** 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.

2.18.2.6. The civilian or MTF provider will include the following information in the medical sufficiency statement **(T-2)**:

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

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

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

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

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

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

2.18.2.6.7. Depending on the circumstances involved in the sufficiency review, the MTF commander or director/designee selects one of the four statements as described in attachment 15 of AFI 36-3026_IPV1.

2.18.2.7. The MTF completing the Medical Sufficiency Statement shall provide the sponsor with the completed request package; however, only an approved Medical Sufficiency Statement must be submitted to Defense Finance and Accounting Service. **(T-1).** The sponsor is responsible for coordinating with the appropriate finance and Military Personnel Section officials.

2.18.2.8. A copy of the Medical Sufficiency Statement and any other supporting medical documentation should be scanned/uploaded in the appropriate section of the patient's electronic health record.

2.18.2.9. The applicant may submit a request for reconsideration to the MTF commander or director if there is new or compelling information. The MTF can review, and if the commander determines a change from original recommendation to the Military Finance Office is warranted, will notify that office. **(T-2).** Defense Finance and Accounting Service-Indianapolis Center remains the ultimate decision authority for granting dependency status based on the Medical Sufficiency Statement and financial support (over 50%) from the sponsor.

2.18.3. TRICARE Extended Care Health Option. MTFs will administer the TRICARE Extended Care Health Option program in accordance with Title 32, Code of Federal Regulations, Part 199.5(g), *TRICARE Extended Health Care Options (ECHO)*, current edition and Title 32, Code of Federal Regulations, Part 199.7, *Claims Submission, Review, and Payment*, current edition **(T-0)**.

2.18.3.1. Extended Care Health Option Home Healthcare. Custodial care services, as defined in Title 32, Code of Federal Regulations, Part 199.2, *Definitions*, current edition may be provided to the extent such services are provided in conjunction with authorized TRICARE Extended Care Health Option home healthcare services, including the Extended Care Health Option Home Healthcare respite care benefit specified in this section. Authorized beneficiaries will receive all home healthcare services and no portion will be provided under the TRICARE Basic Program. **(T-0)**. Reference 32 CFR Part 199.4(e).

2.18.4. Elective Medical Care from Civilian Sources for AD Members. 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. All members assigned or attached to a sensitive duty program, e.g., the Personnel Reliability Program (PRP), Presidential Support Program (PSP), 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. **(T-1).** In addition, any service member seeking elective surgery must comply with AFI 44-102, *Medical Care Management.* **(T-1).**

2.18.4.1. Service members must arrange for the civilian medical facility to send a summary of treatment to the servicing MTF. **(T-1).** For additional information regarding elective civilian medical care for AD service members, refer to AFI 44-102 and AFI 36-3003, *Military Leave Program*.

2.18.5. Requirements for Organ Donation Requests. All AD members must follow the requirements in AFI 44-102 in order to serve as organ donors. **(T-1).**

2.18.6. Authorization for Physical Examinations Other than Flying.

2.18.6.1. Operational Health Assessments (Periodic Health Assessment, Mental Health Assessment, Deployment-Related Health Assessment). Operational Health Assessments are authorized in accordance with DoDI 6200.06, *Periodic Health Assessment (PHA) Program*; DoDI 6490.03; and DoDI 6490.12, *Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation*, and 10 US Code §1074. Scheduling is managed by the Operational Medicine Clinic or Force Health Management as determined by the MTF.

2.18.6.2. Civilian occupational health examinations are performed in accordance with 29 CFR §1910.

2.18.6.3. The MTF commander or director may authorize medical evaluations in the context of a public health emergency in accordance with DoDI 6200.03, *Public Health Emergency Management within DoD*; exposure to bloodborne pathogen in accordance with 29 CFR §1910.1030; and food safety in accordance with AFMAN 48-147, *Tri-Service Food Code*.

2.19. Primary Care Manager Assignments. MTFs shall provide enrollees with the opportunity to register personal preferences for Primary Care Managers from a list of choices as required by

DoDI 6000.14, *DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS).* **(T-0).** The MTF commander or director will also make a provider directory easily accessible to beneficiaries, which is inclusive of all MTF Primary Care Managers alongside the provider information required by DoDI 6000.14. **(T-0).**

2.19.1. MTFs shall not deny Primary Care Manager empanelment/enrollment to beneficiaries based on the sponsor's Service affiliation. **(T-0).** MTFs shall not deny patients the opportunity to initiate Primary Care Manager changes by phone or by web through the Beneficiary Web Enrollment application, or otherwise limit Primary Care Manager change requests to face-to-face transactions. **(T-1).**

2.19.2. MTFs shall only make credentialed and privileged Primary Care Managers available for empanelment. **(T-1).** Primary care managers loaded into DEERS and/or the Composite Health Care System (CHCS) shall be entered using the credentialed provider's name as listed in the MTFs provider directory, not team names or other names that are non-specific to a particular credentialed and privileged provider. **(T-1).** MTFs shall not enter primary care managers into DEERS or CHCS for short-term administrative purposes such as managing disenrollment, over-enrollment, or provider panel acuity/complexity. **(T-1).** MTFs may allow a recently departed primary care manager to remain in DEERS and/or CHCS temporarily until the departed primary care manager's panel can be transferred; however, one or more credentialed and privileged providers must be accountable for the panel until it is transferred. **(T-1).**

2.19.3. MTFs shall honor enrollee primary care manager preference requests subject to the primary care manager's availability, matching patient medical needs with the appropriate level of healthcare provider, and other operational requirements established by the MTF commander or director. **(T-3).** MTFs shall minimize primary care manager changes not requested by enrollees, and shall not disrupt established patient-provider relationships for the sole purpose of rebalancing provider panels; instead, provider panels should be balanced through new patient enrollments and patient attrition. **(T-3).**

2.19.4. MTFs shall not initiate a primary care manager change that transfers an enrollee from a MTF primary care manager to a network primary care manager unless the enrollee's medical needs exceed the MTFs capabilities. **(T-1).** MTFs planning any forced disempanelment of beneficiaries require pre-approval from the Air Force Medical Support Agency and must coordinate with the Defense Health Agency. **(T-1).** Poor patient behavior and/or non-compliance with medical care are insufficient grounds to involuntarily disengage an enrollee from a MTF primary care manager to a network primary care manager, except in rare circumstances where the patient's behavior is so abusive or belligerent that it significantly interferes with execution of the MTF's mission and threatens the safety and wellbeing of the other patients and/or MTF staff. In these cases, the MTF should seek advice from the local Staff Judge Advocate and regional Medical Legal Consultant. If legal authorities advise the patient's abusiveness or belligerency warrants disengagement of the patient from the MTF, and that the individual's entitlement to care doesn't prevent transferring their care to the network, the MTF shall coordinate a transfer of care to a network healthcare team to ensure continuity of care. **(T-3).** If there is an immediate danger to staff or patients, the healthcare team should contact security forces**.**

2.19.4.1. In written documentation, the MTF commander or director will describe the disruptive behavior, its effect, the investigative and determination process, and the probable consequences of disruptive behavior. MTF leadership will consult their servicing legal office early in all cases of disruptive beneficiary behavior.

2.19.4.2. When an active duty service member displays abusive or seriously disruptive behavior in the MTF, the following actions are recommended:

2.19.4.2.1. Obtain objective assessment and documentation of the abusive behavior by witnesses. Documentation should clearly demonstrate how the behavior threatens patient or staff safety.

2.19.4.2.2. Advise the active duty service member of paragraph 2.19.4.5, referencing the patient's responsibility to show respect and consideration to others, and the MTF's authority to respond to the abusive or disruptive behavior.

2.19.4.2.3. If the active duty service member's misconduct continues, ask the member's command authority to arrange security police escort when the member is seeking medical or dental care. Definitive administrative or punitive action is a military command issue.

2.19.4.3. When an active duty family member enrollee engages in disruptive behavior, the MTF commander or director may:

2.19.4.3.1. Arrange a discussion between a senior hospital leader and the beneficiary, with the sponsor present, to dissuade future disruptive behavior and describe potential consequences.

2.19.4.3.2. With the active duty family member's consent, empanel the family member to a network provider, ensuring that the TRICARE contractor is informed of the disruptive issue. **Note:** When an active duty family member is empaneled to the network, if network empanelment is unable to accommodate, the MTF must empanel the beneficiary to a MTF primary care manager unless the family member enrollee elects TRICARE Select.

2.19.4.3.3. Issue a warning letter, in accordance with written MTF policy, conveying the beneficiary's responsibility to uphold appropriate behavior including respect and consideration to other patients and staff in accordance with DoDI 6000.14.

2.19.4.3.4. Ask the installation commander, or designee, to bar the active duty family member from base under 18 USC § 1382. In some instances, an installation bar letter may permit an active duty family member limited access to base for medical care; in such cases, a military police escort may be required.

2.19.4.3.5. When the active duty family member's disruptive behavior amounts to criminal activity, in consultation with the base Staff Judge Advocate, seek to have the family member prosecuted.

2.19.4.4. When confronted with disruptive behavior by a retiree, a retiree's family member, or a TRICARE Plus enrollee, the MTF commander or director has the same options as with an active duty family member enrollee with a notable addition: the MTF commander or director may involuntarily transfer the individual's routine direct care and access to ancillary services to a site outside the MTF. In this case the MTF commander or

director will make efforts, in coordination with the TRICARE contractor, to find an accepting network primary care manager. The TRICARE contractor and network primary care manager must be made aware of past disruptive behavior. A coordinated handoff of care to the network healthcare team is necessary to avoid any appearance of patient abandonment. Should obtaining a network primary care manager prove impossible, self-managed health care using TRICARE Select is likely the beneficiary's only TRICARE option. For those TRICARE Plan and Medicare ineligible (a small minority of TRICARE Plus enrollees) with no other health insurance, finding an accepting primary care manager may be improbable; nonetheless if warranted, the MTF commander or director may transfer empanelment of a TRICARE Plus beneficiary without other insurance to a network provider for routine care and ancillary services.

2.19.4.5. Care providers must document patients' abusive behavior. Commanders must document actions taken to mitigate poor behavior. Transferring care to the network for routine care and ancillary services is not to be used in an arbitrary or capricious manner, such as for an argumentative patient or for patients not compliant with the treatment team recommendations. It must be a compelling situation where the welfare and safety of the patients or staff is seriously threatened. Additionally, if the patient has a history of, or is exhibiting actions that may be due to mental illness or neurological impairment, the MTF must manage these circumstances as a medical matter. MTF commanders and directors should also notify leadership at other multi-service markets for the potential of a seriously threatening patient who may seek care in their facilities.

2.19.5. MTFs with current capacity to provide primary care services to additional patients may reassign TRICARE Prime beneficiaries from network primary care managers to MTF primary care managers when beneficiaries live within a 30-minute drive time of the MTF.

2.19.5.1. When recapturing network Prime enrollees, MTF commanders or directors shall recapture AD family members first and retiree beneficiaries second. **(T-1).** An exception to this requirement are beneficiaries who require a primary care manager with a skillset unavailable at the MTF, or there are strong continuity of care reasons against changing the primary care manager.

2.19.5.2. Involuntary recapture campaigns must include communication with the beneficiaries, multi-service market, if applicable, local elected officials, public affairs officials, the TRICARE regional office, and the managed care support contracts. **(T-1).** See "Enrollments" on Air Force Medical Operations Agency (AFMOA) Health Benefits Knowledge Exchange (Kx) for best practices on conducting involuntary recapture campaigns. **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

2.20. Sexual Dysfunctions, Inadequacies, or Paraphilic Disorders Treatment. For benefit guidelines and instructions reference TRICARE Policy Manual 6010.60-M, Chapter 4, Section 16.1, *Intersex Surgery*.

2.20.1. Surgical procedures related to gender dysphoria may be provided within a MTF if there is a provider appropriately credentialed, trained, current and privileged to perform the procedure. Requests for surgery related to gender dysphoria for active duty must utilize the Supplemental Health Care Program waiver process, in accordance with current Defense Health Agency policy. **(T-1).** Patient travel may be authorized for patients who are referred to the Air

Force Medical Multi-Disciplinary Team at the Wilford Hall Ambulatory Surgical Center in San Antonio, TX for evaluation.

2.20.2. The patient must have appropriate endorsement from the Air Force Medical Multi-Disciplinary Team and their unit commander. **(T-1).** Appropriate rules for billing and duty status apply depending on the type of surgery being provided. Refer to AFI 44-102, for rules on elective care and cosmetic care.

Chapter 3

TRICARE OPERATIONS

Section 3A—Access to Care Guidance

3.1. Access to Care Standards.

3.1.1. Access to care for beneficiaries is a top priority for the MHS. All enrolled beneficiaries regardless of their location, must be afforded access to care according to the standards published in Health Affairs Policy 11-005. **(T-0).** See AFI 44-176, for additional information and DHA IPM 18-001, *Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs).*

Section 3B—Beneficiary Counseling and Assistance Coordinator

3.2. Beneficiary Counseling and Assistance Coordinator Position and Procedural Information.

3.2.1. Beneficiary Counseling and Assistance Coordinators are mandated at each MTF and TRICARE regional office. Beneficiary Counseling and Assistance Coordinators will execute roles and responsibilities in performance of their duties as stated in DoDI 6015.23. **(T-0).** Duties include:

3.2.1.1. Inputting beneficiary associated casework into the Assistance Reporting Tool.

3.2.1.2. Tracking, managing, referring categorizing, and documenting case workload in the Assistance Reporting Tool. Any cases that need referral to a DHA Program Office (to DHA or a TRICARE regional office) must be sent via the Assistance Reporting Tool. Assistance Reporting Tool credentials are requested by e-mailing **dha.ncr.comm.mbx.bcacdcao@mail.mil** .

3.2.2. In the event of system connectivity issues, MTF personnel are encouraged to create and utilize a temporary internal tracking mechanism. MTFs shall move information from their internal tracking tool to the Assistance Reporting Tool when the tool is once again operational. **(T-2).** For training, visit **https://mhs.health.mil/customerservicecommunity/**.

Section 3C—Debt Collection Assistance Officer

3.3. Debt Collection Assistance Officer Position and Procedural Information.

3.3.1. Debt Collection Assistance Officers are mandated at each MTF and TRICARE regional office. Debt Collection Assistance Officers will execute roles and responsibilities in performance of duties as stated in DoDI 6015.23. **(T-0).**

3.3.2. TRICARE Prime Remote members may contact DHA Great Lakes Debt Collection Assistance Officer Representative at 1-(888)-647-6676 for assistance with debt collection issues related to line-of-duty determinations; otherwise, members should work with the appropriate regional managed care support contractor first.

3.3.3. Beneficiary Counseling and Assistance Coordinator - Debt Collection Assistance Officer Directory. Debt Collection Assistance Officers should ensure that contact information is accurately reflected in the online public Beneficiary Counseling and Assistance Coordinator - Debt Collection Assistance Officer directory found on the TRICARE website at (**http://www.tricare.mil/bcacdcao/**). Changes and updates should be forwarded to the TRICARE regional office.

Section 3D—Service Change Requests

3.4. Changes in Clinical Services. DoDI 6015.23 provides that the Secretaries of the Military Departments and the Director, DHA, act on requests for changes in clinical services at MTFs as recommended by respective military command authorities. Headquarters Air Force (HAF) Mission Directive 1-48, The Air Force Surgeon General (AF/SG), states that the Secretary of the Air Force further delegated authority to AF/SG to implement policy, assign responsibilities, and prescribe procedures on provisions of care in the delivery of health care at MTFs pursuant to DoDI 6015.23. Per HAF Mission Directive 1-24, Assistant Secretary of the Air Force Manpower and Reserve Affairs (SAF/MR) retains Secretarial oversight responsibility for all aspects of the Air Force Active Duty, Reserve, and Auxiliary Component Affairs concerning health program benefits and entitlements, to include those authorities delegated directly to the AF/SG. Thus, all service change requests are coordinated with AF/SG, SAF/MR, and DHA before they are approved. **(T-1).** Congressional reporting is required in accordance with NDAA 2019, Section 711, in the interest of maintaining a positive relationship with members of the community and Congress, the Congressional and Public Affairs office (AF/SGL) should be included in the process to provide guidance.

3.4.1. MTFs will submit written request packages, already coordinated with their TRICARE regional offices and MAJCOM command surgeon to Air Force Medical Readiness Agency (AFMRA). AFMRA will then prepare requests and coordinate the package for AF/SG, SAF/MR, and DHA approval. **(T-0).**

3.4.1.1. Permanent changes in services that significantly affect the current annual volume of care provided to one or more categories of beneficiaries at a MTF for one or multiple specialty or ancillary service(s).

3.4.1.2. Changes that impact users in a way that may stimulate local public or congressional objections.

3.4.1.3. Temporary closures of services that are projected to last 90 days or more, or for an indefinite period.

3.4.1.4. Changes in enrollment that result in the recapture or disengagement of 400 or more beneficiaries in a single disengagement or recapture campaign or over a 1 year period.

3.4.2. 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 AFMOA/SGAT as soon as possible of any projected changes in service, keeping in mind the various planning cycles involved in accommodating changes. The planning cycle is at least three fiscal years to facility modifications that involve major construction projects, at least two years for manpower and financial resources, and at least twelve months for personnel

assignments. The content and submission requirements for change in service requests may vary depending on impact and cause of the proposed change.

3.4.2.1. Change in service requests shall include information as outlined below and must arrive at AF/SG at least six months prior to the proposed effective date when the change involves significant downgrading or upgrading in level of services. **(T-2).** 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 assume their request will be approved.

3.4.2.2. 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, economic analyses for Military Construction Projects, and for situations described below. Abbreviated requests or notifications should be coordinated through respective MAJCOM command surgeons and AFMOA/SGAT, with information copies sent to TRICARE regional offices, and should arrive at AF/SG not later than 90 days prior to the effective date of the change.

3.4.2.3. 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 TRICARE regional office, command surgeon, AFMOA/SGAT, and prepare an abbreviated package as soon as possible but arriving at AF/SG 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.

3.4.2.4. Changes in services which are made under the following circumstances do not require prior notification to AF/SG and SAF/MR approval, but the MTF commander or director shall report the change in services to the chain of command **(T-1):**

3.4.2.4.1. A facility rendered structurally unsound by a natural disaster.

3.4.2.4.2. A change in a Status of Forces Agreement.

3.4.2.4.3. An initial response to an emergency deployment of healthcare personnel.

3.4.2.4.4. A change in local Force Protection Condition.

3.4.3. The service change request will include or address the following information:

3.4.3.1. Name and location of the facility.

3.4.3.2. Type of change in service and, if applicable, the Medical Expense and Performance Reporting System specialty area.

3.4.3.3. Proposed effective date of the change and/or the estimated duration of the change.

3.4.3.4. Reason or Justification for the change.

3.4.3.5. 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).

3.4.3.6. 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.

3.4.3.7. Impact on readiness capability, including how training needs will be affected and/or addressed to maintain technical and clinical skills and currency, knowledge, tasks required for wartime, enhancement of a fit force, and improvements in force protection.

3.4.3.8. 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 (DoD) Health Services Region, Air Force, MHS, etc., including implementation of new and innovative ways for promoting better health among beneficiaries and the military community.

3.4.3.9. Estimated workload changes, by Medical Expense and Performance Reporting System specialty area and beneficiary category, including number of non-availability statements, 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 AD dependents, and non-AD dependents.

3.4.3.10. Projected savings (or cost) to the government, by fiscal year, resulting from the change, including operations and maintenance funds (including civilian staffing), military personnel, impact from estimated bid price adjustment, and military construction project costs, if applicable. Submit all calculations used in determining final estimates, including methodology for both full and marginal cost estimates.

3.4.3.11. 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.

3.4.3.12. Analysis of alternative ways to provide care to the beneficiaries affected, including projected increases in cost of each alternative, as well as, the financial implications to the beneficiary. The analysis should include the following:

3.4.3.12.1. 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.

3.4.3.12.2. Cost: Government as well as beneficiary savings or costs.

3.4.3.12.3. Access: Availability of civilian or other federal healthcare providers in the community, including options such as DoD/VA sharing, contracting, TRICARE resource sharing or resource support agreements.

3.4.3.12.4. 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.

3.4.3.12.5. Projected impact in terms of increased reliance on TRICARE managed care support contractor and/or Medicare providers in the service area in which the MTF is located.

3.4.3.12.6. Long-term costs and 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.

3.4.3.12.7. Explanation of how the change is/is not consistent with the MTF strategic resourcing portfolio, business plan, goals and objectives, etc.

3.4.3.13. TRICARE regional office input may include, but is not limited to:

3.4.3.13.1. How the change is/is not consistent with the TRICARE regional office business plan/strategic plan/regional health plan, including comparison with any regional alternatives or initiatives, particularly those involving the TRICARE managed care support contractor.

3.4.3.13.2. Impact on the managed care support contractor, and if available, the net negative or positive cost impact to the region and/or another DoD MTF, particularly in overlapping prime service areas, also known as the areas in which the contractor offers enrollment in TRICARE Prime.

3.4.3.13.3. Coordination/feedback from other Services, MAJCOM command surgeons, and/or AFMOA/SGAT, particularly if impacting graduate medical education programs.

3.4.3.13.4. Recommendations, including estimated timeline.

3.4.3.14. MAJCOM command surgeons must submit evidence of coordination with MAJCOM commanders (through MAJCOM Plans and Programs offices) and shall include in their evaluation **(T-1)**:

3.4.3.14.1. 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.

3.4.3.14.2. Validation of military personnel disposition (e.g., if Military Personnel savings are expected and, if applicable, how MAJCOM command surgeon or Air Force Medical Operations Agency, Manpower Division (AFMOA/SGAP) proposes to redistribute resources in accordance with projected limits to downsizing force in accordance with Air Force Medical Service (AFMS) rightsizing efforts, Base Realignment and Closure plans, and other factors).

3.4.3.14.3. Explanation of how the change is/is not consistent with the MAJCOM command surgeon's business plan, strategic plan, or strategic resourcing portfolio.

Section 3E—Referral Management Program

3.5. Referral Management Program.

3.5.1. Guidance, Policy, and information regarding referral management business rules can be found in AFI 44-176. Best practices regarding referral management can be found on the Air Force Medical Service (AFMS) Kx Referral Management website at **https://kx.health.mil/kj/kx8/AccesstoCare/Pages/referral_management.aspx**.

3.5.2. Support to Geographically Separated Units (GSU)/TRICARE Prime Remote enrollees.

3.5.2.1. GSU members are usually enrolled to a civilian Primary Care Manager through the TRICARE Prime Remote program. When a TRICARE Prime Remote member's medical condition warrants referral to a MTF for either administrative reasons (e.g., Line of Duty, Medical Evaluation Board, 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 and authorization process rests with the referring MTF. Under no circumstance will the Specified Authorization Staff at the DHA-Great Lakes be asked to place an authorization into the system for a TRICARE Prime Remote enrolled patient when a MTF initiated the referral. If the patient's clinical needs exceed the MTF's oversight capability, care management is returned to the civilian Primary Care Manager through the Specified Authorization Staff. These same guidelines apply to RC personnel referred to MTFs for medical and administrative support.

Section 3F—Medical In/Out-Processing Program

3.6. Medical In/Out-Processing Program Overview.

3.6.1. Air Force medical units will apprise all beneficiaries, in particular military service members, 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 resolve problems related to medical care and access during this transitional period, should they arise. **(T-0).** Reference DoDI 6000.14.

3.6.2. Medical In/Out-Processing Program Roles and Responsibilities.

3.6.2.1. MTF Commanders or Directors. MTF commanders or directors 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. **(T-0).** Reference DoDI 6000.14.

3.6.2.2. MTF commanders or directors will ensure MTF staff members are familiar with the typical subject issues and topics discussed at in/out-processing briefings. **(T-0).** Reference DoDI 6000.14.

3.6.2.3. MTF 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. Although not specifically limited as an exclusive TRICARE Operations and Patient Administration obligation, generally, MTF staff

members assigned to this office are responsible for providing the healthcare benefits portion of each in/out-processing function.

3.7. In-processing Requirements. At a minimum, the following information or procedures must be accomplished with, or briefed to, each sponsor during the in-processing briefing(s) by TRICARE Operations and Patient Administration staff **(T-3):**

3.7.1. TRICARE enrollment options.

3.7.2. Choosing a new primary care manager and how to contact their provider or clinical support team.

3.7.3. How to change their primary care manager at the new location.

3.7.4. Benefits of enrolling in TRICARE Prime, including Point of Service option for Non AD Beneficiaries.

3.7.5. Local polices on TRICARE Prime enrollment and CHCS registration data collection.

3.7.6. How to enroll family members in the dental plan.

3.7.7. MTF/TRICARE regional office/managed care support contractor/TRICARE service points of contact.

3.7.8. Exceptional Family Member Program with a brief description of each of the MTF partner programs that support Exceptional Family Member Program, Exceptional Family Member Program-Medical and the Family Member Relocation Clearance processes.

3.7.9. Family Advocacy Program.

3.7.10. How to schedule/cancel appointments.

3.7.11. Out of area care procedures.

3.7.12. Services available at local MTF (s).

3.7.13. How to access services not available at the local MTF and after hours.

3.7.14. Services available in the network.

3.7.15. AFMS health record custody policy.

3.7.16. Mental Health.

3.7.17. Local prescription services.

3.7.18. Personnel Reliability Assurance Program, Presidential Support Program, and other sensitive duties program overview.

3.7.19. How to file a civilian medical or dental claim.

3.7.20. Contact information for the Beneficiary Counseling and Assistance Coordinator/Debt Collection Assistance Officer.

3.7.21. Co-payments and cost-share/deductible fees for care outside the direct care system.

3.7.22. How to enroll or update TRICARE Online member profiles to gaining MTF.

3.7.23. Collect any medical or dental records that the member may be carrying and return to the MTF records room or primary care management team for which the beneficiary is or will be assigned.

3.7.24. Procedures for participation in Secure Messaging, if available at the MTF.

3.8. 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) by TRICARE Operations and Patient Administration staff **(T-3):**

3.8.1. Ensure all laboratory and radiology results are scanned/uploaded into in the individual's electronic health record within 0-5 business days prior to final out-processing appointment for Permanent Change of Station (PCS), separation or retirement.

3.8.1.1. For individuals enrolled in Exceptional Family Member Program, or navigating the Family Member Relocation Program/Process, scan/upload medical documents into their electronic health record prior to the screening as required in accordance with AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP).*

3.8.2. The DoD and AFMS health records custody and control policies.

3.8.3. The process required to file medical claims for care while in transit.

3.8.4. The process required to schedule appointments in transit.

3.8.5. The process required to locate a MTF at the next assignment.

3.8.6. The process required to obtain prescription services while in transit.

3.8.7. The process required to transfer/change the Primary Care Manager to a new MTF.

3.8.8. The process required to avoid point of service charges while in transit.

3.8.9. How to obtain emergency care and the patient responsibilities for contacting her/his Primary Care Manager.

3.9. Limited Capability Out-processing. If a member is going to a medical facility without access to Composite Healthcare System (CHCS)/Health Artifact and Image Management Solution (HAIMS)/Armed Forces Health Longitudinal Technology Application (AHLTA) or MHS GENESIS (such as geographically separated or remote locations, recruiters not near an installation, or Navy members going to a ship, etc.), all electronic health records will be printed and filed in the hard copy record. **(T-0)**. If the member is moving to a traditional location/MTF, only medical records created prior to the implementation of AHLTA (2006) need to be filed in the hard copy record and forwarded to the gaining MTF.

3.10. Retirement/Separation Out-processing. For AD Service Treatment Record disposition (member is separating or retiring), the Air Force Service Treatment Record Processing Center needs all hardcopy encounters/records not captured in AHLTA. AHLTA Web Print will capture all electronic medical records documented. For Non-Service Treatment Record disposition, all records are required to be printed in hard copy format, as the records are legally required to be complete upon arrival at the National Processing Records Center. **(T-0).** Reference DoDI 6040.45, *DoD Health Record Life Cycle Management.*

Section 3G—External Resource Sharing Agreements

3.11. External Resource Sharing Agreement.

3.11.1. MTF Responsibilities. MTFs seeking External Resource Sharing Agreements must coordinate approval with AFMOA/SGAT prior to signing. **(T-1).**

3.11.2. MTFs will request a child Defense Medical Information System Identifier through the Air Force Defense Medical Information System ID coordinator (AF/SGY) for new External Resource Sharing Agreements within 30 days of being signed by the TRICARE regional office director. **(T-1).**

3.11.2.1. MTFs will capture all workload performed under an External Resource Sharing Agreement in the Defense Medical Information System ID set up for the External Resource Sharing Agreement. **(T-1).**

3.11.2.2. Workload performed under a Training Affiliation Agreement shall not be captured under an External Resource Sharing Agreement Defense Medical Information System ID. **(T-1).**

3.11.3. MTFs will forward a copy of new External Resource Sharing Agreements to AFMOA/SGAT within 30 days of being signed by the TRICARE regional office director. **(T-2).**

3.11.4. MTFs will internally review all External Resource Sharing Agreements annually, and document the review locally. **(T-1).** External Resource Sharing Agreements that are no longer active and not anticipated to become active before the next annual review should be terminated in accordance with the External Resource Sharing Agreement's terms.

3.11.5. MTF commanders or directors may only authorize Medicare dual eligible beneficiaries to be seen under an External Resource Sharing Agreements for care that is a non-covered benefit under Medicare. **(T-1)**.

Chapter 4

PATIENT ADMINISTRATION FUNCTIONS

Section 4A—Legal Aspects of Protected Health Information (PHI), Release of Information and Patient Self-Determination

4.1. Laws and Provisions Affecting Disclosure of Medical Information.

4.1.1. Privacy Act of 1974.

4.1.1.1. Medical records are maintained within a system of records protected by the Privacy Act. 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 Air Force Instruction (AFI) 33-332, *Air Force Privacy and Civil Liberties Program*), and the HIPAA Privacy Rule (as implemented by AFPD 41-2, *Medical Support* and AFI 41-200).

4.1.1.2. Refer to AFI 41-200 for guidance on the collection, safeguarding, use, maintenance, access, amendment and disclosure of information. AFI 41-200 explains policy on access, disclosure, time periods, denial authority, judicial sanctions, and accounting of disclosures.

4.1.1.3. 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 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, the DD Form 2005 is not required.

4.1.2. Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Records. Alcohol and Drug Abuse Prevention Program information collected and maintained as part of Alcohol and Drug Abuse Prevention treatment or aftercare services are maintained in accordance with AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program* and AFI 44-172, *Mental Health*. These records are protected from public disclosure and afforded special protections.

4.1.3. Freedom of Information Act (FOIA). See DoDM 5400.07, AFMAN 33-302, *Freedom of Information Act Program*, for specific guidance and procedures related to the release of information from health records.

4.1.4. HIPAA. Reference AFI 41-200.

4.1.5. Provisions Regarding the Release of Mental Health Information. Mental health information will be protected in accordance with AFI 33-332, AFI 41-200, and AFI 44-172.

4.1.6. State Laws, Reporting Guidance for Medical Personnel, and Medical Documentation of Restricted Reports.

4.1.6.1. Providers must consult the supporting medical law consultant or Staff Judge Advocate's office when child abuse, domestic abuse, or sexual assault is evident or suspected. **(T-3)**.

4.1.6.2. Some states require medical providers to report to civilian authorities in situations addressed by DoD policies, to include those DoD polices that provide for restricted reporting. Mandatory reporting laws are typically based on the law of the state where care is currently being provided and not to the state of licensure. However, while working in a MTF, follow DoD and AF policy. If federal law, DoD policy or AF policy require reporting, follow the provisions in such policy. However, any state law or regulation that would require a healthcare professional to disclose the PII or PHI of an adult victim or alleged perpetrator of sexual assault to law enforcement shall not apply, except when reporting is necessary to prevent or mitigate a serious and imminent threat to health and safety.

4.1.6.3. Medical record documentation under restricted reporting must contain sufficient information to allow for continuity of care and coding. **(T-0)**. The following wording in bold type should be placed at the top of each notation in the approved electronic health record or paper record: **"Restricted from disclosure unless and until determined to be releasable by the MTF commander, director or designee. Do not release without specific patient authorization or as specifically authorized by federal law or DoD or Air Force policy."** Electronic records in AHLTA may also be secured via a "break the glass," (means for a person who does not have access privileges to certain information to gain access when necessary) or disclosure function with the above notation in place. This function highlights those entries as restricted and prompts additional review prior to release or electronic review.

4.2. Health Record Custody and Control.

4.2.1. Each MTF will develop policies and procedures for defining levels of access to health information by individuals or groups of individuals (work centers) based on requirements in fulfillment of assigned duties. **(T-1).** At a minimum, guidance should address:

4.2.1.1. Standardized matrix for evaluating specific roles against access requirements.

4.2.1.2. Review and approval process, to include approval authority.

4.2.1.3. Procedures for periodically validating access requirements.

4.2.1.4. Termination of access procedures.

4.2.2. Maintaining custody and control of original medical, dental, and inpatient records.

4.2.2.1. Take necessary precautions to avoid compromise of medical information during the movement of the record inside and outside the MTF.

4.2.2.2. 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.

4.2.2.3. MTF commander or director approval and authorization is required for unescorted access to medical records areas. Written authorization memorandum must be posted near each entrance for ready reference. **(T-2).** If commander's written authorization is required prior to electronic access identification card swipe activation, individuals with

identification 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.

4.2.3. Establish written procedures to ensure highly sensitive records and sensitive medical information are safeguarded. This includes safeguarding x-rays and fetal monitoring strips. Examples of highly sensitive records include mental health records, substance abuse treatment records, records related to sexual assault, records related to child or adult abuse, and records relevant to a claim or suit against the United States. To protect the sensitive nature of the information, medical records staff will only release Mental Health notes that are marked sensitive with approval from the treating mental health provider. Consults marked sensitive will be released only after review and approval by the primary care provider (or mental health provider, if the patient is being treated in mental health).

4.2.4. 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 and label it for periodic updates. Records will be sequestered under the following conditions **(T-2):**

4.2.4.1. When an administrative claim or lawsuit against the government has been filed.

4.2.4.2. When a patient has tried to tamper, alter or illegally remove a record from the facility.

4.2.4.3. When a request is received from an attorney under circumstances indicating claim or law suit is being considered.

4.2.4.4. When an Inspector General (IG), congressional inquiry or investigation has been initiated and when the medical record is relevant to an IG or congressional inquiry/ investigation.

4.2.4.5. When the record becomes relevant to an Air Force Office of Special Investigation (AFOSI) or Security Forces investigation. Annotate sequestered record form with the AFOSI/Security Forces agent's name and case number for annual review process. Contact the medical law consultant, Staff Judge Advocate or HIPAA privacy officer for questions.

4.2.4.5.1. Investigative agencies, such as AFSOI 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. **(T-2).** Account for the disclosure per AFI 41-200 if no request for temporary suspension is made or upon the expiration of a temporary suspension.

4.2.4.5.2. Address military Service Member agents of the AFOSI as "Special Agent," followed by their last name. Refrain from addressing a military Service Member agent using the member's military rank.

4.2.4.6. For purposes of safety or mishap investigations, the MTF Release of Information Office will facilitate the appropriate collection of medical and/or dental records for disclosure to a Safety Investigation Board and/or Accident Investigation Board.

4.2.4.6.1. Original hard copy paper medical and dental records of persons of interest in a safety investigation must be immediately sealed in envelopes and sequestered in a secure location. **(T-3).** Provide a copy of the original records to the Interim Safety Board Medical Officer as soon as one is appointed.

4.2.4.6.2. Records that are only maintained in electronic format will need to be printed or downloaded as encrypted electronic files (CD-ROM, USB drive, etc.), if the investigating medical officer(s) will not have access to the electronic record systems (AHLTA, CHCS, HAIMS, or other approved electronic health record). **(T-2).** Seal these in a separate envelope and also provide to the Safety Investigation Board.

4.2.4.6.3. During the investigation, the Safety Investigation Board or Accident Investigation Board may periodically request an update of any medical records/documents related to the investigation and continuing care.

4.2.4.6.4. At the conclusion of the Safety Investigation Board and/or Accident Investigation Board, all medical and dental records, including any electronic copies, will be returned to the MTF Release of Information Office and handled in accordance with Air Force document retention and destruction requirements.

4.2.4.7. It is the MTF commander's or director's responsibility (with advice from the Quality Services Manager, medical law consultant, or Staff Judge Advocate) to establish local operating instructions regarding sequestered medical records safekeeping policy and procedure. At a minimum, the records will be kept in a separate, locked location, with limited staff and patient access. If the patient is actively being treated 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 module.

4.2.4.8. 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, which details where the record is located, 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.

4.2.4.9. 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. Maintain the copy until the claim or litigation is resolved and the base legal office or Air Force Legal Operations Agency, Claims and Tort Litigation Division (AFLOA/JACC) concurs.

4.3. General Guidelines on Releasing Medical Information.

4.3.1. Original medical documents or records are not released to any non-federal government agency, except in compliance with a valid court order or as otherwise required by law. Always consult the medical law consultant or Staff Judge Advocate prior to releasing medical information under these circumstances.

4.3.1.1. Documentation received via fax can be scanned into Health Artifact and Image Management Solution (HAIMS) or other approved patient electronic health record.

4.3.1.2. The use of a fax machine to transmit provider's orders is permissible. To verify their authenticity, the provider should sign the orders prior to transmission. Reference AFI 44-102, for additional information. If the orders were not signed, do not carry them out until the ordering provider verifies them. **(T-1).** Unless otherwise required by applicable law or regulation, the faxed copy does not require countersignature.

4.3.1.3. Documentation transmitted on thermal paper will fade over time. If a fax machine uses thermal paper, make a photocopy of the document and scan/upload into HAIMS or approved electronic health record. Destroy the thermal paper document and photocopy after scanning/uploading.

4.3.2. Health records may contain information from non-military sources. A patient can be referred to a non-military source for ancillary, diagnostic care, and/or treatment. Documentation from the non-military source that supports the diagnosis and treatment will be scanned/uploaded into HAIMS or approved electronic health 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.

4.3.3. Special Handling of Medical Records.

4.3.3.1. 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 AFMAN 41-210, Chapter 4." 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* in the outpatient record.

4.3.3.2. Radiographs, Radiographic Images or Film (also known as X-Ray). Generally, only the provider's paper document radiographic interpretation or analysis report is provided to the requestor. The cost of producing this paper report is usually free, unless repeated requests for the same document are submitted. Copies of actual radiographs, sometimes referred to as, radiographic film, x-ray film or x-ray images, may be provided upon specific request via hard copy or CD/DVD.

4.3.3.3. All provider social security numbers must be redacted from the health record before issuing a copy. **(T-0)**. 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 the member's own health records. Original medical records shall remain intact and unaltered. The original provider's social security

number must never be deleted from the original health record. **(T-0).** Other social security numbers should be redacted when warranted.

4.3.3.4. All sponsor social security numbers must be redacted from the health record before issuing a copy, unless the copy request is made by the actual sponsor for their own record. **(T-0)**. 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 social security number must never be deleted from the original health record. **(T-0)**. Other Social security numbers should be redacted when warranted.

4.3.3.5. Prior to the release of information, the health record should be reviewed to ensure that information pertaining to other individuals is not contained in the record.

4.3.3.5.1. Erroneously filed documents should be removed in accordance with paragraph 5.3.

4.3.3.5.2. Information pertaining to other individuals (e.g., other family members, Edinburgh Postnatal Depression Scale in infant record) should be considered for redaction. Consult the servicing legal office.

4.3.3.6. If a MTF provides health records electronically (e.g., scanned copy in lieu of paper), the MTF must use standardized nomenclature when naming the file. **(T-3).** 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.

4.3.3.7. Scan 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 into HAIMS, Section III of the electronic health record repository or approved electronic health record for permanent safekeeping.

4.3.3.8. Fees for copying. The MTF is permitted to charge a reasonable, cost-based fee for responding to requests for copies of health records, as outlined in AFI 41-200.

4.3.3.8.1. If the patient requests a copy of the medical record and the copy request is complete, provide the patient with copies at no charge.

4.3.3.8.2. Upon local approval of the MTF commander or director, the Release of Information Office may charge beneficiaries or their agents/representatives, for excessive and repeated personal requests for the same document 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.

4.3.3.8.2.1. If the individual requests a copy of the PHI or agrees to a summary or explanation of such information, the covered entity may impose a reasonable, cost-based fee, provided that the fee includes only the cost of:

4.3.3.8.2.1.1. Labor for the PHI requested by the individual, whether in paper

or electronic form;

4.3.3.8.2.1.2. Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and

4.3.3.8.2.1.3. Preparing an explanation or summary of the PHI, if agreed to by the individual.

4.3.3.8.3. 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.

4.3.3.8.3.1. 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 office by check or money order payable to the Treasurer of the United States.

4.3.3.8.4. Send payment to the Medical Service Account office with the completed copy of the transmittal letter if correct payment is received with the request. If the requested information cannot be obtained on the day the request is received, complete only the required items and send the form and payment to the Medical Service Account office before the ordinary close of business each day.

4.3.3.8.5. If prepayment is not made, use a locally developed form to identify and request 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 RMO. When answering requests for information on injury cases that appear to involve medical affirmative claims action, create a fourth copy of the form and send it to the medical law consultant or Staff Judge Advocate.

4.4. Patient Requests for Copies of Medical Records and Restrictions. This section outlines the patient's right to request copies of their PHI, including copies produced from paper-based and electronic-based medical records, and their right to request restrictions on uses or disclosures of their PHI IAW AFI 41-200. Note that a patient may also be a member of the MTF workforce, as Active Duty (AD), Reservist, civilian, or contractor. MTF workforce members should not be accessing health records systems to obtain copies of their own medical records. MTF workforce members should request copies of medical records in the same manner as any other patient as outlined in paragraph 4.4.5.

4.4.1. 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 AFI 41-200 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. Consult with the medical law consultant or Staff Judge Advocate prior to denying an individual access to their own medical records.

4.4.1.1. 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 the patient 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 health determinations.

4.4.2. 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. Per HIPAA and AFI 41-200, process copy requests within 30 days of receipt of the DD Form 2870, *Authorization for Disclosure of Medical or Dental Information*, or other written request. If, however, the requested medical record copies cannot be provided within 30 days, contact the requestor in writing and inform them of the delay and when the records will be available. Copy requests not completed by the 30th calendar day will be elevated to the squadron commander for immediate explanation and resolution. **(T-3).**

4.4.2.1. 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.

4.4.2.2. 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. 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 records, 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. If a patient has not obtained the necessary documents for the referral visit for an external MTF patient appointment, 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. **(T-3).** 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.

4.4.4. 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 the member's Service Treatment Record to meet expedited Force Management related separation or discharge installation out-processing requirements, the MTF Release of Information office will immediately prioritize the request above all other non-urgent, routine requests. The service member is required to complete the

necessary record copy request, DD Form 2870, for submission to the MTF Release of Information office.

4.4.5. Non-Urgent, Routine Copy Requests. Refer the patient to the appropriate Release of Information office. Release of Information personnel will inform the patient of the average MTF wait-time for non-urgent requests and should use DD Form 2870.

4.4.5.1. The timeline for such request are established in paragraph 4.4.2. 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 Social Security Numbers. The staff assigned to the Release of Information 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.

4.4.5.2. The patient can elect to receive their records by unencrypted/unsecured e-mail or to another individual designated by the patient. Documentation of patient permission to send and receive medical information via electronic communication should be maintained in the medical records or tracked internally in a Release of Information tracking binder/spreadsheet for future requests. Reference AFI 41-200, paragraph 7.6, for a description of requirements.

4.4.6. General rules and individual state laws specify when a power of attorney is required. Refer any questions about power of attorney to the medical law consultant or Staff Judge Advocate.

4.4.7. Amendments to Erroneous Information. A patient has a right to request an amendment to their medical record. The amendment must be granted if it is determined that the information contained in the record created by the MHS is inaccurate or incomplete. **(T-0).** Refer to the MTF's HIPAA Privacy Officer or the Air Force Medical Operations Agency (AFMOA) Health Information Compliance Team Kx website for information on this process (**https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**).

4.4.7.1. The MTF commander or director will appoint in writing the MTF HIPAA privacy officer as the primary point of contact for all matters related to erroneously entered information in AHLTA. **(T-3).**

4.4.7.1.1. The appointment letter can include language that the MTF HIPAA privacy officer is the commander's designee for purposes of signing the "Request for AHLTA Legal Correction of Erroneous Data or Erroneous Personal Health Information" memorandum (MTF Commander's or Director's Memorandum). This letter is required for each AHLTA amendment submission.

4.4.7.2. The MTF HIPAA privacy officer will ensure that policies and procedures are developed at the local level (e.g., Medical Group Instruction) to address patient requests for amendment of PHI. **(T-1).**

4.4.7.3. In the event that erroneous information in an AHLTA record is discovered by someone other than the patient (e.g., provider, Release of Information personnel), the same process for correction as referenced in paragraph 4.4.7 should be followed.

4.4.7.3.1. The MTF HIPAA privacy officer will act on any correction/amendment to the record as soon as practicable, but no later than 30 business days after receiving it in accordance with AFI 33-332. **(T-1).** If the MTF is unable to act on the amendment within 30 days, the time may be extended for no more than an additional 30 days. This may occur if the Medical Group (MDG) provides the patient with a written statement of the reason for delay, and the date by which the amendment request will be completed in accordance with AFI 41-200. **(T-1).**

4.5. Patient Rights (Reference DoDI 6000. 14). MTF staff must inform patients of their rights, according to state law, to make decisions regarding their medical care. **(T-0)**. 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 a 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. Signed advance directives shall become a part of the patient's medical record. **(T-1).**

4.5.1. Each MTF will establish and maintain written policies and procedures to implement patients' rights to make decisions concerning their medical care. **(T-0).** Ensure compliance with state law (whether statutory or as recognized by the courts of the state) respecting advance directives.

4.5.2. Each MTF will 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. **(T-0).**

4.5.3. Document whether or not each patient has an advance directive. This information will 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 cases. **(T-1). Note:** Utilize the DD Form 2766 and/or DD Form 2882, *Pediatric and Adolescent Preventive and Chronic Flowsheet* or Tri-Service Workflow Pediatric Alternate Input Method forms for all new records. See Chapter 5, Health Records Management, paragraph 5.12.5 for more information regarding this DD form 2766. Provider teams are encouraged to ensure comprehensive notes are placed within AHLTA or Essentris (system for inpatient medical care) to document whether or not each patient has an advance directive, however, the hard copy documentation shall remain available. **(T-1).**

4.5.4. Each MTF will provide for education of the staff and community on issues concerning advance directives. **(T-1).**

4.5.5. Check with the servicing medical law consultant or installation Staff Judge Advocate for further guidelines.

4.5.6. Military advance medical directives 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.

Section 4B—Patient Registration & Multiple Healthcare Eligibility

4.6. Patient Registration.

4.6.1. The Patient Administration function has direct oversight of MTF patient registration. MTF clinical work centers such as the pharmacy, laboratory, and the emergency department, require the ability to register patients in CHCS or approved electronic health record. To ensure a balanced and responsible registration process throughout the MTF, Patient Administration personnel, in partnership with CHCS 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. **(T-3).** Requests for registration training should be coordinated and approved by the flight superintendent or flight commander before submitting requests to the MTF TRICARE OPERATIONS AND PATIENT ADMINISTRATION Flight Commander, Patient Administration Officer, Systems or Information Management Flight Commander.

4.6.2. Patient Administration officials will conduct periodic reviews of all MTF personnel with registration capabilities to verify training requirements have been met and registration capabilities remain valid. **(T-3).** Reference MHS, *Patient Identity Management and Registration Guidance*.

4.6.3. 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 **(T-3)**:

4.6.3.1. Patient's name (first, last & middle initial).

4.6.3.2. Sponsor's name.

4.6.3.3. Sponsor's Social security number.

4.6.3.4. Patient's relationship code/family member prefix e.g., 20-Sponsor, 30-Spouse, 01-Child, etc.

4.6.3.5. Patient Category (e.g., F11/Active United States Air Force, A11/Active United States Army, F31/Retired United States Air Force Service Member, M12/Marine Corps RC Member, N41/AD Navy Family Member, etc.).

4.6.3.6. Patient's date of birth.

4.6.3.7. Patient's gender.

4.6.3.8. Patient's Service (sponsor only).

4.6.3.9. Patient's station/unit (sponsor only).

4.6.3.10. Patient's rank (sponsor only).

4.6.3.11. Patient's address & telephone contact information.

4.6.3.12. Organ donor declaration (yes, no, or unknown).

4.6.3.13. Third party health insurance information.

4.6.3.14. MTF where medical record(s) are normally maintained.

4.6.3.15. Marital status (if full registration is used).

4.6.3.16. Race (if full registration is used).

4.6.3.17. Ethnicity (if full registration is used).

4.6.3.18. Individual Patient Social Security Number or available/authorized unique "Person or Personal Identifier" (DoD Identification Number, Foreign Identification Number, Temporary Identification Number, Individual Taxpayer Identification Number, etc.).

4.6.3.18.1. Person or Personal Identifiers. Most patients treated in the AFMS possess a Social Security Number. Individual identification using a person's unique Social Security Number provides a solid framework from which to build a personal eligibility profile in Defense Enrollment Eligibility Reporting System (DEERS) and within the MTF.

4.6.3.18.2. Social Security Numbers 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 Social Security Number for various reasons. Frequently, alternative Person or Personal Identifiers are used to reduce the use of Social Security Numbers or identify patients as individuals who may not possess a Social Security Number. There are multiple alternative Person Identifiers issued, used, and/or created depending on the patient's particular situation. For more technical information on the use of personal identifiers refer to AFMOA Kx Patient Registration Training located at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

4.6.3.19. Command Security if applicable, e.g., Personnel Reliability Assurance Program/Presidential Support Program.

4.6.3.20. 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. **(T-2).**

4.6.3.21. Length of Service (years).

4.6.4. The MHS, when feasible, will limit the use and display of Social Security Numbers while migrating systems and business processes to use the DoD Identification Number. **(T-0)**. Reference DoDI 1000.30, *Reduction of Social Security Number (SSN) Use Within DoD*.

4.6.5. Registration Options. Please refer to the MHS, *Patient Identity Management and Registration Guidance* for current, accurate and complete information on all registration options. For best practices on registration see AFMOA Kx Patient Registration Training located at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

4.7. Patients with Multiple-Eligibility. Beneficiaries will only be registered one time on each CHCS host according to their highest level of eligibility. **(T-0)** See MHS, *Patient Identity Management and Registration Guidance,* for technical information.

4.7.1. The TRICARE Operations and Patient Administration and systems offices must ensure that all MTF staff members who possess registration capabilities are aware of the problems associated with multi-eligible patients and other current patient identity problems. **(T-1).**

4.7.1.1. 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. **(T-1).**

4.7.1.2. MTF TRICARE Operations and Patient Administration staff or system managers are authorized to merge erroneous duplicate records by merging the alias record with the surviving record using the Former Patient Name functionality within CHCS. An alias record indicates that a record is also known or more familiar under another specified record. A surviving record is the complete record remaining after the merge of duplicate records. AHLTA changes must be processed in accordance with current MHS merge/unmerge guidelines. **(T-1).** Reference Assistant Secretary of Defense for Health Affairs Memorandum, *Guidance for Requesting Correction of Erroneously Entered Information in the Armed Services Longitudinal Health Technology Application*.

4.7.1.3. Potential Duplicate Patient Report. Collectively, CHCS Administrators, Patient Administration, and Information Assurance officials will produce a monthly report identifying duplicate records to aggressively find, fix and prevent unnecessary duplicate patient registrations. **(T-1)**.

4.7.1.3.1. When duplicate patient records are detected in either CHCS or AHLTA, duplications shall be reported in the Patient Safety Reporting tool. Once the duplicate record is reported, it will be routed through the Patient Safety Reporting tool to the TRICARE Operations and Patient Administration flight for resolution by either merging the records or submitting a MHS Helpdesk Ticket. **(T-1).**

4.7.1.3.2. There are instances when patients may have multiple eligibilities or are eligible for care under more than one patient category. Refer to websites in paragraph 4.5.5 for a complete listing of the most common patient categories, the multiple eligibility that it presents and clear guidance on how to avoid duplicating patients. The patient category is not static and can be changed; however, it is not automatically updated when the beneficiary's status changes in DEERS. The patient category can and must be changed within CHCS by MTF personnel, when required. **(T-1).**

Section 4C—Patient Travel

4.8. Patient Accountability for Service Members Traveling to Attend Medical Appointments and/or Specialty Care.

4.8.1. All service members traveling to any MTF for outpatient medical follow-up or referred specialty medical care must have the following messages annotated on their travel orders. **(T-1).**

4.8.1.1. Section 11 shall indicate, "MTF – TRICARE Operations and Patient Administration Function and/or AMTU." **(T-1).**

4.8.1.2. Section 16 will indicate, "Service members must report to the MTF TRICARE Operations and Patient Administration Function to have their travel orders validated within 24-hours of arrival, or the next duty day if arriving on a weekend or holiday. **(T-1).** All service members traveling to attend official medical-related appointments or treatment are required to contact the MTF TRICARE Operations and Patient Administration function every two weeks to revalidate their orders." **(T-3).**

4.9. Patient Travel Benefit.

4.9.1. 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 Primary Care Manager, the TRICARE regional office administers the travel benefit. **Exceptions:** Travel orders and funding for AD service members must be the responsibility of the sponsor's respective Service branch. **(T-1).**

4.9.1.1. MTF commander or director will ensure processes are in place for the accountability of patients entered into the Patient Movement system, see paragraph 4.9.1.2. This includes using the designated Patient Movement Automated Information Systems when transport is in excess of 100 miles for ground transportation and for all air transportation provided under the Defense Travel System. Reference DoDI 6000.11.

4.9.1.2. All staff members utilizing Transportation Command (TRANSCOM) Regulating and Command & Control Evacuation System (TRAC^{2}ES) will complete a basics user course and submit a certificate of completion to obtain a TRANSCOM TRAC^{2}ES account. Training can be requested at **transcom.scott.tcsg.mbx.gpmic-global-training@mail.mil**. **(T-1).** Reference DoDI 6000.11.

4.9.1.2.1. TRANSCOM Regulating and Command & Control Evacuation System (TRAC^{2}ES) BASICS training can be accomplished three ways:

4.9.1.2.1.1. In residence classroom training at USTRANSCOM Command Surgeon's Office; 4.9.1.2.1.2. Online through Joint Knowledge Online (JKO) web based training; or

4.9.1.2.1.2.1. In-house with a TRAC^{2}ES Trainer that has completed the in-residence course at the USTRANSCOM Command Surgeon's Office.

4.9.1.2.2. In-residence class schedules are available by contacting the TRAC^{2}ES training coordinator via email at **transcom.scott.tcsg.mbx.gpmic-global-training@mail.mil**.

4.9.1.2.3. Funding is the responsibility of the member's unit. Reference DoDI 6000.11.

4.9.2. TRICARE Prime Travel Benefit. When MTF TRICARE Prime enrollees (family members or military retirees) are referred by their Primary Care Manager for medically necessary, non-emergency specialty care to a location greater than 100 miles from the referring primary care manager's office, the patient must be reimbursed for reasonable travel expenses in accordance with the Joint Travel Regulations available at available at **https://www.dfas.mil/militarymembers/travelpay/regulations.html**. **(T-0).** Travel expenses are charged to the MTF.

4.9.2.1. 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 Primary Care Manager for follow-on specialty care, services and supplies, for that particular disability, to a location greater than 100 miles from the primary care provider's office, the patient must be reimbursed for reasonable travel expenses in accordance with the Joint Travel Regulation. **(T-0). Note:** This also applies to subsequent specialty referrals authorized by a primary care provider. This benefit is not available overseas.

4.9.2.2. GSU Members. The supporting MTF commander or director has direct control of patient travel funding for GSU members. When it is unclear who the supporting MTF commander or director is, the responsibility will default to the nearest Air Force MTF commander or director to the member's permanent duty station, unless MAJCOM policy designates an alternative MTF to provide patient travel support. **(T-2).**

4.9.3. Non-Medical Attendant Travel. Non-medical attendants are appointed by medical authority. Local area travel/transportation expense coverage is authorized when serving as a non-medical attendant 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 area will be reimbursed travel/transportation expenses in accordance with the Joint Travel Regulation. **(T-0).**

4.9.3.1. Non-Concurrent Non-Medical Attendant Travel. Non-concurrent non-medical attendant 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.

4.9.4. 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 AD service member who is seriously ill, seriously injured, or when death is imminent, is treated as an employee in a Temporary Duty (TDY) status.

4.9.5. Travel for Families of Inpatient Service Members who are Very Seriously Ill/Seriously Ill, or Hostile Not Seriously Injured. Travel for family members of inpatient service members who are Very Seriously Ill/Seriously Ill or Hostile Not Seriously Injured is governed by the Emergency Family Member Travel Program (AFI 36-3002, *Casualty Services*, paragraph 2.25). Emergency Family Member Travel Program is not funded by the MTF. Emergency Family Member Travel Program is centrally funded by the Air Force, and managed by Air Force Personnel Center, Casualty Affairs Division (AFPC/DPFC).

4.9.6. Medical Referrals within the Local Permanent Duty Station Area. Travel by personally owned conveyance to obtain medical care within the local permanent duty station 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 or to obtain a medical diagnosis 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 Joint Travel Regulation). **(T-0). Note:** "Ordered" in this context is defined as an order/command that could result in disciplinary action if not obeyed (e.g., commander-directed or required by regulation).

4.9.6.1. Medical Referral Travel at the Member's Expense. Travel to medical appointments within the permanent duty station other than as described in the above paragraph is generally not reimbursable.

4.9.6.2. Service members traveling on official travel orders outside the permanent duty station may be authorized travel and transportation allowances in accordance with the Joint Travel Regulation. Travel must be authorized by the proper medical authority. **(T-0).**

4.9.7. Medical Referral Travel for Government Employees Overseas and Their Family Members. When local medical facilities (military or civilian) at a foreign Outside Continental United States (CONUS) area are not able to accommodate an employee's dependent's needs,

transportation to another location may be authorized for appropriate medical or dental care. Healthcare related travel expenses for an employee or eligible dependent are funded by the employee's unit. Travel and transportation expenses and/or reimbursement are authorized in accordance with the Joint Travel Regulation.

4.9.8. Convalescent Leave Transportation for Illness/Injury. 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 USC § 310. The convalescent travel will be funded by the fund cite on the member's deployment travel orders. **(T-1).** TDY orders are prepared by the member's unit. Additional trips, if deemed necessary by the attending physician, may be authorized through the Secretarial Process. The Secretarial Process is an action by the Per Diem Travel and Transportation Allowance Committee (PDTATAC) Principal member or a subordinate level specified by the Principal. The Secretarial Process is in administrative and procedural issuances issued under the JTR Introduction (Service or DoD Agency Regulation Review Process).

4.9.9. Travel and Per Diem Allowance. Service members traveling to a medical facility to obtain an examination or when traveling to Lackland Air Force Base, TX to attend a formal Physical Evaluation Board, receive travel and per diem (including meals and lodging) allowance (10 USC § 1210 and Joint Travel Regulation). The service member is authorized an escort to the place of examination when the member is not physically or mentally able to travel without assistance.

4.9.9.1. Approximately 20-30 days prior to the reporting date, Air Force Personnel Center, Disability Division (AFPC/DPFD) will send travel orders to the service member. The orders will indicate the exact date, time and place to report and includes the authority for payment of travel costs. **(T-1)**.

4.9.9.2. 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. **(T-3).** The endorsement also serves to verify the service member was released following the examination.

4.9.9.3. If the service member received an examination as an outpatient, the destination MTF must indicate whether the service member occupied government quarters during the stay. **(T-3).** The examining or destination facility must ensure the service member has an endorsed order to submit the claim for reimbursement. **(T-3).** 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. **(T-3).** Refer to the Joint Travel Regulation for further travel entitlement information.

4.10. Transferring Patients Through the Aeromedical Evacuation System. See AFI 48-307V1, *En Route Care and Aeromedical Evacuation Medical Operations*, AFPD 10-29, *Worldwide Aeromedical Evacuation Operation*s.

Section 4D—Quarters Administration

4.11. Quarters Status.

4.11.1. Quarters is a full duty excuse provided to AD 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.

4.11.2. The provider or support staff will notify the member's unit commander or commander's designee regarding the patient's quarters status. The Aerospace Services Information Management System (ASIMS) Quarters-Airman Medical Notification Module is the required mechanism for quarters notifications. **(T-1).** Refer to AFI 41-200, paragraph 3.7.1, 4.3.11.1.1, and 5.1.1.1.2.1 for additional guidance.

4.11.2.1. Disclose only the minimum information necessary.

4.11.2.2. ASIMS automatically accounts for the disclosures at the time it is accessed by the commander or designee.

4.11.2.3. In the event that ASIMS is not available or the member is from another Service:

4.11.2.3.1. Command authority notification must be documented on DD Form 689, *Individual Sick Slip*, or a locally created form. **(T-3).** See examples located in patient administration misc. document folder on the AFMOA Health Benefits Kx page at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

4.11.2.3.2. Forward a copy of the quarters notification or DD Form 689 to the member's unit commander or designee to receive quarters information. Provide a second copy of the DD Form 689 to the member to provide to the member's supervisor.

4.11.2.3.3. If it is necessary to accomplish quarters notification outside of the ASIMS mechanism, disclosures must be accounted for in the PHI Management Tool or AFMS approved centralized disclosure accounting tool. **(T-2).** Reference AFI 41-200.

4.11.3. Develop local procedures for program management, including, but not limited to **(T-3):**

4.11.3.1. Notifying Public Health for communicable disease tracking, in the event that ASIMS is not available or the member is from another Service.

4.11.3.2. Extending quarters past the initial rest period.

4.11.3.2.1. Establishing time limits on 24, 48, & 72-hour quarters. For example, when an individual is placed on 24-hour quarters, the period expires the next day at the start of patient's regular work shift not 24-hours from the time the patient was placed on quarters.

4.11.3.2.2. Equally, for 48 hours, the period extends to the start of work on the second day and for 72 hours, it extends to the start of work on the third day, not to exceed 24, 48, or 72 hours respectively. Unless instructed otherwise, clinic personnel will inform the patient to report for duty in accordance with the guidelines above.

4.11.4. 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. **(T-3).**

Section 4E—Line of Duty Program Administration

4.12. Line of Duty Determinations.

4.12.1. Authority: AFI 36-2910. AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*.

4.12.2. According to AFI 36-2910, a Line of Duty 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 sustains an illness, injury or disease prior to service, while absent without authority, or due to the member's own misconduct is not eligible for certain government benefits.

4.12.3. Following the start of a Line of Duty determination, initial direct care and/or TRICARE network healthcare may not be denied to any AD service member or RC service member.

4.12.4. Following the completion of a Line of Duty determination:

4.12.4.1. Direct care and/or TRICARE network healthcare may not be denied to any AD service member for a Line of Duty determination of Not in Line of Duty is found or identified.

4.12.4.2. Continued direct care and/or TRICARE network healthcare entitlements of RC service member may be impacted by Line of Duty determinations.

4.12.5. The Line of Duty determination process is an AF/A1, Manpower, Personnel and Services, program. The AFMS is not the office of primary responsibility. However, the Line of Duty determination process is initiated with a medical officer's review of the member's illness, injury, disease, or death. The Line of Duty determination process must be accomplished in accordance with AFI 36-2910. **(T-1).** Refer to AFI 36-2910 for information regarding when to initiate a Line of Duty determination.

4.12.6. The service member's personnel status and branch of Service usually dictates what type of Line of Duty form should be used when initiating a Line of Duty determination case.

4.12.6.1. For AD service members and members of the ARC, MTF providers must use the AF Form 348, *Line of Duty Determination* or AF Form 348-R, *Line of Duty Determination for Restricted Report of Sexual Assault*, for restricted reports. **(T-1).**

4.12.6.2. For service members assigned to other Service branches (i.e., United States Army, Navy, Marines), Air Force MTF providers should use the specific Service Line of Duty form or the DD Form 261, *Report of Investigation Line of Duty and Misconduct Status* when initiating a Line of Duty determination case.

4.12.6.3. An illness, injury, disease or death sustained by member in a duty status is presumed to be In the Line of Duty. The presumption can be rebutted when evidence shows the member was not in the Line of Duty. A Line of Duty determination case must be initiated, whether a member is hospitalized or not, for certain illnesses and injuries. **(T-2).** Refer to AFI 36-2910, paragraph 1.6 for definitive information regarding when to initiate a Line of Duty determination for AD service members and RC service members.

4.12.7. For AD service members, 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:

4.12.7.1. None of the mandatory circumstantial factors or Line of Duty determination/case initiation triggers identified by AFI 36-2910 are present.

4.12.7.2. The injury or illness is minor and meets the criteria provided under the Administrative Line of Duty Determination allowances of AFI 36-2910.

4.12.8. If an injured RC service member is taken to a non-MTF for care, the medical officers assigned to the MTF, Reserve Medical Unit (RMU) or Guard Medical Unit (GMU) who provided the initial treatment or had first contact with the RC service member should initiate the Line of Duty determination process.

4.12.9. The medical officer initiating the AF Form 348 will complete blocks 1-11 of the AF Form 348, sign, stamp or type printed name and title, and date the form. **(T-3).** The provider will then contact the appropriate MTF or RC Line of Duty patient administration representative to initiate the administrative coordination process. **(T-3).** The Line of Duty 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. **(T-2).** The Line of Duty administrative representative will fill in the "TO, THRU, and FROM" blocks at the top of the form. **(T-3).**

4.12.10. In cases where the healthcare provider has determined a Line of Duty 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. **(T-3).** Again, the initiating provider completes the appropriate blocks on the AF Form 348, signs the form and coordinates with the appropriate MTF or RC Line of Duty representative. The Line of Duty representative will forward the package to the service member's Military Personnel Section. **(T-1).**

4.12.11. The MTF or RC Line of Duty Medical Focal Point representative shall be appointed in writing by the MTF or RC commander. **(T-3).** The Line of Duty Medical Focal Point representative is responsible for **(T-3):**

4.12.11.1. Educating MTF or RC staff on medical responsibilities for the Line of Duty process.

4.12.11.2. Processing of all LOD paperwork within the MTF quickly and accurately.

4.12.11.3. Routing Line of Duties to the appropriate Military Personnel Section special actions unit or RC personnel processing office in accordance with AFI 36-2910.

4.12.11.4. Ensuring Line of Duties are initiated for local unit attached Individual Mobilization Augmentee and Participating Individual Ready Reserves reservists.

4.12.11.5. Identifying cases requiring Line of Duty and determinations for AD and RC service members.

4.12.11.6. Ensuring the appropriate medical officer signs the AF Form 348 before distributing the AF Form 348 as follows:

4.12.11.6.1. Original: Forward the original and all supporting medical summaries and supporting documentation to the member's servicing Military Personnel Section Special Actions Office.

4.12.11.6.2. Copy: Scan/upload one copy into the member's approved electronic health record.

4.12.11.6.3. Copy: File one copy in the Line of Duty - Medical Focal Point Office.

4.12.12. Line of Duty Requirements for Members of the Reserve Component. Reference DoDI 1241.01, AFI 36-2910 and AFI 36-3212.

4.12.12.1. Government sponsored (Direct Care or TRICARE) healthcare is not authorized at government expense beyond the period of Inactive Duty Training 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.

4.12.12.2. The LOD process should be initiated as soon as possible. If the LOD determination process cannot be initiated by the point of first contact, the process will be initiated by the RC service member's servicing MTF, RMU or GMU. **(T-1).** The LOD determination process must be accomplished in accordance with AFI 36-2910. **(T-1).**

4.12.12.3. Any RC service member seeking government sponsored healthcare must produce at least a partially completed AF Form 348 (1st side completed and signed by the provider initiating the Line of Duty determination process). **(T-1).** The partially completed Line of Duty determination form may be used as healthcare eligibility verification source when the service member seeks government sponsored healthcare without possessing current AD status orders or when a DEERS healthcare eligibility check indicates no current coverage.

4.12.12.4. If a Line of Duty 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.

4.12.12.5. If the final determination is "Not in Line of Duty," medical care at government expense ends. Document the notification of the Line of Duty 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 until transfer to a civilian medical facility.

4.12.12.6. If the final Line of Duty determination is "In Line of Duty," document the notification and advise the patient that care continues at government expense until service member is found fit and returned to duty or separated by the Disability Evaluation System for the documented medical condition.

4.12.12.7. "Interim" Line of Duty Determination for Healthcare: An informal or formal Line of Duty investigation, still ongoing, and where a final Line of Duty determination has not yet been determined. An Interim Line of Duty determination for healthcare is comprised of the completed medical portion (front part) of the AF Form 348 (with a provider signature). The form should contain a description of the service member's illness,

injury or disease, and date of occurrence. In accordance with AFI 36-2910, the military officer's signature does not constitute a completed Line of Duty determination. The Interim Line of Duty determination for healthcare is used to provide eligibility for direct or TRICARE network healthcare when DEERS indicates a RC service member may not be eligible for medical or dental benefits. In other words, the completed first side of the AF Form 348 (including a provider signature) may be used to verify a RC service member's entitlement to medical care at government expense when not on AD orders.

4.12.12.8. If the MTF initiates the AF Form 348, the form must be submitted to the reservist's Air Force Reserve (AFR) unit or to the RC responsible for uploading the information into the Electronic Case Tracking. **(T-1).** The RC will initiate the AF Form 348 through the RC Electronic Case Tracking. **(T-1).**

4.12.12.9. For Individual Mobilization Augmentee and Participating Individual Ready Reserves Service Members: The MTF should initiate an AF Form 348 (1st side with provider signature) and routed in accordance with AFI 36-2910. Notification of ARC Surgeon General's Office of initiated Line of Duties for Individual Mobilization Augmentee and Participating Individual Ready Reserves Service Members is not necessary.

4.12.12.10. Air National Guard (ANG) Service Members: The medical officers who first provide treatment or the medical officers stationed nearest to the non-Air Force medical facility that first provides treatment, in cooperation with the MTF or GMU patient administration or Line of Duty representative, should initiate the AF Form 348.

4.12.12.11. If the MTF initiates the AF Form 348, the form must be submitted to the ANG service member's unit or to the GMU responsible for completing Part I. **(T-1)**.

Section 4F—Air Force Secretarial Designee Program Administration

4.13. Authority. Reference DoDI 6025.23. 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. **(T-0).** The Secretary of Defense and/or the Secretaries of the Army, Navy, and Air Force may designate individuals not otherwise entitled, for DoD healthcare (medical and dental) in MTFs. The Secretarial Designee Program only authorizes care within MTFs. Under HQ Air Force Mission Directive 1-6, *Administrative Assistant to the Secretary of The Air Force*, the Secretary of the Air Force has delegated authority to approve medical designee status to the Administrative Assistant to the Secretary 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 AFMAN or waived by the Office of the Under Secretary of Defense for Personnel and Readiness or the Secretaries of the Military Departments as the approving authorities. **(T-0).** The level of benefit and reimbursement rate is determined by the Military Services, using Military Services-specific criteria.

4.13.1. Reciprocity Among Military Departments and the Defense Health Agency (DHA). Air Force MTFs will provide treatment to Secretarial Designees from other Military services and the DHA, subject to the capabilities of the MTF professional staff, availability of space and facilities, and any other limitations imposed by the approving authority. **(T-0).** Each

Secretarial Designee agreement must identify the specific MTF in which medical care is requested, requiring close coordination among service program managers. **(T-0).**

4.13.2. Each approved Secretary of the Air Force Designee must obtain a signed letter from the SAF/AA establishing eligibility for care. **(T-0). Exception:** When a MTF commander or director authorizes care for newborns of dependent daughters. 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. **(T-2).**

4.13.3. Authorization does not entitle a Designee to utilize TRICARE benefits/entitlements. Approved Designees receive space-available care at the MTF commander's or director's determination, in accordance with Health Affairs Policy 11-005. 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. **(T-2).** Designated MTF personnel may contact AFMOA/SGAT for assistance.

4.13.4. The SAF/AA normally authorizes care for no more than two years. However, extensions for continuity of care are limited as detailed in paragraph 4.14.4., below. 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. **(T-1).** It will not be the process in which to offer an individual debt relief.

4.13.5. Individuals being considered for Secretarial Designee status (not currently eligible for care) shall not receive treatment at Air Force MTFs until Secretarial Designee status has been approved. **(T-2).** An exception to this requirement is Extracorporeal Membrane Oxygenation, or partial heart-lung bypass. In this situation, the MTF is required to initiate a verbal request via telephone communication through the Air Force Surgeon General's Medical Operations Center. **(T-2).**

4.13.6. MTF Secretarial Designee Program Managers should educate MTF professionals, medical support (outpatient and 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.

4.13.6.1. If Secretarial Designee status is identified as a potential option, clinicians and medical support staff should proactively submit a timely application. The staff may identify a potential designee through the normal course of treatment for a MHS beneficiary for whom healthcare benefits are soon to expire; in such case, staff should determine eligibility loss date and begin the application process. Staff may also identify a potential designee when that person is treated as an emergency patient.

4.13.6.2. MTF requests must be received by AFMOA/SGAT no later than 30 days prior to expiration of medical benefits. **(T-2).** 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.

4.13.6.3. Situations where patient healthcare eligibility has expired and Secretarial Designee approval has not been granted could potentially leave the patient without healthcare coverage; further, these situations could force the applicant to incur a financial burden, especially if the designee request is disapproved.

4.13.6.4. Application denials for healthcare already provided will automatically generate charges at the full reimbursement rate. Retroactive requests should be limited to absolutely unavoidable situations such as short-notice separations. The MTF must notify AFMOA/SGAT immediately of urgent cases. **(T-2).**

4.13.7. Each application shall include a DEERS and identification check to verify the status of the patient and sponsor. **(T-2).** The MTF law consultant or base Legal Office will review applications and include the review as part of the Secretarial Designee request. **(T-3).**

4.13.8. Typically, in emergency (life, limb, eyesight, or relief of undue suffering) cases that present at a MTF, healthcare personnel can provide necessary treatment to stabilize the individual without the need to pursue a Secretarial Designation. However, for longer-term care, there could be a need to pursue approval to treat via this Secretarial Designee process identified in this AFMAN.

4.14. U.S. 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 sample format in Attachment 2. When submitting applications, choose the most appropriate category for the request.

4.14.1. 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. **(T-2).** The application must 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 family member rate. Use this paragraph for teaching cases that fall outside paragraph 4.14.2.2 for Extracorporeal Membrane Oxygenation Program cases.

4.14.2. SAF/AA Delegated Approval Authority Programs.

4.14.2.1. Civilian Trauma Program. In certain instances and at certain locations, SAF/AA designates authority to the MTF commander or director to identify civilian trauma patients as Secretarial Designees under the parameters SAF/AA determines appropriate. Upon expiration of eligibility initially established through this delegated authority, additional or continued care requires a full Secretarial Designee application and approval by the SAF/AA. **(T-2).** If the additional or continued care is approved, the Designee will pay the Full Reimbursement Rate for healthcare provided under the Secretarial Designee program.

4.14.2.2. Extracorporeal Membrane Oxygenation Program (partial heart-lung bypass). If a patient requires Extracorporeal Membrane Oxygenation or partial heart-lung by-pass, the MTF will initiate the application with a verbal request through the Air Force Surgeon

General's Medical Operations Center to the SAF/AA. **(T-2).** All verbal requests to grant Secretarial Designee status for Extracorporeal Membrane Oxygenation treatment must include: patient demographics, citizenship of patient, pick up location, type of military transport (air/ground), diagnosis, justification for the mission, requested length of Secretarial Designee status, if follow-on inpatient care at a MTF is required and if patient has health insurance. **(T-2).** Transportation on civilian air or ground ambulances or treatment at a civilian medical facility is not authorized under the Secretarial Designee Program. To gain approval of all requests the Medical Operations Center will notify the appropriate point of contacts. The Medical Operations Center will coordinate with the AF/SG and the Air Force Deputy Surgeon General (AF/DSG) prior to engagement with SAF/AA. The Medical Operations Center will simultaneously notify Secretary of the Air Force International Affairs (SAF/IA) if the request involves a non-United States citizen or a foreign country. The MTF will submit the full and complete electronic application within 24 hours to AFMOA/SGAT. AFMOA will email the formal package directly to SAF/AA with a courtesy copy to the Medical Operations Center. **(T-2).**

4.14.2.3. Human Immunodeficiency Virus (HIV) Research Program.

4.14.3. 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). Care will under most circumstances be provided at the family member rate. **(T-0).**

4.14.4. 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. Care is limited to a period of six months, or in the case of pregnancy, until the completion of the pregnancy. For cases when the justification is continuity of care, the case must be medically supportable. **(T-0).** Include a statement on the medical impact if the Air Force were to deny the individual Designee status.

4.14.4.1. Obstetrics, Maternal, and Pediatric Care Sub-Category: The MTF commander or director or designated representative may approve Designee status for applicants identified below at the family member rate unless the Designee has other health insurance.

4.14.4.1.1. Newborns of eligible family member daughters.

4.14.4.1.2. Pregnant former AD members and their newborns.

4.14.4.1.3. Spouses of former AD and their newborns.

4.14.4.1.4. Family member dependent daughters who became pregnant prior to losing eligibility and their newborns.

4.14.4.1.5. Newborns of widows losing transitional survivor benefits.

4.14.4.2. In the case the Designee has other health insurance, the rate will be the Full Reimbursement Rate. MTF healthcare is generally limited to pre-partum obstetrical care, MTF newborn delivery, one post-partum check-up (for the mother), well baby outpatient visits for the infant and any necessary immunizations for the infant, all to be provided no later than six weeks following delivery.

4.14.5. Abused Family Members and 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 Defense Finance and Accounting Service. If all or some transitional benefits, discussed in AFI 36-3024, *Transitional Compensation for Abused Dependents*, 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 Secretarial Designee 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.

4.14.5.1. Notification or receipt of denial of transitional compensation benefits (from the installation Military Personnel Section or Finance Office) does not necessitate MTF obligation to automatically submit a Secretarial Designee application on behalf of the abused family member(s). The MTF is only required to submit an Air Force Secretarial Designee application to the SAF/AA (via AFMOA/SGAT intermediary), if requested in writing by one or more family members of the discharged service member. **(T-2).**

4.14.5.2. Confirmation of this action must be coordinated with the abused family member dependent(s) or legally authorized representative(s). **(T-0).** The MTF location responsible for assembling the Secretarial Designee package should include the standard application package documentation identified at Attachment 2 and, to include the application letter 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. See example at Attachment 2.

4.14.6. Foreign Military Sales Case. If the country has an open Foreign Military Sales 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 sent to another United States 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.

4.14.7. Special Foreign Nationals. The Secretary of the Air Force may authorize Air Force healthcare benefits to foreign nationals considered to be critically important to the interests of the United States The Secretary of the Air Force may use this authority for individual designations, on a case-by-case basis. Such a designation does not create a new category of beneficiaries.

4.14.7.1. Criteria for selection as a Secretary of the Air Force Designee for foreign nationals:

4.14.7.1.1. 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. **(T-0).**

4.14.7.1.2. Appropriate healthcare must not be available in the nominee's country or in a civilian healthcare facility in the United States. **(T-0).**

4.14.7.1.3. The nominee or his government must agree to assume responsibility for payment of DoD healthcare services (at the Full Reimbursement Rate) if the individual requested and the Air Force approved the cost of aeromedical evacuation. **(T-0).**

4.14.7.2. Designation procedures:

4.14.7.2.1. 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 United States' interests, the pertinent medical information, the billing address, individual or office, and a certification that the nominee meets the necessary criteria. **(T-0).**

4.14.7.2.2. Refer inquiries from foreign embassies in Washington, or other sources to the United States Chief of Mission in the country concerned.

4.14.7.2.3. The State Department reviews the request and refers it to the appropriate agency Secretary with a recommendation for approval.

4.14.7.2.4. The Request is submitted to the Secretary of the Air Force for review. If approved, the Secretary's office forwards it to the Office of the AF/SG 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.

4.15. Applying for Air Force Designee Status. When evaluating a Designee application, MTF commanders or directors 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 36-3026_IPV1, then the MTF commander or director should review and sign the application package recommending whether or not Designee status is warranted. The package is then forwarded to AFMOA/SGAT for processing. The MTF shall electronically submit (via e-mail encryption) a Secretarial Designee application to AFMOA/SGAT no later than 30 days prior to expiration of medical benefits or requested Designee start date. **(T-2).** The 30 day window allows enough coordination time to submit the Secretarial Designee application to the SAF/AA for review and approval consideration. See example of Designee application at Attachment 2.

4.15.1. Forward all United States Air Force 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 HQ using government Common Access Card digital signature and encryption protocols. **(T-0).** If unable to send an encrypted message, the package may be sent using Encryption Wizard/AMRDEC SAFE requirements in accordance with AFI 41-200, paragraph 7.8, or mailed using a commercial overnight express mail shipping company or First Class United States Postal Service overnight or express mail with return receipt or other package tracking option.

4.15.2. Each request is required to be coordinated with an AFMOA/SGAT representative. **(T-2).** AFMOA/SGAT will review and coordinate the request package for a legal review prior to submitting to the SAF/AA. AFMOA will submit all "retroactive" requests to the 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 a legal review. **(T-0).**

4.15.3. If the request pertains to a sponsor or member who is due to separate and/or be discharged from the Air Force, the request package must include a copy of the sponsor's or

member's separation orders and DD Form 214, *Certificate of Release or Discharge from Active Duty*, and the line of duty determination for RC service members, when applicable **(T-3).**

4.15.4. AFMOA/SGAT 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.

4.15.5. AFMOA will forward United States Air Force Secretarial Designee requests via e-mail to the SAF/AA.

4.15.6. The electronic Staff Summary Sheet must contain (at a minimum) purpose, background, discussion, options and recommendation. **(T-1).** The discussion must include a justification that specifies which of the criteria in paragraph 4.14 the request is based upon, and an explanation of how the request relates to those criteria. **(T-1).** The discussion must also include the eligibility duration being requested. **(T-1).**

4.15.7. The Secretarial Designee 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. **(T-1).**

4.15.8. 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. MTF will file a copy of the letter in the individual's outpatient medical record. **(T-3).**

4.15.9. Reporting. The annual Secretarial Designee Log will be forwarded annually (FY) to AFMOA/SGAT no later than 15 October. **(T-1).** Following report collection and quality review, officials at AFMOA/SGAT will then forward the reports to the SAF/AA no later than 30 October.

4.15.9.1. Overseas MAJCOM commander surgeons, MTF commanders and directors will report data on the individuals approved under SAF/AA delegated authority (locally approved). **(T-3).**

4.15.9.2. All reporting data is PHI and will be transmitted in accordance with appropriate safeguards. **(T-0).**

4.16. Certain Senior Officials of the United States Government. Certain senior officials within the Government, including the DoD and the Military Departments, have Secretary of Defense Designee status for medical care and dental care in military medical or dental treatment facilities.

4.16.1. The Secretary of the Air Force recognizes Secretary of Defense Designees in accordance with DoDI 6025.23, Enclosure 2. Family members are not included unless otherwise stated. See DoD 6025.23 for instructions on Health Care Eligibility Under the Secretarial Designee (SECDES) Program.

4.16.2. Applicable charges for Secretary of the Air Force Designees. The Secretary of the Air Force has authorized the individuals listed in DoDI 6025.23 Enclosure 2 to receive space-

available inpatient and outpatient health care services from United States Air Force MTFs on a reimbursable basis.

4.16.3. See AFI 48-307V1 for instructions on Aeromedical Evacuation operations.

4.17. Operating the Air Force Secretarial Designee Program Overseas. In accordance with HAF Mission Directive 1-6, *Administrative Assistant to the Secretary of the Air Force*, HAF Mission Directive 1-48, *The Air Force Surgeon General*, and DoDI 6065.23 *Health Care Eligibility Under the Secretarial Designee (SECDES) Program and Related Special Authorities*, the Command surgeons at HQ United States Air Force Europe Air Forces Africa (HQ USAFE-AFAFRICA) and HQ Pacific Air Forces (HQ PACAF) for their respective theater have the authority to designate individuals for care in overseas MTFs. This authority does not extend to authorizing transportation to the CONUS.

4.17.1. United States Citizens. The Air Force tries to keep the number of United States citizens who commanders can designate to an absolute minimum. Most United States citizens who fall under this paragraph are returning hostages and individuals involved in prisoner exchanges. There may be other occasions when designating United States citizens would be appropriate.

4.17.2. Foreign Nationals. Commanders who use the authority under this paragraph must issue guidelines on medical care for nationals of foreign nations. **(T-2).** These guidelines must identify the categories of persons, both military and civilian, who have authorization for medical care within the provisions of this paragraph. **(T-0).** Individuals, whom the commander designated under this paragraph, must contribute to the advancement of United States public interests. **(T-0).** 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.

4.18. Designee Status Used in Claims Against the United States. Designee status is not used in the claims process.

Section 4G—Exceptional Family Member Program

4.19. Exceptional Family Member Program (EFMP). MTFs will standardize the location of Exceptional Family Member Program enrollment and relocation clearance functions within Medical Management offices. **(T-1).** Refer to AFI 40-701, for additional information.

4.20. Family Member Relocation Clearance Coordinator (FMRCC). The individual responsible for ensuring administrative process requirements are met is the Family Member Relocation Clearance Coordinator. Refer to AFI 40-701, for additional information.

Section 4H—Admissions and Dispositions Program Administration

4.21. Responsibility for Admission Processing. Unless otherwise specified, Patient Administration is responsible for administrative needs required for the admission and disposition of patients.

4.22. Administrative Admission and Disposition Requirements. The Admissions and Dispositions Office will verify authorized eligibility for healthcare for 100% of inpatient admissions.

4.22.1. For all admissions, enter the patient's demographic and personal data via the FULL patient registration menu.

4.22.2. Notify the military patient's commander, first sergeant or other appropriately appointed commander's designee, of member's admission. All disclosures of PHI to commanders will be tracked in accordance with AFI 41-200. (T-0)

4.22.3. Determine at the time of admission if the patient will opt in or opt out of the Facility Directory and make appropriate documentation. See AFI 41-200, paragraph 4.2.1, for additional information.

4.22.4. 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.

4.23. Assuming Administrative Responsibility for Military Members Hospitalized in Non-Military Medical Facilities also known as Absent Sick Status.

4.23.1. The MTF commander or director 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 AD service member referred to, hospitalized, or admitted to a non-military medical facility. **(T-1).** AD service members admitted to non-military civilian medical facilities are referred to as being in an "Absent Sick" or ABS status (menu path in CHCS).

4.23.2. If necessary, the nearest Air Force MTF shall serve as an information conduit between the civilian or non-military medical facility, the service member's family, and the service member's chain of command. **(T-1).**

4.23.3. Each MTF TRICARE Operations and Patient Administration function or Admissions and Dispositions Office is responsible for identifying and tracking each known Air Force AD service member 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 relieve a 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. **(T-1).** 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 been identified as having primary administrative support responsibility.

4.23.4. Notwithstanding the provisions identified immediately above this paragraph, the nearest MTF will assume primary administrative support responsibility for all known Air Force

AD service members, 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.

4.23.5. All known Air Force Wounded Warriors will be identified, tracked, and supported by the nearest Air Force MTF. **(T-3).**

4.23.6. Any seriously ill or injured Air Force AD service members will be identified, tracked, and supported by the nearest Air Force MTF. **(T-3).**

4.23.7. All Air Force AD service members referred from the MTF, to a civilian or non-military medical facility will be monitored and tracked. **(T-3).**

4.23.8. Minimum Processes Required to Identify, Monitor, and Track Absent Sick Patients.

4.23.8.1. Tracking Requirements for Inpatient or Bedded MTFs:

4.23.8.1.1. At a minimum, the Admissions and Dispositions Office will use the CHCS automated computer system to support their identification, monitoring, and tracking, efforts of each known Absent Sick patient. **(T-3).**

4.23.8.1.2. Record the admission in the CHCS Patient Administration module using the Admissions, Discharges, and Transfer secondary menu and Admissions sub-menu.

4.23.8.1.3. 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 (menu path in CHCS) and enters the transfer date and time into CHCS. Maintain the same register number.

4.23.8.1.4. If the service member-patient remains in the civilian or non-military facility for the duration of inpatient treatment, the MTF Admissions and Dispositions Office will change the admission category type from ABI to ABS (Absent Sick). 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.

4.23.8.1.5. 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.

4.23.8.2. Tracking Requirements for Outpatient or Non-Bedded MTFs: 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, the office responsible for administrative support will scan/upload the documents into the patient's electronic health record.

4.23.9. The nearest MTF should recommend to the hospitalized AD service member that an information release authorization should be signed to allow the civilian or non-military medical facility to disclose treatment information to the supporting MTF.

4.23.10. Obtain full patient identification from the civilian or non-military medical facility and promptly notify the patient's unit commander by telephone with the patient's name and location.

4.23.11. When possible, obtain comprehensive medical information regarding the AD service member's condition. The civilian or non-military medical facility is financially reimbursed for the patient's care based on the Diagnosis Related Group, known as a patient classification system that standardizes prospective payment to hospitals. 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.

4.23.12. When no MTF has assumed administrative support responsibility, Air Force points of contact at DHA-Great Lakes should contact the MTF located nearest to the AD service member's location if DHA-Great Lakes received information from:

4.23.12.1. The admitting civilian or non-military medical facility

4.23.12.2. The TRICARE managed care support contractor or regional office

4.23.12.3. An AD service member's family member.

4.23.12.4. Other sources of information.

4.23.13. When hospitalized at a uniformed services treatment facility or VA hospital, the nearest MTF assumes administrative support responsibility. The responsible MTF will arrange for a transfer to a MTF when it is safe to transport the service member. **(T-2).**

4.23.14. If the service member is referred to a Uniformed Services Treatment Facility or VA hospital, the referral MTF maintains administrative support responsibility.

4.23.15. Unit commanders must notify the nearest Air Force MTF and the DHA-Great Lakes (1-888-647-6676) as soon as possible if one of the commander's unit members in the following categories is hospitalized in a civilian or non-military medical facility:

4.23.15.1. ARC service members (related to an In-Line-of-Duty occurrence or incident),

4.23.15.2. AD service members assigned to GSU,

4.23.15.3. TRICARE Prime Remote AD Service Member.

4.23.16. Admissions and Dispositions Office will notify the base occupational safety office and resource management office in accident cases using AF Form 1488, *Daily Log of Patients Treated for Injuries*. **(T-1).** Account for disclosure in accordance with AFI 41-200, paragraph 3.7.

4.24. Assuming Administrative Responsibility for AD U. S. Air Force Members Hospitalized in DoD Facilities.

4.24.1. The nearest Air Force MTF commander or director assumes administrative responsibility and Patient Administration staff ensures that the following procedures are carried out for Air Force personnel hospitalized in Army or Navy MTFs:

4.24.1.1. Facilitates necessary communication between members' unit commander, and officials at the Army or Navy MTF. All disclosures of PHI to commanders will be tracked in accordance with AFI 41-200. **(T-0).**

4.24.1.2. Keeps rosters and pertinent data on hospitalized Air Force patients and notifies the members' unit commander immediately upon notification.

4.24.1.3. Prepares AF Form 348, when applicable, in accordance with AFI 36-2910.

4.24.1.4. Notifies the base occupational safety officer in accident cases.

4.24.2. 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 paragraph 4.68 for Airman Medical Transition Unit assignments.

4.24.2.1. Prepares AF Form 1488 when applicable and forwards it to the base occupational safety office and Resource Management Flight.

4.24.2.2. Serves as the admitted member's local representative for all patient administration related matters.

4.24.3. See Section 4I, Casualty Reporting Program Administration, for Seriously Ill and/or death cases.

4.25. Admitting Infants Born Outside the MTF.

4.25.1. 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.

4.25.2. If the infant's birth and subsequent admission first occurred in a civilian hospital and the mother and baby are later transferred to a MTF, admit the infant in CHCS using the CIV-INITIAL ADM TO NON-U.S. MILITARY HOSP, MOVED TO MIL MTF (NON AD) admission/transfer code (Source of Admission Code 5) instead of a Direct, Newborn, or Liveborn admission.

4.25.3. 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.

4.26. Admitting Generals/Admirals (Flag Officers), Colonels, and Prominent Persons. All disclosures of PHI to Commanders will be tracked in accordance with AFI 41-200. **(T-0).**

4.26.1. Terms:

4.26.1.1. General/Admiral Officer (GO): Includes all AD, RC (of any Uniformed Service branch) and foreign general flag officers (0-7 and above).

4.26.1.2. Colonel: Applies only to AD Air Force colonels that are Seriously Ill /Very Seriously Ill, 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 AFMS colonel (Medical Corps (MC), Dental Corps (DC), Nurse Corps (NC), Medical Service Corps (MSC), and Biomedical

Sciences Corps (BSC)) who has been admitted as an inpatient under emergent circumstances.

4.26.1.3. Prominent Persons:

4.26.1.3.1. Senior Executive Service (SES) federal civilian officials, political officials or officers, high-ranking public officials, federal judges who are expected to be hospitalized for a non-scheduled, emergency hospital stay greater than 10 days. Notifications for persons in this category require the patient's authorization.

4.26.1.3.2. Current Chief Master Sergeant of the Air Force and any AD AFMS Chief Master Sergeant.

4.26.1.4. Admission and Extended Ambulatory Care: Admission to a 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).

4.26.1.5. Information Conduits: Command Posts, Operations Centers at the installation or MAJCOM level. AF/SGXO, Air Force Medical Operations Center can be reached at Defense Switched Network (DSN) 227-9075 or commercial (703) 697-9075.

4.26.2. Local and MAJCOM Notification Procedures when a General/Flag Officer, Colonel, or Prominent Person (fitting the description listed in the above paragraphs), is Admitted.

4.26.2.1. The Admissions and Dispositions Office (or similar Patient Administration location or office) will contact the MTF commander or director and provide sanitized information regarding the admission. **(T-1).**

4.26.2.2. The Admissions and Dispositions Office (or similar Patient Administration 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. **(T-2).**

4.26.2.3. The Admissions and Dispositions Office (or similar Patient Administration location or office) will contact their MAJCOM command surgeon or AFMOA Health Benefits Regional Branch. **(T-2).**

4.26.2.4. The MTF commander or director will notify the installation commander (via appropriate information conduits) and release only minimum necessary information. **(T-2).**

4.26.2.5. Notifications will be made as soon as possible, no later than 12 hours after admission or initial treatment. **(T-2).**

4.26.3. HQ USAF Notification Procedure when a General/Flag Officer, Colonel or Prominent Person is admitted or remains in the MTF.

4.26.3.1. Inpatient/bedded MTFs will contact the Pentagon AF/SG Military Operations Center by 0600 Eastern Time every duty day to include negative replies. **(T-1).**

4.26.3.2. Provide only sanitized information to the Medical Operations Center. Include telephone call back phone numbers so Medical Operations Center officials can obtain comprehensive medical information as needed.

4.26.3.2.1. In unusual circumstances, if the MTF commander or director 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.

4.26.4. HQ USAF/Medical Operations Center Responsibilities:

4.26.4.1. Medical Operations Center officials will create two word-processing (letter) documents from the information. **(T-1).**

4.26.4.1.1. The first document includes sanitized information only.

4.26.4.1.1.1. The sanitized information document is transmitted, in password protected or encrypted mode only, to the Chief, United States Air Force General Officer Matters Office (AFGOMO) via the Pentagon e-mail address.

4.26.4.1.1.2. AF/SG, AF/DSG or a representative will receive the information via live brief or in password protected or encrypted electronic format. AF/SG, AF/DSG or a representative will provide the information to Chief of Staff, United States Air Force (CSAF). **(T-1).**

4.26.4.1.1.3. If the document contains information regarding any colonel that has been admitted or treated and meets the criteria indicated in paragraph 4.25.1.2., the password protected or encrypted electronic transmission will be provided to the United States Air Force Colonel Matters Office Support Division. **(T-1).**

4.26.4.1.2. The second document will include comprehensive medical information and be provided only to AF/SG, AF/DSG or a representative. **(T-1).**

4.27. Reporting Aircraft Accident Admissions.

4.27.1. For specific instructions, see AFI 91-204, *Safety Investigation and Hazard Reporting*. The Medical Group, Chief Aerospace Medicine (MDG/SGP) makes initial notification to the command surgeon of the MAJCOM. The command surgeon of the MAJCOM that the aircraft is assigned notifies Air Force Medical Support Agency (AFMSA)/SG3P, DSN 761-7242 or DSN 761-7616, commercial 703-681-7616) of any admission resulting from an aircraft accident (regular Air Force, AFR, or ANG).

4.27.2. Provide the diagnosis, estimated period of hospitalization, and probable disposition of personnel.

4.27.3. During regular duty hours, notify AFMSA/SG3P (Aerospace Medicine) by telephone. After duty hours, notify AF/SG Duty Officer through the AFMOA, 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.

4.28. Managing Military Patients Expected To Be Hospitalized Over 90 Days.

4.28.1. MTF staff must notify the patient's servicing MTF and Military Personnel Section when a patient will be reassigned or hospitalized over 90 days. **(T-2).**

4.28.2. For patients hospitalized while traveling to a CONUS port for permanent change of station overseas, the staff at the admitting MTF must advise the local Traffic Management

Office and Military Personnel Section of the patient's hospitalization and the expected duration. **(T-2).**

4.28.3. The patient may be assigned or attached to the Airman Medical Transition Unit. See paragraph 4.67 in this AFMAN.

4.28.4. Under this section, all disclosures of PHI to commanders will be tracked in accordance with AFI 41-200. **(T-0).**

4.29. Deployed Military Members who are Aeromedically Evacuated from Contingency Operations to CONUS MTF.

4.29.1. Deployed Air Force service members (who are on Contingency, Exercise, Deployment (CED) orders) and are aeromedically evacuated to a CONUS MTF from a Contingency Area of Responsibility (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). **(T-1).** Medical TDY orders will not be prepared. **(T-1).** The member's per diem is covered by their CED orders.

4.29.2. CED orders will be extended, if necessary, until the member returns to their home station. **(T-2).**

4.29.3. Ambulance Transport for members on CED orders is funded by Defense Health Program Overseas Contingency Operations (OCO) Supplemental Funds.

4.29.4. Travel per diem expenses of Air Force members transported from a MTF to a Comprehensive Care Facility are covered by member's (CED) orders.

4.29.5. Travel and per diem expenses of Air Force members transported from a MTF to home station is covered by member's CED orders.

4.29.6. Travel and per diem expenses of Air Force members from home station MTF to a referral facility, refer to Section 4C, Patient Travel in this AFMAN.

4.30. Readmission of Patients.

4.30.1. 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.

4.31. Canceling Admissions. Annotate the admission work sheet with the reason for cancellation and gather all paperwork generated by the admission (e.g., History and Physical, progress notes, laboratory and x-ray reports, etc.) as one package. Scan/upload into the patient's electronic health record or mail the package to the MTF where the patient's outpatient medical record is normally maintained.

4.32. Inpatient Disposition Procedures.

4.32.1. Discharge to Duty (Military Patient) or Discharge (Non-military Patient).

4.32.1.1. 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.

4.32.1.2. Maintain the AF Form 577 in the Admissions and Dispositions Office for a period of three months and then destroy.

4.32.1.3. Remove any pertinent information from the suspense file and scan/upload in the patient's electronic health record.

4.32.2. Discharging Non-AD Patients Requiring Domiciliary or Custodial Care.

4.32.2.1. Discharge retirees eligible for care in VA facilities as follows:

4.32.2.1.1. Arrange for admission and transportation to a VA medical facility, if acceptable to the patient or legally authorized representative.

4.32.2.1.2. Release retirees declining assistance in getting into a VA facility to the legally authorized representative.

4.32.2.1.3. If the legally authorized representative 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, contact the servicing legal office for assistance.

4.32.2.1.4. 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 legally authorized representative.

4.32.2.1.5. Coordinate the patient's move, with proper escort, to the legally authorized representative or to the civilian authority accepting custody. Advise the accepting party of the expected time of patient's arrival.

4.32.2.2. Discharge other non-AD patients requiring domiciliary or custodial care following procedures similar to those in paragraph 4.31.1 and 4.31.2.1.

4.32.2.2.1. Discharge alternatives must be acceptable to the patient or the legally authorized representative. **(T-3).**

4.32.2.2.2. Release the patient to the legally authorized representative if the arranged or recommended alternatives are declined.

4.32.2.2.3. Request permission to transfer patient custody to civil authorities if the legally authorized representative declines acceptance. Contact the Staff Judge Advocate if the request is denied.

4.32.3. Discharging Patients Not Eligible for Care at VA Expense.

4.32.3.1. Discharge a military patient who, upon expiration of term of service, has physical or mental disabilities and requires custodial care or is not competent to care for themselves as follows:

4.32.3.1.1. Contact the legally authorized representative to determine whether they are assuming custody of the patient and responsibility for care.

4.32.3.1.2. The legally authorized representative must produce affidavits certifying their willingness to make suitable arrangements for the patient and the financial means to do so.

4.32.3.1.3. See 4.32.2.1.3 – 4.32.2.1.4 for procedures to follow when the legally authorized representative declines acceptance.

4.32.3.1.4. Coordinate the patient's move, with proper escort, to the legally authorized representative or to the civilian authority accepting custody. Advise the accepting party of the expected time of the patient's arrival.

4.32.3.2. When the patient is stable enough, transfer a federal civilian employee patient with a physical or mental disability requiring hospital care that exceeds the MTF's capabilities or if the civilian employee is not a beneficiary under the Federal Employee's Compensation Act. Coordinate proposals to move a civilian employee hospitalized in a medical facility outside the United States, or when it is necessary to separate the employee from Federal service for medical or other reasons, with the appropriate Civilian Personnel Office.

4.32.4. 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.

4.32.4.1. A patient who does not exhibit suicidal or homicidal tendencies may request release to the legally authorized representative. See 4.32.3.1.2.

4.32.4.2. Discharge a patient who exhibits suicidal or homicidal tendencies as follows:

4.32.4.2.1. 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 legally authorized representative and authorization for admission from the hospital concerned. A patient with a mental health condition requiring inpatient hospitalization may be eligible for involuntary inpatient admission pursuant to applicable state law.

4.32.4.2.2. 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; or to an acceptable private hospital at the written request of the legally authorized representative. This will also require authorization from the destination hospital. **(T-1).**

4.32.4.3. A non-military psychotic (mental disorder) 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.

4.32.4.3.1. By law, the Department of Health and Human Services may receive and provide care for non-military mental health patients returned to CONUS.

4.32.4.3.2. If the patient is not releasable to the legally authorized representative, and is not authorized further Air Force hospitalization, the overseas commander should ask local United States diplomatic representatives to arrange, through the Department of State, for the Department of Health and Human Services to receive the patient upon arrival in CONUS.

4.32.5. Disposition of Prisoner Patient. When discharging prisoner patients, 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:

4.32.5.1. 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 31-105, *Air Force Corrections System*.

4.32.6. Discharging Patients with Communicable Diseases. Notify Force Health Management if a patient has a communicable disease when the term of service ends and if the patient elects to separate and be discharged from the hospital.

4.32.7. Discharging Non-AD Patients Refusing to Comply with Rules. Contact the Staff Judge Advocate for assistance when a non-AD patient fails or refuses to comply with established patient behavior rules in paragraph 2.19.4.

4.32.8. Discharging Patients with Terminal Illness.

4.32.8.1. Transfer non-Air Force members according to the latest joint service medical/patient regulating guidance.

4.32.8.2. Final decision on the discharge of the patient depends on MTF capability, demand for services and humanitarian considerations.

4.32.8.3. If the AD terminal patient is referred to the Physical Evaluation Board, follow the procedures in Section 4K and AFI 36-3212.

4.32.9. Discharging Patients Absent Without Leave (AWOL). Report a military patient who is AWOL from a medical facility to the individual's servicing Military Personnel Section. Do not carry AWOL patients on the Admissions and Dispositions Office 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 AFI 41-200. **(T-0).**

4.32.10. Discharging Patients through action by Medical Evaluation Board and Physical Evaluation Board. See Section 4K and AFI 36-3212.

4.32.11. Retention of Enlisted or Officer Patients Beyond the Discharge Date. See AFI 36-3208, *Administrative Separation of Airmen*.

4.32.12. Discharging Persons Refusing Professional Care. See Section 4K. 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.

4.33. 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. **(T-1).**

4.33.1. MTF commanders or directors 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. The MTF's MAJCOM command surgeon's office must approve convalescent leave in excess of 90 days. **(T-2).**

4.33.2. The attending healthcare provider may recommend 84 days of postpartum convalescent leave upon discharge, unless the mother's medical condition warrants a longer period.

4.33.2.1. In accordance with AFI 36-3003, table 4.3, Rule 2, if a member is discharged from inpatient status and the medical condition is childbirth but the member does not retain the child, then attending provider will prescribe the amount of recommended convalescent leave on a case-by-case basis. The attending provider will determine the necessary time required for adequate recovery from childbirth, but will not automatically default to the maximum of 84 days of convalescent leave prescribed in AFI 36-3003, table 4.3, Rule 2.

4.33.3. Recommendations for convalescence are also used for outpatients (without related inpatient episode) when the medical condition warrants it.

4.34. Reporting AD Soldiers, Sailors, and Marines Hospitalized in Civilian or Non-Military Medical Facilities.

4.34.1. Upon notification of an AD Soldier, Sailor, or Marine hospitalized in a nearby or regional civilian or non-military medical facility, the TRICARE Operations and Patient Administration 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. **(T-3).**

4.34.2. Contact the DHA-Great Lakes at 1-888-647-6676 when notified of an AD 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 AD service member'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, TRICARE Operations and Patient Administration 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. **(T-3).**

4.34.3. Coast Guard, United States Public Health Service or foreign military personnel admitted to civilian or non-military medical facilities are not admitted and/or tracked as "Absent Sick" definition listed in paragraph 4.22 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/SGAT, or the Air Force Medical Operations Center at the Pentagon unless the admitted Coast Guard, United States Public Service or foreign military member meets the "prominent persons" definition listed in paragraph 4.25.

4.34.4. 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, director or 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.

4.34.5. Admissions and Dispositions Office will notify the base ground occupational office in accident cases using AF Form 1488. **(T-1).**

4.34.6. All disclosures of PHI to commanders will be tracked in accordance with AFI 41-200. **(T-0).**

Section 4I—Casualty Reporting Program Administration

4.35. Reporting Patients in Casualty Status.

4.35.1. This section describes patients and MTF reporting procedures for patients placed in a casualty status in accordance with AFI 36-3002. Categories of patients requiring special casualty reports are as follows:

4.35.1.1. Very Seriously Ill Patients. A Very Seriously Ill patient requires medical attention and medical authority declares it more likely than not that death will occur within 72 hours.

4.35.1.2. Seriously Ill Patients. A Seriously Ill 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.

4.35.1.3. Under this section, all disclosures of PHI to commanders will be documented in accordance with AFI 41-200. Disclosure of PHI associated with the Seriously Ill-Very Seriously Ill status of Non-AD 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 authorization or as required by law. 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 AFI 41-200. All disclosures of PHI must be properly documented in the PHI Management Tool or AFMS approved disclosure accounting tool. **(T-0).**

4.36. Assigning Responsibility.

4.36.1. The patient's attending healthcare provider classifies a patient as Very Seriously Ill or Seriously Ill 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 Patient's Medical Status*, and signing and applying signature stamp where required. Additionally, MTF Patient Administration staff or designated Casualty Affairs Liaison 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 AD patient's immediate family member(s). The MTF Casualty Affairs Liaison is responsible for submitting all MTF Casualty reporting forms/documents/information to the installation Casualty Affairs or Casualty Assistance Representative. At inpatient MTFs, the Casualty Affairs Liaison may be the Admissions and Dispositions Office supervisor, one or more members of the Admissions and Dispositions Office staff, and/or the on-call administrative NCO or Officer of the Day. At outpatient MTFs, the Casualty Affairs Liaison may be the NCOIC, Patient Administration.

4.36.1.1. Preparation of AF Form 570.

4.36.1.1.1. Complete sections I, II, and, III when the report is prepared. Complete section IV when reporting Seriously Ill and Very Seriously Ill patients. If the patient is an organ donor, check the appropriate block and indicate organ to be donated. The Casualty Affairs Liaison will complete section V. Section VI may be used to continue entries from other sections, provide additional information, or request administrative action.

4.36.1.1.2. Upon receiving the AF Form 570, the Casualty Affairs Liaison completes section V and immediately notifies the installation commander via the command post and/or Casualty Assistance Representative in accordance with AFI 36-3002. The Casualty Affairs Liaison 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 PHI Management Tool or AFMSA approved disclosure accounting tool.

4.36.2. For AD personnel in a Seriously Ill, Very Seriously Ill, or Not Seriously Ill/Injured casualty status, the attending physician, MTF commander or director, member's commander, or designated representative or AFPC/DPFC notifies the legally authorized representative in accordance with AFI 36-3002.

4.36.3. If the status of a patient previously reported as Seriously Ill or Very Seriously Ill changes the attending physician or dentist prepares an AF Form 570.

4.36.4. Regardless of the patient category, document all notifications for Seriously Ill and Very Seriously Ill 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. **(T-1).** Document the release of information (for all patient categories) in the PHI Management Tool or AFMS approved disclosure accounting tool. **(T-2).**

4.36.5. Absent Sick Patients: The Chief of Medical Staff, 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 Seriously Ill or Very Seriously Ill 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 Casualty Assistance Representative and member's unit commander or installation command post. **(T-3).** 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 PHI Management Tool or AFMS approved disclosure accounting tool. **(T-2).**

4.37. Requesting and Arranging Travel for Legally Authorized Representative under the Emergency Family Member Travel Program.

4.37.1. In situations where an AD or RC service member patient in a on duty and/or in-line of duty status has been placed on the inpatient Seriously Ill or Very Seriously Ill roster, the attending physician must provide written recommendation to the MTF commander or director 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. **(T-3).** If the MTF commander or director approves the request (in writing), the Casualty Affairs Liaison or the administrative officer or noncommissioned officer of the day must immediately contact the installation Casualty Assistance Representative. **(T-3).** The Casualty Assistance Representative is then responsible for coordinating the MTF commander's or director's recommendation/approval for Emergency Family Member Travel Program with Air Force Personnel Center Casualty Affairs officials. Air Force Personnel Center 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 legally authorized representative information is obtainable. A comprehensive explanation of the entire Emergency Family Member Travel Program is available in AFI 36-3002.

4.37.2. The MTF commander or director or designee must concur and approve the attending physician's request on Emergency Family Member Travel Program Request Memorandum prior to Air Force Personnel Center Casualty Affairs Program securing emergency designated traveler travel arrangements. **(T-3).** Prior to approving the Emergency Family Member Travel Program Request Memorandum, the MTF commander or director or designee must ensure there are no more than a total of three designated travelers between the Emergency Family Member Travel Program and Non-Medical Attendant Program. **(T-2).**

4.37.3. Final emergency designated traveler travel approval is not to be authorized at the MTF.

4.37.4. The Emergency Family Member Travel Program benefit does not apply to Service academy cadets, high school, college, or university ROTC participants.

4.38. Preparing the AF Form 1403, *Roster of Seriously Ill/Very Seriously Ill*.

4.38.1. The Casualty Affairs Liaison prepares the AF Form 1403, 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 Very Important Person reporting). Report initial Seriously Ill/Very Seriously Ill placement status and again if the status changes or is removed.

4.38.1.1. Reporting Seriously Ill and Very Seriously Ill status PHI to external MTF agencies (including, but not limited to, the installation command post or casualty affairs office) regarding non- AD service member, is generally authorized only after obtaining the patient's authorization or exercising professional judgment in the disclosure of relevant information in emergency situations.

4.38.2. Providing Follow-up Information. The Casualty Affairs Liaison provides the installation commander and Casualty Assistance Representative with information received from the patient's healthcare provider for follow-up action in accordance with AFI 36-3002.

4.38.3. Removing Patients from the Roster.

4.38.3.1. When the attending healthcare provider determines that the patient can be removed from AF Form 1403, prepare AF Form 570 and send it to the Casualty Affairs Liaison.

4.38.3.2. The Casualty Affairs Liaison will notify the installation commander and Casualty Assistance Representative 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.

4.39. Responsibility for Preparing Death Cases. As described in the following paragraphs, the individual who is responsible for preparing death cases varies depending on the status of the patient.

4.39.1. Death of a person while being attended outside the MTF: The attending Air Force medical officer.

4.39.2. Death of a person in an Air Force-owned or leased aircraft: The MTF serving the base that investigated the accident.

4.39.3. Death of other Air Force personnel who are not patients in a MTF at time of death: The MTF serving the base that investigated the circumstances of death.

4.39.4. Death of a non-military person on an Air Force base: The MTF serving the base.

4.39.5. Death of a person being staged through an Enroute Patient Staging flight: The MTF supporting the Enroute Patient Staging Flight.

4.39.6. 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 Enroute Patient Staging Flight.

4.39.7. Notwithstanding any other international, federal, state, or county law, or any other DoD or Air Force Issuance, MTF providers, usually the member's Primary Care Manager 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 a MTF provider's signature. Providers should not document or certify a cause of death unless, based on their knowledge of the patient and the circumstances of death, they are able to determine the cause of death to a reasonable degree of medical certainty. Consult with the servicing legal office with any questions or concerns.

4.40. Policies Regarding Deaths.

4.40.1. See AFI 34-501, *Mortuary Affairs Program*, for instructions on preparing, inspecting and shipping remains and completing related forms and reports.

4.40.2. A healthcare provider verifies all deaths occurring at an Air Force MTF and on an Air Force installation.

4.40.3. If a member of the Uniformed Services on AD dies outside the limits of an Air Force installation, do not remove the body without permission of civil authorities or local coroner.

4.40.3.1. The installation commander consults with the Armed Forces Medical Examiner System 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.

4.40.3.2. Obtain a transient or burial permit from the proper civil authority before removing a body from an Air Force base for shipment or burial.

4.40.3.3. 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. Scan/upload the receipt in the deceased's electronic health record.

4.40.4. Initial movement of remains is accomplished as follows:

4.40.4.1. 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 interment location.

4.40.4.1.1. If an autopsy is required, it must be authorized by the base commander or by the Armed Forces Medical Examiner System. **(T-2).** If the local coroner has right of first refusal (in accordance with applicable state law) to conduct the autopsy and the local coroner defers to the Armed Forces, the following guidance takes effect **(T-2):**

4.40.4.1.1.1. 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 postmortem examination with a contracted civilian pathologist.

4.40.4.1.1.2. If the death of an Air Force AD 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 AFMAN 65-605V1_AFGM2018-01, *Budget Guidance and Technical Procedures* 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."

4.40.4.1.2. If an autopsy is required and the local coroner is authorized right of first refusal 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 interment location. Refer to AFI 34-501 for more information regarding available postmortem Mortuary Affairs responsibilities and services.

4.40.4.2. 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 AD

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 Defense Health Program money regardless of who performs the examination.

4.40.4.2.1. In the case of a death in a foreign country, refer to any applicable treaty, Status of Forces Agreement or other international agreement to determine authorization for autopsy. Reference DoDI 5154.30, *Armed Forces Medical Examiner System (AFMES) Operations*.

4.40.4.2.2. In a disaster or multiple death situation, 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.

4.40.5. When a patient dies, notify the Casualty Affairs Liaison or their representative immediately.

4.40.6. 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 legally authorized representative. The executor, administrator or nearest legally authorized representative, as appropriate, signs the inventory as a receipt for effects. Scan/upload the receipt in the patient's electronic health record.

4.40.7. 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 requirements. However, the death certificate must be signed by a physician with knowledge of the primary and contributory cause(s) of death. **(T-1).** This may be the pronouncing physician, the deceased's primary physician, or another member of the medical staff with that knowledge. Scan or upload one copy of the certificate in the deceased patient's electronic health record or extended ambulatory record. In overseas locations, prepare DD Form 2064, *Certificate of Death (Overseas)*, per AFI 34-501.

4.40.8. Reporting Deaths. The MTF commander or director reports deaths as required by AFI 36-3002 when a person dies at an Air Force MTF or enroute to the MTF.

4.40.9. Reporting Stillbirths. Prepare a death certificate 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 legally authorized representative requests the coroner or medical examiner to do so.

4.40.10. Comply with AFI 34-501 when deceased, uniformed services personnel cannot be identified by local means. Utilize the resources of the Armed Forces Medical Examiner System to the maximum extent possible to support the identification of remains.

4.41. Performing Postmortem (Autopsy) - Non-Forensic Cases.

4.41.1. Perform a hospital or non-forensic postmortem only with the consent of the legally authorized representative, person(s) having a right of burial, or at the request of the local coroner or medical examiner (except in the circumstances described in paragraph 4.40.4). Scan or upload the authorization to perform a postmortem examination in the deceased's electronic health record.

4.41.2. Under normal circumstances, complete the postmortem within 24 hours after the remains are received, appropriate records are available and authorization has been granted.

4.41.3. Record the postmortem on SF 503, *Medical Record-Autopsy Protocol*, except those performed under AFI 91-204. Scan and upload the original copy in the electronic health record of the deceased. Maintain a completed copy of the certificate in the clinical laboratory.

4.41.4. A death, military or civilian, is a medical examiner case subject to forensic autopsy when it meets the criteria listed under DoDI 5154.30. These cases do not require consent from the legally authorized representative. If the death meets any one of the criteria listed in DoDI 5154.30, it must be referred to the Armed Forces Medical Examiner System. **(T-0).** The Armed Forces Medical Examiner System may be contacted 24 hours a day, seven days a week at commercial 302-346-8648. Reference DoDI 5154.30.

4.41.5. Authorization for Postmortem on United States Uniformed Services Personnel. The installation commander or Armed Forces Medical Examiner is the approving authority for the postmortem 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 United States and its Territories, existing Status of Forces Agreements apply. When the host government relinquishes its authority, the Armed Forces Medical Examiner or installation commander authorizes the postmortem. This approving authority may be delegated to the MTF commander or director, but must be written and always current. **(T-2).**

4.41.6. Performing a Postmortem Examination on a Civilian.

4.41.6.1. Obtain the written, signed permission of the nearest legally authorized representative, 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 requirements of local authorities.

4.41.6.2. For postmortem purposes, treat the remains of members of the National Guard, Reserve Officers Training Corps and other RCs not on AD for training, as civilians.

4.41.6.3. When consent of the legally authorized representative is required, check to verify notification and obtain the required consent on SF 523, *Medical Record-Authorization for Autopsy*.

4.41.6.4. After deliverance of casualty notice to the family or legally authorized representative and confirmation of its receipt, the MTF commander or director sends a condolence letter to the family or legally authorized representative and requests permission for a postmortem. The consent is scanned/uploaded in the patient's electronic health record.

4.41.6.5. At overseas installations, request the family or legally authorized representative send the reply to the request for postmortem consent to AFMOA/Chief of Medical Staff.

Upon receipt of reply, AFMOA/Chief of Medical Staff 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 scanning/uploading into the patient's electronic health record. **(T-2).**

4.41.7. Performing a Postmortem Examination on Foreign Military Personnel. When performing a postmortem examination on foreign military personnel, obtain permission from the military attaché of the foreign embassy. Include this request for permission in the casualty report required by AFI 36-3002.

4.41.8. Organ Disposal Following Postmortem. Return all organs and tissues removed during postmortem 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 legally authorized representative or required by law (see DoDI 6465.03, *Anatomic Gifts and Tissue Donation*).

4.42. Disposition of Outpatient Records on Deceased AD Personnel. See AFI 36-2608, *Military Personnel Records System* and AFI 36-3002 for guidance on the disposition of the outpatient record when an AD member of the United States Armed Services expires.

4.43. Deceased Patient Kit.

4.43.1. Local or state law may require the local medical examiner or coroner to respond for each fatality that occurs on a military installation.

4.43.2. The response may include managing, reviewing or pronouncing death in these cases. Sometimes these responsibilities are deferred to the installation MTF. Such deferrals are more likely when no suspicious circumstances exist that require an investigation by the local medical examiner or coroner. These deferrals are also more likely when the MTF has histopathology or postmortem examination capability.

4.43.3. 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.

4.43.4. 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).

4.43.5. 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.

4.43.6. 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. **(T-1).**

4.43.6.1. SF Form 523.

4.43.6.2. AF Form 146, *Death Tag*.

4.43.6.3. AF Form 570.

4.43.6.4. Release of Remains.

4.43.6.5. Request for Postmortem Examination.

4.43.6.6. AF Form 1122, *Personal Property and Personal Effects Inventory*.

4.43.6.7. Fax Notification.

4.43.6.8. Death Certificate Worksheet.

4.43.6.9. Death Certificate (Issued by state. If overseas use, DD Form 2064).

Section 4J—Birth Registration Program Administration

4.44. Birth Registration in the CONUS.

4.44.1. 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.

4.44.2. Updating Personnel Records. Advise parents to report to the Military Personnel Section 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. **(T-3).** When both the parents are AD, recommend that the same sponsor be identified in CHCS and DEERS in order to eliminate confusion with the records.

4.44.3. Refer parents to the TRICARE customer service phone number for TRICARE options, including TRICARE Prime enrollment.

4.45. Registering Births Overseas.

4.45.1. Overseas Air Force MTFs must cooperate with consular officers in registering births of infants born to United States citizens in areas overseas. **(T-0)**. **Exceptions:** Register births in American Samoa, Guam, Puerto Rico, the Trust Territories, and the United States Virgin Islands through the special offices of the Vital Statistics Division, Public Health Services, United States Department of Department of Health and Human Services, or specified local United States Government offices.

4.45.2. Completing Department of State Form DS-2029, *Application for Consular Report of Birth Abroad of a Citizen of the United States of America*, available at **https://eforms.state.gov/Forms/ds2029.pdf**. The form DS-2029 will be completed in four copies. The (U.S. citizen) parent will sign each copy of the forms under oath before a military officer qualified to administer oaths. **(T-0).**

4.45.3. If the mother is not a U.S. citizen, the U.S. citizen father must sign form DS-2029 if he is available. **(T-0).** 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 U.S. Consular Office. **(T-0).**

4.45.4. Registration of Birth. Advise the parents that a fee for registering the child's birth will be charged. The U.S. Consular Officer issues them a copy of the Department of State Foreign Form FS-240, *Consular Report of Birth Abroad* when the birth is reported, available at **https://travel.state.gov/content/travel/en/international-travel/while-abroad/birth-abroad.html**.

Section 4K—Medical Evaluation of Service Members for Continued Military Service

4.46. Purpose of the Disability Evaluation System.

4.46.1. The Disability Evaluation System provides examination standards for fair and equitable examination practices. The system identifies those who can no longer perform the duties of their office, grade, or rating. The system also is designed to ensure fair compensation for members whose military careers are shortened due to a service-incurred or aggravated disability Reference AFI 36-3212 for further information.

4.47. Eligibility for Disability Evaluation Processing. AFPC determines eligibility for disability processing. Reference AFI 36-3212 for further information.

4.48. Entrance into the Integrated Disability Evaluation System.

4.48.1. The Integrated Disability Evaluation System integrates the Air Force Disability Evaluation System with the 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.

4.48.1.1. One of the goals of the Air Force is to carefully screen service members with potentially unfitting conditions, so they are appropriately referred into the Integrated Disability Evaluation System only when a return to duty adjudication is not likely.

4.48.1.2. In order to minimize inappropriate referrals to the Integrated Disability Evaluation System, there is a two-step Integrated Disability Evaluation System pre-screening process for all potential Medical Evaluation Board cases. The first step is accomplished by the MTF Deployment Availability Working Group. The second step, if required, is accomplished by the Air Force Personnel Center, Medical Retention Standards Branch (AFPC/DP2NP) or the appropriate ARC Surgeon General's Office. Cases that AFPC/DP2NP direct for a Medical Evaluation Board are referred into the Integrated Disability Evaluation System. AFPC/DP2NP and ARC Surgeon General's Office disposition may result in a Return to Duty decision. AFPC/DP2NP or ARC Surgeon General's Office is the final disposition authority on Return to Duty determinations.

4.48.1.2.1. Airmen who have conditions that may render them unfit for continued military service in accordance with AFI 48-123, or are found to be unable to deploy must undergo an initial review-in-lieu-of that will serve as the Integrated Disability Evaluation System pre-screening. **(T-0).** Initial review-in-lieu-of is an initial review of medical records in lieu of a full medical examination. In addition to those conditions specifically listed in AFI 48-123, Airmen may require an initial review-in-lieu-of due to a duty limiting condition which has resulted or likely will result in a mobility restriction for 365 days or longer. Additionally, other diseases or defects not specifically listed in AFI 48-123 may also be cause for an initial review-in-lieu-of based upon the medical judgment of the examining physician and concurrence of the Deployment Availability Working Group.

4.48.1.2.2. Once the initial review-in-lieu-of case is identified, the Physical Evaluation Board Liaison Officer will coordinate activities to retrieve information required for the Deployment Availability Working Group review. **(T-3).** Appropriate information might include medical record entries AHLTA or hard copy), consultant or special examination reports, the applicable AF Form 469, *Duty Limiting Condition Report*, the most recent AF Form 422, *Notification of Air Force Member's Qualification Status* or any other information deemed relevant. After the case is reviewed by the Deployment

Availability Working Group it is forwarded to AFPC/DP2NP for adjudication. RC service member cases are forwarded to the appropriate ARC Surgeon General's Office.

4.48.1.3. If AFPC/DP2NP or the appropriate ARC Surgeon General's Office directs that an initial review-in-lieu-of should undergo an Medical Evaluation Board, the service member is entered into the Integrated Disability Evaluation System as of the date the referring provider signs and dates the VA Form 21-0819, *DoD Referral to Integrated Disability Evaluation System (IDES)* form available at **https://www.va.gov/vaforms/form_detail.asp?FormNo=21-0819**. The provider will forward the form to the Physical Evaluation Board Liaison Officer who will then enter the initial case information into the Veteran's Tracking Application within 3 calendar days. **(T-1).** The Physical Evaluation Board Liaison Officer will enter or update the case data required in the Veteran's Tracking Application Integrated Disability Evaluation System module within 3 calendar days of the data becoming available. **(T-1).**

4.48.1.4. Within 30 calendar days after the pre-screening package, the initial review-in-lieu-of is reviewed by the Deployment Availability Working Group. The initial review-in-lieu-of is signed by either the Chief of Medical Staff or Chief of Aerospace Medicine. The package is then submitted to the Physical Evaluation Board Liaison Officer. Once received, the Physical Evaluation Board Liaison Officer will forward it to AFPC/DP2NP or ARC Surgeon General's Office for disposition within 5 calendar days. **(T-1).** In turn, AFPC/DP2NP or ARC Surgeon General's Office should disposition the case and return the results to the Physical Evaluation Board Liaison Officer within 10 calendar days. When the Physical Evaluation Board Liaison Officer receives the results, the Deployment Availability Working Group shall be advised. **(T-3).** If a medical board is directed, the service member's healthcare provider should refer the member to the Integrated Disability Evaluation System by signing the VA Form 21-0819. The VA Form 21-0819 is forwarded to the Physical Evaluation Board Liaison Officer to facilitate enrollment in the Integrated Disability Evaluation System via the Veteran's Tracking Application within 3 calendar days. Reference AFI 10-203, *Duty Limiting Conditions*.

4.49. Trigger Events that Require Preliminary Deployment Availability Working Group Review.

4.49.1. A trigger event is a condition or occurrence which may indicate a service member 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 Physical Evaluation Board Liaison Officer or Guard Medical Unit and Medical Standards Management Element, so a summary of the member's information can be obtained for preliminary presentation at the next scheduled Deployment Availability Working Group meeting. **(T-3).** Each Deployment Availability Working Group should establish procedures and guidelines for reporting trigger events at its respective MTF. Trigger events include, but are not limited to, the following:

4.49.1.1. A provider (Primary Care Manager or specialist) identifies an Airman with a diagnosis which does not meet retention standards for continued military service. The provider that initially identifies the case will be the referring provider and will be responsible for coordinating the clinical aspects of Deployment Availability Working Group review. **(T-3).** The provider will contact the Physical Evaluation Board Liaison

Officer and/or Medical Standards Management Element who will advise the provider on what actions are needed to present the case to the Deployment Availability Working Group. **(T-3).** If the provider is uncertain whether the case requires Initial Review-In-Lieu-Of, it will still be referred for Deployment Availability Working Group review.

4.49.1.2. If during Assignment Availability Code (AAC) 31 (temporary medical deferment) surveillance, the Deployment Availability Working Group identifies an Airmen with a long-standing AAC 31 and the medical condition appears unlikely to resolve within 300 cumulative days of initiation of the AAC 31, the Deployment Availability Working Group may request consultation with the provider that initiated the AAC 31.

4.49.1.3. When an airman's commander requests evaluation due to poor duty performance or deployment concerns stemming from a potential medical or mental health condition.

4.49.1.4. A PCS, TDY, or deployment is cancelled for a medical or mental health reason.

4.49.1.5. AFPC/DP2NP or ARC Surgeon General's Office directs the Initial Review-In-Lieu-Of.

4.49.2. Preliminary review of a trigger event should occur at the next scheduled Deployment Availability Working Group meeting, and not more than 45 calendar days after the case is referred to the Physical Evaluation Board Liaison Officer or Medical Standards Management Element by the provider. The Deployment Availability Working Group will review each case following guidance provided in AFI 10-203. **(T-1).** The review can result in the following:

4.49.2.1. Initial review-in-lieu-of referral. If there is any doubt that the Airman is fit for continued unrestricted duty (i.e., might require an Assignment Limitation Code-C code to be applied (See 4.72.1) or might require a Medical Evaluation Board for consideration for separation.), the case becomes an Initial Review-In-Lieu-Of. Once the Deployment Availability Working Group determines that the case warrants Initial Review-In-Lieu-Of, the Physical Evaluation Board Liaison Officer will ensure that all requirements for the initial review-in-lieu-of package are completed. **(T-3).**

4.49.2.2. Case Dismissal. If the Airman is found to be fit for continued military service and mobility based on the information considered, the AF Form 469 may be updated appropriately and the case dismissed to routine medical care. Case dismissal does not preclude the Airman being considered for Deployment Availability Working Group review again in the future for the same condition if the Airman's status changes. A note will be placed in the Airman's medical record indicating that the condition was reviewed for possible Medical Evaluation Board and found to meet retention standards without need for initial review-in-lieu-of or Medical Evaluation Board. **(T-3).**

4.49.3. Once the initial review-in-lieu-of package is complete (to include all specialty consultations and special studies), the entire package must be reviewed by the Deployment Availability Working Group and signed off by either the Chief of Medical Staff or Chief of Aerospace Medicine to ensure that it is complete and accurate. **(T-1).** This step serves as a final quality review and will be completed no more than 30 calendar days after the case was initially reviewed at the Deployment Availability Working Group. **(T-1).** If the final review is delayed beyond 30 calendar days, the reason for the delay will be documented in the Deployment Availability Working Group minutes. **(T-1).** The packages will be forwarded to DP2NP or ARC Surgeon General's Office as applicable for disposition with a recommendation

from the Deployment Availability Working Group for either Medical Evaluation Board or Return to Duty. **(T-1). Note:** this recommendation is not binding on the disposition by AFPC/DP2NP or ARC Surgeon General's Office.

4.49.3.1. Application of Assignment Availability Code (AAC) 37 (pending medical evaluation/physical evaluation board) will be directed by the Deployment Availability Working Group Chair, and applied in ASIMS by the Medical Standards Management Element as soon as the case is identified for the Initial Review-In-Lieu-Of. **(T-3).** Only the Deployment Availability Working Group and AFPC/DP2NP may direct an AAC 37 personnel status. **(T-1).** Once applied, the AAC 37 will remain in effect until AFPC/DP2NP directs removal via the Air Force Personnel Center, Form Letter 4 (AFPC/FL 4). For ARC service members, the ARC Surgeon General's Office and/or Deployment Availability Working Group chair will apply AAC 37 after verification of the service member's entitlement to disability processing. **(T-1).**

4.49.4. Once a case is identified for the Initial Review-In-Lieu-Of, the Physical Evaluation Board Liaison Officer should: (1) notify the member of being referred for potential Medical Evaluation Board, (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 the office, rank, grade and/or rating, and forward the standardized letter template to the commander via e-mail that includes a 5 calendar day timeline for completion and return (ARC commanders are contacted via ARC full time ARC staff), and (3) contact the provider (or providers, in cases where multiple specialty consult narratives are required) to request a copy of the initial review-in-lieu-of Narrative Summary, supporting consultant notes/studies, and current AF Form 469 prior to the next scheduled Deployment Availability Working Group. For ARC units, the ARC may write the Narrative Summary for medical cases, if a full time provider is available. For all mental health cases, the MTF shall make arrangements for the mental health Narrative Summary to be accomplished. **(T-1).**

4.49.4.1. Any extenuating circumstances resulting in delays in receipt of the Narrative Summary or other package documentation should be documented in the Deployment Availability Working Group minutes.

4.49.4.2. In unique circumstances, the Deployment Availability Working Group chair may request the provider expedite the package and/or may call an ad hoc (done for a specific purpose) Deployment Availability Working Group meeting for expedited case review. These circumstances should also be documented in Deployment Availability Working Group minutes.

4.49.4.3. Narrative Summaries. The same format is used for both the initial review-in-lieu-of and for the formal Medical Evaluation Board narrative. For best practice and ease of use providers may use the PDF fillable Narrative Summary template that can be found on the Air Force Personnel Medical Retention Standards Branch page of the AFMS Knowledge Exchange at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**. A single Narrative Summary format is used throughout the process to alleviate the need for complete Narrative Summary rewrites if an initial review-in-lieu-of is later directed for a Medical Evaluation Board.

4.49.4.4. Consultant Notes and/or Special Studies. Conditions which require a consultant note and/or studies can be found at Attachment 3, Consult Notes and Specialty Studies Guide. 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 review-in-lieu-of 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 calendar days old when received at Air Force Personnel Center, Physical Disability Division (AFPC/DPFD). **(T-1).**

4.49.4.5. AF Form 469. If the AF Form 469 is more than 30 calendar 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)). **(T-1).** A comment will then be made in the Restrictions section, "Provider reviewed restrictions and they are deemed accurate and appropriate on (date inserted)." **(T-1).**

4.49.5. Deployment Availability Working Group initial review-in-lieu-of recommendations can be one of the following:

4.49.5.1. Medical Evaluation Board Recommended. It is determined that it is more likely than not the member has medical conditions that will prevent the member from reasonably performing the duties of the office, grade, rank or rating. The package is forwarded to AFPC/DP2NP by the Physical Evaluation Board Liaison Officer for disposition. A standardized coversheet checklist is located at attachment 4 and a PDF fillable version is available in the Knowledge Exchange at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**. The Deployment Availability Working Group chair must sign the standardized coversheet, stating the package is recommended for the Medical Evaluation Board. **(T-1)**.

4.49.5.2. 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 the 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 AFPC/DP2NP by the Physical Evaluation Board Liaison Officer for disposition. The Deployment Availability Working Group chair must sign the standardized coversheet, stating the package is recommended for a return to duty decision. **(T-1).**

4.49.5.3. Other. With the information available in the narrative summary, consults, AF Form 469 and commander's letter, the Deployment Availability Working Group may make a determination that the case does not require AFPC/DP2NP review at this time, and may dismiss the case entirely or schedule it for Deployment Availability Working Group surveillance.

4.49.6. For ARC service members, the initial review-in-lieu-of will be forwarded to the appropriate ARC Surgeon General's Office for review. **(T-2).** The appropriate ARC Surgeon General's Office, who possesses the same authority for ARC cases as AFPC/DP2NP possesses for AD cases, will provide final disposition instructions, i.e., assignment of Assignment Limitation Code-C, Deployment Availability Code-42, or Integrated Disability Evaluation

System entry via Medical Evaluation Board initiation, to the service member's supporting ARC and AD medical facility. **(T-1).**

4.50. AFPC/DP2NP Medical Retention Standards Branch. The AFPC/DP2NP is the reviewing body for all AD Review-In-Lieu-Of reviews, the final authority for Airman Medical Transition Unit assignments, AD Assignment Limitation Code-C, Medical Hold, and non-emergent surgery during a service member's final six months of service (defined as surgery which while necessary is not required urgently or emergently to save life, limb, or eyesight). In addition, to meet DoD established timelines. AFPC/DP2NP has sole authority to approve all non-emergent surgery requests for service members (SMs) who are referred to, or undergoing Disability Evaluation System processing. AFPC/DP2NP is the office of primary responsibility for implementing AF/SG policy on medical standards for continued AD service, and may provide interpretations of areas of ambiguity within this AFMAN consistent with current AF/SG intent. AFPC/DP2NP will provide oversight of standardized templates and other guides utilized in the initial review-in-lieu-of and Medical Evaluation Board phases.

4.50.1. AFPC/DP2NP Review and Disposition of Initial Review-In-Lieu-Of:

4.50.1.1. Following Deployment Availability Working Group review of an Initial Review-In-Lieu-Of, cases are forwarded to AFPC/DP2NP for disposition. Disposition shall be forwarded to the base Physical Evaluation Board Liaison Officer via the AFPC/FL 4. **(T-1)**.

4.50.1.2. The determination by AFPC/DP2NP is final and has the same effect and authority as a Medical Evaluation Board. Dispositions are:

4.50.1.2.1. Return to Duty (with/without an Assignment Limitation Code) and remove AAC 37.

4.50.1.2.2. Direct a Medical Evaluation Board and maintain AAC 37.

4.50.1.2.3. Direct a Medical Evaluation Board at another MTF and maintain AAC 37.

4.50.1.2.4. Returned without Action (reason and disposition of AAC 37 will be specified).

4.50.1.2.5. Continued Military Medical Observation and Care and maintain AAC 37.

4.50.1.3. If a Medical Evaluation Board is required on a Flag Officer, AFPC/DP2NP will designate a MTF to conduct the board. **(T-1).** AFPC/DP2NP will forward initial notification to AF/DSG and AF/SG by electronic secure transmission and provide final notification when the Medical Evaluation Board/Physical Evaluation Board action is complete if the Flag Officer is returned to duty. **(T-1).** AFPC/DPFD will make the final notification if the Flag Officer is medically separated or retired. **(T-1).**

4.50.1.4. Presumption of Fitness. For service members with an approved retirement date within 12 months, the case may begin with a presumption that the member is fit (known as a presumption of fitness) during the AFPC/DP2NP review disposition process. This may result in a return to duty decision without a full medical evaluation board. Presumption of fitness applies to retirement, not to separation of members who are not eligible for retirement. Presumption of fitness will also be applied to cases for ARC members who have been non-retained. These members will be reviewed for Return to Duty decision

unless they overcome the presumption of fitness. Refer to AFI 36-3212 for additional information.

4.50.1.5. Only AFPC/DP2NP, ARC Surgeon General's Office, AFPC/DPFD (Informal Physical Evaluation Board and Formal Physical Evaluation Board), and the Secretary of the Air Force may invoke presumption of fitness (Fit for Duty). MTF providers, the Deployment Availability Working Group, and MTF Medical Evaluation Board members are prohibited from using or claiming presumption of fitness to deny a service member Medical Evaluation Board consideration. **(T-0).**

4.50.1.6. Medical Hold is a method of retaining a service member beyond an established retirement or separation date for reasons of disability processing, when presumption of fitness does not apply. It may be necessary to place members on Medical Hold if AFPC/DP2NP directs a Medical Evaluation Board, and the member is within 60 calendar 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 AD. Separation or retirement processing continues until Medical Hold is approved.

4.50.1.6.1. Medical Hold is requested by a provider (generally the Primary Care Manager), directly contacting AFPC/DP2NP for AD service members or the appropriate ARC Unit for ARC service members. For ANG service members, ANG/Chief of Aerospace Medicine (SGP) is the approval authority. For AFR service members, Air Force Reserve Command (AFRC)/Chief of Medical Operations (SGO) 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:

4.50.1.6.1.1. Date of projected separation or retirement.

4.50.1.6.1.2. Whether initial review-in-lieu-of processing has been initiated, and if so, the estimated time until the package will be ready for submission to AFPC/DP2NP.

4.50.1.6.1.3. Whether administrative separation or Court-Martial charges are pending.

4.50.1.6.1.4. Servicing Military Personnel Section implementing separation or retirement.

4.50.1.6.1.5. Whether service member desires to be retained in duty status for disability processing.

4.50.1.6.1.6. Member's Air Force Specialty Code (AFSC).

4.50.1.6.1.7. Confirmation that the Physical Evaluation Board Liaison Officer and either the Chief of Medical Staff or Chief of Aerospace Medicine has been notified of the provider's intent to request Medical Hold.

4.50.1.6.2. AFPC/DP2NP (or ARC Surgeon General's Office) may direct a modified (expedited) Review-In-Lieu-Of prior to approving Medical Hold.

4.50.1.6.3. Enlisted service members may refuse Medical Hold beyond their Date of Separation or Expiration of Term of Service, and must agree, in writing, to a Medical Hold. **(T-1).** For officers, Medical Hold does not require consent, but AFPC/DP2NP may request consent in writing. The Physical Evaluation Board Liaison Officer must contact AFPC/DP2NP immediately when notified that a service member may decline Medical Hold. **(T-1).**

4.50.2. DP2NP initial review-in-lieu-of results returned to MTF:

4.50.2.1. If the service member is Return to Duty with or without an Assignment Limitation Code-C, the Physical Evaluation Board Liaison Officer is notified by DP2NP via the AFPC/FL 4. In turn, the Physical Evaluation Board Liaison Officer notifies the Primary Care Manager and the Medical Standards Management Element. AF Forms 422 and 469 will be generated or updated as indicated in accordance with AFI 10-203. **(T-1).**

4.50.2.2. If DP2NP directs a Medical Evaluation Board, the Physical Evaluation Board Liaison Officer is notified via AFPC/FL4. The Physical Evaluation Board Liaison Officer, in turn, notifies the Primary Care Manager, the Deployment Availability Working Group chair, and the Chief of Medical Staff. The Primary Care Manager (or alternate provider if Primary Care Manager is unavailable) will complete the VA Form 21-0819 and return it to the Physical Evaluation Board Liaison Officer. **(T-2).** The date the provider signs the VA Form 21-0819 is the date that the member officially enters into the Integrated Disability Evaluation System.

4.50.3. Service members shall not refuse, decline, nor stop any review-in-lieu-of, Medical Evaluation Board, Physical Evaluation Board, or fitness for duty evaluations except in cases prescribed in DoDI 1332.18, *Disability Evaluation System*, waiver of Medical Evaluation Board/Physical Evaluation Board Evaluation, or in cases where Medical Evaluation Board/Physical Evaluation Board processing would take an enlisted member beyond the date of separation or retirement, and the member does not consent to Medical Hold. **(T-3).**

4.50.4. Leave/Temporary Duty. Once the service member is notified by the Physical Evaluation Board Liaison Officer that a Medical Evaluation Board has been directed, the service member must be available throughout the Integrated Disability Evaluation System process, to include all appointments and counseling sessions. **(T-3).** MTFs must develop local processes and procedures with unit commanders to ensure the member's availability. **(T-3).** As the approval authority, before approving leave requests, the unit commander should coordinate all requests with the Physical Evaluation Board Liaison Officer who will, in turn, notify the Primary Care Manager and AFPC/DPFD (if case has been sent to the Physical Evaluation Board) to ensure there is no conflict with the Integrated Disability Evaluation System process. **(T-3).**

4.51. Integrated Disability Evaluation System Program Management.

4.51.1. The service member's date of entry into the Integrated Disability Evaluation System (referral date) is the date the provider signs the VA Form 21-0819. Disability Evaluation System timeliness goals are detailed in DoDM 1332.18 Volume 1, *Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards*.

4.51.2. Once the VA medical evaluations have been completed in the form of the Compensation and Pension evaluation, the Physical Evaluation Board Liaison Officer receives the Compensation and Pension results and provides them to the Primary Care Manager/Integrated Disability Evaluation System referring provider, or to a reviewing provider who has been assigned by the Deployment Availability Working Group.

4.51.3. Narrative Summary Review, Update, and Completion. Once the designated provider receives the Compensation and Pension exam results, the provider will: (1) review the Compensation and Pension report; (2) verify the Narrative Summary covers the full spectrum of potentially unfitting conditions; (3) addend/update the Narrative Summary appropriately; and (4) return the updated Narrative Summary to the Physical Evaluation Board Liaison Officer. **(T-1).** A signed/dated addendum with pertinent updates must be located at the end of the Narrative Summary, and must clarify inconsistencies between the initial Narrative Summary and Compensation and Pension only for conditions which are considered unfitting for continued military service. **(T-1).** If there are no inconsistencies or updates, the provider will sign/date the following statement at the end of the Narrative Summary, "I have reviewed the C&P exam results and find the information within the Narrative Summary to be current and complete." **(T-1).** This date now becomes the new date for Narrative Summary currency. This is also the final date that is entered in the Veteran's Tracking Application for the Narrative Summary DATE.

4.51.3.1. For cases in which a single Narrative Summary is replaced by multiple specialty consult Narrative Summaries, a single reviewing physician may review both the Compensation and Pension Exam and the multiple specialty Narrative Summaries, and provide a signed and dated addendum on a continuation sheet, which becomes a permanent part of the Medical Evaluation Board package. In this case, the date on the continuation sheet becomes the new date of the Narrative Summary for currency purposes. Service Members shall not refuse, decline, nor stop any review-in-lieu-of, Medical Evaluation Board, Physical Evaluation Board, or fitness for duty evaluations except in cases prescribed in DoDI 1332.18, waiver of Medical Evaluation Board/Physical Evaluation Board Evaluation, or in cases where Medical Evaluation Board/Physical Evaluation Board processing would take an enlisted member beyond the date of separation or retirement, and the member does not consent to Medical Hold. **(T-3).**

4.51.3.2. The preparing and reviewing physicians will not include in the Narrative Summary any verbal or written comments that refer to disability process results. **(T-3).**

4.52. Non-physician providers preparing the Narrative Summary. Disability Evaluation System Narrative Summaries signed by non-physicians (e.g. physician assistant, nurse practitioner) do not require a physician co-signature. This includes Narrative Summaries required for initial Review-in-Lieu-of, medical evaluation board and compensation and pension examination reconciliation activities. Initial Review-in-Lieu-of, Medical Evaluation Board, and Disability Evaluation System Narrative Summaries for mental health conditions may be prepared and signed by non-physicians (e.g., physician assistants, nurse practitioners, clinical psychologists, and licensed clinical social workers) and do not require physician co-signature. For AFR, either a psychiatrist or a psychologist with a doctorate must sign narrative summaries for mental health diagnoses that require non-duty related full case processing to the Air Force Physical Evaluation Board **(T-0).**

4.53. Conducting the Medical Evaluation Board. After the Narrative Summary is reviewed, updated and the completed Narrative Summary has been returned to the Physical Evaluation Board Liaison Officer, the Medical Evaluation Board is convened.

4.54. Location of Medical Evaluation Boards.

4.54.1. Service member Medical Evaluation Boards should be processed 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 a MTF with appropriate services.

4.54.2. If an AD member is hospitalized away from the installation of assignment or in a non-Air Force facility, the nearest Air Force MTF will accept administrative responsibility for the Line of Duty and Medical Evaluation Board process. **(T-3).** The member's Primary Care Manager shall remain informed of the patient's condition. **(T-3).**

4.54.3. Commanders at all levels, and officers who have convening and approval authority for medical boards, will not have their own Medical Evaluation Board or their clinical evaluation and board processing at a MTF that is within their command and control or official influence. In this circumstance, AFPC/DP2NP will designate a MTF to accomplish the board. **(T-1).**

4.54.4. Any MTF-assigned officer requiring a Medical Evaluation Board shall not meet the Medical Evaluation Board at the officer's own MTF without a policy waiver from AFPC/DP2NP. **(T-1).** The MTF commander or director may submit a waiver request detailing why a Medical Evaluation Board should be conducted at the officer's own facility, as well as why the commander has no concern for a conflict of interest.

4.54.5. Personnel at a MTF will not conduct a Medical Evaluation Board 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. **(T-1).** If a waiver is requested from AFPC/DP2NP, the MTF commander or director is required to include a brief statement indicating the nature of the disciplinary problem. **(T-1).** Once received, AFPC/DP2NP will respond with disposition instructions.

4.55. Medical Evaluation Board Support for Service Members assigned to Geographically Separated Unit (GSU) or enrolled to TRICARE Prime Remote locations. If unique circumstances mandate that some or all Disability Evaluation System requirements be accomplished via TRICARE Prime Remote network providers, then the Deployment Availability Working Group must approve the use of those providers. **(T-1).**

4.55.1. The Deployment Availability Working Group must review the status of GSU service members undergoing pre-Integrated Disability Evaluation System workup every 30 calendar days. **(T-1).**

4.55.2. The Physical Evaluation Board Liaison Officer will (1) notify the DHA-Great Lakes Case Management Division that the service member's pre-Integrated Disability Evaluation System medical care will be provided by TRICARE/TRICARE Prime Remote network providers; (2) obtain medical release authorization from the patient and contact the civilian provider(s) every 30 calendar days for written clinical updates/consults; and (3) notify the DHA-Great Lakes of the Medical Evaluation Board outcome. **(T-1).**

4.56. Multi-Service Medical Evaluation Board Processing.

4.56.1. Air Force MTFs have the authority to conduct cross-Service Disability Evaluation System activities in support of non-Air Force MTFs and providers. The Physical Evaluation Board Liaison Officer at the receiving Air Force MTF collects required documentation and forwards it to the Deployment Availability Working Group to review for accuracy and completeness. If additional documentation is required, the Physical Evaluation Board Liaison Officer should request it.

4.56.2. All service members whose cases are processed in Air Force MTF complete the pre-screening, initial review-in-lieu-of and other Integrated Disability Evaluation System activities regardless of their Service affiliation. In the event AFPC/DP2NP decides the member must be medically boarded (process to determine if the member is fit/unfit for continued service), the Medical Evaluation Board can be conducted with approval from the parent Service. **(T-1).**

4.56.3. It is the responsibility of a service member's parent Service to make the Fitness for Duty decision.

4.57. Processing Medical Evaluation Boards for Service Members from other Services.

4.57.1. Air Force MTFs may refer members from other Services to their local Deployment Availability Working Group provided all the following requirements are met:

4.57.1.1. The Deployment Availability Working Group Chair approves the action.

4.57.1.2. The Medical Evaluation Board president has reasonable operational knowledge of the specific Service's medical retention standards.

4.57.1.3. Written permission is obtained prior to the referral. The permission is signed by one of the following: MTF commander or director, 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 service member in question, is obtained.

4.57.1.4. The approving sister Service official should acknowledge that Air Force Medical Evaluation Boards may be processed differently from their Service's processes and retention standards may be different.

4.57.2. The Air Force MTF will forward the results of the Medical Evaluation Board and all related medical supporting documents to the nearest MTF that shares the same Service affiliation of the service member for a fitness decision to be made and for further processing in the Service's system. **(T-1)**.

4.57.3. Air Force MTFs that have the potential to regularly process Medical Evaluation Boards for service members from the other Services are highly encouraged to establish agreements (memorandum of understanding or agreement) with the referring medical units.

4.58. Composition of the Medical Evaluation Board.

4.58.1. Only physicians may participate as voting members. The board is normally comprised of three privileged (qualified to perform specific services) physicians, ideally AD Medical Corps officers of the United States Uniformed Services, however, two member boards are acceptable. 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.

4.58.2. Before initially serving as a member of the Medical Evaluation Board, and annually thereafter, each member is required to complete training to be familiarized/updated with Medical Evaluation Board processes and Disability Evaluation System program objectives. **(T-3).** The training will be documented locally (i.e., AF Form 797, *Job Qualification Standard Continuation/Command JQS*, TRICARE Operations and Patient Administration Training Records or the member's Provider Activity File). The Chief of Medical Staff is encouraged to contact AFMOA/Chief of Medical Staff to obtain the latest training information. Physicians are also invited to attend Physical Evaluation Board Liaison Officer training courses (when offered).

4.58.3. The Chief of Medical Staff or the Chief of Aerospace Medicine will serve as the Medical Evaluation Board President. The Deputy Chief of Medical Staff and Deputy Chief of Aerospace Medicine, when appointed by the MTF commander or director in writing, are authorized the same Medical Evaluation Board authority as the permanent or primary officials in absence of the primary official.

4.59. Required Medical Documentation for the local MTF Medical Evaluation Board. Each local MTF Medical Evaluation Board package shall contain, at a minimum, the following documentation. **(T-1).**

4.59.1. Narrative Summary.

4.59.2. Consultation Notes.

4.59.3. AF Form 1185, Commander's Impact Statement for Medical Evaluation Board. For regular Air Force members, ensure the AF Form 1185 is no more than 30 days old when received by AFPC/DP2NP, Medical Retention Standards office (AD). For ARC members, ensure the form is no more than 60 days old when received by the appropriate ARC Surgeon General's Office.

4.59.4. AF Form 469, *Duty Limiting Condition Report*.

4.59.5. AF Form 618, *Medical Board Report*.

4.60. Convening the Medical Evaluation Board.

4.60.1. The Medical Evaluation Board members shall meet at the same time for interactive discussion and case review. **(T-3).** Exceptions can only be granted by the Chief of Medical Staff or Chief of Aerospace Medicine.

4.60.2. Personal appearance of the service member is not required, but the board president may allow the service member to appear before the board. There is no right to counsel or to challenge the Medical Evaluation Board or its members while the board is convened.

4.60.3. Medical Evaluation Board recommendations. The Medical Evaluation Board membership may choose from the following two actions: (1) Return to Duty or (2) Refer to Informal Physical Evaluation Board. **Note:** Even though the Medical Evaluation Board was initially directed by AFPC/DP2NP following Initial Review-In-Lieu-Of, rare instances may arise where new information may become available (e.g., condition changes, updated consults, information from Compensation and Pension (C&P) Exam, updated commander's letter, etc.)

that result in a Return to Duty decision instead of Refer to Informal Physical Evaluation Board. When this occurs, the complete case will be forwarded to AFPC/DP2NP or ARC Surgeon General's Office, instead of being forwarded to AFPC/DPFD (Informal Physical Evaluation Board).

4.60.4. Medical Evaluation Board members shall sign AF Form 618, block 26. **(T-3)**. In accordance with DoDI 1332.18, either a psychiatrist or a psychologist with a doctorate must sign the AF Form 618 as one of the required Medical Evaluation Board providers for cases involving mental health diagnoses. **(T-0).**

4.60.5. Whenever discussion does not result in a unanimous decision, the board recorder documents the vote tally and the reason for the disagreement on the back of the AF Form 618 and marks block 27 appropriately.

4.60.6. The following applies to boards for a mental health diagnosis or when cognitive dysfunction is expected:

4.60.6.1. Whenever a psychiatrist, is a member of the board, mark an "X" in the box to the right of the signature on AF Form 618, block 26. **(T-3).**

4.60.6.2. Psychiatric evaluations must include the degree of social and industrial impairment for civilian life, and degree of impairment for military service. **(T-3).**

4.60.6.3. The Medical Evaluation Board members must ensure that special provisions for reporting psychiatric cases have been followed. **(T-3).** When describing the degree of impairment for civilian, social and industrial adaptability for all boardable diagnosis (diagnosis that may render a member fit/unfit for continued service), use of terms for the level or degree of disability is limited to: Total, Severe, Considerable, Definite, Mild, or None. For degree of impairment for military service, use the degree of the service member's current and projected impairment for military service: No Impairment, Minimal, Moderate, or Marked.

4.60.7. Competency Boards and Sanity Boards. In a case where a service member's competency for pay and records is called into question, or in a Court-Martial case where a service member's sanity is called into question, the Medical Evaluation Board must be composed of three Uniformed Services Medical Corps officers, one of whom must be a psychiatrist. **(T-1).** [If the member is comatose, the member 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 the determination of the member's competence and annotates this in block 23a of the AF Form 618. If the member is declared incompetent for pay and records, check "OTHER" in block 22A, and add "AFMAN 65-116 V1." 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 the signature on AF Form 618, block 26. **(T-3).** For information/procedures for handling mentally incompetent individuals for pay purposes refer to Chapter 50 of AFMAN 65-116 V1, *Defense Joint Military Pay System Active Component (DJMS-AC) FSO Procedures*.

4.60.7.1. If member is found incompetent send an additional copy of the AF Form 618 to Accounting and Finance without delay. **(T-1).** Failure to safeguard the pay of members declared mentally incompetent to manage their own affairs has caused serious hardship to members and their families.

4.60.8. Boards under unique situations:

4.60.8.1. Service members who refuse required professional, medical or dental care, and/or other necessary treatment options may be required to meet a Medical Evaluation Board. Refer when:

4.60.8.1.1. The service member was clearly advised of the necessary course of treatment, therapy, medication, or duty limiting or physical restriction.

4.60.8.1.2. The service member's failure or refusal was willful or negligent and not the result of mental disease or of physical inability to comply.

4.60.8.1.3. The service member 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 Medical Evaluation Board determines:

4.60.8.1.3.1. Whether or not the service member requires the procedure in order to properly perform military duties or establish medical qualification for continued service.

4.60.8.1.3.2. 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 service member still refuses, forward the initial review-in-lieu-of package to DP2NP.

4.61. Medical Evaluation Board Review and Approval Authority. Clinical sufficiency review authority rests with the Chief of Medical Staff and Chief of Aerospace Medicine. The Medical Evaluation Board President, whether the Chief of Medical Staff or Chief of Aerospace Medicine, must review each completed Medical Evaluation Board package before it is submitted to AFPC/DPFD (IPEB), attesting to the following final review. **(T-1).**

4.61.1. The SM's potential Service-disqualifying medical condition and associated healthcare, has been adequately documented in the Narrative Summary which will not be older than 30 calendar days when received by AFPC/DPFD, and with appropriate attached consults that will be no older than 180 calendar days when received by AFPC/DPFD. **(T-1)**. **Note:** the 30 day timeline excludes the time the member is granted to submit a rebuttal, and the time the Convening Medical Authority is granted to respond to the rebuttal.

4.61.2. A physician's review of the Compensation and Pensions recorded via an addendum. A Narrative Summary with updated comments, or with a dated statement that no additions or clarifications were required, or a continuation statement, is substituted if multiple narrative summaries are present.

4.61.3. 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 office, rank, grade and/or rating. Ensure that the commander's letter used the template required by AFPC/DPFD, and will not be more than 180 calendar days old when received by AFPC/DPFD.

4.61.4. The AF Form 469 has been reviewed by a physician, preferably the Primary Care Manager and/or provider submitting the Narrative Summary, within the last 30 calendar days,

and a dated statement of review is located in the restrictions section of the AF Form 469. See paragraph 4.49.4.5.

4.61.5. Service member'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.

4.61.6. The MTF commander or director is not required to sign AF Form 618, blocks 28 (a-d). Until the new AF 618 is produced, "not required per AFMAN 41-210" will be printed in block 28(c), prior to having the service member sign AF Form 618.

4.62. Notification of Medical Evaluation Board Results to Service Member. Following the recommendation of the Medical Evaluation Board, the Physical Evaluation Board Liaison Officer or Medical Evaluation Board clerk must ensure that blocks 1-27 of AF Form 618 are completed. **(T-2).** The Physical Evaluation Board Liaison Officer will meet with the member, provide a copy of the AF Form 618 and Narrative Summary/consults and commander's letter to the member, and explain the findings of the Medical Evaluation Board (without speculating on potential Physical Evaluation Board outcome) and answer any questions the service member may have regarding the content. **(T-2).**

4.62.1. The Physical Evaluation Board Liaison Officer will then explain the options of the Impartial Review and/or Rebuttal Letter, and give the service member three calendar days to decide if the member requests (1) an Impartial Review (with or without subsequent Rebuttal Letter); (2) to decline the Impartial Review and submit a Rebuttal Letter within three calendar days of the decision; or (3) to decline the Impartial Review and the Rebuttal Letter options. **(T-2).**

4.62.2. If the service member declines the Impartial Review and Rebuttal Letter options, the Physical Evaluation Board Liaison Officer will ask the service member to sign and date the AF Form 618, blocks 29(a) and 29(b) signifying that the member has been informed of the findings and recommendations of the Medical Evaluation Board. **(T-2).**

4.62.2.1. After the member signs the AF Form 618, the Physical Evaluation Board Liaison Officer assembles and forwards the Medical Evaluation Board package to the Informal Physical Evaluation Board.

4.63. Impartial Review. If the service member requests an impartial review, an impartial physician or other appropriate healthcare professional (not involved in the service member's Medical Evaluation Board process) must be assigned to offer a review of the medical evidence presented by the Narrative Summary and associated consults. **(T-2).**

4.63.1. The impartial medical provider shall advise the service member within three calendar days on whether the Medical Evaluation Board findings adequately reflect the complete spectrum of injuries and/or illnesses. **(T-2).** For cases in which the Impartial Review does not validate the Medical Evaluation Board findings, the Impartial Reviewer will contact the Medical Evaluation Board President (Chief of Medical Staff or Chief of Aerospace Medicine who signed block 26 on AF Form 618) concurrently with notification to the service member. **(T-3).**

4.63.1.1. In such cases, the Medical Evaluation Board President must consider whether changes to the Medical Evaluation Board package are warranted, and whether to reconvene the Medical Evaluation Board once changes have been documented. **(T-3).**

4.64. Rebuttal Letters. Armed with the decision of the Medical Evaluation Board and, if requested, the information from the Impartial Review, the member may choose to submit a Rebuttal Letter to the Medical Evaluation Board Convening Medical Authority.

4.64.1. The Convening Medical Authority is the MTF commander, director or a senior medical officer appointed by the MTF commander or director. The Convening Medical Authority should have detailed knowledge of directives pertaining to standards of medical fitness and disposition of patients, disability separation processing, and be familiar with the VA Schedule for Rating Disabilities. The Convening Medical Authority or acting Convening Medical Authority should not be one of the three physicians who served on the Medical Evaluation Board and should not be the Impartial Reviewer for the case being rebutted.

4.64.2. If the service member requested an Impartial Review, the service member shall be afforded three calendar days from the date of Impartial Reviewer notification of review results to prepare a Rebuttal Letter. **(T-3).** Submit it to the Medical Evaluation Board Convening Medical Authority, who shall be afforded three calendar days to consider the Rebuttal Letter and return the fully documented decision to the service member. **(T-3).**

4.64.3. If the service member does not request an Impartial Review, but chooses to submit a Rebuttal Letter, the service member will be afforded three calendar days from the date of decision established in paragraph 4.61.1 to prepare a Rebuttal Letter and submit it to the Medical Evaluation Board Convening Medical Authority, who shall be afforded three calendar days to consider the Rebuttal Letter and return the fully documented decision to the service member. **(T-3).**

4.64.4. If the member submits a Rebuttal Letter, the Medical Evaluation Board results shall not be forwarded to the Physical Evaluation Board until the Rebuttal process is finalized and Medical Evaluation Board results indicate the service member may be unfit for duty. The fully documented Rebuttal Letter must state the reason for rebuttal submission; all documents to include the response will be included with the Medical Evaluation Board package sent to the Physical Evaluation Board. **(T-2).** Exceptions to timelines may be granted by an authority appointed by the SECAF.

4.64.5. At the conclusion of the Impartial Review and/or Rebuttal process, the Physical Evaluation Board Liaison Officer will inform the member of the results and ask the member to sign and date the AF Form 618, blocks 29(a) and 29(b) signifying that the member has been informed of the findings and has received the response to the Rebuttal Letter, and recommendations of the Medical Evaluation Board. **(T-3)**.

4.64.5.1. After the Physical Evaluation Board Liaison Officer meets with the member, the Physical Evaluation Board Liaison Officer assembles the package and forwards it to Informal Physical Evaluation Board.

4.64.6. If the service member has been determined to be incompetent (blocks 22 and 23 of AF Form 618), the Medical Evaluation Board recorder or Physical Evaluation Board Liaison Officer addresses the above mentioned action to the service member's legally authorized

representative, who is entitled to the same rights, privileges, and counseling benefits as the service member.

4.65. Physical Evaluation Board Liaison Officer Medical Evaluation Board Special Considerations. The following paragraphs detail special considerations that may be necessary for processing a Medical Evaluation Board.

4.65.1. For privileged providers undergoing Medical Evaluation Board, the Chief of the Medical Staff will submit a statement regarding the current status of the privileges. **(T-2).** A simple memorandum format is acceptable, although a DD Form 2499, *Health Care Practitioner Action Report*, is recommended if the provider is unlikely to return to full and unrestricted duty. For non-credentialed providers enrolled to Graduate Medical Education training programs, the Program Director will provide this statement for the package.

4.65.2. A copy of AFPC/DP2NP waiver approval to conduct Medical Evaluation Board locally for certain service members assigned to the MTF. Refer to paragraphs 4.53.3-4.53.5.

4.65.3. AF Form 565 if applicable.

4.65.4. Other reports as needed or requested for ARC service members.

4.65.5. Cases returned from AFPC/DPFD due to the need for additional information, the MTF commander or director, or designee, is required to respond by endorsement confirmation, that the requested information was obtained. **(T-1).** AFPC determines the package return suspense date.

4.65.6. The MTF commander or director or designee will advise members of the Medical Evaluation Board and examining physician that the case was returned, the reason for its return, and suspense any requests. **(T-3)**.

4.65.7. Changes in Condition/New Condition in Service Members undergoing Informal Physical Evaluation Board adjudication.

4.65.7.1. If a service member, for whom a Medical Evaluation Board case has already been sent to the Informal Physical Evaluation Board, is diagnosed with a new boardable condition, the case may require a recall of the previously submitted case. A boardable condition is a condition that may render a member fit/unfit for continued service. If a recall is indicated, the MTF commander or director or designee will contact AFPC/DPFD in writing per AFI 36-3212, Chapter 2, to request the recall. **(T-1).**

4.65.7.2. If a service member receives or possesses orders for separation or retirement as a result of a disability determination, and the service member has not yet been released from AD and then experiences a significant clinical change in their condition, the MDG/CC or designee will contact AFPC/DPFD (not DP2NP) to ascertain whether retirement or separation orders should be revoked and another Medical Evaluation Board be initiated. **(T-1)**.

4.65.8. Unit Commander Notification of Disability Evaluation System Findings Process:

4.65.8.1. The Physical Evaluation Board Liaison Officer will enter the commander, first sergeant, or designee email address into Right Now Technology via myPers. This allows the commander, first sergeant, or designee to receive Right Now Technology notifications

via electronic mail from the Air Force Personnel Center notifying recipients of the service member's case status throughout the Disability Evaluation System process.

4.65.8.2. Once the Disability Evaluation Board findings are received, within 24 hours of receipt, the Physical Evaluation Board Liaison Officer must notify the commander, first sergeant, or designee prior to providing the service member their Informal Evaluation Board, Formal Evaluation Board or Secretary of the Air Force findings. **(T-1).**

4.66. MTF Commander or Director Responsibilities in the Disability Evaluation System. Every MTF commander or director must establish and maintain a viable Medical Evaluation Board process. **(T-3)**. The MTF commander or director will appoint in writing the primary and secondary Convening Medical Authorities. **(T-3).**

4.66.1. Copies of current appointment letters will be updated, at least annually, and whenever new members are appointed. **(T-3).** Letters are maintained by the TRICARE Operations and Patient Administration Flight Commander or Flight Chief. Copies are forwarded to AFPC/DP2NP and AFMOA/Chief of Medical Staff 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 TRICARE Operations and Patient Administration Flight's files.

4.66.2. Each MTF will identify an experienced NCO, SNCO, officer, federal civilian employee or contract employee (with commensurate experience and/or skill level) as the Physical Evaluation Board Liaison Officer. It is recommended MTFs consider the importance of continuity when identifying a Physical Evaluation Board Liaison Officer. The TRICARE OPERATIONS AND PATIENT ADMINISTRATION Flt/CC or NCOIC will notify AFPC/DP2NP and AFMOA/SGAT of any Physical Evaluation Board Liaison Officer changes. **(T-1).** The MTF shall maintain all initial and current annual Physical Evaluation Board Liaison Officer proof of training documents (copies of training certificates and/or letters of training certification or validation). **(T-3).** Maintain these documents within the MTF TRICARE Operations and Patient Administration Flight's records for the duration of the Physical Evaluation Board Liaison Officer's tenure.

4.66.2.1. The primary reference points for Physical Evaluation Board Liaison Officer responsibilities include this AFMAN and AFI 36-3212. Various other reference materials and tools can be found on the AFMS Knowledge Exchange in the AFMOA Health Benefits site at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

4.66.2.2. Physical Evaluation Board Liaison Officer Training. Physical Evaluation Board Liaison Officer responsibilities are varied and numerous, which makes a sole source for training difficult. Minimal, core Physical Evaluation Board Liaison Officer training requirements are outlined in DoDI 1332.18, Disability Evaluation System (DES). If a formal Physical Evaluation Board Liaison Officer training course is available, every effort should be made to allow each active MTF Physical Evaluation Board Liaison Officer to attend. A formal course is defined as a training program recognized either by AETC or other standardized joint-service academic certification authority. Other training venues, to include web-based platforms, can be used to provide Physical Evaluation Board Liaison Officer training. Regardless of the venue, the MTF should have a means to periodically measure and document each Physical Evaluation Board Liaison Officer's proficiency level.

All training documentation will be maintained in TRICARE Operations and Patient Administration training records for each individual for at least three years or the duration of the Physical Evaluation Board Liaison Officer's assignment. **(T-3).**

4.66.2.3. In rare cases, a Physical Evaluation Board Liaison Officer may be deemed qualified in lieu of formal or informal training. Based upon the recommendations by 1) the Patient Administration Officer, TRICARE Operations and Patient Administration Flight Commander, 2) the Chief of Medical Staff, and 3) the Chief of Aerospace Medicine. The MTF commander or director must determine when a Physical Evaluation Board Liaison Officer trainee is qualified. **(T-3).** The trainee is qualified when a reasonable minimum training and job qualification experience level is reached. This determination must be documented and maintained in the TRICARE Operations and Patient Administration Training Records. **(T-3).** This is maintained for a period of no less than three years from the date the determination is made by the MTF commander or director.

4.66.3. Upon assignment, each new Physical Evaluation Board Liaison Officer should spend at least one full work week working with an experienced Physical Evaluation Board Liaison Officer before assuming fulltime Physical Evaluation Board Liaison Officer duties. If no experienced Physical Evaluation Board Liaison Officer is available within the MTF to provide required training, the MTF commander or director should consider the alternative to, a) arrange for the new Physical Evaluation Board Liaison Officer to travel to another MTF to receive training or, b) sponsor a Physical Evaluation Board Liaison Officer from another MTF to travel to their MTF to provide required training. Verification of required Physical Evaluation Board Liaison Officer training shall be forwarded to AFMOA/SGAT on a quarterly and annual basis according to the established reporting format. **(T-1).** On-the-job training will be documented and specifically targeted to meet the requirements identified on a standardized AF Form 797. **(T-3).**

4.66.4. The Physical Evaluation Board Liaison Officer's active Medical Evaluation Board caseload (Medical Evaluation Board and Temporary Disability Retired List cases) shall not exceed 34. **(T-3).** If exceeded, opportunities should be explored to supplement the Physical Evaluation Board Liaison Officer manning. In the event the caseload exceeds 34 on a consistent basis, the MTF should research and pursue available options to permanently increase the number of Physical Evaluation Board Liaison Officers.

4.66.5. Integrated Care Coordination for Airmen in the Disability Evaluation System.

4.66.5.1. When Airmen enter into, and as they progress through the phases of the Disability Evaluation System, their care, guidance, and support is entrusted to the Care Management Team. The Care Management Team consists of the Recovery Care Coordinator, Veterans Affairs Medical Service Coordinator, Physical Evaluation Board Liaison Officer, Medical Case Manager, Non-medical Case Manager, medical providers and other key personnel. The responsibilities and requirements of the Care Management Team and the definition of the Continuum of Care are contained in AFI 34-1101, *Warrior and Survivor Care*.

4.66.5.2. The MTF commander or director will develop processes to ensure integrated coordination of care for Airmen entered into and/or progressing through the Disability Evaluation System at their MTF. **(T-1).**

4.66.5.2.1. The primary means to accomplish this coordination will be to ensure a single nexus point—physical or virtual—which promotes the following best practices:

4.66.5.2.1.1. Centralized access - To the greatest extent possible, provides Airmen easy access to all members of the Care Management Team to conduct services in a single visit and/or location (i.e., one stop resolution).

4.66.5.2.1.2. Warm hand-offs - Referral practices allowing the transfer of care/support between two members of the Care Management Team. Preferably, the hand-off occurs in front of the Airman in real time.

4.66.5.2.1.3. Intake meetings/process - A coordinated approach that aligns expectations, achieved by an initial meeting which outlines the roles of each member of the Care Management Team, and considers the goals of the Airman.

4.66.5.2.1.4. Case tracking - A method/technique to bring transparency to a process allowing all Care Management Team members and the Airman to remain informed of when an activity is taking place, reducing confusion, and ensuring accountability.

4.66.5.2.1.5. Cross-functional communication - Encourages each member of the Care Management Team to bring their functional expertise to work towards the common goal of assisting the Airman through Continuum of Care processes.

4.67. Performance Reporting and Oversight. Mandatory DoD quarterly and annual Disability Evaluation System reporting requirements were established by DoDI 1332.18, Disability Evaluation System (DES). Other reporting requirements may be established by agencies within the DoD. Guidance for those requirements should be provided by the requesting agency.

4.67.1. Mandatory Disability Evaluation System Quarterly Reports:

4.67.1.1. Caseload & Training Reporting. Quarterly, each MTF responsible for processing active Medical Evaluation Board cases will provide the required data for that quarter. Each MTF will report **(T-1):**

4.67.1.1.1. The total number of cases (separated by category) for active Medical Evaluation Board cases, Temporary Disability Retired List cases, initial review-in-lieu-of cases, and Integrated Disability Evaluation System Pre-screening.

4.67.1.1.2. The number of assigned Physical Evaluation Board Liaison Officers.

4.67.1.1.3. The percentage of assigned Physical Evaluation Board Liaison Officers who are 100% trained.

4.67.1.2. Report this information to AFMOA/SGAT no later than the fourth calendar day following the close-out of each reporting quarter. **(T-1).** Officials at AFMOA/SGAT will consolidate all the data into one report and forward to AFMSA/SG3S no later than the sixth duty day after the close out date of the reporting quarter. AFMSA will consolidate further and forward final data reports to AFPC/DPFD and other agencies as required.

4.67.2. Mandatory Disability Evaluation System Annual Report: Following the close-out of each fiscal year, each Service is required to submit an annual Disability Evaluation System Report to Office of the Under Secretary of Defense for Personnel and Readiness. In addition to validating composite data for the entire year, any additional queries requested from

Personnel and Readiness are provided as well. Forwarding of the report to AFPC/DPFD and other agencies remain the same as the quarterly reports.

4.67.3. Internal Metrics/Tracking Systems: Each MTF will create metrics to identify and monitor delays in the medical board process. **(T-3).** MTFs will document and track causes for delays until corrected. **(T-3).** Monthly, MTFs will report to AFMOA/SGAT any delays causing a case file to exceed established timelines and what corrective actions have been taken. **(T-1).** AFMOA/SGAT will maintain centralized Integrated Disability Evaluation System timeliness metrics for all MTFs.

4.68. Airman Medical Transition Unit (AMTU) Assignment.

4.68.1. 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 Medical Evaluation Board processing.

4.68.1.1. Care will not be delayed for the purposes of completing paperwork for an AMTU assignment, even when that is a likely outcome. Chief of Medical Staff coordination is required prior to initiating an attachment TDY to an AMTU. Prior to placing a service member in TDY status, the service member's home MTF should notify the accepting/gaining Chief of Medical Staff, Medical Support Squadron (MDSS) commander, and the Physical Evaluation Board Liaison Officer at the gaining MTF of the service member's status and anticipated length of treatment. Unless a PCS action occurs, the service member remains assigned and accountable to their home unit and the associated MTF Physical Evaluation Board Liaison Officer. Generally, an attachment TDY to an AMTU will be limited to the following situations:

4.68.1.2. Required medical care is not available in the service member's local or regional areas.

4.68.1.2.1. There is reasonable medical evidence which suggests the service member is expected to return to home station duty.

4.68.1.2.2. Immediate and/or urgent medical care or evaluation is required.

4.68.2. An AMTU can be established at any Air Force MTF regardless of size. When AFPC/DP2NP assigns/directs a service member to an AMTU, the member is relocated via official orders in either PCS or Permanent Change of Assignment (PCA) capacity. The MTF commander or director shall assume assignment and command authority over officers and enlisted members assigned to this unique unit. **(T-1).** The MTF commander or director may appoint an officer under the commander's or director's command to serve as the AMTU commander.

4.68.2.1. The appointed AMTU commander assumes administrative oversight and the Uniformed Code of Military Justice authority for assigned patients who have been PCSd. The Uniformed Code of Military Justice authority for patients attached TDY remains with the home unit.

4.68.2.2. Once an AMTU has been established, it may be designated as a flight, or a section of the TRICARE OPERATIONS AND PATIENT ADMINISTRATION flight.

4.68.3. Assignment (PCS or PCA) to an AMTU. AFPC/DP2NP is the sole approving authority for Active Duty AMTU PCS assignments and will base assignments on current

AF/SG and AFPC policy. Generally, assignment (PCS or PCA) to an AMTU will be limited to the following situations:

4.68.3.1. Required medical care is not available at CONUS/OCONUS MTFs or reasonably available in the local or regional areas.

4.68.3.2. The service member is incapacitated, is unable to serve the current line unit in any capacity, and is not likely to be retained on active duty.

4.68.3.3. When hospitalization beyond the service member's date of separation is expected. Contact AFPC/DP2NP to request a Medical Hold.

4.68.3.4. For overseas service members; when hospitalization beyond the member's Date Eligible for Return from Overseas is expected.

4.68.3.5. When a service member undergoes prolonged and/or intensive treatment, and requires proximity to a family support network.

4.68.4. Permanent Assignment Process: The requesting MTF Chief of Medical Staff initiates an AMTU PCS assignment by completing an AFPC/DP2NP - approved AMTU PCS worksheet and submitting it to AFPC/DP2NP. An example of an AMTU PCS worksheet is available on the AFMOA Health Benefits Kx page at **https://kx2.afms.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

4.68.5. Attachment TDY to an AMTU: MTF commanders/directors may publish TDY orders to move patients between MTFs. The patients may be temporarily attached to a 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 the member's home unit commander. Attaching patients to an AMTU does not require AFPC/DP2NP approval; however, AFPC/DP2NP can be consulted for lengthy TDYs or if TDY turns into a PCS.

4.68.6. Special Circumstances.

4.68.6.1. 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.

4.68.6.2. 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 action.

4.68.6.2.1. The AMTU commander in each case above will continue the administrative or discharge action. **(T-3).**

4.68.6.3. PCS action does not apply to RC Airmen who may travel to a MTF to receive Line of Duty related, pre-Medical Evaluation Board diagnostic treatment, and/or Medical Evaluation Board case processing. While at the MTF, RC service members are considered attached to the MTF.

4.68.6.4. Service members 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/DP2NP.

4.68.7. When AFPC/DP2NP dispositions (makes a determination) the case of a member currently assigned to an AMTU, and the member is found to meet medical retention standards, AFPC/DP2NP will notify the appropriate officer or enlisted assignment department at AFPC to send a message to the local Military Personnel Section with assignment instructions. **Note:** Service members must meet minimum PCS retainability requirements. **(T-2).**

4.68.8. Service members are not retained as hospital patients for rehabilitation in order to gain retention on active duty.

4.68.9. Service members are not placed in an AMTU in order to preserve terminal leave or otherwise to retain a member beyond the member's date of separation or retirement without specific guidance from AFPC/DP2NP. Once a service member is placed on terminal leave, the member is not permitted to change duty status without prior approval for Medical Hold or admission to a hospital for an emergency.

4.68.10. A service member is not placed in the AMTU when a LOD determination (formal or informal) is pending.

4.68.11. AMTU Staff Responsibilities.

4.68.11.1. Verify the TDY/PCS orders of each patient to ensure proper assignment and attachment, and assist the patient in correcting errors. **(T-3).**

4.68.11.2. Notify the First Sergeant of newly assigned or attached personnel. **(T-3).**

4.68.11.3. Assist the patient with unit, group, and wing in-processing requirements. **(T-3).**

4.68.11.4. Refer the patient to case management and other departments as appropriate. **(T-3).**

4.68.11.5. Ensure the patient is briefed on entitlements by responsible base support agencies. **(T-3).**

4.68.11.6. Provide appropriate updates on the patient's status to the AMTU commander and Chief of Medical Staff. If the patient is attached (TDY), keep the home unit updated on the patient's status. **(T-3).**

4.68.11.7. Maintain daily accountability and tracking of all patients assigned and attached. **(T-3).**

4.68.11.8. Assist, as necessary, with lodging and resolving related issues. **(T-3).**

4.68.11.9. Assist, as necessary, with pay/finance issues. **(T-3).**

4.68.11.10. Assist, as necessary, with career milestones activities such as promotion and retirements ceremonies. **(T-3).**

4.68.11.11. Ensure patient goes to their medical appointments and if necessary, assist patient in getting to their appointments. **(T-3).**

4.68.11.12. Provide patient with a 24-hour point of contact for the AMTU. **(T-3).**

4.68.11.13. Mentor/counsel patient as needed. **(T-3).**

4.68.11.14. In coordination/approval by the AMTU commander, may place both assigned and attached patients in a MTF or external line unit work center provided:

4.68.11.14.1. The patient is physically and/or mentally capable of completing reasonable normal daily activities.

4.68.11.14.2. The temporary placement of a patient within a work center can be safely accomplished without interfering with the member's treatment, Medical Evaluation Board, or clinical or non-clinical case processing.

4.68.11.14.3. The patient's attending provider supports the decision, and duty restrictions are documented on the AF Form 469.

4.68.11.14.4. The patient is able to wear the uniform (shoe waiver may be used).

4.68.11.14.5. The AMTU commander is able to secure placement approval or permission to place the patient within the work center.

4.68.12. For situational awareness and support, the AMTU commander will notify the wing commander (or equivalent) when patients are assigned or attached to the AMTU. **(T-3).**

4.69. VA Office. See benefits eligibility guidance based on service member's status in AFI 36-3026_IPV1. The VA should be contacted directly for counseling on available benefits.

4.69.1. Request for Bed. If required, a VA bed may be obtained for a service member if prolonged hospitalization will be required. This request is processed through the TRANSCOM Regulating and Command & Control Evacuation System (TRAC^{2}ES).

4.69.2. Patient Status. Active Component service members who must be treated at a VA Hospital before retirement are ordered Permanent Change of Station (PCS) without Permanent Change of Assignment (PCA). **(T-3).** The servicing Military Personnel Section retains responsibility. If a service member has a PCS to a VA hospital, they will be assigned to the nearest Air Force MTF AMTU. **(T-3).**

4.70. The Recovery Care Coordinator.

4.70.1. The Recovery Care Coordinator serves as an independent advocate for wounded, ill and injured airmen. The ultimate purpose of the Recovery Care Coordinator is to ensure that recovering Airmen and families understand the likely path of the member's recovery, the types of care and services that will be needed and provided, and how much time recovery may take. Recovery Care Coordinators work with Medical Care Case Manager and Physical Evaluation Board Liaison Officer to assist in activities associated with the Integrated Disability Evaluation System process. Recovery Coordination Program management guidance is provided in AFI 34-1101.

4.70.1.1. For the convenience of the Recovering Service Member, Recovery Care Coordinators are often provided office space within the MTF. However, Recovery Care Coordinators perform services in furtherance of personnel activities, and do not function in roles of Treatment, Payment, or Healthcare Operations on behalf of the MTF. Because they are neither healthcare personnel nor healthcare business associates, Recovery Care Coordinators are not required to complete HIPAA training.

4.70.1.2. Disclosures of PHI to Recovery Care Coordinator personnel fall under the category of 'Required by Law,' and must be properly documented in the PHI Management Tool or the AFMS approved disclosure accounting tool. **(T-0).** The Recovering Service Member does not have to give authorization for disclosure of the PHI as part of the initial

referral process. Recovery Care Coordinator access to PHI is limited to Recovering Service Members participating in the Recovery Coordination Program, therefore, no disclosure of PHI should occur beyond the Recovering Service Member's tenure in the program, nor should disclosure of PHI occur for those Recovering 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 AFI 41-200, to avoid logging each disclosure. MTF HIPAA privacy officers may obtain additional information on proper use of this provision by contacting the AFMS HIPAA Support Team.

4.70.1.3. To allay concerns MTF staff members may have about limiting disclosure of PHI to the relevant requirements of the law under AFI 41-200, Recovering Service Members may be asked to sign a DD Form 2870. A signed and valid DD Form 2870 provides the Recovery Care Coordinator broad access to PHI, to the full extent of the Recovering Service Member's authorization in Section II of the form. A signed DD Form 2870 should eliminate any dispute between the MTF staff and the Recovery Care Coordinator regarding the scope of information needed by the Recovery Care Coordinator.

4.70.2. Recovering Service Members may self-refer to the Recovery Coordination Program, or be referred by their command or medical provider after medical screening. To optimize teamwork, care coordination, and the recovery process of Recovering Service Members participating in the Recovery Coordination Program, the MTF commander or director shall:

4.70.2.1. Establish procedures to verify the identity of Recovering Service Members participating in the Recovery Coordination Program. **(T-3)**

4.70.2.2. Establish effective communication processes with local Recovery Care Coordinators to ensure timely referrals of Recovering Service Members who might benefit from the program's services. **(T-3)**

4.70.2.3. Ensure Healthcare Providers and Medical Care Case Manager are well-versed with the Recovery Coordination Program. **(T-3)**

4.70.2.4. Ensure Physical Evaluation Board Liaison Officers develop a solid partnership with the Recovery Care Coordinators assigned to work with Recovering Service Members at their MTF, location, or region and keep the Recovery Care Coordinators advised of the Recovering Service Member's status throughout the Integrated Disability Evaluation System process. **(T-3)**

4.70.2.5. Ensure Recovery Care Coordinators are invited to meetings in which the cases of Recovering Service Members participating in the Recovery Coordination Program are discussed. **(T-3)**

4.71. Temporary Disability Retired List.

4.71.1. Temporary disability retirement occurs when a service member is found unfit for duty, and subsequently entitled to disability retirement status, yet the service member's medical condition is not yet stable enough to ascertain whether the medical condition may improve or warrant permanent disability retirement status.

4.71.2. Title 10, USC § 1210, requires reexamination of all members on the Temporary Disability Retired List at least every 18 months to monitor changes in the condition(s). The medical facility conducts the examination according to AFI 48-123. AFPC/DPFD usually

schedules the initial examination 16 months after placing the member on the Temporary Disability Retired List so the medical facility can complete it before the end of the 18th month. Schedule the exams at the Air Force medical facility, with the required capability, nearest to the member's home, or the nearest DoD medical facility if indicated by the member's medical condition. Extensive guidance is located in AFI 36-3212. See further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement in AFI 36-3026_IPV1.

4.71.3. Procedures for Periodic Examinations.

4.71.3.1. Approximately 60 calendar days prior to the reporting date, Air Force Personnel Center, Directorate of Airmen and Family Care (AFPC/DPFDC) will send the previous Temporary Disability Retired List medical records and instructions to the examining facility and request a Temporary Disability Retired List medical appointment. **(T-1).** The MTF must respond within 10 calendar days and provide date and time of the appointment. **(T-1).** If the medical facility cannot conduct the examination, it must return the records within 15 calendar days of receiving the request to AFPC/DPFDC. **(T-1).** The member shall provide to the examining physician, for submission to the Physical Evaluation Board, copies of all medical records (civilian, VA and all military medical records) documenting treatment since the last examination. **(T-1).** If the member fails to report for the examination on the scheduled reporting date, the medical facility must advise AFPC/DPFDC immediately. **(T-1).**

4.71.3.2. 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 AFPC/DPFD within 30 calendar days of examination and ensure all laboratory studies and consultations have been completed and included in the report. The commander advises AFPC/DPFD in writing of any delay and provides an estimated date of report completion.

4.71.3.3. 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 in accordance with AFI 48-123. **(T-1).**

4.71.3.4. Temporary Disability Retired List members who are imprisoned or confined by civil authorities must also have a periodic examination. **(T-2).** AFPC/DPFD requests a report of examination and a copy of the commitment order, when appropriate, from the confinement institution.

4.71.4. If a military retiree on the Temporary Disability Retired List requires a mental competency status determination, AFPC/DPFD will designate a MTF to conduct this board. Further, the MTF will conduct the Temporary Disability Retired List periodic evaluation.

4.71.5. Travel and Per Diem Allowance. Service members traveling to a medical facility for examination, or to Lackland Air Force Base, TX for the formal Physical Evaluation Board, receive travel and per diem (including meals and lodging) allowance based on their retired grade (Joint Travel Regulation).

4.71.5.1. The service member is authorized an escort to the place of examination only when the member is not physically or mentally able to travel without help.

4.71.5.2. Approximately 20-30 calendar days prior to the reporting date, AFPC/DPFD 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.

4.71.5.3. The medical facility endorses the order to verify whether they examined the service member as an inpatient or outpatient, as well as the dates and times the member reported and was released after completing the examination.

4.71.5.4. If the examination was in outpatient status, indicate whether the member occupied government quarters. The examining facility must ensure the service member has an endorsed order to submit the claim for reimbursement. **(T-3).** The service member submits a travel voucher for reimbursement. Reference the Joint Travel Regulation for further travel entitlement information.

4.72. ARC and Air Reserve Command Surgeon or Air Surgeon. For ARC personnel, the respective ARC Surgeon General's Office is the approval authority for Assignment Limitation Code, Medical Hold decisions, and non-emergent surgery requests within final six months of service. AD MTFs should contact the appropriate ARC Surgeon General's Office when confronted with these issues involving ARC personnel. **(T-3).**

4.72.1. Procedures for ARC Service Members. Medical Evaluation Boards for ARC service members entitled to disability evaluation processing shall be convened at AD MTFs. **(T-1).** Refer to AFI 36-3026_IPV1 for further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement.

4.72.1.1. Determining Eligibility and Pre-Medical Evaluation Board Case Processing. Medical Evaluation Board initiation or case processing cannot begin for any ARC service member without a properly completed AF Form 348 or DD Form 261. Whenever an ARC service member is referred for a Medical Evaluation Board, the Physical Evaluation Board Liaison Officer will establish contact with the medical Air Reserve Technician or ANG Health System Technician at the ARC service member's supporting ARC unit. **(T-2).** In cases where the ARC service member is on Medical Continuation orders and is processing through Integrated Disability Evaluation System (see AFI 36-2910, Chapter 5), the Physical Evaluation Board Liaison Officer will also contact the ARC Case Management Division. **(T-2).** The medical Air Reserve Technician, ANG Health Services Technician, and Physical Evaluation Board Liaison Officer will maintain contact with the ARC service member to obtain all required documents and arrange for medical TDY. **(T-2).** The Physical Evaluation Board Liaison Officer will notify the Air Reserve Technician or ANG Fulltime Point of Contact prior to initiating the Medical Evaluation Board. **(T-3).** If the Physical Evaluation Board Liaison Officer is unable to contact the medical Air Reserve Technician or ANG Fulltime Point of Contact, the Physical Evaluation Board Liaison Officer shall contact the respective ARC Command level Medical Support (Surgeon General) or Aerospace Medicine (SGP) office for assistance. **(T-2).**

4.72.1.2. Line of Duty. A completed AF Form 348, or DD Form 261 with an "In Line of Duty" determination is required before any ARC service members can be considered for disability. **(T-2).** If the necessary Line of Duty determination form is not in the medical records, or if the Line of Duty determination is unclear or confusing, the ARC service member will be referred to the supporting ARC for Line of Duty review. **(T-2).** Once 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 AF Form 348, or DD Form 261, shall be identified on the AF Form 618 as the reason for Medical Evaluation Board processing. **(T-2).**

4.72.1.3. The appropriate administrative Line of Duty representative at the ARC service member's unit must contact the DHA-Great Lakes and inform the service office that the ARC service member has been referred for Medical Evaluation Board review. **(T-2).** The unit Line of Duty representative will also furnish a completed copy of the Line of Duty report to the DHA-Great Lakes. **(T-2).**

4.72.1.4. Medical Records on ARC service members undergoing Medical Evaluation Board or Review-In-Lieu-Of will be forwarded along with the Medical Evaluation Board report, the commander's letter and other supporting documentation, and the following:

4.72.1.5. 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.

4.72.1.6. A completed and signed copy of the AF Form 348, or DD Form 261, as appropriate.

4.72.1.7. Medical documentation and medical information unique to Reserve personnel.

4.72.1.8. Expedited Processing of ARC Medical Evaluation Board Continuation Cases at 59th Medical Wing, Joint Base San Antonio-Lackland, TX.

4.72.1.8.1. ARC service members who are injured or become ill while on USC, Title 10 military orders may be eligible for Medical Continuation orders while receiving treatment for their condition.

4.72.1.8.2. During the treatment process, it may be determined that the ARC service member requires a Medical Evaluation Board. It is at this time that the MTF historically responsible for providing the majority of medical support to the ARC military unit, is generally responsible for processing the Medical Evaluation Board.

4.72.1.8.3. The objective of Medical Continuation is to enhance utilization and readiness of personnel while preserving their health and preventing further injury or illness. Medical Continuation extends AD for ARC service members when further medical evaluation is warranted, as set forth in AFI 48-123. Refer to AFI 36-2910 for information regarding policy, responsibilities, and procedures for authorizing Medical Continuation orders.

4.72.1.8.4. Processing ARC Medical Evaluation Board cases can prove to be difficult for 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 ARC Medical Evaluation Board 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 Medical Evaluation Board process locally.

4.72.1.8.5. The criteria established for expedited processing of Medical Continuation cases at the 59th Medical Wing are as follows:

4.72.1.8.5.1. Cases identified for imminent Medical Evaluation Board processing AAC 37 personnel status – with completed Line of Duty determination.

4.72.1.8.5.2. Appointments required but not available at the local MTF or within a reasonable one day's travel (by automobile) at a TRICARE network provider. Unavailable appointments may be any of the following types; medical, surgical, or mental health.

4.72.1.8.6. ARC personnel with significant medical conditions that require persistent clinical care may be attached, not assigned, to a MTF AMTU during Medical Evaluation Board processing.

4.72.1.8.7. The MTF commander or director will notify the appropriate ARC command surgeon when a Medical Evaluation Board is required for an ARC flag officer. **(T-2).**

4.72.1.8.8. The list below contains contact information for the appropriate ARC Surgeon General's Office:

Air Force Reservists.
HQ AFRC/SGO
135 Page Road
Robins Air Force Base, GA 31098

Individual Mobilization Augmentees.
RMG/IRMS
233 North Houston Road, Suite 131A
Warner Robins, GA 31098

Air National Guardsmen
HQ NGB/SGPA
3500 Fetchet Avenue
Joint Base Andrews MD 20762-5157

4.72.1.8.9. AFR members not entitled to disability processing will be evaluated in accordance with AFI 48-123 and AFR medical policy guidance. ANG members not entitled to disability processing will be evaluated in accordance with AFI 48-123 and ANG medical policy guidance. For mission purposes, commanders and their designees, to include personnel offices, must receive medical information. **(T-2).** Only the minimum necessary will be provided. If disclosures of this information have not been previously authorized by the service member, the MTF will account for the disclosures in accordance with AFI 41-200. **(T-0).**

4.73. Assignment Limitation Code.

4.73.1. Definition. Assignment limitations, permanent or semi-permanent, are used to alert personnel managers of long term constraints on assignment or utilization of Airmen. They broadly restrict, or limit the selection of Airmen for assignment to or from certain duties or areas and apply to a duration longer than just to the current duty assignment. Reference AFI 36-2110, *Total Force Assignments*. When an AD member has been returned to duty by the Air Force Disability Evaluation System as fit, DP2NP will review the case to determine if an

Assignment Limitation Code needs to be placed in the Personnel Data System. This action is taken by the appropriate ARC Surgeon General's Office when the member is an ARC service member. 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 Assignment Limitation Code 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.

4.73.2. Authority. AFPC/DP2NP retains sole authority to assign or remove the Assignment Limitation Code on AD members, while the respective ARC Surgeon General's Office is the authority to assign or remove the Assignment Limitation Code or Deployment Availability Code-42 for ARC service members.

4.73.2.1. DP2NP (or the appropriate ARC authority) may assign the following Assignment Limitation Code 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 DP2NP or the respective ARC Surgeon General's Office.

4.73.2.1.1. Assignment Limitation Code X with a C1 Stratification: This stratification will be used primarily to identify individuals with temporary or mild conditions requiring medical follow-up but whose condition is clinically quiescent (inactive or unlikely to cause serious impact) if untreated or treatment is limited to primary care during periods of deployment or assignment.

4.73.2.1.2. Assignment Limitation Code Y with a C2 Stratification: This stratification 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 Outside CONUS (OCONUS) or to non-fixed environments if appropriate specialty care is available, or for short periods of time.

4.73.2.1.3. Assignment Limitation Code C with a C3 Stratification: This stratification designates members who should not be deployed or assigned away from specialty medical capability required to manage their unique medical condition.

4.73.2.2. Officials at DP2NP (or ARC Surgeon General's Office) will stratify Assignment Limitation Codes during each annual Review-In-Lieu-Of review.

4.73.2.3. AD and ARC MTF commanders/directors are responsible for tracking and keeping wing commanders updated on those members of the command who are on Assignment Limitation Code or Deployment Availability Code-42 and will assure timely medical review as specified by DP2NP or the appropriate ARC Surgeon General's Office during the year indicated. **(T-3).** Medical reviews are conducted periodically, as specified by the appropriate authority, depending on the diagnosis.

4.73.3. Requests to Allow Deployment or Overseas Assignment for Airmen with an Assignment Limitation Code. The Assignment Limitation Code is designed to limit, but not prevent 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.

4.73.3.1. Initiation of Waiver Requests. When a service member who carries an Assignment Limitation Code restriction is notified of an overseas PCS or deployment, the member's garrison MTF must initiate and process an Assignment Limitation Code waiver request in an expeditious manner. **(T-3).** The MTF may become aware of the member's selection for deployment/PCS via notification from the member, the member's commander, the Military Personnel Section, 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 will contain the following information **(T-3):**

4.73.3.1.1. The most recent Review-In-Lieu-Of narrative.

4.73.3.1.2. A current AF Form 469 with all duty and deployment limitations reviewed/validated within the last 30 calendar days.

4.73.3.1.3. The most recent medical record entry (typically from AHLTA) or similar electronic system) that addresses the condition for which the service member was issued an Assignment Limitation Code. If the most recent medical record entry is greater than 30 calendar days old, the Primary Care Manager 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 Primary Care Manager 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 Primary Care Manager is not required, but may be accomplished within the 10-day window if the Primary Care Manager feels it is indicated.

4.73.3.1.4. 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 will allow the waiver authority to specifically assess the deployed assignment.

4.73.3.2. Within 10 duty days of MTF notification of the assignment, the waiver review package will be forwarded to the appropriate waiver authority. **(T-3).** If it is determined that additional testing or evaluation is required to fully assess the service member's ability to meet the assignment requirements, the package may be delayed for an additional 10 duty days, upon approval of the Chief of Medical Staff or Chief of Aerospace Medicine, in order to accomplish these clinical evaluations. However, if obtaining these additional evaluations will take longer than 20 total calendar days from initial assignment notification, the waiver package will be sent to the waiver authority within the first 10 calendar days of

initial notification with an explanation of how long it is projected for the evaluations to be completed. **(T-3).**

4.73.3.2.1. If the member is being followed by specialists, the most recent specialty note should also be included, if not fully detailed in the Review-In-Lieu-Of. 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 the primary care manager determines 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 Chief of Aerospace Medicine or Chief of Medical Staff. The Primary Care Manager will notify the Physical Evaluation Board Liaison Officer, who will work with the TRICARE Operations and Patient Administration office to ensure that the member's consult for deployment clearance is expedited. **(T-3).** Approvals for delayed (greater than 10 duty days) Assignment Limitation Code waiver request submissions must be documented in the Deployment Availability Working Group minutes, and for any delayed waiver request, the time from initial request, to submission to the waiver approval authority, must be tracked by the Deployment Availability Working Group. **(T-3).** Any time submission of a waiver request exceeds 20 (twenty) duty days, the Physical Evaluation Board Liaison Officer must contact (1) the office that initiated the waiver request and (2) the service member's commander, to inform them of the delay in processing the waiver. **(T-3).**

4.73.3.3. Waivers for Members with Assignment Limitation Code X with C1 Stratification. All Assignment Limitation Code waiver requests will be documented in the next Deployment Availability Working Group meeting with explanations of any delays in processing. **(T-3).** However, it is not necessary to delay processing a waiver package until the next Deployment Availability Working Group meeting. This will allow the Deployment Availability Working Group to monitor trends in this process.

4.73.3.3.1. Assignment Limitation Code X with C1 Stratification: Deployable/Assignable to Global DoD fixed facilities with intrinsic Medical Treatment Facilities (except for the locations listed in 4.73.3.3.2), without an Assignment Limitation Code waiver. For a list of fixed MTFs, refer to the AFPC Medical Retention Standards Branch.

4.73.3.3.2. Assignment Limitation Code X with C1 Stratification requires a waiver for PCS, Deployment or TDY to any isolated or remote installations overseas, including bases at Soto Cano, Moron, Diego Garcia, Thule, Al Udeid, Izmir, etc. Lajes Field, Eielson Air Force Base, 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 Assignment Limitation Code-C1 identifier require a waiver to be assigned.

4.73.3.3.3. Assignment Limitation Code X with -C1 Stratification 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.

4.73.3.3.4. The waiver approval authority for Airmen with Assignment Limitation Code X with C1 Stratification is usually the gaining MTF commander or director (may be delegated to Chief of Medical Staff or Chief of Aerospace Medicine). If no MTF is co-located, the gaining MAJCOM or Combatant Command (COCOM) command surgeon is the waiver authority. **Note:** The waiver approval authority for all PCS, Deployment and TDY to Southwest Asia is the Air Forces Central Command (AFCENT) command surgeon's office, not the specific gaining MTF.

4.73.3.4. Waivers for Members with Assignment Limitation Code Y with C2 Stratification. 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 Review-In-Lieu-Of review by DP2NP or ARC Surgeon General's Office). The MTF should make every effort to keep the member's unit (commander, first sergeant, unit deployment manager/commander's support staff deployment monitor for example) updated on the progress of the waiver package, particularly estimates on completion of any additional requirements of the waiver authority.

4.73.3.4.1. Assignment Limitation Code Y with C2 Stratification: 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.

4.73.3.4.2. Assignment Limitation Code Y with C2 Stratification does not require a waiver for Elmendorf or Hickam Air Force Base assignments.

4.73.3.4.3. The Waiver Approval Authority for those with Assignment Limitation Code Y with C2 Stratification is the gaining MAJCOM or COCOM command surgeon (may be delegated to MAJCOM/COCOM Chief of Medical Staff or Chief of Aerospace Medicine).

4.73.3.5. Waivers for Members with Assignment Limitation Code C with C3 Stratification.

4.73.3.5.1. Assignment Limitation Code C with C3 Stratification: 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.

4.73.3.5.2. The Waiver Approval Authority for those with Assignment Limitation Code C with C3 Stratification is AFPC/DP2NP, 550 C Street West, Suite 26, Randolph Air Force Base, TX 81150-4718 (for AD members) or appropriate ARC Surgeon General's Office (for ARC members).

4.73.3.5.2.1. Special Requirements for Assignment Limitation Code C with C3 Stratification - Waiver Packages. In addition to the requirements for Assignment Limitation Code- waiver packages noted above in paragraph 4.73.3.2, there are special requirements for those with Assignment Limitation Code C with C3 Stratification. Because Assignment Limitation Code C with C3 Stratification is assigned to Airmen with unique conditions, waivers of Assignment Limitation Code C with C3 Stratification are only granted when the benefit of deploying or

assigning the member overseas outweighs the potential risks.

4.73.3.5.2.2. 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. **(T-3).** It should indicate that the commander is aware of the member's Assignment Limitation Code-C, and that despite this, the service member 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). **(T-3).** The memo must also state that care for the member's condition has been coordinated with the gaining MTF and MAJCOM/COCOM command surgeons. **(T-2).** A corroborating statement from the gaining Surgeon General, indicating that care is available to meet the member's needs, is also required. **(T-2).**

4.73.4. MTF Action for Return to Duty with an Assignment Limitation Code. The MTF will complete an AF Form 469 appropriate for the service member's current condition, code and stratification. In completing the AF Form 469, the MTF will adhere to the following guidance **(T-1).**

4.73.4.1. Assignment Limitation Code X with C1 Stratification:

4.73.4.1.1. Worldwide (mobility) Restrictions will be marked.

4.73.4.1.2. The release date will be dashed or left blank.

4.73.4.1.3. The "Remarks" section will contain the phrase "Service member has been 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 Chief of Medical Staff or Chief of Aerospace Medicine must approve exceptions to this restriction in writing. The appropriate ARC Surgeon General's Office must coordinate on all Palace Chase/Front assignment actions into the ARC prior to final approval. This Assignment Limitation Code must be reviewed by DP2NP or ARC Surgeon General's Office periodically. Submit an annual Review-In-Lieu-Of at the time, and with the specialty consultation, specified on the most recent FL-4 sent by DP2NP or the ARC Surgeon General's Office.

4.73.4.2. Assignment Limitation Code Y with C2 Stratification:

4.73.4.2.1. Worldwide (mobility) Restrictions will be marked.

4.73.4.2.2. The release date will be dashed or left blank.

4.73.4.2.3. The "Remarks" section will contain the phrase "Member has been 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 Chief of Medical Staff or Chief of Aerospace Medicine. The MAJCOM or COCOM Surgeon General must approve exceptions to this restriction in writing. The appropriate ARC Surgeon General's Office must coordinate on all Palace Chase/Front assignment actions into the ARC prior to final approval. This Assignment Limitation

Code must be reviewed by DP2NP or ARC Surgeon General's Office periodically. Submit an annual Review-In-Lieu-Of at the time, and with the specialty consultation, specified on the most recent FL-4 sent by DP2NP or the ARC Surgeon General's Office.

4.73.4.3. Assignment Limitation Code C with C3 Stratification:

4.73.4.3.1. Worldwide (mobility) Restrictions will be marked.

4.73.4.3.2. The release date will be dashed or left blank.

4.73.4.3.3. The "Remarks" section will contain the phrase "Member has been 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/DP2NP. The appropriate ARC Surgeon General's Office must coordinate on all Palace Chase/Front assignment actions into the ARC prior to final approval. This Assignment Limitation Code must be reviewed by DP2NP or ARC Surgeon General's Office periodically. Submit an annual Review-In-Lieu-Of at the time, and with the specialty consultation, specified on the most recent FL-4 sent by DP2NP or the ARC Surgeon General's Office. **(T-1).**

4.73.4.3.4. The appropriate ARC Surgeon General's Office must coordinate all Palace Chase/Front assignment actions into the ARC prior to final approval. **(T-1).**

4.73.5. ARC service members are placed on Assignment Limitation Code or Deployment Availability Code-42 by the appropriate ARC Surgeon General's Office. The appropriate ARC Surgeon General's Office will provide profiling instructions and other guidance on AF Form 422 completion. **(T-1).**

Section 4L—Tumor Registry Program Administration

4.74. The Tumor Registry Program.

4.74.1. All Air Force MTFs will maintain a tumor registry of reportable diagnoses (a condition of malignancy, precancerous lesion, benign central nervous system, brain tumor, or certain hematopoietic conditions). **(T-1).** All Air Force MTFs that diagnose and/or treat patients with reportable diagnoses must have a cancer program or cancer reporting process (for Reporting MTFs) and will comply with the requirements of the American College of Surgeons' Committee on Cancer (ACoS CoC). **(T-1).** The Cancer Program, in accordance with AFI 44-110, *The Cancer Surveillance Program*, is 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 and is thus referred to as a Reporting MTF.

4.74.2. The Reporting MTF will perform a case finding function and report all new cancer cases to its lead Regional Cancer Registry monthly. **(T-1).**

4.74.2.1. MTFs in multi-service markets may establish a memorandum of understanding with Army or Navy MTFs and will be coordinated with the Air Force Cancer Registry Consultant. **(T-1).**

4.74.2.2. Case finding may be performed by working a query of reportable diagnosis codes as well as review/obtain available pathology, radiology, procedure/operative, and other appropriate reports.

4.74.2.3. Ensures all new cancer cases, including TRICARE beneficiaries who are diagnosed and/or treated in civilian facilities, are reported.

4.74.2.4. Cancer case information will be transmitted from the Reporting MTF to the Regional Cancer Registry via encrypted e-mail reports or other HIPAA compliant methods. **(T-1).**

4.74.3. The Tumor Registry is the principal database for evaluating the care of cancer patients in the MTF. Patient Administration actions will include:

4.74.3.1. Use of Automated Central Tumor Registry to create and track cases. Requests for Automated Central Tumor Registry access (limited to cancer registry personnel) are made through the Air Force Cancer Registry Consultant.

4.74.3.2. Reporting MTFs retain the responsibility for maintaining follow-up information for the lifetime of each cancer patient according to American College of Surgeons' guidelines.

4.74.4. Data requests for research using Automated Central Tumor Registry reports are routed through the Air Force Cancer Registry Consultant.

4.74.5. 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, fetal monitor strips, 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 or dental care. Maintenance of records at the MTF is required in accordance with this AFI. Refer to Army Regulation (AR) 40-66, *Medical Record Administration and Healthcare Documentation* for additional information on United States Army health records maintenance. Refer to Manual of the Medical Department (MANMED), NAVMED P-117, Chapter 16, *Health Records* 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 are maintained in the MTF of enrollment. **(T-0).** Reference DoDI 6040.45 and DHA Interim Procedures Memorandum 18-018, *Physical Custody and Control of the DoD Health Record*.

5.1.2. Management of medical records includes quality and security assurance which is the responsibility of administrative, clinical, and information technology staff.

5.1.3. MTF Commander or Director. The MTF commander or director will serve as Custodian of Records and ensure that all health records are prepared, maintained, used, protected, and controlled as required in accordance with this manual. **(T-2).**

5.1.3.1. Ensures that records and loose documents are retired or disposed of according to the Air Force Records Information Management System (AFRIMS), Records Disposition Schedule.

5.1.3.2. Must be knowledgeable concerning the control of health records and protected health information (PHI), release of information from the records, and provider of care documentation requirements. Commanders ensure that these important functions are properly supported.

5.1.3.3. Manages custody and control, and security assurance of paper-based and automated or electronic medical records.

5.1.4. Chief of Dental Services. The Chief of Dental Services serves as the custodian of the dental records and is responsible to the MTF commander or director for dental record management functions including custody, control and security assurance of paper-based and automated or electronic dental records.

5.1.5. Healthcare Providers. 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. **(T-2).** This description must adequately address current medical, administrative, and legal requirements. **(T-1).** Ensure that proper identification information is entered on various forms and that records are returned to the appropriate file as quickly as practical, but no later than 72 hours after treatment is rendered. **Note:** Dental encounters should follow guidance as outlined in AFMAN 47-101, *Managing Dental Services*.

5.1.6. Records created and maintained at a joint 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 System Records Disposition Schedule website: **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm**, the *Medical Record Tracking, Retirement and Retrieval User Guide* is located at the AFMS Knowledge Exchange.

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. The Joint Commission accredits and certifies nearly 21,000 health care organizations and programs in the United States. Only authorized individuals make entries in the original hard copy medical record using black or blue-black ink. No other annotations are authorized. For care received outside of the Direct Care System ensure that the memorandum of understanding 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 and the Privacy Act, to access their health records and request amendment if they think the documentation is in error. However, there is no requirement for the MTF 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 applies:

5.3.1.1. Records or Primary Care Manager support staff may remove an outdated DD Form 2766C 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 DD Form 2992, *Medical Recommendation for Flying or Special Operational Duty* and AF Form 1418, *Recommendation for Flying or Special Operational Duty – Dental* with recommendations for special operations and/or flying status in accordance with Attachment 8.

5.3.2. The request to amend any part of the health record (electronic or paper) must be made in writing and be signed by the patient or authorized representative and filed in section 3 of AF Form 2100A, *Health Record - Outpatient* or left side of AF Form 2100B, *Health Record - Dental*. **(T-1).**

5.3.3. Refer to AFI 33-332 and AFI 41-200 for response timeline.

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 or a system of records under the Privacy Act.

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. If an error is identified and the responsible practitioner is available and recalls the circumstances, for paper records:

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 or 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. **(T-1).**

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. **(T-1).** 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 **(T-0).** 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 instructions, such as AFI 33-332 and AFI 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, 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 Air Force Base TX 78150-4742, the MTF will take no action until contacted by the board representatives. See AFI 36-2603 Chapter 3 for application procedures and who may apply. If there are questions regarding an amendment, contact the Staff Judge Advocate or area medical law consultant.

5.3.9. MTF should ensure careful adherence to the process of legal corrections of erroneous data or information in a patient's electronic health record. Legal corrections of erroneous data may require Tier III Help Desk Support. Tier III Help Desk Support is a resource external to

the MTF that handles advanced technical issues. Defense Health Agency (DHA) has developed a specific process to request the legal correction of erroneous PHI in situations where the incorrect information identifies another individual and the MTF is not able to make the correction at the local level. This direction is located in the "*Policy for Legal Correction of AHLTA Erroneous Data or Information*" and the process is contained in updated guidance found on AFMOA Health Benefits Kx at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

5.3.10. All provider Social security numbers must be redacted and made 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). **(T-2).** Specifically, the MTF will make an initial copy of the record(s), then within the copy, sanitize the entire Social security number, 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 the individual's own records for any reason. Original medical records should remain intact. The original provider's social security number must never be deleted from the original health record. **(T-0).**

5.4. The Electronic Health Record.

5.4.1. Since 2006, the AFMS has used AHLTA; the Department of Defense's (DoD) approved electronic health record for the day-to-day outpatient care documentation processes. Until completely transitioned to an electronic health record, the AFMS will use a hybrid record consisting primarily of the electronic health record and include 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 AFMS:

5.4.2.1. AHLTA and CHCS – outpatient medical and dental care which is stored in the Central Data Repositories.

5.4.2.2. Essentris – inpatient medical care which is stored in the MTF Global Data Repositories.

5.4.2.3. Composite Health Care System (CHCS) II-Theater (Armed Forces Health Longitudinal Technology Application-Theater (AHLTA-T)).

5.4.2.4. Health Artifact and Image Management Solution (HAIMS) – enterprise-wide data sharing capability for all types of artifacts and images.

5.4.2.5. Military Health System (MHS) GENESIS – new electronic health record for MHS providing a single health and dental record for beneficiaries.

5.4.3. Medical Systems and Applications Not Considered Part of the Official Air Force Medical System electronic health record:

5.4.3.1. Unless approved by competent authority, MTFs may not acquire, deploy or use electronic health record systems other than those described in paragraph 5.4.2. This prohibition applies to applications, systems or components of electronic health records intended to temporarily or permanently document patient healthcare. Competent authority resides with the Assistant Surgeon General, Health Care Operations; the Air Force Surgeon

General (or deputy); or officials of the Office of the Assistant Secretary of Defense, Health Affairs (ASD/HA).

5.4.3.2. Any non-AFMS or non-MHS standardized electronic system, application, or clinical management tool is not considered part of the official Air Force electronic health record. The documents contained within these tools are not considered part of the electronic health record. To be approved for use, these tools must provide for the permanent transferability of electronically generated or documented health information into the following:

5.4.3.2.1. MHS Central Data Repositories,

5.4.3.2.2. Individual or regional MTF inpatient Global Data Repositories,

5.4.3.2.3. MHS or Air Force standardized and approved data repository or database,

5.4.3.2.4. Official VA single medical data repository. **(T-1).**

5.4.3.3. 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 electronic health record or standardized and AF/SG approved data repository or printed and scanned into HAIMS. **(T-1).**

5.4.4. MTF commanders or directors may require that all or some of the medical records maintained within the MTF be filed in hard copy format, regardless of electronic health record capabilities, to fulfill mission requirements and to ensure comprehensive continuity of care. MTF commanders or directors must be knowledgeable of health record management practices as they apply to members assigned to the Sensitive Duties Programs. **(T-2).**

5.4.5. Service Members assigned to Sensitive Duties may be temporarily or permanently decertified, suspended, or removed from their duty position(s). This determination may be based on their medical, dental, mental health status, or the type of medications prescribed. Sensitive duties programs include the Personnel Reliability Assurance Program, Presidential Support Program, or other sensitive duty national security program(s). The current DoD electronic health record cannot automatically provide for the mandatory notification and receipt confirmation documentation. Notification must occur between the MTF competent medical authority and individual unit commanders or installation operational assurance officials. **(T-1).** This notification must include the service member's health status, operational capabilities/limitations, or fitness for duty following each patient encounter. **(T-1).** Following proper notification and documentation (either electronic or written), all documents will be uploaded into the service member's outpatient medical electronic health record via HAIMS or filed in the dental treatment record. **(T-1).**

5.4.6. The combination of the electronic health record 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 HIPAA safeguard requirements, Air Force Inspection Agency and Joint Commission standards.

5.4.7. Prior to a beneficiary's Permanent Change of Station (PCS) reassignment, personal geographic location move, MTF reassignment, or change to TRICARE enrollment location,

all laboratory and radiology CHCS results, must be printed and filed into the patient's health record. **(T-2).** Since AHLTA is operational at all Active Duty (AD) MTFs, MTF health records personnel are not required to print AHLTA patient encounter notes. However, if a beneficiary is moving or has a PCS to a remote location without access to AHLTA, then all historical AHLTA patient encounter notes must be printed and filed into the patient's health record. **(T-1).**

5.4.8. MTF personnel must establish procedures to provide beneficiaries copies of their medical documentation from their electronic record when requested. **(T-0).** 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 HIPAA, and any revisions to DoDM 6025.18 regarding modes of transmission to the beneficiary. **(T-0).** Refer to AFI 41-200, paragraph 7.6 for additional information.

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 electronic health record that would not normally be available to patients. Examples of these inappropriate entries are documents created or governed by quality assurance, business rules, including peer review results or any Quality Assurance 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 Central Data Repositories. **(T2)**

5.4.9.2. The operational processes listed herein were current at the time of this publication. Advances in technology often outpace policy development; therefore this policy attempts to outline rules of the current technology and to clarify operating parameters when advances occur. This manual also includes actions for moving to an electronic environment (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. These actions include firm policy guidance. When certain milestones are reached, a specific set of actions must occur.

5.4.9.3. The development of alternative plans independent of 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 Central Data Repositories, are not authorized without approval from AF/SG3. Any other use of technology contrary to guidance provided in this manual must be discontinued until permission is granted for process continuation. **(T-2).** Forward all requests for permission to depart from these operational rules to AFMSA/SG3S. Exceptions must clearly state why the facility cannot change to an approved methodology. **(T-1).** Waiver requests will be considered with a global or Service-wide standardization impact perspective. **(T-1).**

5.4.9.4. Every Air Force MTF will use AHLTA or approved electronic health record to document outpatient care. **(T-1).** All outpatient MTF entries (except emergency department entries and dental treatment entries) must be entered into AHLTA. **(T-1).** Use of structured text within approved electronic health records 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.

5.4.9.5. Printing AHLTA Information and Encounters. Printing and filing of patient encounters stored in AHLTA is not required. **Exception:** Until further notice, all information in AHLTA for non-service treatment records must be printed and filed prior to disposition of the medical and dental record before physically mailing the record(s). **(T-1).** Any automated clinical encounters, results, or notes that a provider feels a patient would need or benefit from are authorized to be printed during a patient visit and handed to the patient.

5.4.9.6. 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.

5.4.9.7. Placement of Scanned/Uploaded/Imported Documents, Files, and Images into AHLTA.

5.4.9.7.1. 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 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.

5.4.9.7.1.1. 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 or user who created the original encounter note. The notification mechanism lets the original creator know that someone has appended the member's original patient encounter note.

5.4.9.7.1.2. Appending a previously closed encounter with an uploaded image will not change the original encounter information. The user adding the additional image or document must also electronically sign the appended patient encounter notes. **(T-2).** 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.

5.4.9.7.2. 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/SG3S. Managing the capability to create, import, or upload, stand-alone scanned documents should be accomplished through HAIMS application.

5.4.9.7.3. 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/SG3S. Identified below is 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.

5.4.9.7.3.1. 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.

5.4.9.7.3.2. No later than 30 days following the date they create the electronic file, staff must destroy the contents the file. Those contents include reports or referral results received, scanned and imported into HAIMS from external MTF providers. This rule assumes AFMSA/SG3S did not authorize an exception that allows importing and/or uploading reports or results into HAIMS. **(T-3).**

5.4.9.7.3.3. There is no limitation (unless prescribed locally) to specific file size or type (in the MTF shared computer server).

5.4.9.7.3.4. The MTF will 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 those 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) is scanned into HAIMS. **(T-3).**

5.4.9.7.3.5. The official government e-mail transfer of consultation reports and referral results 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. **(T-0)**. Shared computer folders and files must offer limited user access and password protection. **(T-0).** Once a data-at-rest solution is deployed, PHI on shared drives must be encrypted in accordance with security standards. **(T-0).**

5.4.9.8. Filing, Scanning and Uploading New Documents into HAIMS. All specialty care and urgent primary care results, Emergency Room (ER) notes, discharge summary reports, laboratory results, and radiology reports generated by providers and health care organizations external to the MTF shall be scanned and imported into HAIMS within three working days from receipt of results. **(T-0).** Referring providers/Primary Care Managers will be notified of the new results/report via telephone consult or locally established protocol. **(T-0).** Providers will have three business days from the date of receipt to review the results. **(T-0).** Tips on importing/scanning and standard naming conventions can be found in "The Management of Artifacts Scanned into HAIMS" located in Medical Records/HAIMS folder on the AFMOA Health Benefits Kx page at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**. If a particular type of paper document was regularly reviewed and signed (by hand) by a provider and

filed into the paper record, the same document must still be signed (by hand) before scanning into HAIMS. **(T-2).** See 5.4.7 and 5.7.1 for additional instructions on printing.

5.4.9.9. Scanning Entire Paper Health Records for Importing or Uploading into HAIMS or other Secure Database.

5.4.9.9.1. The practice of scanning entire original paper health records for permanent storage, importing, or uploading into HAIMS or similar DoD approved document management system is unauthorized.

5.4.9.9.2. The only exception to bulk scanning is when the MTF is processing records for service members on active Presidential Support Program or Personnel Reliability Assurance Program status and the mission needs require rapid electronic access to the service treatment record. The MTF is then authorized to bulk scan the record into HAIMS and mail the hard copy in accordance with standard procedures.

5.4.9.9.3. In support of the Personnel Reliability Assurance Program Administrative Qualification Central Cell process, all paper health treatment records will be requested from the losing MTF. **(T-3).** Paper medical and dental records must be scanned into HAIMS within seven calendar days. **(T-3)**.

5.4.9.9.4. Refer to Attachment 5: PERSONNEL RELIABILITY ASSURANCE PROGRAM ADMIN CERT HAIMS SCAN GUIDE, also 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**.

5.4.9.10. 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:

5.4.9.10.1. 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, and/or HIPAA and its various implementing regulations and must be protected in accordance with those provisions." **(T-0).**

5.4.9.10.2. Scanned documents, files, and images are not stored on any local computer or MTF computer hard drive permanently. 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. **(T-0).**

5.4.9.10.3. Digital or electronic memory, compact or read-writable discs or storage media are not included with paper health records when forwarded to the National Personnel Records Center or to the VA Records Management Center via approved Air Force health records disposition intermediary.

5.4.9.11. 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, Armed Forces Health Longitudinal Technology

Application –Theater (AHLTA-T), Essentris, and TRICARE Online. Electronic signatures and initials in these systems are equivalent to full handwritten signatures and initials.

5.4.9.12. Retrieving Outpatient Medical Records by Exception. The MTF commander or director, with the recommendations from the Executive Committee of the Medical Staff and Health Records Committee may stop or suspend the practice of routinely retrieving paper outpatient medical or dental treatment records for provider use. It should be done only after careful consideration and on the recommendations of the Executive Committee of the Medical Staff and Health Records Committee. Only after addressing the following minimum questions should a requesting work center, clinic, specialty group, or Family Health Element team submit a request for retrieval and delivery of paper records to the Executive Committee of the Medical Staff function.

5.4.9.12.1. Have procedures been developed to validate the beneficiary's acknowledgement of the *MHS Notice of Privacy Practices*? See AFI 41-200 paragraph 3.2 for additional information and requirements.

5.4.9.12.2. 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?

5.4.9.12.3. 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?

5.4.9.12.4. With recommendation from the Health Records Management Committee, medical record retrieval variations may exist within a 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.

5.4.9.13. Historic scanning by exception. If a provider identifies any document from the patient's paper medical or dental record the document must be uploaded into the electronic health record. **(T-3).** Following scanning, the original source document, file, or image must be re-filed into the paper health record. **(T-3).** Once an item is uploaded into HAIMS, the provider should determine whether the data is specific to an episode of care. If it is, the item should be uploaded to the current patient encounter note without delaying the coding process. The provider should also determine if the item should be uploaded as an independent, stand-alone document.

5.4.10. HAIMS. HAIMS is a MHS strategic project that enhances medical informatics through seamless integration of medical digital images into the electronic health record. The objective of HAIMS is to give healthcare providers global awareness and access to essential health artifacts and images throughout the continuum of care from Theater to the Sustaining Base to the VA. HAIMS provides a single enterprise-wide image sharing capability for all types of artifacts and images, including radiographs, photographs, wave forms, audio files, video files and scanned documents.

5.4.10.1. Using HAIMS in the MTF. HAIMS is required to be used at all MTFs.

5.4.10.2. HAIMS Administration. The MTF (outpatient records, referral management centers, clinical departments, etc.), must use HAIMS exclusively to scan loose paperwork. **(T-3).**

5.4.10.2.1. MTF Staff will cease filing loose paperwork in the hard-copy medical record and instead scan/upload them into HAIMS. **(T-3).**

5.4.10.2.2. Once a loose document has been scanned, validated and uploaded into HAIMS, the document shall be destroyed. **(T-3).**

5.4.10.2.3. Lackland Air Force Base, Maxwell Air Force Base, and United States Air Force Academy will bulk scan entry paperwork. New paper records will not be created. Members will not hand-carry medical records. **(T-3).**

5.4.10.2.4. New paper records will not be created for new dependents. **(T-3).**

5.4.10.3. HAIMS Training. MTF clinical systems trainers and super users are responsible for training any users.

5.4.10.4. HAIMS Guidance. Tips on how to use HAIMS can be located on the Kx at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

5.4.10.4.1. HAIMS provides functionality that can be used to support the clinical practice of medicine by making artifacts and images that are not already part of the electronic health record accessible to providers.

5.4.10.4.2. Business Process Standardization. The requirement of appending artifacts and images, by copying and pasting Clear and Legible Reports into AHLTA clinical notes, is no longer in effect at MTFs due to the full implementation of HAIMS. The standardized business process will now include placing these items into HAIMS. In multi-service market areas, there must be close coordination between the Services regarding this policy so that all the providers in those market areas will be able to access the Clear and Legible Reports for individual patients. **(T-3).**

5.4.10.4.3. Artifacts and Images scanned into HAIMS are called assets. These assets are identified by a process known as metadata tagging. Metadata must be entered before an asset is saved in HAIMS. **(T-3).** In The HAIMS Clinical User Guide Table 1, there is a brief explanation of nearly 20 data entry fields. **(T-2).**

5.4.10.4.3.1. Patient Name: Auto-populates when the patient is selected in the search function. Provides Patient Name, Social security number, Date of Birth, Gender, and family member prefix/sponsor social security number. Search function is similar to that currently employed with AHLTA.

5.4.10.4.3.2. Author Name: Free text. The author is considered the person responsible for the original artifact (e.g. ordering provider or network provider). Enter the full name of the author of the asset in “last name, first name” format.

5.4.10.4.3.3. Document Type: (Dropdown Menu). Click on the down arrow, scroll down to and highlight the appropriate document type (e.g. Encounter Note, Consultation) and enter.

5.4.10.4.4. In addition to the above three required metadata tags, HAIMS users will utilize the following fields as much as possible within the constraints of local resources:

5.4.10.4.4.1. Mark as Sensitive: Click on Box. Mark the document as "Sensitive" to restrict access to it. When an asset is restricted, unauthorized users will not have access to the document. All authorized users have access after acknowledging they will be viewing sensitive data and will be subject to auditing. If in doubt whether a document would be marked sensitive, HAIMS users will consult with the provider or the mental health clinic to determine sensitive information.

5.4.10.4.4.2. MHS Form Number: Auto-Populate Field. Type a few characters contained in the form number (e.g. 600). Highlight the proper form number (e.g. SF 600, *Chronological Record of Medical Care*) and enter. Use this field when there is a known form number.

5.4.10.4.4.3. Procedure or Service: Auto-Populate Field. Type a few characters contained in the procedure or service code number. Highlight the proper service (e.g. Ultrasound) or code number (e.g. 335.20) and enter.

5.4.10.4.4.4. Installation/Facility: Auto-Populate Field. Enter the first letter(s) of the installation/facility. A dropdown list will appear. Select the appropriate installation/facility and enter.

5.4.10.4.4.5. Facility Name: Free Text Field. If the asset was received from a place not listed in the "Installation/Facility" field, enter the name of the organization where the asset originated.

5.4.10.4.4.6. Clinic: Dropdown Menu. Click on the down arrow, scroll down to and highlight the proper clinic type (e.g. Cardiology) and enter.

5.4.10.4.4.7. Specialty: Auto-complete field. Type a few characters contained in the specialty name (e.g. obstet). Highlight the proper service (e.g. Obstetrics) and enter.

5.4.10.4.5. Enclosures. There are 8 enclosures found within the clinical use of HAIMS Guidance. Each enclosure provides guidance for acquiring assets and using assets in the HAIMS embedded mode within AHLTA. The enclosures are listed below and examples can be found on the Kx at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

5.4.10.4.5.1. ACQUIRING ASSETS

5.4.10.4.5.2. SCANNING ARTIFACTS

5.4.10.4.5.3. ENTERING HAIMS METADATA

5.4.10.4.5.4. ACCESSING HAIMS VIA "EMBEDDED MODE"

5.4.10.4.5.5. ASSOCIATING ASSET TO AHLTA CURRENT ENCOUNTER

5.4.10.4.5.6. ASSOCIATING ASSET TO AHLTA PREVIOUS ENCOUNTER

5.4.10.4.5.7. ASSOCIATING ASSET TO AHLTA PROBLEM

5.4.10.4.5.8. ASSOCIATION REMOVAL

5.4.10.4.6. Guidance for Making the Service Treatment Record Available for Access by the VA

5.4.10.4.6.1. Air Force Service Treatment Record Processing Center: The AFMS has opted to centralize the Service Treatment Record digitization, for retiring/separating members, into HAIMS for access by the VA. The Service Treatment Record disposition process can be found in this manual in paragraph 5.7.

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

5.5. Electronically-Generated Forms.

5.5.1. Use only the Air Force-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. Most Air Force, Standard Forms (SF) and Optional Forms (OFs) can be obtained from the Air Force e-Publishing website at: **http://www.e-publishing.af.mil**.

5.5.2. The only exception to the rule in 5.5.1 is permission to use the forms for which AFMOA/SGAT has identified standard data elements. For these forms, the standard elements are required but mirror imaging of the paper form is no longer required. **(T-1).** 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. Include the following patient information blocks on both inpatient and outpatient forms: Name (last, first, middle), patient family member prefix/last four digits of the sponsor's social security number, DoD Identification Number, Sex, Date of Birth, Rank/Grade, Department/Service Where Records Maintained, and Relationship to Sponsor. Under Sponsor Information, include Name (last, first, middle) and last four digits of the Sponsors Social security number and/or DoD Identification Number. Under Facility Information, include Name of MTF. Additionally, add blocks for Register Number and Ward Number on inpatient forms.

5.5.4. To date, the forms for which standard data elements have been identified for the body of the form are: SF 93, *Report of Medical History,* SF 505, *Medical Record – History Parts 2 and 3,* SF 506, *Medical Record – Physical Examination,* SF 509, *Medical Record – Progress Report,* SF 526, *Medical Record – Interstitial/Intercavitary Therapy,* SF 551, *Medical Record – Serology,* SF 558, *Medical Record – Emergency Care and Treatment,* SF 559, *Medical Record – Allergen Extract Prescription – New and Refill,* 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. OF 275, *Medical Record Report,* may be used in lieu of SFs, Air Force forms and DoD forms, available at **https://www.gsa.gov/forms-library/medical-record-report**. OF 275, if used, must indicate the form number and title of the form being replaced. **(T-3).** Information entered on the form must include all of the same information as the form it represents. **(T-2).** Scan and upload the OF 275 into the patient's electronic health record. This form is not to be used for the creation of local forms.

5.5.6. If a MTF desires to create a local form in lieu of a form that already exists, a waiver must be requested from AFMOA/SGAT. **(T-1).**

5.5.7. In an effort to reduce the unnecessary use of Social security numbers, DoD has begun the use of alternative Personal Identifiers in place of the Social security number. The alternative Personal Identifiers include the DoD Identification 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. The MHS, when feasible, should limit the use and display of Social security numbers while migrating systems and business processes to use the DoD Identification Number.

5.5.7.1. Local MTF forms must be reviewed for the necessity of Social security number use. **(T-3).** MTFs are encouraged to use DoD Identification Numbers in place of Social security numbers on local forms. To locate Social security numbers, MTFs may obtain the Social security number from General Inquiry of Defense Enrollment Eligibility Reporting System (DEERS) Web Application by cross matching the DoD Identification Number on the Identification card or form with the DoD Identification Number in the system.

5.5.7.2. If the MTF determines the continued use of the Social security number on a local form is necessary, the MTF must comply with the justification procedures set forth in AFI 33-332. **(T-2).**

5.6. Overprinting of Forms. An overprint is a form displaying identical entries in an appropriately captioned area or fillable field existing on a form. Overprints do not change the information collected on a form and are authorized in accordance with 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 or director. **(T-3).** Follow instructions in AFI 33-360 concerning inclusion of the name of the organization followed by "overprint" in the lower right margin of the form; for example, 579 Medical Group (MDG) Overprint. 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 570, *Notification of Patient's Medical Status*.

5.6.6. AF Form 577, *Patient's Clearance Record*.

5.6.7. AF Form 2700L, *Health Record Year Grid*.

5.6.8. AF Form 745, *Sensitive Duties Program Record Identifier*.

5.6.9. AF Form 1403, *Roster of Seriously Ill/Very Seriously Ill*.

5.6.10. AF Form 1942, *Clinic Index*.

5.6.11. AF Form 3066, *Doctor's Orders (multiple copy format).*

5.6.12. AF Form 3066-1, *Doctor's Orders (cut sheet format)*.

5.7. Service Treatment Record Disposition Instructions for Airman Retiring, Separating and Transitioning to the RC. There are two categories of Health Records: The first category is the Service Treatment Record - the outpatient medical record and dental treatment record for a member of the United States Military. It is made up of the patient's medical and dental encounters incurred throughout the course of their military career. The Service Treatment Record begins upon entry to AD (Military Entrance Processing Station/intake physical or commissioning physical) and ends upon discharge, retirement, separation or death (if death occurred while on AD). The second category is the Non-Service Treatment Record - 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. Dependent, Non-NATO Foreign military, and Retiree Non-Service Treatment Records are retired to the National Personnel Records Center using the Medical Record Tracking application in CHCS. Federal Civilian Employee Non-Service Treatment Records are provided to the local Civilian Personnel Office or retired to National Personnel Records Center.

5.7.1. The Service Treatment Record on-time submission goals to meet the Under Secretary of Defense Personnel and Readiness expectations are 95% on-time submission of Active Component Service Treatment Records and 75% on-time submission of RC Service Treatment Records.

5.7.1.1. The Service Treatment Record process mandated that all AD Air Force MTFs and ARCs begin mailing Service Treatment Records for retiring and separating Airmen (with a separation or retirement date effective 1 January 2009 and thereafter) to the Air Force Service Treatment Record Processing Center instead of forwarding records to the Air Force Personnel Center.

5.7.1.2. Service Treatment Records shall be sent to the Air Force Service Treatment Record Processing Center at 3370 Nacogdoches Rd, Suite 116, San Antonio, TX 78217. **(T-1).** The cell will continue to receive bulk shipments of paper Service Treatment Records for retiring and separating Air Force Service Members. Upon receipt, the cell will digitize the paper records into HAIMS. **(T-1).** The original paper Service Treatment Record will then be dispositioned according to DoD and National Archives and Records Administration guidance.

5.7.1.3. Total Force Applicability: This Service Treatment Record disposition policy applies equally to the AD MTFs and the RCs. Although the language that follows in this paragraph 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 ARC Service Treatment Records. Air Force Service Treatment Record Processing Center is the only Air Force agency authorized to forward AD and RC Service Treatment Records to the VA. MTFs and RCs are not authorized to mail records directly to the VA. **(T-0).** Reference DoDI 6040.45.

5.7.1.4. All MTF and Dental Treatment Facility records management personnel will apply the following directions to their Service Treatment Record disposition plan. **(T-0).** MTF records managers and supervisors must work closely with their Dental Treatment Facility counterparts and local Military Personnel Section, Military Personnel Element, Military

Personnel Squadron or Force Support Squadron officials to make this transition as smooth as possible. **(T-0).** Reference DoDI 6040.45.

5.7.1.5. Incorporate the Service Treatment Record disposition instructions into all standard MTF, Dental Treatment Facility, and RC Service Treatment Record disposition instructions for retiring, separating, discharging, and transitioning members. Reference DoDI 6040.45.

5.7.2. AFPC Retirement/Separation Notification Roster (also known as LOSS Roster).

5.7.2.1. In order to streamline the process and standardize LOSS Rosters acquisition procedures, a Medical Records Management SharePoint website was created so MTF, Dental Treatment Facility, and ARC records managers could easily obtain this time sensitive information.

5.7.2.2. Personnel LOSS rosters include a listing of all projected retiring, separating, transitioning, and discharging Air Force service members (AD and ARC), to include those assigned to GSU. The rosters also identify Airmen who retired or separated in previous months which the Air Force Service Treatment Record Processing Center has not received a complete Service Treatment Record. The column with a header of "Record Required" on each roster indicates the original component(s) which have still not been received by the Air Force Service Treatment Record Processing Center. **Note:** These records will continue to remain on the roster until the Air Force Service Treatment Record Processing Center receives the records or a Non-Availability Letter.

5.7.2.3. Identified MTF, Dental Treatment Facility, and ARC personnel must obtain the LOSS roster from the Medical Records Management SharePoint each month. **(T-1).** The local Military Personnel Section will continue to provide support in the case of short-notice changes and any other questions which might arise. As the LOSS rosters contain Personally Identifiable Information, and the SharePoint site contains all rosters for all facilities, access to the page is restricted to only those individuals who require access to perform Service Treatment Record disposition duties.

5.7.2.4. Each MTF or ARC is authorized one primary and four alternate points of contact, for a total of five (5). ARCs are authorized an additional two members in order to identify the Senior Air Reserve Technician and the Medical Administrative Officer. It is recommended that the primary point of contact should be the individual with direct oversight of the records process (NCOIC, in most cases). **(T-1).** Alternates should be a dental representative, flight commander or superintendent. Each member must be designated in writing by the unit commander. **(T-1).** An example of an appointment letter is available on the Medical Records Management SharePoint and the AFMOA Health Benefits Kx page. As the rosters are in Excel format, they can be downloaded, saved and distributed locally as the facility deems necessary. However, given the information on the spreadsheet, access must be limited to only those with a need to know. **(T-0).** E-mail messages containing Personally Identifiable Information must be digitally signed and encrypted. **(T-0).**

5.7.2.4.1. The appointment letter must include the reason for request and must be signed by the squadron commander. **(T-1).** Appointment letters can be updated/resubmitted at any time; letters will be updated at least annually. **(T-1).**

5.7.2.4.2. Address appointment letters to AFMOA/SGAT and scan/e-mail the document to **usaf.jbsa.afmoa.mbx.str-processing-center@mail.mil**.

5.7.2.4.3. Once the appointment letter has been submitted and approved, the Air Force Service Treatment Record Processing Center Managers will grant access to the Medical Records Management SharePoint. **(T-1).**

5.7.2.5. At MTFs with decentralized medical record filing rooms, the TRICARE Operations and Patient Administration office is responsible for distributing the LOSS rosters to each record room.

5.7.2.6. Once the appointment letter has been submitted and approved, the Air Force Service Treatment Record Processing Center Managers will grant access to the Medical Records Management SharePoint. **(T-1).**

5.7.2.7. The LOSS rosters are located in the main folder "Medical Record Rosters", and then in the sub-folder "Medical Record Departure Rosters" for the applicable month. The folders correspond with the month the roster was run.

5.7.2.8. Each roster on the SharePoint is listed separately by Personnel Accounting Symbol (PAS) Code. A number of installations have RCs 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 RC PAS Codes are identified by an ALPHA Numeric code. For instance, McConnell Air Force Base could appear three times: McConnell (MK); McConnell (D6); 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).

5.7.2.9. Some larger MTFs have more than one Military Personnel Section providing services at their installation; therefore, MTFs and RCs also need to know the two-digit PAS Code for each of those Military Personnel Section/GSU for which they provide care/maintain records. A memorandum of understanding/memorandum of agreement is required for each MTF or RC if co-located with another MTF/RC (regardless of Service affiliation) to ensure correct Records Management procedures/policies are followed and addressed.

5.7.2.10. PAS codes can be obtained from the AFPC secure web site at: **https://mypers.af.mil/app/login/redirect/home**. After accessing the site, click "OK," then "PAS CODES." The PAS codes are also located on the Medical Records Management SharePoint in the Departure Rosters folder.

5.7.2.11. For questions regarding which roster to obtain, contact the local Force Support Squadron, or the Reserve, Guard, or AFMOA Health Benefits regional representative for assistance.

5.7.2.12. Facilities have a window of opportunity when records should be mailed to arrive at the Air Force Service Treatment Record Processing Center. The LOSS roster contains two columns for shipment dates for the Service Treatment Record to arrive at the Air Force Service Treatment Record Processing Center, "no earlier than" and is due "no later than." The no earlier than date is the member's date of retirement/separation; the no later than date is 30 days after the member's date of retirement/separation. Medical records

personnel at all Air Force MTFs and ARCs must mail a retiring/separating member's Service Treatment Record to arrive at the Air Force Service Treatment Record Processing Center no earlier than the Date of Retirement/Date of Separation and no later than 30 days past the Date of Retirement/Date of Separation. **(T-0).** Reference DoDI 6040.45.

5.7.2.13. GSU: Service Treatment Records for retiring and separating Air Force service members assigned to remote units or GSU must be maintained at the MTF serviced by the Military Personnel Section to which the member is assigned. **(T-3).** If the Airman is enrolled to a TRICARE network Primary Care Manager, civilian medical documents are maintained at the network Primary Care Manager Office. If the individual appears on the MTFs/Reserve Medical Units roster, that specific MTF/RC is responsible and will be held accountable for its disposition. **(T-1).**

5.7.2.14. Outside Continental United States (OCONUS) Based Member Retiring/Separating: Based on AFPC guidance, retiring/separating members assigned OCONUS are directly retired/separated by the OCONUS Military Personnel Section; members are no longer allowed to receive a PCS 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 Service Treatment Record LOSS roster normally reflects the member as retiring/separating. It is the OCONUS MTF's responsibility to ensure the Service Treatment Record is appropriately dispositioned to the Air Force Service Treatment Record Processing Center.

5.7.2.15. ARC LOSS Rosters will be assessed and downloaded from the AFPC Medical Records Management SharePoint. **(T-1).**

5.7.3. Retirement/Separation/Transition Orders.

5.7.3.1. AD Personnel Responsibilities:

5.7.3.1.1. Retiring/Separating Airmen are required to report to the central MTF health records customer service location and the installation Dental Treatment Facility 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 Dental Treatment Facility records departments.

5.7.3.1.2. 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 AD 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 AD separation order. (Specific rules regarding the disposition or the transfer of Service Treatment Records for Airmen transitioning from the Active to the RC are identified in paragraph 5.7.5.11.)

5.7.3.2. MTF/Dental Treatment Facility Responsibilities:

5.7.3.2.1. The MTF and Dental Treatment Facility will each place one copy of the orders in the member's outpatient medical and dental treatment records. **(T-1).** In the outpatient medical record, the member's orders will be placed in Section II. **(T-1).** In

the dental treatment record, the member's orders will be placed on the inside right-side folder section. **(T-1).**

5.7.3.2.2. 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. **(T-0).** It is also recommended to include a reference to where the record is located (transitory file) until the record is mailed. Reference DoDI 6040.45.

5.7.3.2.3. Missing Orders. MTFs and RCs should not delay processing Service Treatment Records for transfer to the Air Force Service Treatment Record Processing Center due to missing service member orders. If, after contacting the Military Personnel Section or accessing the Virtual Military Personnel Section, a copy of the orders cannot be obtained, the Service Treatment Record may be sent without the orders. MTFs and RCs must verify or check with the military personnel section prior to shipment to ensure the Airman did not re-enlist or extend the enlistment. **(T-1).**

5.7.3.2.4. AD Virtual Military Personnel Section Checklist Confirmation. Outpatient medical and dental records managers and Force Health Management officials will work together to ensure each outbound Airmen has fulfilled all of the MTF out-processing responsibilities. **(T-0).** Reference DoDI 6040.45.

5.7.3.2.5. Checklist Operation. Multiple (at least two) staff members assigned to MTF and Dental Treatment Facility records departments will be granted Virtual Military Personnel Section Checklist access to ensure each departing service member is informed of the requirement to provide the MTF and Dental Treatment Facility with copies of the member's orders at the time of MTF/Dental Treatment Facility out-processing. **(T-1).** 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 Military Personnel Section system, records managers can forecast the timeframe when separating and/or retiring Airmen will visit the MTF and Dental Treatment Facility to out-process. **(T-1).** MTF and Dental Treatment Facility 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 Service Treatment Record no earlier than 179 calendar days and no later than 30 days prior to the date of their final separation or retirement date.

5.7.3.3. AFR Personnel. Each month, the servicing Reserve Military Personnel Section will provide the servicing RMU a copy of the retirement/discharge/transition orders. **(T-1).** Alternatively, the AF Form 1288, *Application for Ready Reserve Assignment* may be provided. Orders are provided to the RMU for assigned Airmen serviced by the Military Personnel Section, including GSU personnel, with a 60-day projected retirement, discharge, or transition to inactive status date.

5.7.3.4. ANG Personnel. Guard members receive their retirement/discharge orders from the Retirements/Separations department of the Military Personnel Section located at their ANG Wing. These retirement/separation orders should be received at the monthly Unit Training Assembly immediately preceding the final service obligation date.

5.7.4. Making Copies of Outpatient Medical and Dental Records.

5.7.4.1. For the AD Service Member:

5.7.4.1.1. Separating and retiring Airmen may request one complete copy of their Service Treatment Record 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 free of charge is authorized. The goal is to have one complete Service Treatment Record copy ready for the separating or retiring Airman by the time of his final MTF/Dental Treatment Facility 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 the VA requires the record in electronic format. Do not scan the medical or dental record into HAIMS, as the Air Force Service Treatment Record Processing Center is the only entity that has the authority to place complete records into HAIMS. 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.

5.7.4.1.2. 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 Service Treatment Record copy requests as early as possible. **(T-3).** The volume of electronic patient encounter documents generated from MTF or Dental Treatment Facility visits that fall within the 30-day cut-off copy request date through the Airman's MTF/Dental Treatment Facility 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.

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

5.7.4.2. For the ARC Service Member:

5.7.4.2.1. Separating and discharging ARC service members may request one complete copy of their Service Treatment Record 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 free copy is authorized. The goal is to have one complete Service Treatment Record copy ready for the retiring or discharging Airman by the completion of the final medical unit out-processing appointment.

5.7.4.2.2. Copy requests from MTFs should be fulfilled no later than 30 days from the date of copy request receipt. Requests for copies from ARCs will be fulfilled. **(T-1).** ARCs are not regularly staffed as well as full-time AD MTFs. 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. Records managers must use all available resources within their means

to ensure ARC retiring and discharging Airmen understand to submit their Service Treatment Record copy requests as early as possible. **(T-3).** The volume of electronic patient encounter documents generated from MTF, Dental Treatment Facility or RC visits that fall within the period from the 90-day cut-off copy request date through the Airman's MTF, Dental Treatment Facility or ARC 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.

5.7.4.2.3. For those ARCs without AHLTA, CHCS, or HAIMS access, records managers are required to contact the AD MTF to obtain copies of all AHLTA/CHCS encounters, ancillary laboratory and radiology results. **(T-1).** Provide a copy of the service member's pharmacy prescription medication history only upon specific request.

5.7.4.2.4. Although the Transition Assistance Program may not be available for many ARC Airmen, ARC unit commanders, first sergeants, personnel staff, and medics are encouraged to inform retiring or discharging ARC Airmen of the necessity to obtain a complete copy of their Service Treatment Record as soon as possible.

5.7.4.3. Service Treatment Record Composition.

5.7.4.3.1. The Service Treatment Record includes traditional paper outpatient medical and dental documents stored in the outpatient medical and dental records as well as ancillary laboratory and 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 visit, and/or Medical Evaluation Board actions should already be filed in Part I or III of the member's outpatient record. However, MTF records managers or Release of Information staff will verify that any narrative summaries and/or operation reports generated from past inpatient, ambulatory procedure visit or Medical Evaluation Board actions completed at the same MTF responsible for the Service Treatment Record disposition, are included in the paper outpatient medical record. **(T-1).**

5.7.4.3.1.1. AHLTA Web Print. AHLTA Web Print is a feature in AHLTA that allows a user to print or generate a PDF file of a patient's entire electronic health record, or specific sections thereof, with one command. The AHLTA Web Print 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.

5.7.4.3.1.2. Given that AHLTA Web Print file comes complete with a Table of Contents which specifies page numbers for each item, it is no longer logical to file individual items 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 electronic health record 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 electronic health record must be printed/filed, MTFs/RCs (utilizing AHLTA Web Print) should file the AHLTA Web Print PDF as a complete packet in one of the following ways **(T-3):**

5.7.4.3.1.2.1. If the patient's original paper record is small enough, the entire packet can be filed as the top documents in Section 2.

5.7.4.3.1.2.2. If the patient's original paper record is too large, the AHLTA Web Print packet should be placed in its own jacket (another volume), filed in Section 2.

5.7.4.3.2. AHLTA Web Print and Service Treatment Record Disposition. The availability of AHLTA Web Print in the AFMS has provided significant benefits to reducing the workload associated with printing electronic health record 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 to forwarding to the Air Force Service Treatment Record Processing Center. The Service Treatment Record Processing Center will utilize AHLTA Web Print to generate all AHLTA electronic health record documents into the AHLTA Web Print PDF and upload it into HAIMS during Service Treatment Record digitization, thereby making the complete Service Treatment Record available to the VA in one process. **(T-1).**

5.7.4.3.3. AHLTA Web Print and Non-Service Treatment Record Retirement. Non-Service Treatment Record, outpatient medical records for patients in all other categories (dependents, civilians, foreign military, retirees, etc.), are retired to National Personnel Records Center using e7m,8Treatment Record Retirement, is outlined in detail in paragraph 5.7.12. Until necessary data communication links are permanently established between both the MHS and National Personnel Records Center electronic health record systems. MTF records personnel must continue to print and file (into the patient’s paper record) all available ancillary, diagnostic or clinical information electronically stored electronic health record prior to final records retirement processing and shipment. **(T-0).** 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 Primary Care Manager 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 Non-Service Treatment Record.

5.7.4.4. To ensure reasonable continuity of care and or VA disability evaluation/consideration, documents generated from civilian healthcare providers, stored in any MTF health record, are included in the Service Treatment Record. Examples include:

5.7.4.4.1. Reports and documents received from civilian referral healthcare providers.

5.7.4.4.2. 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 Primary Care Manager, civilian documents are owned and maintained at the network civilian Primary Care Manager office. At the

time of the separating or retiring Airman's MTF, Dental Treatment Facility or ARC records department out-processing appointment, each Airman enrolled to a TRICARE civilian Primary Care Manager should complete an authorization to obtain healthcare information from the civilian Primary Care Manager and/or any civilian healthcare provider. These documents should be forwarded to the MTF where the Service Treatment Record is maintained so that Release of Information staff can make the patient a copy, then include these civilian documents into the Service Treatment Record. MTF records managers are expected to communicate this process to separating and retiring Airmen attending Transition Assistance Program class so last minute civilian Primary Care Manager requests do not delay Service Treatment Record disposition.

5.7.4.5. Providing Copies for the Benefits Delivery at Discharge Program.

5.7.4.5.1. The Benefits Delivery at Discharge Program is a joint initiative between the VA and the DoD. This program enables VA representatives to help transitioning Airmen assemble and prepare their disability claim packages for VA disability compensation and benefits review prior to their service separation or retirement. The original Service Treatment Record is not provided to the Benefits Delivery at Discharge office. Instead, the MTF will provide the member with a paper copy or electronic copy (CD/DVD) of the Service Treatment Record at the member's request. **(T-1). Note:** this copy is counted as the member's one complete copy free of charge.

5.7.4.5.2. Regardless of who maintains the records, if the individual appears on the MTF/Reserve Medical Units roster, that specific MTF/ARC is responsible for searching and sending the record or an acceptable Non-Availability Letter to the Air Force Service Treatment Record Processing Center and will be held accountable for its disposition.

5.7.4.5.3. Service Treatment Record records managers, as stewards of the Medical Corps and appointed maintainers of the medical/dental records, have an obligation to Veterans – to ensure their complete Service Treatment Record is ready and available to the VA when the member chooses to file a claim. While a claim can be initiated with a copy of the medical record, it is not official or complete without the original records. Without the original record, the member's claim will be left incomplete and unfiled and the member will not receive their due compensation.

5.7.5. Collecting and Preparing Service Treatment Records for Shipment.

5.7.5.1. 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 Service Treatment Records in chronological order according to the LOSS Roster shipment date. This will help ensure the Service Treatment Records are mailed to arrive at the Air Force Service Treatment Record Processing Center by the deadline. Service Treatment Records must be mailed no earlier than Date of Separation/Date of Retirement and no later than 30 days after the member's final date of separation/retirement. **(T-1).**

5.7.5.2. No later than one business day after the Airman's date of separation/retirement, MTF and Dental Treatment Facility 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 Air Force Service Treatment Record Processing Center. **(T-1). Note:** The outpatient medical and dental records for each Airman must be bundled together before shipping to the Air Force Service Treatment Record Processing Center. **(T-0).** Reference DoDI 6040.45. Do not mail the outpatient and dental records separately. **(T-0).** Reference DoDI 6040.45. **Exception:** Separate shipment may be necessary, for those medical or dental records or other record volume that may be at another installation. Do not hold medical or dental records after the member's Date of Separation to include documentation or encounters generated for any care they may receive after Date of Separation.

5.7.5.3. Missing Records: With the DoD-wide implementation of AHLTA, almost all Service Members have patient medical encounters documented electronically. MTFs/RCs must have and implement thorough in and out-processing procedures to ensure all records for a patient are available as soon as possible. **(T-0).** Reference DoDI 6040.45.

5.7.5.3.1. Each Service has developed its own process to provide Service Treatment Records to the VA. The VA provides metrics for each Service (similar to the Service Treatment Record metrics) to Office of the Secretary of Defense (OSD), the White House and Congress.

5.7.5.3.2. Each Service is held 100% accountable for missing records/record components. Regardless of who maintains the records, if the individual appears on the MTF/Reserve Medical Units roster, that specific MTF/ARC is responsible for searching and sending the record or an acceptable Non-Availability Letter to the Air Force Service Treatment Record Processing Center and will be held accountable for its disposition. **(T-1).**

5.7.5.4. Non-Availability Letter, Verification Checklist, for Lost Original Paper Records:

5.7.5.4.1. If the original hardcopy dental or outpatient medical records cannot be located send a Non-Availability Letter and completed Verification Checklist indicating which original record is lost. If both hardcopy records cannot be located, include a Non-Availability Letter and two completed verification checklists. An example is available on the Medical Records Management SharePoint and the AFMOA Health Benefits Kx page at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**. **Note:** If both the original paper dental and original paper outpatient medical record(s) are lost, include a Non-Availability Letter and two completed Verification Checklists.

5.7.5.4.1.1. If a Service Treatment Record cannot be located upon notification of a member separating or retiring, the Verification Checklist and signed Non-Availability Letter to declare unavailability must be completed. **(T-0).** These items must arrive to the Air Force Service Treatment Record Processing Center no later than the member's Date of Separation/Date of Retirement plus 30 calendar days (Date of Separation/Date of Retirement + 30). **(T-0).** Also, bundle these items with all available parts of the Service Treatment Records. **(T-2). Note:** If the MTF cannot find a full or partial Service Treatment Record but sends a compliant package, the Air Force Service Treatment Record Processing Center will complete due diligence for 10-12 days. If Service Treatment Record components are not

located the Air Force Service Treatment Record Processing Center will certify all available documents to the VA with AHLTA Web Print, prior to the Date of Separation +45 deadline. Despite this certification by the Air Force Service Treatment Record Processing Center, the MTF is still required to process a Non-Availability Letter and complete due diligence, to include initiating a HIPAA breach report.

5.7.5.4.1.2. MTFs will mail complete Service Treatment Records or any loose documentation to the Air Force Service Treatment Record Processing Center no later than date of Separation/Date of Retirement +30 days in order to allow the Air Force Service Treatment Record Processing Center enough time to certify the Service Treatment Record by Date of Separation/Date of Retirement +45 days.

5.7.5.4.1.2.1. The Air Force Service Treatment Record Processing Center will provide the unit a list of records that were certified, after due diligence, without MTF input. MTFs will complete HIPAA breaches, defined as the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule which compromises the privacy or security of the PHI for incomplete Service Treatment Records. Refer to AFI 41-200.

5.7.5.4.1.2.2. MTFs will support the Air Force Service Treatment Record Processing Center (respond to queries) as the Air Force Service Treatment Record Processing Center completes due diligence during its research of incomplete Service Treatment Records. **(T-1).**

5.7.5.4.1.2.3. MTFs will mail any Service Treatment Records that are found to the Air Force Service Treatment Record Processing Center, even after the Service Treatment Record has been certified. **(T-1).**

5.7.5.4.2. The commander of the MTF, group, or clinic responsible for the day-to-day maintenance and storage of the lost record identified in the letter must wet or digitally CAC sign the Non-Availability Letter. (T-1). **Exception:** The Medical Administrative Officer is allowed to sign ANG letters and the Senior Air Reserve Technician is allowed to sign AFR letters. The signature block must reflect the job title of the person signing. **(T-1).** Signature delegation is not authorized. **(T-1).**

5.7.5.4.3. Air Force Members Empaneled to Sister-Service MTFs: Service Treatment Records for AD service members are normally maintained at the MTF where the member receives primary care, regardless of service affiliation. The health record management officials at the Air Force MTF located nearest to the member's Sister-Service Primary Care Manager/MTF location must establish a local Service Treatment Record Support Agreement (memorandum of understanding/memorandum of agreement) (For an example of the memorandum, see AFMOA Health Benefits Kx page at (**https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**) with the Sister-Service MTF. **(T-1).** Memorandum of understanding verbiage should include both service processes. The agreement should identify how the Service Treatment Records will be transferred from the Sister-Service MTF. How this is accomplished is jointly decided by the MTFs, but acceptable methods include:

5.7.5.4.3.1. The Sister-Service MTF may mail the Service Treatment Record to the

nearest Air Force MTF for subsequent mailing to the Air Force Service Treatment Record Processing Center.

5.7.5.4.3.2. The Sister-Service MTF may forward the Service Treatment Record directly to the Air Force Service Treatment Record Processing Center if they use the instructions outlined in this document. Include a copy of the Service Treatment Record disposition instructions with the agreement if this method is chosen.

5.7.5.4.4. There may be instances when the member is assigned to a GSU and the responsible Air Force MTF is not the nearest MTF to the member's Sister-Service Primary Care Manager/MTF location. In these cases, see rules for managing GSU records in the instructions that follow.

5.7.5.5. Non-Air Force Service Members Empaneled to Air Force MTFs:

5.7.5.5.1. Service Treatment Records for non-Air Force service members are normally maintained at the Air Force MTF when the member is empaneled to the Air Force MTF. Unless there is a local Service Treatment Record Support Agreement stating otherwise, Service Treatment Records for Sister-Service members should be mailed to the applicable address included in Attachment 11 of this AFMAN, with the appropriate documentation (i.e. orders, Non-Availability Letter, etc.).

5.7.5.5.2. If a local Service Treatment Record Support Agreement is established with another Service, the agreement must identify how the Service Treatment Record will be transferred to the applicable Service. **(T-1).**

5.7.5.6. Personnel Assigned to GSU.

5.7.5.6.1. If the MTF identified on the LOSS Roster is not the MTF that maintains the retiring/separating member's Service Treatment Record, the LOSS-Roster-named MTF must coordinate with the MTF where the record is regularly maintained in order to ensure the Service Treatment Records are mailed to the Air Force Service Treatment Record Processing Center. **(T-1).** (**Note:** Names and numbers of the points of contact at each Air Force MTF and RC are located on the Medical Records Management SharePoint).

5.7.5.6.2. Once contacted, the MTF maintaining the Service Treatment Record must mail the Service Treatment Record to the Air Force Service Treatment Record Processing Center in accordance with this guidance. **(T-1).**

5.7.5.7. Packaging and Shipping Service Treatment Records

5.7.5.7.1. Items included in Service Treatment Record Bundles:

5.7.5.7.1.1. Outpatient medical record or Non-Availability Letter, Verification Checklist.

5.7.5.7.1.2. Dental record or Non-Availability Letter, Verification Checklist.

5.7.5.7.1.3. 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. **(T-1).** 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. **(T-1).**

5.7.5.7.2. Include the following items in the shipment box; the LOSS roster as an inventory sheet stapled to an AF Form 330, *Records Transmittal/Request* and the records bundles. **(T-1).**

5.7.5.7.2.1. Print the LOSS roster inventory sheet with only the following columns showing: Social security number, Name, Date of Separation, Medical Records (Yes/No)/In Health Artifact and Image Management Solution, Dental Records (Yes/No)/Never Created, Date Record Mailed, Remarks, and NCOIC Signature.

5.7.5.7.2.2. Place the records bundles in order of the listed records on the LOSS roster. 5.7.5.7.2.3. Write "SEE ATTACHED ROSTER" in the “Name” block on the AF Form 330 type and staple together with the roster (inventory sheet). **(T-1).**

5.7.5.7.2.3.1. The NCOIC or records department supervisor must sign the roster stating they have quality checked the shipment. **(T-1).** Annotate the mailing date and annotate any remarks relevant to shipping. **(T-1).**

5.7.5.7.2.4. **Note:** MTF records management personnel must keep a copy of the AF Form 330 and LOSS roster permanently or until the Office of the Under Secretary of Defense for Personnel and Readiness and the Services establish a disposition rule for AD records. **(T-0).** Reference DoDI 6040.45. Place together with the postage tracking/arrival confirmation notice in a central location within the Outpatient Records department.

5.7.5.8. Shipment Containers.

5.7.5.8.1. Boxes - Records personnel are required to use standard white record retirement boxes or other same-sized box, purchased specifically for shipping. **(T-1).** The maximum weight per shipping box is 50 pounds. Do not bundle standard shipping boxes within larger containers for shipment as the Air Force Service Treatment Record 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 Service Treatment Records or delays in arriving at destination.

5.7.5.8.2. Envelopes – If the Service Treatment Record 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 Service Treatment Records or delays in arriving at destination. **(T-1).**

5.7.5.9. Shipping Service Treatment Records.

5.7.5.9.1. Service Treatment Records will be mailed to arrive at the Air Force Service Treatment Record Processing Center no earlier than the member’s Date of Retirement/Date of Separation and should arrive no later than 30 calendar days after the member’s date of retirement/separation/discharge or transition to inactive status. **(T-0).** Reference DoDI 6040.45. All OCONUS MTFs will use commercially available global delivery services to mail the Service Treatment Record to arrive at the Air Force Service Treatment Record Processing Center on the no-earlier-than date to prevent the

Service Treatment Record from arriving late at Air Force Service Treatment Record Processing Center.

5.7.5.9.2. Do not mail a member's outpatient and dental records separately; they must be mailed together as a bundle. **(T-0).** Reference DoDI 6040.45.

5.7.5.9.3. Service Treatment Record 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.

5.7.5.10. Preferred Mailing Method.

5.7.5.10.1. Forward Service Treatment Record boxes/envelopes to the Air Force Service Treatment Record Processing Center using standard First Class United States mail with immediate delivery confirmation/acknowledgment, certified mail, or other commercially available option, e.g., FedEx, that offers package tracking and delivery/arrival confirmation.

5.7.5.10.2. If standard first class United States Postal Service 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 or the Base Information Transfer Center (BITC) at each major installation.

5.7.5.10.3. Commercial priority mailing services are usually offered through the MTF mailroom.

5.7.5.10.4. Records personnel must keep postage tracking/arrival confirmation notice permanently or until the Office of the Under Secretary of Defense for Personnel and Readiness and the Services establish a disposition rule for AD records. **(T-0).** Place together with the Air Force Form 330 and LOSS roster in a central location within the Outpatient Records department.

5.7.5.10.5. Use of standard First Class United States Postal Service mailing method alone, without package tracking and immediate delivery confirmation/acknowledgment or certified mail receipt, is prohibited. **(T-1).** 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. **(T-1).**

5.7.5.11. For Airmen transitioning from AD to the RC, records personnel will forward the AD component to the Air Force Service Treatment Record Processing Center. The AD service period will be available electronically for the RCs.

5.7.5.12. Medical Record Tracking Transition in CHCS. Update the CHCS Medical Record Tracking Function to annotate the record has been mailed to the Air Force Service Treatment Record Processing Center. Health records personnel will TRANSFER the record in the CHCS Medical Record Tracking menu to the appropriate location. **(T-1).**

5.7.5.13. Handling Clarification Queries from the Air Force Service Treatment Record Processing Center. Queries for clarification on Service Treatment Records (e.g., requests for missing documents/records) must receive immediate MTF/ARC record management action. **(T-2).** The Air Force Service Treatment Record Processing Center only has a 15-

day window from time of Service Treatment Record receipt to ensure it is digitized appropriately in HAIMS.

5.7.5.13.1. Track Air Force Service Treatment Record Processing Center queries and their outcome in a local database. The method is left up to the MTF/ARC and could include an electronic spreadsheet, simple ledger, or other method.

5.7.5.13.2. MTF/Dental Treatment Facility/ARC 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 AFMOA/SGAT. **(T-1).**

5.7.5.13.3. The MTF/Dental Treatment Facility/ARC may be contacted by phone or e-mail. MTF/Dental Treatment Facility/ARC records managers may contact officials at the Air Force Service Treatment Record 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 Air Force Service Treatment Record Processing Center. Annotate the results in the computer spreadsheet.

5.7.6. Managing Loose and/or Late-Flowing Medical Documents Following Service Treatment Record Shipment. Loose and/or late-flowing medical documents are those medical or dental documents discovered in the MTF or Dental Treatment Facility after the Service Treatment Record has already been mailed to the Air Force Service Treatment Record Processing Center or the departing member's gaining RC.

5.7.6.1. Loose and/or Late-Flowing Medical Documents must be digitized into HAIMS in accordance with the HAIMS scanning policy. **(T-0).**

5.7.6.2. Loose paperwork may be digitized at any facility with HAIMS access.

5.7.7. Large Shipments of Pre 1 Jan 14 Medical and Dental Records/Loose Documents Processing:

5.7.7.1. The following guidance applies only to records collected for Airmen who separated/retired before 1 January 2014. Due to limited space and storage capabilities at the Air Force Service Treatment Records Processing Center, shipments of Pre-January 2014 Service Treatment Records must be coordinated and approved prior to sending. **(T-1).**

5.7.7.2. 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. **(T-1).** Ensure the following steps are taken:

5.7.7.2.1. If the information on hand is only loose documentation or less than 10 pages, digitize it in HAIMS. **Exception:** If the service member is an Entry Level Separation, the record may be less than 10 pages and should be mailed to the Air Force Service Treatment Records Processing Center.

5.7.7.2.2. Complete an AF Form 330 along with an inventory list containing the required data elements listed below. See examples located in patient administration misc. document folder on the AFMOA Health Benefits Kx page at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

5.7.7.2.2.1. NAME (Last, First).

5.7.7.2.2.2. SOCIAL SECURITY NUMBER.

5.7.7.2.2.3. MEDICAL RECORD (YES/NO).

5.7.7.2.2.4. DENTAL RECORD (YES/NO).

5.7.7.2.2.5. COMMENTS.

5.7.7.2.2.6. SIGNATURE BLOCK (Flight Commander, NCOIC, or Records Department Supervisor).

5.7.7.3. Maintain the records in the central records storage location until directed by AFMOA/SGAT to mail them to the Air Force Service Treatment Record Processing Center. Do not mail these records until directed to do so by AFMOA. Large pre-coordinated shipments of Service Treatment Records will be mailed to the Air Force Service Treatment Record Processing Center at the following address: **(T-1).**

AF STR Processing Center
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

5.7.8. AD and ARC records disposition rules are subject to frequent changes. For the latest information, contact the Records Management Support Team, AFMOA/SGAT via e-mail at **usaf.jbsa.afmoa.mbx.str-processing-center@mail.mil**.

5.7.9. Sequestered/Deceased Member's Records. In the event a Service Treatment Record is sequestered for legal reasons or has already been provided to the installation Casualty or Mortuary Affairs office in the event of an AD or ARC service member's death, MTF records managers must notify the Air Force Service Treatment Record Processing Center via email at **usaf.jbsa.afmoa.mbx.str-processing-center@mail.mil** that the Service Treatment Record is sequestered. **(T-1).** If unable to forward original record, the Service Treatment Record Center will accept a certified copy of the original record along with a notarized affidavit.

5.7.9.1. Service Treatment Records for Service Members Killed in Action. Immediately following an AD service member'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 Air Force Base 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. **(T-1).** Document the records transfer using the appropriate electronic records tracking mechanism.

5.7.9.1.1. If outpatient medical or dental treatment records are discovered (at a location not specifically identified as the AD service member's home-of-station support MTF), after the remains have been transported to the Dover Air Force Base 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 service member's deployed unit chain of command or Personnel Support for Contingency Operations unit to ascertain from which installation the Airman deployed. In the records package, include a completed AF Form 330, DD

Form 2138 *Request for Transfer of Outpatient Records* or other appropriate form or letter that informs the receiving MTF that, a) the AD service member has died, and b) informs the receiving MTF the health records they received were intentionally forwarded.

5.7.9.1.2. 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 AD service member 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. Forward the Service Treatment Record to the Air Force Service Treatment Record Processing Center according to processes identified earlier within this section, no later than 30 days following notification of the service member's death. The Air Force Service Treatment Record Processing Center will digitize the Service Treatment Record in HAIMS, thus making it available to the VA. **(T-1).** Surviving family members may be eligible for Service or VA death benefits or compensation. The deceased Airman's Service Treatment Record may be required as part of the VA death benefits or compensation evaluation. If, at any time, while preparing to ship the Service Treatment Record to the Air Force Service Treatment Record 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 Service Treatment Record.

5.7.9.2. Service Members Placed in Appellate Review Leave Status or When a Prisoner is transported to a Correctional Detention Facility Immediately Following a Trial.

5.7.9.2.1. Appellate Review Leave. Under the Uniform Code of Military Justice, 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 AD 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 review leave.

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

5.7.9.2.3. While on appellate review leave, the service member must remain enrolled in TRICARE Prime and be enrolled to a MTF. **(T-0).** If the service member relocates to another area, prior to departure the servicing MTF must brief the member on the processes required for obtaining health care for themselves and any dependents. **(T-0).** Service members on appellate leave cannot enroll into TRICARE Prime Remote or choose a civilian Primary Care Manager. Reference 32 CFR Part 199.17. Also, see Section 2A for additional information on enrollment.

5.7.9.2.4. When a member is placed on appellate leave, the service member's Service Treatment Record will be forwarded (in a sealed envelope) to the Wilford Hall Ambulatory Surgical Center at Lackland Air Force Base, TX where it will be maintained until the appellate review period has completed. **(T-1).**

5.7.9.2.5. 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.

5.7.9.2.5.1. Place one copy in a charge-out guide.

5.7.9.2.5.2. Locate and retrieve the service member's outpatient medical record.

5.7.9.2.5.3. 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.

5.7.9.2.5.4. Locate and retrieve the dental treatment record – bundle together with the Outpatient Medical Record.

5.7.9.2.5.5. 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 59th Medical Wing under routine PCS transfer rules. See the *Medical Record Tracking, Retirement and Retrieval User Guide* on the AFMOA Health Benefits Kx to learn how to create or set-up new records borrower/destination locations.

5.7.9.2.5.6. Place the complete Service Treatment Record in shipping package.

5.7.9.2.5.7. Prepare, complete, and sign an AF Form 330 and insert the form into the package. Keep a copy of the AF Form 330.

5.7.9.2.5.8. No later than three days following the start of the appellate review period, mail the complete Service Treatment Record and AF Form 330 to the address identified below: following the steps outlined in paragraph 5.29.5.5.

Wilford Hall Ambulatory Surgical Center
ATTENTION: Lackland STR Manager
1100 Wilford Hall Loop
JBSA-Lackland Air Force Base, TX 78236-9908

5.7.9.3. Upon completion of the appellate review, if the service member is officially and permanently discharged from the Service, the member's name will appear on the installation personnel LOSS roster for Lackland Air Force Base. The records department at Wilford Hall Ambulatory Surgical Center is responsible for forwarding the original Service Treatment Record to the Air Force Service Treatment Record Processing Center. If the service member is removed from appellate leave and returned to duty, Wilford Hall will transfer the original Service Treatment Record to the service member's previous assignment support MTF or to another MTF based upon written direction or orders. **(T-1).** Medical records personnel will not release or forward the Service Treatment Record to anyone, any place, or any agency without obtaining written direction or orders. **(T-1).**

5.7.9.4. 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.

5.7.9.4.1. During the appellate review period, even if a service member is immediately transported to a correctional facility, the MTF where the service member's Service Treatment Record is normally maintained is responsible for forwarding the original Service Treatment Record to Wilford Hall Ambulatory Surgical Center in accordance with the instructions (associated with appellate review record disposition) previously identified in this section. **(T-1).**

5.7.9.4.2. Records personnel at the service member's support MTF and/or the Wilford Hall Ambulatory Surgical Center are prohibited from providing or forwarding the original Service Treatment Record to any prisoner escort detail or correctional facility. **(T-1).** Instead, provide the escort detail or confinement facility with a complete Service Treatment Record copy. If a copy cannot be immediately provided, a copy will be mailed to the destination military correctional facility within five duty days. **(T-1).** Copies of Service Treatment Records 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.

5.7.9.4.3. Address questions concerning this program to the Records Management Support Team, AFMOA/SGAT at **usaf.jbsa.afmoa.mbx.str-processing-center@mail.mil**.

5.7.9.5. United States Air Force Academy Cadets and Airmen with Less than 180 days of Continued Service. This applies to members of the United States Air Force Academy and all other Air Force recruits separated or discharged prior to accruing 179 days or less days of military service. Forward Service Treatment Records for these two beneficiary categories to the Air Force Service Treatment Record Processing Center. Follow the same Service Treatment Record disposition instructions as identified for AD and ARC service members identified earlier in this manual. Place a copy of the separation or retirement order or personnel document ordering the separation, discharge, or retirement inside the Service Treatment Record.

5.7.10. NATO Military Personnel and NATO Family Member Non-Service Treatment Records. Deliver outpatient records of NATO military personnel and their family members in a sealed envelope to the individual concerned upon transfer to another United States military base. Upon return of personnel to the NATO country, transfer records to the specific national military medical authority. Address questions concerning this program to the Records Management Support Team, AFMOA/SGAT at **usaf.jbsa.afmoa.mbx.sgat@mail.mil**.

5.7.11. Non-NATO Foreign Military Personnel Non-Service Treatment Records. Retire outpatient records for non-NATO foreign military personnel to National Personnel Records Center two years after the end of the calendar year of the last date of treatment, in accordance with AFRIMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website, and the *Medical Record Tracking, Retirement and Retrieval User Guide*, available for download on the AFMOA Health Benefits Kx.

5.7.12. Non-military (including family members and retired personnel) Non-Service Treatment Records. Air Force MTFs are required to at least annually (no later than 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 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 April 2011. Retire records two years after the end of the calendar year of the last date of treatment. **Note:** Do not use the most current treatment date identified inside the paper health record. Review the patient's appointment history in the electronic health record. Retire or purge records in accordance with AFRIMS Records Disposition Schedule, Series 41, accessible via the Air Force Portal website and the *Medical Record Tracking, Retirement and Retrieval User Guide*, available for download on the AFMOA Health Benefits Kx.

5.7.13. Non-Service Treatment Records for Family Members of Service Members Assigned to GSU. 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 Non-Service Treatment Records for family members of service members assigned to a GSU, and/or enrolled to TRICARE Prime Remote. As such, a family member's Non-Service Treatment Record may be kept on file at the MTF closest to the service member's GSU TRICARE enrollment. If this is the case, there may be no evidence in either the military electronic health record 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. **(T-1).** 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).

5.7.14. Federal Civilian Employee Non-Service Treatment Records. Federal Civilian Employee Non-Service Treatment Records are maintained in SF 66D, *Employee Medical Folder* and is a chronological, cumulative record of occupational and non-occupational information pertaining to the health of a civilian employee during the course of employment. A SF 66D can be obtained at **https://www.gsa.gov**.

5.7.14.1. This record consists of personal and occupational health histories, exposure records, medical surveillance records, Office of Worker's Compensation Programs records, and the documented notes, evaluations and tests results generated by healthcare providers in the course of examination, treatment and counseling.

5.7.14.2. Maintain Non-Service Treatment 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, forward the SF 66D to the Military Personnel Section, Civilian Personnel Section within 10 days of transfer or separation.

5.7.14.3. It is the responsibility of the Military Personnel Section to forward the Non-Service Treatment Record to the appropriate custodian. However, federal civilian

employees must complete installation and unit and/or installation out-processing checklists similar to their AD counterparts (as applied to MTF out-processing requirements). **(T-1).**

5.7.14.4. Typically, AD members are required to visit the installation Outpatient Record 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 Military Personnel Section - MTF transfer process.

5.7.14.5. Federal civilian employees are also required to visit the local servicing MTF Outpatient Record department where their Non-Service Treatment Record is maintained. This process will ensure that the MTF receives notice from the civilian employee of an upcoming transfer or retirement, regardless of any Military Personnel Section records relocation/retirement notification.

5.7.14.6. Information regarding creation and maintenance of these Non-Service Treatment Records is available for download on the AFMOA Health Benefits Kx.

5.7.14.7. If civilian employee records are found years after the employee has relocated or retired, then:

5.7.14.7.1. Ensure records are in a SF 66D. Each employee will have his own folder.

5.7.14.7.2. Annotate the SF 66D with the employee's last name, first name, middle initial and Social security number on the upper right hand corner - preferably typed on a white folder tab.

5.7.14.7.3. Box the records in a container which will safely make it through the United States Postal Service mailing process.

5.7.14.7.4. Create a shipping list for each container. Detail the contents by name and Social security number of each employee's record. A SF 135, *Records Transmittal and Receipt* is not needed.

Mail the container(s) to:

National Personnel Records Center Annex
1411 Boulder Boulevard
Valmeyer, IL 62295

5.7.14.7.6. Mail the record containers using standard first class mail, certified mail, or other available option. If standard first class United States Postal Service is used, return receipt confirmation is required.

5.7.15. Retirement of Inpatient Records, Extended Ambulatory Records, and Fetal Monitor Strips to National Personnel Records Center. Additional information regarding creation and maintenance of these records is available for download on the AFMOA Health Benefits Kx.

5.7.15.1. Inpatient Records. Retire inpatient records of all service members and their family member dependents to National Personnel Records Center, in accordance with AFRIMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website and the *Medical Record Tracking, Retirement and Retrieval User Guide* available for download on the AFMOA Health Benefits Kx.

5.7.15.1.1. Dispose or retire inpatient records according to the year of hospitalization discharge, not date of admission.

5.7.15.1.2. 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 Air Force Records Officer and National Personnel Records Center. 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.

5.7.15.2. NATO Military Personnel Inpatient Records: in accordance with NATO Standardization Agreement for Basic Military Hospital (Clinical) Records, Inpatient and/or Clinical records will accompany the patient upon transfer between hospitals, and will be forwarded to the patient's specific national military medical authority. See NATO STANAG, *Basic Military Medical Record***,** AMedP-8.2 Edition B, 15 January 2018.

5.7.15.3. Non-NATO Military Personnel Inpatient Records: Retire inpatient records in accordance with AFRIMS, Records Disposition Schedule, Series 41 and the *Medical Record Tracking, Retirement and Retrieval User Guide*, available for download on the AFMOA Health Benefits Kx.

5.7.15.4. Extended Ambulatory Records. The retirement rules for extended ambulatory records are the same as those for inpatient records. For teaching MTFs, the extended ambulatory record 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 Air Force Records Officer and National Personnel Records Center. Contact AFMOA/SGAT for assistance when requesting a waiver. For non-teaching facilities, the extended ambulatory record will be retired one year after the end of the calendar year of the last documented episode of care.

5.7.15.4.1. Retire the extended ambulatory record folder to National Personnel Records Center along with the inpatient records and any applicable fetal monitor strips (i.e., in the same box.)

5.7.15.4.2. Place the extended ambulatory record folder behind any fetal monitor strips for that patient, or behind the applicable inpatient record folder if there are no fetal monitor strips.

5.7.15.4.3. If the patient does not have an inpatient record but does have an extended ambulatory record, the extended ambulatory record is still included in the shipment of inpatient records.

5.7.15.5. Fetal Monitor Strip. Retire the fetal monitor strips to National Personnel Records Center in accordance with AFRMS Records Disposition Schedule, Series 41 Internet website, accessible via the Air Force Portal website and the *Medical Record Tracking, Retirement and Retrieval User Guide*, available for download on the AFMOA Health Benefits Kx. (**Note:** Digitized, or other format, fetal monitor strips that can be printed out on an 8 ½" 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).

5.7.15.5.1. Retire the fetal monitor strips to National Personnel Records Center using the same disposition schedule as that for inpatient records.

5.7.15.5.2. Attach the envelopes containing the fetal monitor strips to the inside of an appropriately labeled folder (only two envelopes per patient per folder).

5.7.15.5.3. Annotate the outside of the folder with the name and register number of the infant, sponsor's name and Social security number, name of the MTF and date of infant's birth.

5.7.15.5.4. File these folders in the same box as the applicable inpatient record (baby's or mother's) directly after that record.

5.7.16. General Inpatient Records Disposition Procedures:

5.7.16.1. Prepare National Personnel Records Center required index of records shipment file. Outpatient and Inpatient medical records require separate indexes (fetal monitor strips and extended ambulatory records must be included on the Inpatient records index). **(T-3).**

5.7.16.2. Follow the applicable tables and rules in accordance with AFRIMS, Records Disposition Schedule, Series 41, to determine record retirement eligibility.

5.7.16.3. Utilize the step-by-step instructions provided in the *Medical Record Tracking, Retirement and Retrieval User Guide* to create/run the retirement index**.** The *Medical Record Tracking, Retirement and Retrieval User Guide* is available for download on the AFMOA Health Benefits Kx. Address questions concerning this program to the Records Management Support Team, AFMOA/SGAT at **usaf.jbsa.afmoa.mbx.sgat@mail.mil**.

5.7.16.4. The CHCS 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. For future use, print and maintain a copy of each index. This information is invaluable when determining whether or not a record has been retired to National Personnel Records Center.

5.7.16.5. Forward a copy of each shipment index to the Base Records Management Office for their files.

5.7.16.6. Requests for Medical Records from the National Personnel Records Center.

5.7.16.6.1. When requesting medical records retired to National Personnel Records Center prior to CY 2003, use the DD Form 877-1, *Request for Medical/Dental Records from the National Personnel Records Center (NPRC) (St Louis, Missouri)* or other specific form identified by National Personnel Records Center records managers. National Personnel Records Center request forms contain space for the minimal information required for their agency to institute a search for the requested record.

5.7.16.6.2. To obtain medical records retired to the National Personnel Records Center from CY 2003 and beyond, use the National Personnel Records Center Medical Registry System 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*. **(T-2).** An electronic version of the form along with instructions for completion can be obtained at the Medical Registry System website at **https://www.archives.gov/st-louis/military-**

personnel/agencies/medical-registry-system.html. Additionally, MTF personnel may use the step-by-step records retrieval instructions provided in the *Medical Record Tracking, Retirement and Retrieval User Guide* available for download on the AFMOA Health Benefits Kx.

5.7.16.6.3. Use the DD Form 2138 or 877, *Request for medical/Dental Records or Information* when requesting records from another MTF.

5.8. Base Closures and Medical Records Management.

5.8.1. Inpatient Records are retired to the National Personnel Records Center upon inactivation of the hospital (or upon downsizing to a clinic) in accordance with AFRIMS Records Disposition Schedule at **https://www.my.af.mil/afrims/afrims/afrims/rims.cfm** and the *Medical Record Tracking, Retirement and Retrieval User Guide* available for download on the AFMOA Health Benefits Kx website and the AF/SG's Contingency Operations Plan. Reference AFI 41-106, *Medical Readiness Program Management*.

5.8.2. If early retirement is desired (i.e., out of cycle), the MTF commander or director must request early retirement from Secretary of the Air, Chief Information Officer, Compliance Division (SAF/CIO A6XA). **(T-1).** 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 National Personnel Records Center who will notify the MTF commander or director of the decision. The request must include the following **(T-3):**

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 National Personnel Records Center.

5.8.4. Health records of AD members and their family members are transferred to the member's gaining base.

5.8.5. Health 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 health records to that facility with a cover letter explaining why the records were forwarded.

5.8.5.2. If a civilian medical facility 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 National Personnel Records Center in accordance with AFRIMS Records Disposition Schedule and the *Medical Record Tracking, Retirement and Retrieval User Guide*. Maintain an AF Form 1942 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 AD 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 Staff Judge Advocate. 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, Social security number, DoD Identification Number and location to which the medical record was forwarded. **(T-3).** Forward a copy of the Chain of Custody document to the MAJCOM command surgeon and the Records Management Support Team, AFMOA/SGAT.

5.8.11. Upon inactivation of the MTF, the old retained SF 135s, (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 and the Records Management Support Team, AFMOA/SGAT.

5.9. Health Record Review Committee/Functions.

5.9.1. Record review functions will be performed at each MTF by either an established Medical Record Review Committee or incorporated into other committees that review records. **(T-1).** Record review function examines and evaluates the following: record quality and clinical pertinence; information assurance practices; and, inpatient and outpatient records completion times. Also examined are whether the records are prepared and maintained according to directives and Joint Commission standards. Finally the records review function is the approval authority for locally created forms. **(T-0).** 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. Reference under DoDI 6025.13, *Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)*. Responsibilities of this committee will include but not be limited to the following items **(T-0):**

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 or as directed by the MTF commander or director.

5.9.1.3. Review the Service Treatment Record disposition process and progress on meeting the standards of completeness and timeliness and report to the Executive Committee of the Medical Staff or as directed by the MTF commander or director.

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. These data reports are then forwarded to the Executive Committee of the Medical Staff for review or as directed by the MTF commander or director.

5.9.2. Committees tasked with records review must approve locally overprinted SFs filed in health records. **(T-2).** 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. Creation of Outpatient Record Folders. The AFMS no longer creates hard copy outpatient record folders. Outpatient records will be created and maintained in the approved electronic health record. **(T-0).** Arrangement of content, record filing methodology and use of electronic health records are consistent throughout Air Force MTFs. For those existing hard copy original paper medical records in the MTF that may need a replacement folder see Table 5.1 for preparing outpatient records folders and Attachments 6, 7, 8 and 9.

Table 5.1. Preparing Outpatient Record Folders Table.

If the patient is:	Use Social security number of:
AD/ARC	Member
Family Member	Sponsor
Family Member and RC Service Member	Sponsor
Civilian Employee	Employee
Retired Military	Retired Military (Note paragraph 5.10.4.)
Civilian Emergency	Patient

5.10.1. Dual eligibility presents a concern for both medical records personnel and clinicians. Medical records personnel must ensure that the correct Social security number is used when creating the Service Treatment Record/Non-Service Treatment Record for a dual eligible member who presents for care at the MTF. **(T-0).** In accordance with DoDI 1000.13 and AFI 36-3026_IPV1, medical records personnel will create a record based upon the highest level of eligibility. **(T-0).** Refer to paragraph 4.7 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 AD 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 RC service members, 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 Social security number here and status as a member of the AFR or ANG, or other multi-service RC 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.

5.10.3. Outpatient medical and dental records for (Category A) RC service members are usually maintained with the member's reserve unit. Already existing paper based records will be maintained as listed below. Only create one electronic health record per dual eligible patient. If the RC service member 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 Social security number and 999-99-9999 as the sponsor's Social security number:

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 RC/AD family member prefix/social security number 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/Individual Mobilization Augmentee/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 on the shelf.

5.10.3.2. Volume 2 will be the record used for the RC/AD paperwork (20/000-00-0000). Activated RC service member 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 family member prefix/social security number with a label or white tape and annotate the correct family member prefix/social security number for this record (20/000-00-0000).

5.10.3.2.1. Write "CROSS-REFERENCE" on the cover and annotate "RC/AD family member prefix/social security number 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 by exception, 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 family member prefix and social security number 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 as a result of remarriage to another military sponsor, record forms filed under the former Social security number should be consolidated under the current sponsor Social security number. Once the patient has been registered in CHCS under the current sponsor's Social security number, 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 Social security number may be created for beneficiaries without a Social security number. This process occurs in DEERS when the personnel technician issues an identification card or enters the beneficiary into DEERS. Either a Foreign Identification Number or a Temporary Identification Number is generated.

5.10.7. Civilian Emergencies. No paper based records will be created for civilian emergencies. Already existing records will be filed by Social security number in a manila folder and maintained separately from the main file if desired. However, they must be interfiled by Social security number with the rest of the records when retired to National Personnel Records Center. **(T-1).**

5.10.8. Civilian employees [including Air Reserve Technicians] who are also members of a 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 the individual's 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 Personnel Reliability Assurance Program/Presidential Support Program or Sensitive Duties Program position or job will have one medical record maintained as indicated in paragraph 5.12.5.7 until such time as they are removed from the program or are transferred to another federal agency or separated from federal service.

5.10.9. When individuals who are not attached to the base are receiving medical care on base (for example, Air Force Institute of Technology (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.

5.11. 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 Air Force form in the 2100A series according to the last two digits of the applicable Social security number:

Table 5.2. Terminal Digit Health Record Filing System.

Last two digits of Social security number:	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 Identification area.

5.11.4. Print the sponsor's Social security number 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 Social security number. Check the TRICARE DEERS website for the DEERS Dependent Suffix for the patient or if not available, number in birth date order for family member children.

5.11.4.2. The family member prefix will not change as long as the patient is still associated with the same sponsor and social security number.

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 36-3026_IPV1 are treated in the MTF as their own sponsor. Create medical records for these patients using a "20" family member prefix and the un-remarried spouse's own social security number. If the patient's previous record, filed under the deceased sponsor's Social security number, 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 Social security number, work with the Systems Office to correct. See paragraph 2.7 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 Social security number digit. Use a black pen, black felt-tip marker or ½ inch-wide black tape. If a pen or 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" and "S" blocks 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 pen or black felt-tip marker. **Note:** Do not prepare another folder if the available year selections on the original record jacket fill-up. Attach AF Form 2700L, *Health Record Year Grid*, to AF Form 2100A series 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 and Retired Military Member, select the appropriate category, blot the corresponding block, and document the patient's status. Enter the Service and rank for AD and retired military personnel. Enter the country for non-United States military personnel. (A copy of the non-United States military member's orders should be placed in the health record). Use pencil for rank only. See paragraph 5.10.5 for family members who are also members of the AFR or ANG.

5.11.6. Personnel Reliability Assurance Program/Presidential Support Program, or Sensitive Duties Program Folder Markings: Use red pen, red permanent marker or red tape instead of black to identify a Personnel Reliability Assurance Program/Presidential Support Program member's folder. Cover the appropriate last Social security number 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 approximately 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 Assurance Program. Cover the red marking with a black marking or black tape when a member is removed from the program. All other colors are unauthorized.

5.11.6.2. An AF Form 745 will be affixed to Section 2 of the active Volume of the outpatient medical record. **Note:** In existing records, the use of the AF Form 745 in closed/inactive volumes is authorized, but not required.

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 pen, 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. Ensure the tape strip covers both the "R" and "S." Start tape strip over the left side edge of the first numerical digit block of the sponsor's last 4 digits of the Social security number and continue to the right edge of the numerical digit block "9" at the top of the folder. Place the tape on the folder so that half of the strip folds to the rear side of the folder. Never cover the family member prefix or social security number.

5.11.7.1. Stamp or label the outside of the record jacket with the word "FLY" (ALL IN CAPS) in approximately 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 4.3.3.1.) or, e) MEDICATION ALLERGIES is discouraged.

5.11.9. If the patient 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 Medical Record Tracking bar code label to the health record folder in the upper right hand corner. See the *Medical Record Tracking, Retirement and Retrieval User Guide* for instructions on label requirements.

5.11.12. Acknowledgement of *Notice of Privacy Practices*. Each patient will receive a copy of the *MHS Notice of Privacy Practices*. **(T-0)**. See AFI 41-200, paragraph 3.2 for additional information on providing the notice and documenting receipt. Reference DoDM 6025.18.

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. **(T-1).** Documents will contain the name and location of the MTF maintaining the record to ensure the document is

sent to the proper MTF. **(T-1).** The documents will also contain the name of the outpatient record location. **(T-1).**

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 Social security number 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.

5.12.3. Paperwork Filing Order for the AF Form 2100A Series, *Health Record-Outpatient* (four-part folder). Refer to the tables located at attachment(s) 6-9 in this AFMAN.

5.12.4. Electronically generated forms.

5.12.4.1. Tri-Service Workflow is the standard documentation method for Patient Centered Medical Home in Family Medicine, Internal Medicine, and Pediatrics for the entire MHS.

5.12.4.2. No matter the form automation mechanism, when electronically generated forms are used in place of SF, DD, or Air Force forms, each automated form must contain the statement "SF, DD or AF Form XXXX (EF) [name and producer/vendor (if any) of the software used]." **(T-1)**. See Section 5A for guidance on overprinted and electronically generated forms. Reference DoDI 7750.07-M.

5.12.5. Documenting the DD Form 2766 for AD Service Members/ RC Service Members – Continuity of Care Documentation.

5.12.5.1. The DD Form 2766 is the primary folder used to document medical and dental treatment for AD, AFR, ANG, and deployable federal civilian employees while in a deployed environment. The original outpatient medical and dental records for each deployed AD, RC service member and deployed 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, unless exempted by COCOM/Component reporting instructions. 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 should not have a DD Form 2766. Reference DoDI 6490.03.

5.12.5.2. The Tri-Service Workflow Core Alternate Input Method form ("Tri-Service Workflow Core") in AHLTA will serve as the initial intake form for all primary care visits (both AD and non-AD) and serves as the primary mechanism for communicating continuum of care information between healthcare team members and MTFs.

5.12.5.3. MTF providers and clinical support staff are required to update the Tri-Service Workflow Core continuum of care elements at each visit, but are not required to review or update the cardstock DD Form 2766. If information is handwritten on the card stock DD Form 2766, it should be validated and transferred to the Aerospace Services Information Management System (ASIMS) DD Form 2766 for AD and ARC service members. The form should then be marked (with a stamp or hand-printed in bold letters) "**Data**

Transferred to electronic ASIMS Form 2766 on (insert date of transfer)" at the top of each card stock page.

5.12.5.3.1. No medical information is to be hand-written on an ASIMS DD Form 2766 generated document. Information collected on the card stock DD 2766 during a deployment will be merged with the electronic ASIMS DD Form 2766 within 30 days following a service member's return from deployment in accordance with DoDI 6490.03.

5.12.5.3.2. The electronic ASIMS DD Form 2766 will be updated during the annual Periodic Health Assessment 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 PCS. Unless, exempted by COCOM/Component reporting instructions, the most current version of the ASIMS DD Form 2766 and DD Form 2766C will be printed and placed into the cardstock DD Form 2766 (secured with the metal prongs) for all AD and ARC service members during pre-deployment screening, and prior to completing PCS out-processing for PCS locations that do not utilize AHLTA. 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.

5.12.5.4. 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. **(T-3).**

5.12.5.5. 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.

5.12.5.6. For service members assigned to Sensitive Duties Programs (e.g., Personnel Reliability Assurance Program and Presidential Support Program), MTF records personnel will attach an AF Form 745, inside the DD Form 2766 cardstock record at the time of deployment. **(T-3).** Additionally, stamp "Personnel Reliability Assurance Program" or "Presidential Support Program" 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.

5.12.6. Documenting Preventative and Chronic Care for Non-AD Adult Beneficiaries.

5.12.6.1. The Tri-Service Workflow Core template in AHLTA will serve as the initial intake form for all primary care visits (for both AD and non-active-duty adult patients) and serves as the primary mechanism for communicating.

5.12.6.2. Tri-Service Workflow Core will replace the need for completing the card-stock DD Form 2766 for non-AD adult beneficiaries. **(T-3).** All discontinued DD 2766 forms, already filed in the medical record, must remain in the outpatient medical record. **(T-3).** Do not destroy old or seemingly irrelevant medical documents.

5.12.7. Documenting and Filing the DD Form 2882.

5.12.7.1. This form will be used for all DoD TRICARE Prime pediatric and adolescent beneficiaries to provide continuity of care in the TRICARE system. **(T-3).** 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. **(T-3).** 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. **(T-3).**

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, as identified by the current edition of the United States Preventive Services Task Force Guide to Clinical Preventive Services (**https://www.uspreventiveservicestaskforce.org**) and the TRICARE Prime benefit package. This form is not intended to be used as current age-specific recommendations for care of newborns through adolescence 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. Tri-Service Workflow Pediatric Alternate Input Method forms have replaced DD Form 2882 for documentation of pediatric and adolescent preventive and chronic medical information. Although DD Form 2882 has been replaced, it may still be present in original paper medical records and utilized at locations that do not have access to AHLTA.

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 Primary Care Manager medical staff are authorized to transcribe pertinent medical information from this document to the electronic health record 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 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-AD adult beneficiaries do not need a replacement DD Form 2766.

5.12.9. Unauthorized Storage of Second, Back-up, or Shadow Files. There will be only one storage area for medical records. **(T-0).** Medical information which documents, illustrates, depicts, or describes clinical data will not be stored in more than one MTF location. **(T-0).**

This data includes but not limited to outpatient encounters, dental encounters, inpatient healthcare, same day surgeries, ambulatory surgery, or diagnostic care. (T-0).

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 electronic health record 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 electronic health record or applicable cardstock medical record. Copies will not be maintained anywhere. **(T-0).**

5.13. Filing Outpatient Records.

5.13.1. "Terminal Digit" Filing System: File records by Social security number, 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 or director 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 paragraph 5.13.5. **(T-3).** The numerical files of personnel assigned to the Personnel Reliability Assurance Program, Presidential Support Program or any other sensitive duty program are also maintained in a separate secured location. See paragraph 5.13.6. In MTFs with authorized decentralized records rooms, the CHCS Medical Record Tracking function will identify where the numerical file is regularly stored and will document inter-facility borrower history. Use of AF Form 614, *Charge Out Record* will not be required unless the CHCS Medical Record Tracking function is not used or the MTF Records Custodian deems non-use appropriate.

5.13.4. Annual AD Inventory. MTFs will establish local procedures to perform an annual inventory of all AD Air Force records by 31 March. **(T-1).** AFMOA will contact the local Military Personnel Section and obtain a roster of all assigned and/or attached AD personnel and provide a copy to medical records personnel. **(T-1).** Medical records personnel should sort the roster by terminal digit order. If missing record(s) and/or volumes(s) are discovered during

the initial audit, records personnel will perform monthly follow-up audits until the missing record(s) and/or volumes(s) are retrieved or located. **(T-1).**

5.13.5. Flight and Operational Medicine Records: If authorized by the MTF commander or director, outpatient records for Airmen and family members empaneled 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 empaneled to the Flight Clinic.

5.13.6. Outpatient medical and dental treatment records for personnel assigned to the Personnel Reliability Assurance Program, Presidential Support Program, or any other sensitive duty program will be maintained in a separate, secured location. **(T-3).** Again, as mentioned in paragraph 5.13.3., proper use and management of the CHCS Medical Record Tracking 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 prime service areas or who are assigned to a) United States Air Force Recruiting Service posts, b) Reserve Officer Training Corps (ROTC) units, c) GSU, d) authorized TRICARE Prime Remote locales, e) health records for TRICARE Prime family members enrolled to civilian Primary Care Managers and f) overseas United States embassy support 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 Air Force MTF is not the nearest MTF to where the member is assigned or the family member is enrolled. In these instances, the responsible Air Force MTF must coordinate with the nearest MTF maintaining the records to ensure the records are correctly processed when the member retires, separates, receives a PCS to another location or enrolls to another MTF. **(T-2).** Family members and sponsors will not hand-carry their Service Treatment Records/Non-Service Treatment Records to these locations. **(T-0).** See paragraphs 5.15 and 5.29 for additional instructions.

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. **(T-3).**

5.13.8.2. Login to CHCS and from the Medical Record Tracking module, verify that the multi-volume record is properly referenced, and if not, create a new electronic volume reference, print a new bar-scan Identification 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 Identification 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-AD medical record to the National Personnel Records Center in accordance with established record retirement procedures. For records of deceased AD and RC service members, refer to the Sequestered/Deceased Member's Records. See paragraph 5.7.2.

5.13.10. Use of AF Form 1942, to manage records is optional. However, if a MTF Records Custodian chooses to continue using the form, prepare and maintain an AF Form 1942 for each record permanently forwarded 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. **(T-1).**

5.13.12. When personnel from the United States Army and United States 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 a 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 United States Army or United States 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 ARC Outpatient Records.

5.14.1. Health records for members of the AFR (Category A) and ANG or members of the ARC who are on tours of active duty for less than 30 days are normally maintained with their respective medical units, unless a local agreement or memorandum of understanding exists between the MTF and the ARC unit(s) requires the MTF to maintain them.

5.14.1.1. The MTF may maintain health records for members of the AFR (Category A) and ANG who have or are, a) placed on AD orders for more than 30 days; b) are currently empaneled to a 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 AD and/or removal from active MTF enrollment.

5.14.1.2. If the service member's ARC unit does not provide the outpatient medical records to the MTF during the ARC service member's period of AD 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 RC service member) that have already been created. Only maintain one electronic health record per dual eligible patient. See Section 4B for additional guidance regarding dual or multiple eligibility patient record maintenance. Medical and dental records for Category B (Individual Mobilization Augmentee) and E (Participating Individual Ready Reserves) are maintained at the Individual Mobilization Augmentee service member's servicing MTF usually co-located at or near the service member's unit of attachment. Individual Mobilization Augmentee medical and dental records will be maintained in accordance with the paragraph below. **(T-3).**

5.14.3. Maintain health records for Individual Mobilization Augmentees (Category B) according to the following instructions:

5.14.3.1. Maintain records for centrally managed Individual Mobilization Augmentees (HC, JA, and SG) with the AD MTF unit of attachment.

5.14.3.2. Maintain records of non-centrally managed Individual Mobilization Augmentees with the AD MTF unit of assignment.

5.14.3.3. Complete an annual inventory of all ARC health records on file as of 31 March.

5.14.3.3.1. Readiness Management Group/Individual Reservist Medical Section maintains a registry of Individual Mobilization Augmentee/Participating Individual Ready Reserves records/locations, and can furnish a list of the records identified in paragraph 5.14.3.1. Notify AFRC/Chief of Aerospace Medicine if records are not located or if a records transfer (due to reassignment, retirement) is required.

5.14.3.3.2. The inventory will include:

5.14.3.3.2.1. Identify and remove Service Treatment Records of personnel no longer assigned, or those who have retired or separated.

5.14.3.3.2.2. Identify records which are unaccounted, find or replace the records, and take actions as required in AFI 41-200, paragraph 6.3.

5.14.3.3.2.3. Report summarized results of the inventory to the Executive Management Committee.

5.15. Active Association and Geographically Separated Unit Outpatient Records Management.

5.15.1. An Active Association is a construct which an AFR or ANG Sponsor Organization shares a mission with one or more Regular Air Force Associate Organizations. The majority of service members assigned to an Active Association and their family members will be

enrolled in TRICARE Prime Remote. Similar to GSU, the nearest MTF will maintain the official health records of Active Association members.

5.15.1.1. The nearest Air Force MTF commander or director and service member's GSU commander will ensure mechanisms are in place to access medical documentation generated from civilian medical facilities and update the service member and family member's official health record.

5.15.1.2. For additional details on Active Association refer to AFI 90-1001, *Planning Total Force Association (TFAS)* and for best practices AFMOA Health Benefits Kx page at: **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

5.15.1.3. Personnel who are assigned to Active Associations will follow the same guidelines as those assigned to Geographically Separated Units as outlined below this section.

5.15.2. GSU personnel are AD service members, and their family members, assigned to a unit 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.

5.15.3. In accordance with DoDI 6040.42, *Medical Standards for Medical Coding of DoD Health Records*, all beneficiary medical records are the property of the DoD. Their maintenance and availability are key to appropriate medical care and legal and administrative proceedings. As such, the original health records of GSA service members and their family members (if family members accompany the sponsor) will not be hand-carried or maintained by the sponsor, the family members, or provided to the sponsor or family members' civilian Primary Care Manager Office. Alignment of Geographically Separated Unit s with MTFs for medical records support will be based on proximity, past history, and Major Command (MAJCOM) prerogatives. For tips and best practices see AFMOA Health Benefits Kx page at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

5.15.4. Affix the following statement to the outside of each original health record(s) using an address label: "Assigned to an Active Association/GSA at or near (Enter City, State, Territory, or Province name here). In accordance with AFMAN 41-210, Section 5B, DO NOT RETIRE THIS OUTPATIENT RECORD." See Figure 5.1 GSA Label.

5.15.5. 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 Active Association/GSU. Forward these records to the appropriate MTF and inform the sponsor which MTF will maintain their and their family members' records. AD personnel and their family members preparing to PCS to an Active Association/GSU may obtain, and hand-carry, a complete copy of their records to these locations (to be obtained from the losing MTF prior to departure). Members must request copies of their records no later than 30 days prior to departure, to allow the MTF sufficient time to fill the request. **(T-3).** 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. When the members relocate to a non-remote location, upon in-processing, they should notify the gaining MTF to request the records from the original losing MTF.

5.15.6. Exception for Sensitive Duties Program Participants: The original Service Treatment Record of service members assigned to a GSU may be required to be maintained or stored at the unit to maintain sensitive duties program participation. If the original Service Treatment Record 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 commander and the commander's designee for the Personnel Reliability Assurance Program, Presidential Support, and FLY programs. A good example of this type of scenario would apply to service members assigned to remote Munitions Sites (MUNS) GSU in USAFE-AFAFRICA. The nearest Air Force MTF commander or director 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 Service Treatment Record and that all health records are maintained in accordance with this manual. **(T-3).**

5.15.7. The MTF will educate the service members and family members on the process for receiving medical and dental care at the new assignment. If the service members and family members will be enrolled into TRICARE Prime Remote, educate beneficiaries on the TRICARE Prime Remote program and assist with enrollment into the program.

5.15.8. 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. **(T-3).** See Figure 5.2 GSU Record Copy.

5.15.9. Miscellaneous or loose medical documents generated by an MTF for Active Association/GSU members and/or their family members will be scanned into Health Artifact and Image Management Solution (HAIMS).

5.15.10. Upon reassignment from the Active Association/GSU to a military installation and subsequent MTF Primary Care Manager assignment, the gaining MTF will send a DD Form 877 or DD Form 2138, 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/Primary Care Manager shall 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. **(T-3).**

5.15.11. The MTF will educate the service members and family members on the process for receiving medical and dental care at the new assignment. If the service members and family members will be enrolled into TRICARE Prime Remote, educate beneficiaries on the TRICARE Prime Remote program and assist with enrollment into the program.

Figure 5.1. Sample GSU Label.

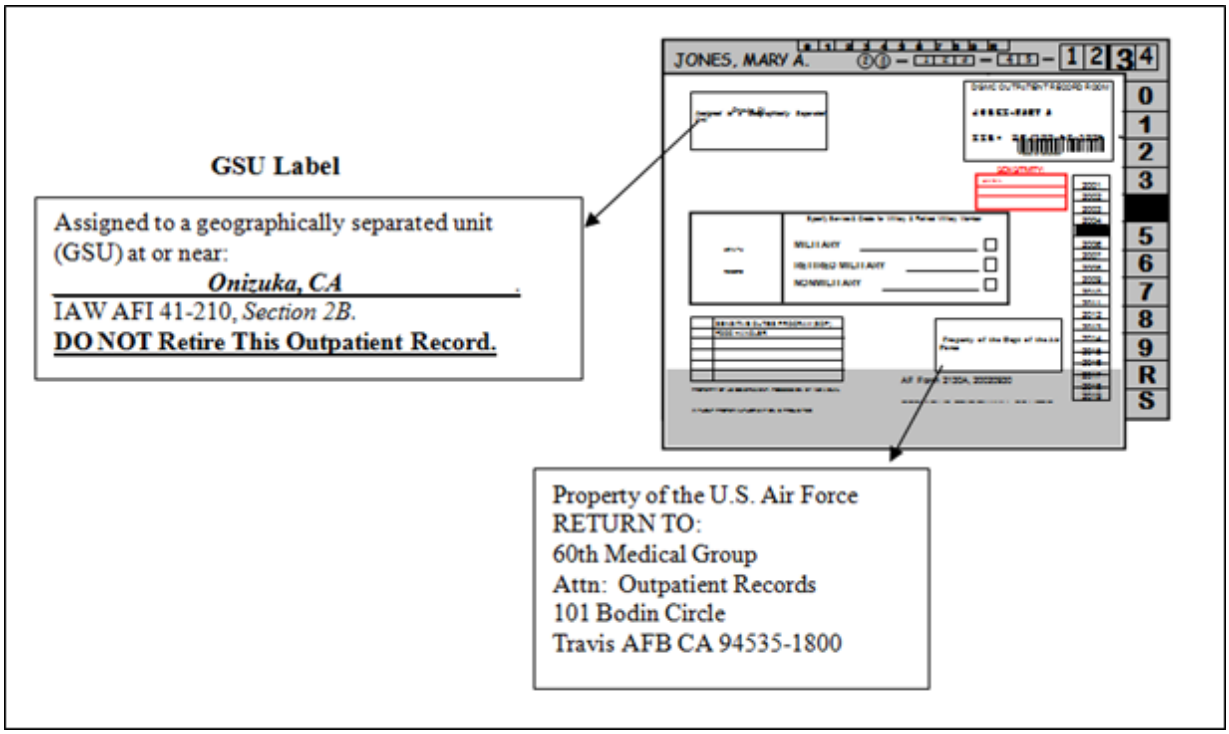
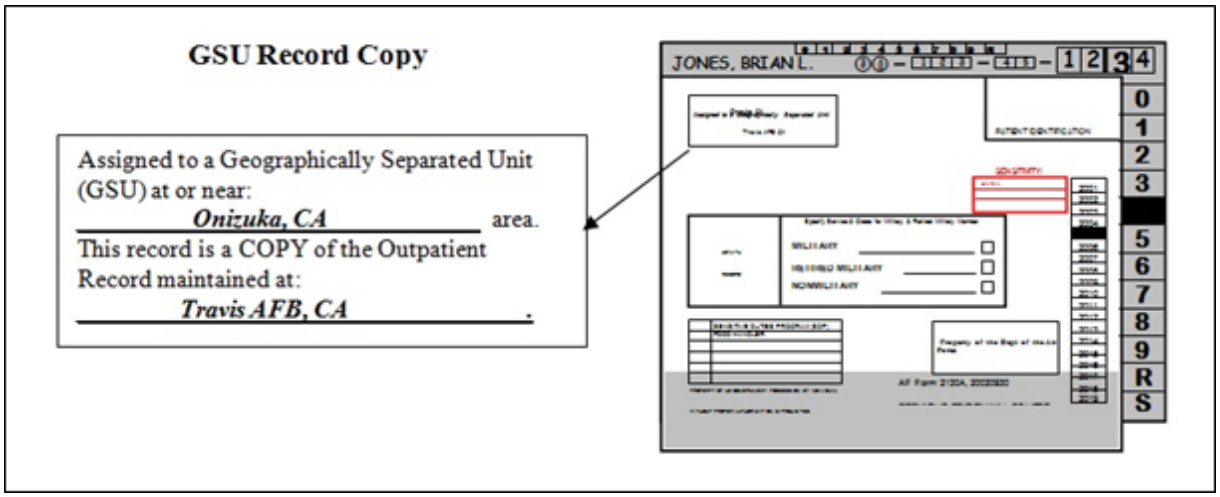


Figure 5.2. Sample GSU Record Copy.



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. In accordance with 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. Refer to DoDI 6040.42. Agency obligations mandate the health records be available for continuity of care purposes and to support national accreditation and DHA clinical coding auditing actions. The lack of medical records and documentation may adversely impact individual patient medical continuity of care as well as Joint Commission accreditation. Generally, beneficiaries are not

authorized to hand-carry their health records in accordance with DHA policy and Air Force policy identified in this manual. Local MTF records management policy must include measures to **(T-1):**

5.16.1.1. Establish a methodology to obtain beneficiary medical record(s) upon arrival on-station if hand-carried.

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 4.4 for instructions on responding to patient requests for copies of health records.

5.16.2. MTF personnel will 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 or director. (Only on a case by case basis.) **(T-3).**

5.16.3. All miscellaneous, loose or late-flowing documents must contain sufficient patient identification information to allow for proper scanning into HAIMS and or filing into paper record when authorized in accordance with paragraph 5.12. **(T-3).** Additionally, these documents must identify the outpatient records location and the MTF where the record is maintained. **(T-3).**

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 the rank (if applicable), first and last name, office symbol, name of duty or work location, and telephone contact number. **(T-3).** The record must be returned to the records library as soon as possible. **(T-3).** 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. **(T-3).** When an extension is granted, "RE-CHARGE" the record to the borrower.

5.16.5. Service Treatment Record and Non-Service Treatment Record In-processing. Upon receipt of each new Service Treatment Record not already maintained in the MTF records file system, outpatient records personnel will perform a quality assurance inspection of the medical record. **(T-3).** 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) ensure that medical documents are filed in their appropriate place, c) remove any misfiled wrong-patient documents and forward the documents to the appropriate patient record or MTF, and d) ensure Service Treatment Records contain the patients' complete history of documented healthcare (including all record volumes). **(T-3).** In the event a record is missing (i.e. received Vol. 2 without Vol.1) the gaining MTF will contact the losing MTF to retrieve the missing record. The losing MTF will mail the missing record as soon as possible but no later than five days after request. **(T-3).**

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. **(T-3).** MTFs should establish local guidance to best facilitate this process.

5.16.7. Using Charge-Out Guides. Use AF Forms 885, 886, and 887 and AF Form 250, to indicate the location of an outpatient record removed from the file. Use of the Medical Record Tracking module in CHCS is required as a tool to track movement of outpatient records. **(T-3).** 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, paragraph 5.30.1 and the two reasons below indicate when MTF records managers are allowed to provide health records to beneficiaries.

5.16.8.1.1. **Exception #1.** Applies to service members assigned to: Personnel Reliability Assurance Program, Presidential Support Program, and overseas United States embassy support. These members may also hand-carry their dental records. See paragraph 5.28 for additional Personnel Reliability Assurance Program records transfer instructions.

5.16.8.1.2. **Exception #2.** The MTF commander or director (Custodian of Records) or 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 or directors may not issue general blanket orders or MTF policy that allows any beneficiary to hand-carry 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 authorization 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 there is a particular standard in the local community that requires the maintenance of hard copy diagnostic test results or specifically prohibits the storage of these results in electronic media, then the MTF must also comply. **(T-0).** Otherwise, there is no requirement to print and file (into the paper outpatient medical record) a hardcopy diagnostic or clinical test result.

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 any CHCS laboratory, radiology, and/or clinical diagnostic results that have accumulated from the departure or losing MTF for each departing beneficiary that are not available in AHLTA due to age (i.e. prior to 2004/2005 depending on the implementation date of AHLTA at the specific MTF). **(T-2).** This rule applies to Services

Members, retirees, and family members alike. The losing MTF must still transfer the paper record to the gaining MTF. **(T-3).** The gaining MTF will usually not be able to access or view older 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.

5.18. Researching Appropriate Host MTF Record Locations.

5.18.1. Scan health record documents in the appropriate electronic health record as soon as possible. The practice of blindly mailing medical documents or records to the MTF closest to where the beneficiary lives or works is prohibited. **(T-1).** 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. AD Service Members: AD service members may incur several PCS assignments; same station - Permanent Change of Assignment (PCA) relocations; 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 AD 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. Primary AD Research Methods: Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the General Inquiry of DEERS Internet website at **https://www.dmdc.osd.mil/opsconnect/**. Defense Medical Information System Identification location, military installation name, and current patient address are listed. Sponsor Social security number is required to complete search. User Identification and personal password are required to access this website application. Contact the Site Security Manager (SSM) to obtain necessary access. Contact AFMOA/SGAT if the Site Security manager is not known.

5.18.2.2. Alternate Methods:

5.18.2.2.1. When researching Air Force service member, access the Air Force Portal website's "White Pages" locator at **https://www.my.af.mil/**. User Identification and personal password are required. Additionally, the Air Force Global e-mail directory may be used as another alternative reference method.

5.18.2.2.2. 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 AD 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 AD or retired military in the medical record at the MTF where the majority of care is provided or where the dependents are

empaneled 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 Internet website at **https://www.dmdc.osd.mil/opsconnect/**. Defense Medical Information System Identification location, military installation name, and current patient address are listed. Sponsor Social security number is required to complete search. User Identification and personal password are required to access this website application. Contact the SSM to obtain necessary access. Contact AFMOA/SGAT if the Site Security Manager is not known.

5.18.3.2. In all other cases where the record cannot be located use the patient's identification to scan the documents into the approved electronic health record.

5.18.4. If patient cannot be properly identified, return document(s) to the originating clinic for required identification 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/scanning, contact the Medical Record Review Committee chairperson or the Chief of Medical Staff. If after an extensive review the documents in questions cannot be identified by name, Social security number, date of birth, or by any other available means, the Record Review Committee, with approval from the Chief of Medical Staff, may destroy unidentifiable health documents.

5.19. Loose Leaf, Orphaned, or Miscellaneous Medical Documents.

5.19.1. Health record documents, separated from the primary health record will follow the HAIMS guidance referenced in paragraph 5.4.10.2.1.

5.19.1.1. AD Air Force Personnel. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the General Inquiry of DEERS Internet website at **https://www.dmdc.osd.mil/opsconnect/**. Follow the 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 Service Treatment Record disposition center or to the AFPC world-wide personnel locator office.

5.19.1.2. AFR Personnel. Although the CHCS-DEERS eligibility menu option or the General Inquiry of DEERS Internet website may not identify the service member's AFR location, it may identify the individual's home address, unit Personnel Accounting Symbol Code, and/or last known AD Defense Medical Information System Identification location (if the service member was activated at some point in the recent past). 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 the service member's unit, contact the AFRC Command

Surgeon's Office, Robbins Air Force Base, Georgia (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 AFRC, nor to any AFR unit as they do not maintain records for retirees or dependents.

5.19.1.3. ANG Personnel. Although the CHCS-DEERS eligibility menu option or the General Inquiry of DEERS Internet website may not identify the service member's Guard Medical Unit location, it may identify the individual's home address, unit Personnel Accounting Symbol Code, and/or last known AD Defense Medical Information System Identification location (if the service member was activated at some point in the recent past). 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 member's unit, contact Office of the Air Surgeon (NGB/Chief of Aerospace Medicine), NGB, Joint Base Andrews, Maryland, for additional guidance. Do not forward medical documents to NGB without prior approval from a NGB official. Furthermore, do not forward dependent or retiree health records or loose/orphaned documents to this HQ command, nor to any ANG Unit as they do not maintain records for retirees or dependents.

5.19.1.4. United States Air Force Individual Mobilization Augmentee Personnel. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the General Inquiry of DEERS Internet website at **https://www.dmdc.osd.mil/opsconnect/**. 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 Individual Mobilization Augmentee's unit of attachment, contact Readiness Management Group/Individual Reservist Medical Section, Warner Robins Air Force Base, Georgia, 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. United States Army Personnel. Forward United States Army health records or document(s) according to the instructions listed below:

5.19.1.5.1. Locate a patient's Primary Care Manager and primary record location by referencing the General Inquiry of DEERS Internet website at **https://www.dmdc.osd.mil/opsconnect/**. Defense Medical Information System Identification location, military installation name, and current patient address are listed. Follow the 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:

AMEDD Record Processing Center
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

5.19.1.6. United States Navy Personnel. Forward United States 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 System Internet website at **https://www.dmdc.osd.mil/opsconnect/**. Defense Medical Information System Identification location, military installation name, and current patient address are listed. Follow the 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 Social security number 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 National Personnel Records Center or to the VA Records Management Center. For more information, visit the United States Navy Personnel Command website at **http://www.npc.navy.mil/**.

5.19.1.7. United States Marine Corps Personnel. Forward United States 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 General Inquiry of DEERS Internet website at **https://www.dmdc.osd.mil/opsconnect/**. Defense Medical Information System Identification location, military installation name, and current patient address are listed. Follow the 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 United States Marine Corps (USMS) Worldwide Locator Service, Commandant of the Marine Corps, Headquarters USMC, Code MMSB-10, Quantico, VA 22134-5030.

5.19.1.8. United States Coast Guard. Locate a patient's primary record location by accessing the CHCS-DEERS eligibility menu option or by referencing the General Inquiry of DEERS) Internet website at **https://www.dmdc.osd.mil/opsconnect/**. Defense Medical Information System Identification location, military installation name, and current patient address are listed.

5.19.1.9. United States Public Health Service Commissioned Corps records or documents with a complete name and social security number should be forwarded to the Office of Commissioned Corps Support Services, Medical Branch, 5600 Fishers Lane, Parklawn Building, Room 4C-04, Rockville, MD 20857-0435.

5.19.1.10. National Oceanic and Atmospheric Administration records or documents with a complete name and social security number, should be forwarded to:

U.S. Public Health Service
Commissioned Personnel Center
Attn: CDR Hobson-Powell
National Oceanic and Atmospheric Administration
8403 Colesville Road, Suite 500
Silver Spring, Maryland 20910.

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 General Inquiry of DEERS Internet Website at **https://www.dmdc.osd.mil/opsconnect/**. Defense Medical Information System Identification location, military installation name, and current sponsor/patient address are listed. Sponsor's social security number is required. If unable to locate the family member's Primary Care Manager and/or primary records custody location, place the loose documents in a charge-out guide and follow instructions listed in paragraph 5.18.3.1.

5.19.2. Remember to identify the primary health records custody location Identification for all patient categories, in all services. First try the CHCS-DEERS System eligibility menu option, then reference the General Inquiry of m Internet Website at: **https://www.dmdc.osd.mil/opsconnect/**. Finally, be sure to follow the individual Uniformed Services forwarding instructions or contact the agency in question before mailing the documents via the United States Postal System.

5.19.3. 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 National Personnel Records Center. **(T-3).**

5.19.3.1. National Personnel Records Center. For loose documents belonging in records stored at National Personnel Records Center and those recalled from National Personnel Records Center.

5.19.3.2. When loose documents are identified but the original medical record has already been transferred to the National Personnel Records Center, then:

5.19.3.2.1. Place documents in a folder (manila folder is acceptable).

5.19.3.2.2. Label the folder with the patient identifiers using a standard CHCS label to include at a minimum; last name and first name, sponsor social security number, patient date of birth, and record volume number (e.g., volume 2). **Note:** the label can be handwritten vs. CHCS output.

5.19.3.3. Add the record to the retirement index (via CHCS) for transfer to National Personnel Records Center in accordance with the disposition rules in AFRIMS.

5.19.3.4. Do not mail or return recalled records to National Personnel Records Center directly. Recalled records must be created within CHCS as a new volume and retired when eligible in the MTF's next scheduled retirement. **(T-3).**

5.20. Missing and Lost Health Records.

5.20.1. Health records, both in electronic and paper form are considered PHI and Personally Identifiable Information subject to HIPAA and the provisions of the Privacy Act. Once a health record is deemed "lost," specific steps must be taken in order to report the information and notify the affected beneficiary or party. **(T-3).**

5.20.2. There are several instances when a health record may be considered "missing." Some of the most common examples are:

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. **(T-1).** When records are discovered to be missing, each MTF staff member is responsible for searching their immediate work area(s). MTF personnel will mobilize and help search for a missing record.

5.20.3.1. The following procedures are required after discovering a record is missing: Check to identify possible borrower charge-out locations in the automated Medical Record Tracking 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 the member/beneficiary is in possession of the record. **(T-1).** If the record still has not been located following the preceding minimum search requirements, begin processing the Non-Availability Letter for Service Treatment Records and breach notifications. In addition, the MTF Verification Checklist must be completed in accordance with paragraph 5.7.5.4. **(T-0).**

5.20.3.2. After all efforts to find the lost health record(s) are exhausted the MTF commander or director may deem the missing health record as "lost." Once the MTF commander or director has deemed a record "lost," MTF HIPAA privacy officer must follow the guidelines and procedures identified in AFI 41-200, paragraph 6.5., in consultation with the installation public affairs officer, as applicable and available installation legal staff and/or the medical law consultant. **(T-0).**

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 Medical Record Tracking function to properly manage, track, and locate health records. **(T-1).** Efficient use of associated Medical Record Tracking system tools like the records bar code scanner and electronic AF Form 250 will save time and reduce misplaced paper health records. Any non-MTF organization authorized to maintain AD service member or RC health records without using the CHCS computer Medical Record Tracking module to identify and manage their record inventory, shall establish a manual tracking system. **(T-1).**

5.21.2. The CHCS computer Medical Record Tracking 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. **(T-1).** Records managers should

create or build borrowing locations within the Medical Record Tracking module for all locations/borrowers that regularly request health records. Contact the 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 5 days. **(T-1).** Records personnel are required to identify each overdue record and contact the last known borrower to inquire about the status of the record. **(T-1).** Establish a local process to retrieve records that have been loaned to borrowers for more than 5 days. Overdue records will be identified by viewing the CHCS Overdue Records List Report or similar CHCS records management reporting mechanism. **(T-1).** 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 Record Review Committee (or similar records review function), and to the TRICARE Operations and Patient Administration Flight Commander or Patient Administration Officer. The TRICARE Operations and Patient Administration function is responsible for creating an aggregate MTF total of overdue or missing records. The TRICARE Operations and Patient Administration 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. **(T-1).** Refer to paragraph 5.14 for potential medical records availability exceptions for RC service members on AD 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 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. **(T-1).** The two basic medical records availability metrics standards outlined below measure a MTF's compliance.

5.21.4.1. Service Provider Point of Service Record Availability Standard. Unless a 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 95% (goal is 100 percent) AFMS provider point-of-service availability standard. **(T-1).** AFMS 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 Record Review Committee or function and to the AFMOA/SGAT office by the 10th duty day following the close of the previous reporting month.

5.21.4.1.2. 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. **(T-1).** 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.

5.21.4.2.2. If a MTF can prove record availability, according to this standard, by pinpointing the specific location of the record within a MTF medical records department(s) or MTF borrower location, using the CHCS computer Medical Record Tracking 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. **(T-1).**

5.21.4.3. Report monthly AFMS availability and Office of the ASD for Health Affairs availability percentages to the MTF Health Record Review Committee. The committee chairperson will report this information monthly to the Executive Committee of the Medical Staff unless otherwise directed by the MTF commander or director. **(T-1).**

5.21.4.4. Refer to paragraph 5.14 for potential records availability exceptions for RC service members placed on AD.

5.21.5. Converting to a Paper Medical Records Retrieval or by Exception Process: The Health Record Review Committee and the Executive Committee must support any decision to suspend or discontinue retrieving or pulling outpatient medical records for daily outpatient appointments. **(T-3).**

5.21.5.1. The MTF Chief of Medical Staff, in coordination with the unit commander(s) are 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. **(T-2).**

5.21.5.2. If the Chief of Medical Staff and respective unit commander(s) support the decision to suspend daily paper outpatient medical records retrieval and distribution, the MTF commander or director may approve the decision or determine another course of action. Approval may be for defined specialty groups, Family Health Elements, clinics and/or entire facilities. Documentation of approval must include any sub-groups that will continue to require paper records on a regular basis. **(T-3).**

5.21.5.3. Prior to approving any retrieve or pull records by exception policy, the MTF commander or director must ensure that the requesting clinical work center(s) have created a process to verify patients have signed the *MHS Notice of Privacy Practices* for each empaneled patient. **(T-0).** Refer to AFI 41-200, paragraph 3.2 for specific information and expectations regarding HIPAA (*MHS Notice of Privacy Practices* requirements.

5.21.5.4. If the MTF commander or director decides to suspend traditional daily paper outpatient medical records retrieval and distribution processes, an immediate six-month trial phase will 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 Record Review Committee and to AFMOA/SGAT. **(T-1).**

5.21.5.7. After the six-month trial phase, the chief of medical stall will coordinate options with the unit commander responsible for health records. Also, the chief of medical staff will receive input from the Health Record Review Committee, the Executive Committee of the Medical Staff and the provider staff. After these coordination efforts, the chief of medical staff will recommend one of the following option to the MTF commander or director:

5.21.5.7.1. Permanently or temporarily cease MTF daily outpatient paper medical records retrieval and distribution processes,

5.21.5.7.2. Implement a limited cessation or selective cessation (based on MTF-unique circumstances) of paper medical records retrieval and distribution,

5.21.5.7.3. Institute another trial period, or

5.21.5.7.4. Determine some other appropriate action. Additionally, whatever process is chosen, paper documents from internal and external sources will be scanned and uploaded into Health Artifact and Image Management Solution (HAIMS) or the approved electronic health record. **(T-1).**

5.21.5.7.5. **Exception:** For official auditing purposes, the MTF must either supply the auditor with a paper copy of the applicable patient encounters, or provided access to AHLTA to review the outpatient encounter documentation. **(T-3).**

5.21.6. Using Charge-Out Guides. Use AF Forms 885, 886, and 887 and AF Form 250, to indicate the location of an outpatient record removed from the file. Use of the Medical Record Tracking 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. **(T-3).** The following instructions must be adhered to ensure sound health records management operations **(T-3):**

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 Medical Record Tracking 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 Medical Record Tracking module to locate 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 or director 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 United States

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 AFI 41-200, paragraphs 4.1.-4.3., Use and Disclosure of PHI, 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. Medical Cost Reimbursement Program 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.

5.21.7.5.2. All money recovered will be returned to the MTFs or DHA. Medical Cost Reimbursement Program legal personnel may require access to health records and MTFs should coordinate the appropriate access to needed health information. For more information on Medical Cost Reimbursement Program, 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 a MTF. **(T-1).**

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. **(T-1).** 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 outlined in AFI 41-200.

5.21.8.2. Training will be documented in the Career Field Education and Training Plan or other official record of personnel training accomplishments. **(T-1).**

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. **(T-1).**

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. **(T-3).**

Inform the patient they may receive a free copy of the record but the original must be maintained at the MTF. **(T-3).**

5.21.9.2. If the patient does not return the record after contact, take the following actions:

5.21.9.2.1. AD 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 the previous attempts to collect the record(s) in accordance with this manual. 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 the sponsor and/or patient 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, but that a signed authorization is required to obtain the record of any dependent authorized to consent for their own care. 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 the 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 the MTF: If, after requesting the record(s) in accordance with the directions found in this manual, 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 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 **(T-3):**

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 Medical Record Tracking 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 Medical Record Tracking 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. **(T-1).** SFs, 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 **(T-1):**

5.22.1.2.1. SF 504, *Clinical Record-History Parts I and II.*

5.22.1.2.2. SF 505, *Clinical Record-History Parts II and III.*

5.22.1.2.3. SF 506, *Clinical Record-Physical Examination*.

5.22.1.2.4. Nursing assessments and interventions.

5.22.1.2.5. SF 509, *Medical Record – Progress Notes* 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, *Medication Administration Record* 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 in accordance with AFI 44-172, in Section III of the outpatient medical record, or scanned and uploaded into HAIMS as applicable. **(T-1).** Illnesses related to mental health will be filed in the mental health record. **(T-1).**

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 and Emergency Room (ER) Death. All MTF Dead on Arrival and ER Death encounters will be reported in the automated ambulatory data collection system or other ambulatory data collection and coding system. Appropriate clinical coding and Medical Expense and Performance Reporting System code assignment is required. Any documents created for these patients will be filed in an extended ambulatory record and maintained in a secure, limited access area, separate from inpatient/outpatient health records. **(T-3).**

5.23.4. Variations in the disposition and maintenance of records in clinics are not authorized. The MTF commander or director 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. **(T-3).** 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. **(T-3).**

5.24. Mental Health Records Documentation Requirements. 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. **(T-1).** See AFI 44-172, Chapter 5, for details on mental health records and records management.

5.25. Prenatal Records Documentation Requirements. 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 10 for filing instructions. **(T-1).** For exceptions, see the following:

5.25.1. If a patient is transferred or relocates before delivery, give the patient a copy of the prenatal record to hand-carry to the next MTF. If the patient does not expect to deliver in a MTF, copies of the prenatal record should be given to the patient and the original documents scanned into HAIMS.

5.25.2. Prenatal records shall be screened quarterly. **(T-1).** 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 electronic health record.

5.26. Family Advocacy Program (FAP) Documentation Requirements.

5.26.1. The Family Advocacy clinic or office maintains the original Family Advocacy Program patient record. The Family Advocacy Program 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. **(T-1).** Treatment entries, documenting only minimal information, are inserted into AHLTA by Family Advocacy Program 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. **(T-1).** The initial Family Advocacy Program Clinical Case Staffing (CCS) recommendations will be placed in AHLTA, as well as the transfer/closure summary for each patient treated in Family Advocacy Program.

5.26.2. When patients are seen in Family Advocacy Program 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 Education Programs. Documentation requirements will be as outlined by the Accreditation Council for Graduate Medical Education (**https://www.acgme.org**) in their common and specific program requirements. **(T-1).**

5.28. Managing Service Treatment Records for Service Members Assigned to the Personnel Reliability Assurance Program and Presidential Support Program

5.28.1. Transferring Service Treatment Records for service members Assigned to a Personnel Reliability Assurance Program position. Medical records personnel will take all steps necessary to ensure the gaining MTF has access to the service member's complete service treatment record. For service members being assigned to a duty location that does not have access to the electronic health record [AHLTA/Health Artifact and Image Management Solution (HAIMS)], a complete copy of their medical record in paper or digital format will be provided to the service member. **(T-0).** Reference DoDM 5210.42, *Nuclear Weapons Personnel Reliability Program*.

5.28.2. The only exception for hand-carry of outpatient medical records are those service members in or going into an active Personnel Reliability Assurance Program status whose record will not be reviewed by the Administrative Qualification Central Cell. **Note:** These members must also hand-carry their dental records.

5.28.3. Physical Separation from the Main File for Service Treatment Records of service members assigned to Personnel Reliability Assurance Program. Outpatient medical and dental treatment records for Airmen assigned to Personnel Reliability Assurance Program, shall be maintained in a separate, secured location. **(T-1).** Access to these physical Service Treatment Records must be restricted to only those medical personnel with an official need for access. **(T-1).**

5.28.4. Airmen meeting the personnel status conditions identified in Section 5.28.2 are required to hand-carry their health treatment records (in a sealed envelope) from the losing MTF or RC 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. **(T-1).**

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 official's initials along the sealed flap seam and legibly write or place a pre-worded ink stamp that identifies the losing MTF or installation Dental Treatment Facility unit name, office symbol, address, installation name, zip code, point of contact name and contact telephone number. **(T-3).**

5.29. Transferring Health Records Between MTFs or Medical Units.

5.29.1. Transferring Service Treatment Records 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: Hand-carry of outpatient medical and dental records in a sealed envelope during a PCS or PCA reassignment is now prohibited for all Airmen, with the exception of Airmen assigned, or who will likely be assigned, to Personnel Reliability Assurance Program, Presidential Support Program, and overseas United States embassy support.

5.29.1.2. MTF and RC records managers at the departure or losing MTF or RC are required to forward the Service Treatment Records for departing service members, to the gaining MTF or RC responsible for maintaining the service member's health records. **(T-1).** Service Treatment Records will be mailed no later than five duty days following the service member's PCS/PCA departure or date of separation/transition to the gaining MTF or RC. **(T-1)**. Records managers will not mail the records in conjunction with the monthly purge. **(T-3).** Records will be mailed on a daily basis as needed. **(T-3).** Mail the records via standard First Class United States mail with immediate delivery confirmation/acknowledgment, certified mail, or other commercially available option, e.g., FedEx, that offers package tracking and-delivery/arrival confirmation. Use of standard First Class United States Postal Service mailing method alone **usaf.jbsa.afmoa.mbx.sgat@mail.mil**, 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 or other manual delivery confirmation receipt option. **(T-3).**

5.29.1.2.1. MTF and RC records managers at the departure or losing MTF or RC are required to expedite the mailing of original outpatient medical and dental treatment records for departing service members and accompanied family members on PCS orders to all overseas locations utilizing a commercial carrier (i.e. FedEx or DHL). **(T-**

3). The expedited mailing ensures scheduled/guaranteed and tracked delivery of no more than seven calendar days from the mailing date. United States Postal Service first class and certified mail do not currently meet this standard – generally taking four to six weeks for delivery to any OCONUS location. All MTF and RC Outpatient Records sections have been provided updated and tested mailing addresses for commercial carriers such as FedEx that only utilize local/physical addresses. The current list of addresses can be located on the AFMOA Health Benefits Kx page at **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**.

5.29.1.2.2. In addition to the requirements of paragraph 5.29.1.2, MTR and RC records managers will coordinate mail-outs with the Dental clinic to ensure the complete medical and dental records are mailed together to the gaining MTF/RC. Records will be mailed with a copy of the member's orders and contain "ATTN: OUTPATIENT RECORDS" in the address. **(T-3).**

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 RC prior to final departure from the installation or organization. **(T-3).** Records managers at the losing MTF or RC 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. **(T-3).** In the event a copy of the service member's PCS orders are not available, the MTF or RC will include a completed AF Form 330 in place of the orders. **(T-3).**

5.29.1.4. MTF and Dental Treatment Facility In/Out-Processing PCS Customer Service Locations: Ideally, each MTF and Dental Treatment Facility should provide one central in-processing and out-processing customer service location for health records respective to each facility. For the installation Dental Treatment Facility, 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 or directors may choose instead to align multiple outpatient medical customer service locations alongside or co-located with Primary Care Manager or Patient Centered Medical Home clinic operations.

5.29.1.5. Airmen PCS Departure Out-Processing Procedures: All service members empaneled to the MTF and scheduled for reassignment to another station are required to out-process through the MTF and Dental Treatment Facility before final installation departure. The purpose of the out-processing visit is to ensure MTF and Dental Treatment Facility 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 Dental Treatment Facility and MTF no earlier than the fifth duty day before their final installation out-processing Military Personnel Section appointment. **(T-3).** 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 Dental Treatment Facility, two copies

for the MTF). **(T-3).** Depending on local operating policy, service members may be required to visit a centrally located MTF records customer service office or out-process through their Primary Care Manager records room location. MTF & Dental Treatment Facility records personnel will ensure local installation out-processing checklists include MTF & Dental Treatment Facility records out-processing requirements. **(T-3).**

5.29.1.8. Dental Treatment Facility Record Processing: No later than the close of business each duty day, Dental Treatment Facility records managers will ensure two copies of each departing Airman's PCS reassignment orders are filed properly. **(T-3).** One copy will be placed on top of all other documents in Section II of the AF Form 2100B series. The second copy will be placed in a plastic AF Form 885-887 series.

5.29.1.8.1. Complete an AF Form 250 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, place the documents and the copy of the PCS reassignment order in an envelope and mail directly from the Dental Treatment Facility to the member's gaining Dental Treatment Facility. 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, Dental Treatment Facility records managers will forward the dental treatment record(s) to either a central MTF records room or to the Primary Care Manager records room where the service member is empaneled. **(T-3).** 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. **(T-3).**

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. **(T-3)**

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. **(T-3).** One copy will be placed on top of all other documents in Section II of the AF Form 2100A series. The second copy will be placed in a plastic AF Form 885-887 series.

5.29.1.9.1. Complete an AF Form 250 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. **(T-3).**

5.29.1.9.2. MTF records managers must mail the medical and dental records bundled together and follow the procedures outlined in paragraph 5.29.1.2. (T-3).

5.29.1.9.3. Select and enter the appropriate transfer code in the CHCS Medical Record Tracking module and enter the name of gaining MTF in the "MTF Location Remarks Section."

5.29.1.9.4. After 90 days, retrieve the charge-out guide from the main file and scan any loose or late flowing documents that may have collected in the charge-out guide into the HAIMS repository or into another approved electronic health record.

5.29.2. Transferring Service Member Service Treatment Records 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 the service member's original service treatment record will remain at the MTF where the service member is enrolled. **(T-3).** Upon return records staff will forward the original service treatment record to the gaining assignment once written direction or orders are received. **(T-3).** 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, dental treatment encounter form, service transition order, or AF Form 1288.

5.29.2.2. Unless exempted by the COCOM/Component Reporting Instructions, following the AD or RC service member'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 ASIMS DD 2766 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 deployment team leader) is responsible for transporting the original DD Form 2766 along with the documents listed above, leaving the original Service 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 home installation, the DD Form 2766 and any documents generated in theater are removed from the DD Form 2766 and scanned into patient's electronic health 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 Service Treatment Record from the departure or losing home installation MTF. **(T-3).**

5.29.2.4. **Exception:** When a service member receives a 365-day PCS order to a deployed location where the site is adequately resourced to manage medical records, exercise 24/7 operations and have an approved waiver authorizing the maintenance of medical records, the member may hand-carry a copy of their service treatment record. The losing MTF will forward the original service treatment record to the gaining deployed location (in a sealed package secured by the departure MTF). **(T-2).** Upon arrival, the service member is required to relinquish their Service Treatment Record to the Expeditionary Medical Support facility or to the installation MTF. **(T-3).** These facilities will be identified and added to the exception list maintained by the AFMOA/SGAT.

5.29.3. Transferring service member Service Treatment Records During PCS, PCA or Duty Location Reassignment for Air Force Members Empaneled to Sister-Service MTFs. The fact that some Airmen are enrolled to non-Air Force MTFs 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 primary care, regardless of service affiliation. To facilitate appropriate health records transfer procedures for Air Force service members the following actions must occur. **(T-3).** Health records staff at Air Force MTFs nearest to the service member's sister-service Primary Care Manager/MTF location must establish a local memorandum of agreement or memorandum support agreement. **(T-3).** The agreement with the sister-service MTF and the service member's servicing Military Personnel Section will ensure all final out-processing documents, checklist requirements, Military Personnel Section-generated PCS notices, and PCS orders are completed and/or forwarded. **(T-3).** The agreement must identify how the health records of Air Force personnel will transfer to the MTF at the next duty location. **(T-3).** Transfer options may include, but are not limited to instructions that specify health records, a) be mailed to the requesting Air Force MTF by the sister-service MTF or, b) forwarded to the MTF at the Airman's next duty location.

5.29.3.1. **Note:** Local procedures may be required if an agreement on how to forward medical records cannot be reached between the sister-service primary care manager or MTF, the local installation military personnel section and the MTF nearest the service member's GSU. If such an impasse occurs, the local military personnel section and the nearest MTF to the GSU may have to initiate local procedures to ensure the Airman's health records are properly forwarded and delivered to the Airman's next duty station.

5.29.4. AD Virtual Military Personnel Section Checklist Confirmation. Although the Force Health Management staff may have additional medical out-processing checklist approval authority or obligations, they should not sign or approve any outpatient medical or dental treatment record out-processing tasks on a service member's Virtual Military Personnel Section out-processing checklist. Outpatient medical and dental records managers and Force Health Management officials will work together to ensure each outbound Airmen has fulfilled all the MTF out-processing responsibilities.

5.29.4.1. Checklist Operation: Multiple (at least two) staff members assigned to MTF and Dental Treatment Facility records departments should be granted Virtual Military Personnel Section Checklist access to ensure each departing service member is informed of the requirement to provide the MTF and Dental Treatment Facility with copies of orders at the time of MTF/Dental Treatment Facility out-processing.

5.29.4.2. 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. MHS beneficiaries are prohibited from hand-carrying their medical records. The standard procedure throughout the AFMS is to mail family member hard-copy outpatient medical records from one MTF to another during reassignments. Only the MTF commander or director can make a case-by-case exception to deviate from this process.

5.29.5.2. Upon notification from the sponsor of being re-assigned to another installation several actions must take place. MTF records personnel will check the typed PCS/PCA orders to determine if the reassignment is to be "ACCOMPANIED" (with family members) or "UNACCOMPANIED" (without family members). **(T-3).** If the service member's

orders indicate an ACCOMPANIED assignment, records personnel will ask the service member if all of the family members are to accompany. **(T-3).** If all family members are accompanying the service member, then records personnel will verify the departure date with the sponsor. **(T-3).** Records personnel will obtain any available dental treatment records, and then combine all of the family member health records into one package. **(T-3).** MTF records personnel may also add the sponsor's Service Treatment Record 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 no later than five calendar days following the sponsor's departure date.

5.29.5.3. If the sponsor's orders indicate UNACCOMPANIED or the sponsor indicates one or more family members are not accompanying, records personnel must validate family member enrollment. Records personnel must verify with the sponsor if the remaining family members will stay enrolled at the current MTF. **(T-3).** If not the remaining health records should be forwarded to another facility where TRICARE enrollment is expected. **(T-3).** The following actions must take place when family members are expected to receive direct healthcare at another MTF, apart from where the sponsor. **(T-3).** Upon re-enrollment at the new MTF, the sponsor, spouse, or legally-aged (per state law) family member must contact the records department to complete the necessary records request paperwork. **(T-3).** After receiving a completed DD Form 2138, or DD Form 877 from the requesting MTF, the current MTF will release and forward the requested records. **(T-3).**

5.29.5.4. For Retired Service Members, and/or Their Family Members, and AD Family Members Who Wish to Change Their MTF TRICARE Enrollment Location Without Associated Sponsor PCS/PCA. This process is required whether the move be across the country or within a multi-market service location (e.g., changing MTF/Primary Care Manager 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. **(T-3).** Only after receiving a properly completed DD Form 2138 or a DD Form 877 or another suitable request form (from the requesting MTF) will the 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 MTF change, provide the sponsor with a DD Form 2138. Instruct the sponsor to complete Sections I and II of the 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, CONUS based MTFs/RCs mailing health records or loose, late flowing medical documents to other stateside CONUS MTFs/RCs will follow the mailing procedures outlined in paragraph 5.29.1.2. **(T-3).**

5.29.5.5.1. Under all circumstances, OCONUS based MTFs/RCs mailing health records or loose, late flowing medical documents to other OCONUS and CONUS MTFs/RCs will use a commercial carrier (i.e. FedEx or DHL). **(T-3).**

5.29.5.5.2. Use of United States Postal Service first class and certified mail are not authorized.

5.29.5.6. MTF commanders or directors (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 the family aged 18 years or older without written authorization from the family member.

5.29.5.7. Forward health records critical to potential, pending, or active litigation using only shipping options with an immediate delivery confirmation/acknowledgment feature. **(T-3).** Shipping options may include certified mail via official military mail, United States Postal System or other commercially available option, e.g., FedEx, that offers package tracking and arrival confirmation. Use of standard First Class United States Postal Service mailing method alone, without immediate delivery confirmation/acknowledgment, is prohibited. **(T-3).**

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. **(T-3).** 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. Upon return from a 365-day PCS overseas location, if the sponsor receives a follow-on assignment to a different installation the member will contact the gaining MTF upon arrival (at the new installation) and initiate a formal request to obtain family-member dependent medical records from the losing MTF. **(T-3).**

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 follow protocol outlined in Section 5.29.5.3.

5.29.6.4. Insert a charge out guide with a copy of PCS orders, DD Form 877, or DD Form 2138. Scan all loose medical documents in the approved electronic health record.

5.29.7. Transferring Mental Health Records. See AFI 44-172 for procedures detailing the transfer of Mental Health Records.

5.30. Providing Health Records to AD Members During Temporary Duty Periods.

5.30.1. With the enterprise-wide use of the electronic health record, there are very few situations where an Airman would be required to bring 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 a copy of their medical record or copies of recent encounters. As a general rule, MTF outpatient records departments should only provide a complete copy of 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 the record while TDY. Ensure all pertinent electronic health record documents are printed and filed into the record prior to the service member's departure. If a copy of the health record is to be provided, the record(s) must be enclosed in a strong envelope or package and sealed. **(T-3).**

5.30.2. MTF Staff who care for Personnel Reliability Assurance Program members while member is in TDY status will help to ensure that appropriate documentation and notifications are made to member's home unit. **(T-3).** Following the completion of all official TDY assignments, the TDY assignment location MTF staff will ensure that the member receives a copy of all medical documentation that occurred during the member's TDY assignment. **(T-3).**

5.30.3. All TDY Airmen normally assigned to a Personnel Reliability Assurance Program position who are not expected to perform or fill an active operational Personnel Reliability Assurance Program position or job at the TDY location, are not required to hand-carry their Service Treatment Record to the TDY. Following each episode of care at the TDY location, personnel assigned to the Personnel Reliability Assurance Program, flight medicine clinic or any official(s) responsible for managing the integrity of the MTF portion of the Personnel Reliability Assurance Program notification system, will print out a copy of the electronic health record note and mail a copy (via Certified military or United States Mail with immediate delivery confirmation/package tracking) to the MTF at the Airman's home station. **(T-3).** MTF personnel at the TDY location will also provide a copy of the printed electronic health record note to the service member. **(T-3).** The service member is required to bring the printed electronic health record note to the provider at home station. The returning Airman's provider is required to review the electronic health record 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. **(T-3)**

5.30.4. Before copies of health records are provided to the member, outpatient and/or dental records personnel will follow the procedures for sealing the records that are set out in paragraph 5.28.5. **(T-3).**

Section 5C—Inpatient Records Administration

5.31. Creating Inpatient Records.

5.31.1. MTFs that create and maintain inpatient records will use guidelines from this chapter and from Joint Commission standards. **(T-0).** Records must to be completed within 30 days after the patient's discharge in accordance with Joint Commission standards. **(T-0)** Reference The Joint Commission Standards at **https://www.jointcommission.org/facts_about_joint_commission_accreditation_standards/**.

5.31.2. MTFs will create an inpatient record for the following episodes **(T-0):**

5.31.2.1. 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.

5.31.2.1.1. 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.

5.31.2.1.2. If the patient is readmitted after midnight, or the reason for readmission is different from that of the previous admission, create a new record.

5.31.2.2. 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. **(T-3).**

5.31.2.3. 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.

5.31.2.4. All patients admitted to an Expeditionary Medical Support facility or fixed contingency hospital during deployment. See Section 5D, Deployed Assignment Medical Record Management for further instructions.

5.31.3. 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 electronic health record. Record and code the episode as an outpatient encounter.

5.32. Creation of the Master Patient Index.

5.32.1. The Master Patient Index serves as an alphabetical index of all hospital patients and patients for whom administrative responsibility is assumed (e.g., AD military in non-federal hospital). **Note:** Do not destroy - maintain for 50 years.

5.32.2. The Master Patient Index is created by and stored in the current automated system.

5.32.3. MTFs without automated Admissions & Dispositions Office functions will maintain hard-copy paper index cards.

5.33. Preparing Inpatient Record Folders.

5.33.1. Create records at time of disposition and completion of each patient hospitalization for future retirement. Ensure discharge summary is scanned/uploaded into approved electronic health record. Number folders according to the sponsor's social security number. 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 social security number of:
AD/RC	Service Member
Family Member	Sponsor
Civilian Employee	Employee
Retired military	Member
Civilian Emergency	Patient

Foreign national, allied or other military member without social security number	Construct a social security number

5.33.2. See paragraph 5.10.6 for guidance regarding the creation of a pseudo social security number when a patient's own social security number is not known or does not exist.

5.33.3. MTFs that create and maintain inpatient records will use AF Form(s) 788A-788J series, as appropriate, according to the last two digits of the applicable social security number. To increase the likelihood that the paper inpatient record will be filed and retrieved easily, enter information on the front of the folder as indicated by the following paragraphs. See paragraph 5.36 for filing instructions.

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 Identification area.

5.33.3.2. Enter the sponsor's social security number 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 social security number.

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 social security number, 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 Medical Record Tracking bar code label to the inpatient record folder. See the *Medical Record Tracking, Retirement and Retrieval User Guide* for instructions on label requirements.

5.33.3.8. Stamping or labeling the front cover of the inpatient record with any large-letter identifiers other than "CROSS-REFERENCE," or with infant-adoption related notifications is discouraged. See paragraph 4.3.3.1 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 National Personnel Records Center, documents are permanently affixed to the folder.

5.34. Contents of the Inpatient Record.

5.34.1. Upon the patient's disposition, MTFs will arrange paper copies of forms in the order listed below as applicable to the case. **(T-1). 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 special instruction column in Attachment 10 for proper filing location. Command and locally developed medical forms should be filed in the appropriate order as according to purpose. See Attachment 10 for arrangement of forms in the inpatient record.

5.34.2. Problem Oriented Medical Record. If a MTF elects to use the Problem Oriented Medical Record format, then the MTF will 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. **(T-3).**

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. **(T-3).** 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 electronic health record for reference. **(T-3).**

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 10 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 DoD Identification Number, patient's family member prefix, patient's and sponsor's social security number, and MTF organization and/or treatment name. **(T-1).**

5.35.2. SFs Available on Internet. Many SFs are now available at the GSA Forms Library website. Most forms are in "PDF" format and should be downloaded with the Adobe Reader, available on the website. Forms not available on the website must be ordered from: **(T-1)**

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 Air Force Specialty Code (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, *Operation Report*, etc. **(T-1).**

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 social security number.

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 January 2004, 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 January 2004.

5.36.5. Only authorized personnel at the MTF may access inpatient records. Substitute an AF Form 614 for the inpatient record when removed from the file and charge out the record in the Medical Record Tracking module of CHCS.

5.36.6. Fetal Monitor Strip Filing Procedures. Maintain the fetal monitor strips on the obstetrical unit with the prenatal record until delivery.

5.36.6.1. After discharge of the infant, send the fetal monitor strips to the inpatient records department for maintenance until retirement to the National Personnel Records Center. Annotate the envelope with the name and register number of the infant, sponsor's name and social security number, 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 National Personnel Records Center. **Note:** Digitized, or other format, fetal monitor strips 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 Medical Record Tracking bar code label to the folder.

5.36.6.3. When an undelivered patient is transferred, send all fetal monitor strips prepared with the copy of inpatient records to the receiving MTF.

5.36.6.4. Send the fetal monitor strips with the patient, when a newborn is transferred to another MTF during initial hospitalization.

5.36.6.5. File fetal monitor strips 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.

5.36.6.6. In instances where the case outcome is unclear, send the outpatient fetal monitor strips to the inpatient record department. File the fetal monitor strips in a record created under the mother's name, family member prefix and sponsor's social security number.

5.36.6.7. All fetal monitor strips will be retired to National Personnel Records Center in the same shipment as the inpatient records and the extended ambulatory record. **(T-3).**

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 the diagnoses and procedures according to the current version of the International Classification of Diseases (ICD) or other government approved coding classification system.

5.37.1.3. Signatures are required on all documentation before the record is coded. **(T-2)**

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 and transmit it by the 5th working day.

5.37.2. The provider's social security number must not appear anywhere in the patient's inpatient record. **(T-1).**

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 Diseases. 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 scanned and uploaded 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 cover sheet is used to summarize the inpatient episode of care with the identification of the principal diagnosis and procedure, any co-morbidities (presence of one or more conditions simultaneously with a primary condition), or complications, and the sequencing of the diagnoses and procedures. Provider terminology will be used for diagnoses and procedures. **(T-3).** No provider signature is required on the cover.

5.37.4.2. At local MTF option, 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. Scan and upload a copy of the AF Form 565 in the outpatient record after final disposition of the case.

5.37.4.4.3. Scan and upload a copy of the AF Form 565 in the outpatient record of patients being transferred to another facility.

5.37.5. The Joint Commission (**https://www.jointcommission.org**) 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 eight 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 eight 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. **(T-3).**

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. Scan and upload 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. Scan and upload a copy in the patient's outpatient record.

5.37.5.5.3. Send one copy to the Commandant (G-KMA), United States Coast Guard, Washington DC 20590, when United States Coast Guard members on AD are discharged.

5.37.5.5.4. Upon disposition of a uniformed services member who is already on the Temporary Disability Retired List 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 AD patient pending final disposition of 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 following forms as specified in Attachment 10.

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 44-119, *Medical Quality Operations* 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 the mid-wife 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, *Abbreviated Medical Record* 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. Scan and upload information into the patient's electronic health 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. **(T-0)**.

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, must include the date and time of the dictation, their clinical occupational specialty, and their AFSC, if applicable. **(T-2).** Transcriptionists will include the aforementioned data, the transcribed clinical content, and the date of transcription on all transcribed reports, including operative reports, SFs: 502, 504-506, 516, etc. **(T-3).**

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. **(T-3).**

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-United States physicians and dentists assigned to overseas facilities use their medical or dental license number instead of a Drug Enforcement Agency 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, *PRN Medication Administration Record* and 3069, *Medication Administration Record*.

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 the mother's home 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 the MTF, scan and upload the prenatal package (as a whole package with prenatal treatment documents filed chronologically between the SF 533, *Prenatal and Pregnancy Medical Record* and AF Form 3915, *Labor and Delivery Flowsheet*) in the mother's electronic health record.

5.39. The Extended Ambulatory Record.

5.39.1. The extended ambulatory record is a folder that contains information on treatment received during an ambulatory procedure visit, an observation stay, ER Death, Dead on Arrival, or other similar status.

5.39.1.1. Create records at time of disposition and completion of each episode of care for future retirement. Ensure discharge summary is scanned/uploaded into approved electronic health record. Create a separate folder for each episode.

5.39.1.2. Maintain the extended ambulatory record folder in a method similar to the inpatient record, using the inpatient record folder (AF Form 788A-J, *Inpatient Record*). Annotate the folder with the patient's name, family member prefix, and sponsor's social security number. Attach the CHCS Medical Record Tracking bar code label to the folder. The extended ambulatory record will be filed by the sponsor's social security number (same as the outpatient and inpatient records). **(T-3).**

5.39.1.3. The extended ambulatory record will be maintained in a limited access area.

5.39.1.4. Although the paperwork for these cases is filed in the extended ambulatory record 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 Records.

5.40.1. File original documentation on a patient seen during an ambulatory procedure visit episode in the extended ambulatory record folder.

5.40.2. Create an ambulatory procedure visit record for those cases when a patient is seen in the ER or specialty procedure room, an ambulatory procedure visit 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 ambulatory procedure visit record will be filed by the sponsor's social security number, (same as the outpatient and inpatient records). **(T-3).**

5.40.4. Clinical Application of Ambulatory Procedure Visit Records.

5.40.4.1. The medical record documentation for the ambulatory procedure visit must meet the standards of documentation similar to the short-term stay (abbreviated medical record). **(T-1).** The record documentation must comply with Joint Commission standards. **(T-0)**. 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. **(T-2).** 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 ambulatory procedure visit records. All diagnoses and procedures will be written in full, without symbols or abbreviations, and in acceptable provider terminology. **(T-3).**

5.40.4.3. The following forms are recommended for use in ambulatory procedure visit 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, *Anesthesia Medical Record* or locally produced form.

5.40.4.3.6. OF 517, *Request for Administration of Anesthesia and for Performance of Operations and Other Procedures*.

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, *Intravenous Record*.

5.40.4.4. Until Standard, Air Force or DD Forms (for ambulatory procedure visit 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 Ambulatory Procedure Visits.

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 coding references or current government approved coding classification system.

5.40.5.3. Utilize the Ambulatory Data Module in CHCS to capture the coded information on each ambulatory procedure visit.

5.40.5.4. Utilize the Ambulatory Data Module Patient Encounter Forms or the automated ambulatory procedure visit form used for coding in the ambulatory procedure visit record for auditing and quality assurance purposes.

5.40.6. Admission of Ambulatory Procedure Visit Patients.

5.40.6.1. Admit as an inpatient an ambulatory procedure visit 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 ambulatory procedure visit 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 ambulatory procedure visit procedure is maintained in the ambulatory procedure visit record."

5.40.6.3. Do not combine the original ambulatory procedure visit documentation with the inpatient record but maintain it separately in the extended ambulatory record folder.

5.40.6.4. Include copies of the Ambulatory Data Module 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 as determined by the provider.

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 standards will apply. **(T-3).**

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 documentation standards. **(T-3).**

5.41.4.2. SFs, 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 extended ambulatory record 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 ICD coding references or current government approved coding classification system.

5.41.5.2. Code procedures/operations according to the Current Procedural Terminology coding references or current government approved coding classification system.

5.41.5.3. Utilize the Ambulatory Data Module 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 extended ambulatory record 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. **(T-1).** 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 Absent Without Leave (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 AD patient is transferred to a VA hospital pending separation or retirement from the uniformed services.

5.43.5. Forward original records of 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 and/or contracting officer's technical representative.

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 visits dictated operative reports must be transcribed and filed in the medical record immediately following surgery. **(T-3).** In accordance with The Joint Commission, MTFs must generate clear policy/guidance to all providers in their facility regarding the scope of medical transcription services they intend to offer. **(T-3).**

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 Quality Assurance Evaluator/Contracting Officer's Technical Representative of inpatient records.

5.44.2.3. The supervisor or Quality Assurance Evaluator/Contracting Officer's Technical Representative 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/ambulatory procedure visit 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. Unless exempted by COCOM/Component reporting instructions, the DD Form 2766is the principle folder used to document primary medical and dental care for AD, AFR, ANG, and deployed federal civilian employees. 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 in accordance with DoDI 6490.03, AFI 10-403, *Deployment Planning and Execution*, and AFI 48-122, *Deployment Health*. **(T-0)**.

5.45.3. Unless exempted by the COCOM/Component reporting instructions, deployed medical unit records managers will use the cardstock DD Form 2766 to document primary medical and dental care. **(T-0).** Reference DoDI 6490.03. Deployed records personnel are required to file all primary local, Service-specific, SFs, and OFs generated from primary care provider-patient encounters, into the cardstock DD Form 2766. **(T-0).** Reference DoDI 6490.03. 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 Records 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, or otherwise exempted by COCOM/Component

reporting instructions, 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 Expeditionary Medical Support/Air Force Theater Hospital. Utilization of the SF 600, is the primary form used to document most ambulatory care. AF Form 3910, *Critical Care Flow Sheet (Small MTF)* is used to record critical care patients' treatment/progress. All ambulatory care healthcare forms and documents must be filed into the DD Form 2766. **(T-0).** Reference DoDI 6490.03. The outpatient healthcare information collected on these forms must return to the member's host MTF. **(T-0).** Reference DoDI 6490.03.

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 Aeromedical Evacuation mission. If not available, substitute this form with the DD Form 601, *Patient Evacuation Manifest*. The AF Form 3899, *Aeromedical Evacuation 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, *Tactical Combat Casualty Care (TCCC) Card*. 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 Aeromedical Evacuation 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.

5.45.5.2. Required deployed healthcare minimum documentation forms include **(T-1):** SF Form 600; DD Form 1380; DD Form 2992; AF Form 422; AF Form 579, *Controlled Substances Register*; SF 516, OF 517; and DD Form 599, *Patient's Effects Storage T*ag.

5.45.6. Deployed MTF medical staff will:

5.45.6.1. Conduct redeployment processing in accordance with DoDI 6490.03, AFI 10-403 and AFI 48-122. Work with the deployed Military Personnel Section 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. If required, conduct DD Form 2796, *Post-Deployment Health Assessment*, in accordance with Air Force Instruction 48-122.

5.45.6.3. Complete DD Form 2796 electronically via ASIMS. Hard copy forms will not be accepted.

5.45.6.4. A legible copy of the DD Form 2796 must be documented in the deployer's electronic health record, if the capability exists. **(T-0).** Otherwise, MTF medical personnel are required to print a hard copy of the electronic DD Form 2796 and place it in the member's deployment medical record (DD Form 2766). **(T-2).** For more specific instructions for ASIMS/AHLTA documentation, see AFI 48-122.

5.45.6.5. If the deployer 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 Form 2766; "Member unable to Electronically Complete DD Form 2796 in Theater. **(T-3).** Member must report to Public Health within 5 duty days of returning to home unit to complete the electronic DD Form 2796." **(T-2).**

5.45.7. Deployed MTF support (records) staff will **(T-1):**

5.45.7.1. File the signed/stamped hard copy DD Form 2796 into the DD Form 2766 for later transcription into ASIMS and documentation in AHLTA by a host station MTF provider, when the location does not have electronic health record capability.

5.45.7.2. 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 the troop commander. If no troop commander exists, identify the senior ranking member in the group and transfer the records to the ranking member, or 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 the member 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 harm if the member 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).

5.45.7.3. 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:

5.45.7.3.1. Smallpox vaccination screening forms (SF 600 Overprint).

5.45.7.3.2. 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).

5.45.7.3.3. Environmental/Occupational Health Exposure Data (SF 600 Overprint).

5.45.7.3.4. Physical therapy and dental visit records.

5.45.7.3.5. 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 harm if the member 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).

5.45.7.3.6. Provider signed, dated, and Identification stamped DD Form 2796.

5.45.7.3.7. 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, "PHI 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. A complete list of expeditionary electronic health record management platforms and systems can be found at the Defense Health Clinical Systems website: **https://www.health.mil/**.

5.47. Emergency Medical Service and AF Form 552, *Air Force Patient Care Report*.

5.47.1. Patients transported to a MTF for care/treatment/admission. If the patient is transported to the MTF, the information on the AF Form 552 is relevant to their care. The healthcare provider should include the AF Form 552 as part of the patient's health record.

5.47.1.1. A copy should be sent to the Medical Director for peer review and a copy to TRICARE Operations and Patient Administration for billing considerations.

5.47.1.2. Copies should be retained in accordance with normal retention standards.

5.47.2. Patients transported to a non-DoD facility with existing record. If the patient is empaneled to the MTF or otherwise has an existing record (e.g., occupational health record) the AF Form 552 is relevant to their care and should be included as part of the patient's health record.

5.47.2.1. A copy should be sent to the Medical Director for peer review and a copy to TRICARE Operations and Patient Administration for billing considerations.

5.47.2.2. Copies should be retained in accordance with normal retention standard.

5.47.3. Patients transported to DoD facility (non-beneficiary). Due to legal and liability considerations, maintain a copy of the AF Form 552 for a minimum of two years. If the patient is not a beneficiary, the form can be kept in an alphabetical file and maintained similar to AFRIMS rule T41-08 R 09.00 **https://afrims.cce.af.mil/afrims/rims.cfm**.

5.47.4. Any copies of the AF Form 552 provided to or used by other areas of the MTF, as deemed appropriate by the Medical Director, should be maintained in accordance with existing retention standards.

DOROTHY A. HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

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AF Form 230, *Request for Patient Transfer*

AF Form 250, *Health Record Charge Out Request*

AF Form 552, *Air Force Patient Care Report*

AF Form 560, *Authorization and Treatment Statement*

AF Form 565, *Record of Inpatient Treatment*

AF Form 570, *Notification of Patient's Medical Status*

AF Form 577, *Patient's Clearance Record*

AF Form 614, *Charge Out Record*

AF Form 618, *Medical Board Report*

AF Form 788A-J, *Inpatient Record*

AF Form 1403, *Roster of Seriously Ill/Very Seriously Ill*

AF Form 1480, *Summary of Care (Canceled)*

AF Form 1480A, *Adult Preventive and Chronic Care Flowsheet*

AF Form 1480B, *Adult Preventive and Chronic Care Flowsheet Continuation Sheet*

AF Form 2100A, *Health Record - Outpatient*

AF Form 2100B, *Health Record - Dental*

AF Form 2110A, *Health Record - Outpatient*

AF Form 2120A, *Health Record - Outpatient*

AF Form 2130A, *Health Record - Outpatient*

AF Form 2140A, *Health Record - Outpatient*

AF Form 2150A, *Health Record - Outpatient*

AF Form 2160A, *Health Record - Outpatient*

AF Form 2170A, *Health Record - Outpatient*

AF Form 2180A, *Health Record - Outpatient*

AF Form 2190A, *Health Record - Outpatient*

AF Form 3066, *Doctor's Orders*

AF Form 3066-1, *Doctor's Orders*

AF Form 3068, *PRN Medication Administration Record*

Adopted Forms

AF Form 40A, *Record of Individual Inactive Duty Training*

AF Form 100, *Request and Authorization for Separation*

AF Form 330, *Records Transmittal/Request*

AF Form 348, *Line of Duty Determination*

AF Form 348-R, *Line of Duty Determination for Restricted Report of Sexual Assault*

AF Form 422, *Notification of Air Force Member's Qualification Status*

AF Form 469, *Duty Limiting Condition Report*

AF Form 579, *Controlled Substances Register*

AF Form 745, *Sensitive Duties Program Record Identifier*

AF Form 797, *Job Qualification Standard Continuation/Command JQS*

AF Form 885, *Medical Record Charge Out Guide (Red) (For use by USAF Medical Treatment Facilities ONLY)*

AF Form 886, *Medical Record Charge Out Guide (Yellow) (For use by USAF Medical Treatment Facilities ONLY)*

AF Form 887, *Medical Record Charge Out Guide (Blue) (For use by USAF Medical Treatment Facilities ONLY)*

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AF Form 1122, *Personal Property and Personal Effects Inventory*

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AF Form 1288, *Application for Ready Reserve Assignment*

AF Form 1418, *Recommendation for Flying or Special Operation Duty - Dental*

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AF Form 2700L, *Health Record Year Grid*

AF Form 3067, *Intravenous Record Medical/Dental Records or Information*

AF Form 3069, *Medication Administration Record*

AF Form 3830, *Patient Manifest*

AF Form 3899, *Aeromedical Evacuation Patient Record*

AF Form 3910, *Critical Care Flow Sheet (Small MTF)*

AF Form 3915, *Labor and Delivery Flowsheet*

DD Form 137-5, *Dependency Statement*

DD Form 214, *Certificate of Release or Discharge from Active Duty*

DD Form 261, *Report of Investigation Line of Duty and Misconduct Status*

DD Form 599, *Patient's Effects Storage Tag*

DD Form 601, *Patient Evacuation Manifest*

DD Form 602, *Patient Evacuation Tag*

DD Form 689, *Individual Sick Slip*

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DD Form 2766C, *Adult Preventive and Chronic Care Flowsheet (Continuation Sheet)*

DD Form 2770, *Abbreviated Medical Record*

DD Form 2796, *Post-Deployment Health Assessment*

DD Form 2825, *Internal Receipt*

DD Form 2870, *Authorization for Disclosure of Medical or Dental Information*

DD Form 2882, *Pediatric and Adolescent Preventive and Chronic Care Flowsheet*

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DoL Form LS-1, *Request for Examination and/or Treatment*

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DoL Form LS-202, *Employer's First Report of Injury or Occupational Illness*

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OF 275, *Medical Record Report*

OF 517, *Request for Administration of Anesthesia and for Performance of Operations and Other Procedures*

OF 522, *Anesthesia Medical Record*

OF 523B, *Medical Record – Authorization for Tissue Donation*

SF 66D, *Employee Medical Folder*

SF 93, *Report of Medical History*

SF 135, *Records Transmittal and Receipt*

SF 502, *Medical Record – Narrative Summary (Clinical Resume)*

SF 503, *Medical Record-Autopsy Protocol*

SF Form 504, *Clinical Record-History Parts I and II*

SF 505, *Medical Record – History Parts 2 and 3*

SF 506, *Medical Record – Physical Examination*

SF 509, *Medical Record – Progress Report*

SF 516, *Operation Report*

SF 523, *Medical Record-Authorization for Autopsy*

SF 526, *Medical Record – Interstitial/Intercavitary Therapy*

SF 535, *Medical Record - Newborn*

SF 551, *Medical Record – Serology*

SF 558, *Medical Record – Emergency Care and Treatment*

SF 559, *Medical Record – Allergen Extract Prescription – New and Refill*

SF 600, *Chronological Record of Medical Care*

VA Form 21-0819, *DoD Referral to Integrated Disability Evaluation System (IDES)*

VA Form 9957, *ACRS Time Sharing Request Form*

Abbreviations and Acronyms

AAC—Assignment Availability Code

AD—Active Duty

ADAPT—Alcohol and Drug Abuse Prevention and Treatment

AFI—Air Force Instruction

AFMOA—Air Force Medical Operations Agency

AFMS—Air Force Medical Service

AFMSA—Air Force Medical Support Agency

AFOSI—Air Force Office of Special Investigation

AFR—Air Force Reserve

AFRC—Air Force Reserve Command

AFRIMS—Air Force Records Information Management System

AFSC—Air Force Specialty Code

AHLTA—Armed Forces Health Longitudinal Technology Application

AMTU—Airman Medical Transition Unit

ANG—Air National Guard

ARC—Air Reserve Component

ASD—Assistant, Secretary of Defense

ASIMS—Aerospace Services Information Management System

AWOL—Absent Without Leave

CED—Contingency, Exercise, Deployment

CHCS—-Composite Healthcare System

CLIA—Clinical Laboratory Improvements Amendments

COCOM—Combatant Command

CONUS—Continental United States

DC—Dental Corps

DEERS—Defense Enrollment Eligibility Reporting System

DHA—Defense Health Agency

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

DoDM—Department of Defense Manual

DSN—Defense Switched Network

EFMP—Exceptional Family Member Program

ER—Emergency Room

FOIA—Freedom of Information Act

GSU—Geographically Separated Unit

HAIMS—Health Artifact and Image Management System

HIPAA—Health Insurance Portability and Accountability Act

HIV—Human Immunodeficiency Virus

IG—Inspector General

Kx—Knowledge Exchange

MAJCOM—Major Command

MC—Medical Corps

MDG—Medical Group

MDSS—Medical Support Squadron

MHS—Military Health System

MTF—Military Treatment Facility

NATO—North Atlantic Treaty Organization

NC—Nurse Corps

NCO—**-**Non-Commissioned Officer

OCO—Overseas Contingency Operations

OCONUS—Outside Continental United States

OSD—Office of the Secretary of Defense

PAS—Personnel Accounting Symbol

PCA—Permanent Change of Assignment

PCS—Permanent Change of Station

PHI—Protected Health Information

PME—Professional Military Education

RC—Reserve Component

RMO—Resource Management Office

ROTC—Reserve Officer Training Corps

SAF—Secretary of the Air Force

SAF/MR—Assistant Secretary of the Air Force for Manpower and Reserve Affairs

SAPR—Sexual Assault Prevention and Response

SECAF—Secretary of the Air Force

SES—Senior Executive Service

SF—Standard Form

SM—Service Member

SNCO—Senior Non-commissioned Officer

TOL—Tricare Online

TRAC^{2}ES—TRANSCOM Regulating and Command & Control Evacuation System

USC—United States Code

VA—Veterans Affairs

Terms

Active Duty (AD)—Applies to members serving full-time duty in the active military service of the United States. It includes members of the RC serving on AD or full-time training duty, but does not include full-time National Guard duty. The term Inactive Duty for Training does not apply to this definition when considering healthcare eligibility.

AD Training or AD for Training—A tour of AD 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 AD training is completed. It includes annual training, special tours of AD for training, school tours, and the initial duty for training performed by non-prior service enlistees.

Active Guard and Reserve—National Guard and Reserve members who are on voluntary active duty providing full-time support to National Guard, Reserve, and Active Component organizations for the purpose of organizing, administering, recruiting, instructing, or training the Reserve Components. Also called AGR.

AHLTA—The Department of Defense legacy electronic health record, is a clinical information system that generates, maintains, stores and provides secure electronic access to comprehensive patient records.

Air Reserve Component (ARC)—Units, organizations, and members of the ANG and the AFR.

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 Uniformed Services Health Benefits Program and this manual.

Business Associate—A person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity defined in terms.

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 (MDG) Operating Instructions.

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.

Commander—The principle commissioned officer responsible for all activities, operations, and resources under the officer's 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.

Convalescent Leave—An authorized leave status granted to AD 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).

Covered Entity—In the HIPAA rules as (1) health plans, (2) health care clearinghouses, and (3) health care providers who electronically transmit any health information in connection with transactions for which HHS has adopted standards. Generally, these transactions concern billing and payment for services or insurance coverage.

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 AD member or retired; or a retired member of a RC who elected to participate in the Survivor Benefit Plan (for information on this plan, contact the Personal Affairs department at the local Military Personnel Section), but died before reaching age 60.

Definitive Diagnosis—For purposes of an Medical Evaluation Board evaluation, any condition that significantly interferes with performance of duties appropriate to a service member's office, grade, rank, or rating.

Dependency Determination—A determination by the Air Force Accounting and Finance Center, that individuals may retain their status as dependents of an AD 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 AD 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—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 Disability Evaluation System should include a medical evaluation board, a physical evaluation board, 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).

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 AD—A tour of AD, normally for more than 90 days, that members of the RC perform. Strength accountability changes from the RC to the AD force. AD for training is not creditable as Extended AD.

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.

Former Spouse—As the status relates to this manual, an individual who is no longer married to an AD member, but was in the past for a sufficient length of time to become eligible for healthcare.

Health Artifact and Image Management Solution (HAIMS)—Provides an enterprise-wide data sharing and content management capabilities for all types of artifacts and images, including radiographs, clinical photographs, electrocardiographs, waveforms, audio files, video files and scanned documents.

Health Insurance and Portability Accountability Act (HIPAA) Breach—The acquisition, access, use, or disclosure of protected health information (PHI) in a manner not permitted under the HIPAA Privacy Rule which compromises the privacy or security of the PHI.

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 RC 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 RC 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.

Integrated Disability Evaluation System—The Integrated Disability Evaluation System integrates the Disability Evaluation System with the Veterans Affairs (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.

Legally Aged Family Member—The age of 18 years and older, however, can vary by state law with respect to the matter at issue.

Medical Care—Inpatient, outpatient, dental care, and related professional services.

MHS GENESIS—The new electronic health record for the

MHS, provides enhanced, secure technology to manage health information. MHS GENESIS integrates inpatient and outpatient solutions that will connect medical and dental information across the continuum of care, from point of injury to the military treatment facility.

Military Patient—A patient who is a member of the Uniformed Services of the United States on AD, or RC status eligible for military care, or an AD member of a foreign government eligible for military care.

Military Treatment Facility—A military treatment facility is every fixed facility established for the purpose of furnishing medical and/or dental care to eligible individuals, including all operations of each such facility and all health care delivery associated with each such facility.

Military Treatment Facility Commander or Director—The person appointed on orders as the commanding officer of the MTF.

North Atlantic Treaty Organization—Security alliance of 28 countries with the fundamental goal to safeguard the Allies' freedom and security by political and military means. North Atlantic Treaty Organization 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 Employee—A Government employee whose pay comes from other than appropriated funds (for example, bowling alley and Base Exchange employees).

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.

Prime Service Areas (PSAs)—Are areas in which the contractor offers enrollment in TRICARE Prime in compliance with the travel time access standard. PSAs encompass the entire area of all the ZIP codes lying within or intersected by the 40 mile radius around enrolling MTFs/enhanced Multi-Service Markets (eMSMs) (both hospitals and clinics) and Base Realignment and Closure (BRAC) sites. Zip codes enclosed entirely within a PSA's boundary shall also be included. For BRAC sites, the 40 mile radius shall be determined based on the physical address of the former MTF location. If the former MTF address is no longer valid, the 40 mile radius shall be determined from the geographic center of the BRAC site zip code as of the date of contract award.

Reserve Components—Reserve components of the Armed Forces of the United States are: the ANG of the United States, the AFR, the Army National Guard of the United States, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, and the Coast Guard Reserve. For the purpose of this manual, 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 AD service member's status to the authorized AD service member's commander or the commander's properly appointed designee.

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 or director.

Transitional Assistance Management Program—Offers transitional healthcare coverage under TRICARE Prime where offered, TRICARE Extra, and TRICARE Standard to certain separating AD 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 Identification card facility or contacting the Defense Manpower Data Center Support Office toll free at (800) 538-9552. To locate the nearest Identification card facility, visit **www.dmdc.osd.mil/rsl/**. Refer to paragraph 2.21 for additional information. Effective 1 January 2018, TRICARE Standard and Extra are replaced by TRICARE Select.

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 DoD in cooperation with regional civilian contractors. TRICARE uses the MHS as the main delivery system augmented by a civilian network of providers and facilities serving AD (including Reservists/National Guard), their families and retired military/families and survivors world-wide.

TRICARE Prime Remote—TRICARE Prime Remote provides healthcare coverage through civilian providers for those United States 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, United States 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. TRICARE Prime Remote is offered in the 50 United States only.

Uniformed Services—The Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanic and Atmospheric Administration, and United States Public Health Service.

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 AD after 16 October 1981, is not eligible for benefits from the Department of Veterans Affairs unless the member completes the lesser of 24 continuous months of AD 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.

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

SECRETARY OF THE AIR FORCE DESIGNEE EXAMPLE REQUEST

Date

MEMORANDUM FOR (MAJOR COMMAND NAME AND ADDRESS)

FROM: (MILITARY TREATMENT FACILITY NAME AND ADDRESS)

SUBJECT: Secretary of the Air Force Designee Program Application

1. Request the following individual be granted Secretarial Designee status. The following information is provided in accordance with AFMAN 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 social security number.
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 and estimated cost of military transport.
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 (Defense Switched Network 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 military treatment facility (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 status: Indicate if the MTF accepts/does not accept Right of First Refusals.

2. For additional information please call the caseworker at the above phone number.

//SIGNATURE BLOCK//

Attachment 3

CONSULT NOTES AND SPECIALTY STUDIES GUIDE

Table A3.1. Consult Notes and Specialty Studies Guide.

Diagnosis	Required Consults	Required Studies/Info
Asthma	Pulmonology (ONLY if Complicated)	Spirometry (MCT or HC if diagnosis in doubt)
Burns		% BSA, ROM, Photographs of affected areas
Collagen Vascular Disease	Rheumatology	
Arthritis	Rheumatology	
Fibromyalgia	Rheumatology	Trigger point summary
Coronary Artery Disease	Cardiology	ETT, Echo or Cath, NYHA class
Diabetes	Endocrinology if Insulin Dependent	FBS, A1C, Optometry or Ophthalmology
Hearing	ENT	Audiogram
Eyes	Ophthalmology	Visual Acuity and Visual Field exam
Neuromuscular	Orthopedics (PT if available)	ROM (percent), Strength, Function, EMG if appropriate
Musculoskeletal	Orthopedics (PT if available)	ROM (percent), Strength, Function
Cancer (Brain)	Oncology, neurosurgery, & psych	5 year prognosis
Cancer (Skin)	Dermatology	5 year prognosis
Cancer (Head and Neck)	ENT	5 year prognosis
Cancer (renal or GU)	Urology	5 year prognosis
Cancer (other)	Oncology	5 year prognosis
Multiple Sclerosis	Neurology	MRI, spinal tap
Headache	Neurology	MRI, Log with # prostrating HA's last 12 months
Seizure	Neurology	EEG, MRI, Log of seizure frequency
Renal	Neurology	Lab progression over time
Crohn's/Ulcerative Colitis	GI	Scope/Biopsy, Log of flare freq & severity
Psych	MD/DO Psych review and cosign	Military & Social-Industrial Impairment
TBI	Neuropsychiatry	MRI, Military & Social-Industrial Impairment

Attachment 4

INITIAL RILO COVER SHEET/ CHECKLIST

Figure A4.1. Initial RILO Cover Sheet/Checklist.

INITIAL RILO COVER SHEET/CHECKLIST				Date:	
Member's Last Name:		First Name Middle Initial:		SSN:	
Member's Rank:					
Base:		Remarks:			
PEBLO's Name:		PEBLO's email:		PEBLO's DSN #	

Potentially unfitting diagnos(es) that require(s) evaluation for continued military service IAW AFI 48-123.	Month/Year Onset	AFI 48-123, Chapter 5, Para or MSD #	Cumulative months on AAC 31	Cumulative months on AAC 37
1)				
2)				
3)				
4)				
5)				

DAWG CHAIR INITIALS		CHECKLIST QUESTIONS
YES	NO	
		1. Is the course of treatment progress relatively predictable? (Pt does not need to have maximized recovery as long as treatment course can be predicted).
		2. If there is no definitive diagnosis, does the clinical evidence suggest a probable underlying cause in which the condition progression appears relatively predictable?
		3. DAWG has reviewed the referred condition and determined it is NOT an unsuiting condition
		4. The narrative clearly states whether or not the member is unable to reasonably perform his/her duties.
		5. The narrative clearly states whether or not the member is expected to be able to perform his/her duties within the next 12 months and provides a prognosis and treatment plan for the next 3 years (reasonable prediction).
		*** The following require Initial RILO even if the condition doesn't limit the ability to perform duties and/or deploy:
		6. This a chronic condition which imposes unreasonable requirements on the military to either maintain or protect the member.
		7. An Initial RILO been directed by DP2NP? If so, date:_____
		8. This is an Initial RILO for a condition with 12 months of cumulative AAC 31 and/or AAC 37 status for the same or related issues, and the DAWG review has established that condition(s) warrants an I-RILO?
		9. This is an Initial RILO submitted secondary to refusal to obtain required medical and/or dental care which would be necessary to achieve fitness, or for significant non-compliance?
		SPECIAL CIRCUMSTANCES
		This is a neoplastic disease. Even though prognosis may not be clear, oncology consult clearly delineates expected treatment course, to include length of treatment.

DAWG recommendation: _____ Return to Duty _____ Full MEB

Comments:

I certify that this package has been reviewed by the DAWG and includes the (1) narrative summary (2) attached consults/studies (3) current AF 469 with appropriate restrictions (updated and/or signed within last 30 days by provider), (4) CC letter. I further certify that an AAC 37 has been applied to this member's record.

DAWG Chair Signature: _____ ☐ Check if acting SGH or SGP

SGH/SGP Digital Signature

Attachment 5

PERSONNEL RELIABILITY ASSURANCE PROGRAM ADMIN CERT HAIMS SCAN GUIDE

Figure A5.1. Personnel Reliability Assurance Program Admin Cert HAIMS Scan Guide.

PERSONNEL RELIABILITY PROGRAM (PRP) ADMINISTRATIVE CERTIFICATION SERVICE TREATMENT RECORD (STR) HAIMS SCANNING GUIDE

STEP 1	**DOC PREP**
	• Pull ALL volumes of paper medical and dental records for service member requiring PRP ADMIN CERT • Search all MDG CHCS and actual records rooms and applicable exam rooms/office areas for missing volumes FOR MISSING VOLUMES: Search all MDG CHCS and actual records rooms and applicable exam rooms/office areas for missing volumes Account for missing volume by inserting a sheet of plain white bond paper containing the following example statement "VOLUME 1 OR (APPROPIATE NUMBER) OF 4 MISSING; THIS IS NOT A COMPLETE RECORD", Type in LARGE BLACK LETTERS on a piece of white bond paper in place of missing document TO PREPARE FOR SCAN • Separate each record volume into Sections 1 - 4 • Combine ALL Volume/Section 1s together; repeat for Volume/Sections 2 - 4 (Add tabs in-between combined sections for record reconstruction at end of process (Example, if member has 3 Volumes, add section 1 for all volumes in chronological order together) VALIDATE EACH SECTION WITH THE FOLLOWING • Validate paperwork belongs to member • Paperwork in chronological order • Remove staples, paperclips, etc. • Fix bent corners, straighten creases, repair ripped docs, etc. • Photocopy and adjust resolution to documents that are faded and not legible
STEP 2	**SCAN/VALIDATION PROCESS**
	Scan each section separately in PDF format, i.e., all volumes of Section 1, all volumes of Section 2 etc., Use the following naming format: LAST NAME, LAST 4, M-1(for Medical Record section 1, repeat with 2-4) For Dental Record use: LAST NAME, LAST 4, D-1or 2 Validate each section separately • Remove any blank pages • Rotate pages as necessary • Review clarity, completeness, and accuracy of each page
STEP 3	**UPLOAD TO HAIMS**
	Navigate to secure shared drive (like ROI drive; request one added the purpose of PRP Cert Records) Open patient folder Validate file for the following: • Blank page removal • Pages rotated • Review clarity, completeness, and accuracy of each page Upload file to HAIMS Using the Following File Names • LAST NAME, FIRST NAME STR PRP ADMIN CERT M-1 • LAST NAME, FIRST NAME STR PRP ADMIN CERT M-2 • LAST NAME, FIRST NAME STR PRP ADMIN CERT M-3 • LAST NAME, FIRST NAME STR PRP ADMIN CERT M-4 Validate uploaded document to ensure documents loaded into correct medical record

PRP STR HAIMS SCAN GUIDE Last Modified: 6 Jan 16

Please send feedback to afmoa.sgat@us.af.mil

PERSONNEL RELIABILITY PROGRAM (PRP) ADMINISTRATIVE CERTIFICATION SERVICE TREATMENT RECORD (STR) HAIMS SCANNING GUIDE (CON'T)	
	IMPORTANT: DO NOT USE STR Medical Record Part 1 – 4 **Specified "Document Type" to use for PRP ADMIN CERT records** **HAIMS DOCUMENT TYPE – ADMINISTRATIVE** **HAIMS DOCUMENT TITLE – PRP ADMIN CERT (Parts 1 - 4) See below** **• LAST NAME, FIRST NAME STR PRP ADMIN CERT M-1** **• LAST NAME, FIRST NAME STR PRP ADMIN CERT M-2** **• LAST NAME, FIRST NAME STR PRP ADMIN CERT M-3** **• LAST NAME, FIRST NAME STR PRP ADMIN CERT M-4** **HAIMS PRACTICE SETTING – OUTPATIENT** **HAIMS INSTALLATION/FACILITY – (YOUR MTF NAME)**
STEP 4	**RECONSTRUCTION/DISPOSTION FOR PAPER RECORD**
	Reconstruct Paper Medical Record into original jacket(s) Ensure that all volumes are complete Using a stamp or black marker, in large bold letters on the outer cover of each volume document the following: "THIS STR HAS BEEN COMPLETELY SCANNED INTO HAIMS AND CERTIFIED AS COMPLETE" Also add this statement on plain white bond on top of section 2 in each volume File record back into appropriate medical records file room

Attachment 6

ARRANGEMENT OF FORMS IN THE AF FORM 2100A SERIES, HEALTH RECORD OUTPATIENT SECTION 1

Table A6.1. Arrangement of Forms in the AF Form 2100A Series, 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 Aerospace Services Information Management System (ASIMS) also utilizes an automated version of the form. Each time a member receives an updated immunization, ASIMS 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*	
Form Number and Title	Special Instructions

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.
DD Form 2569, *Third Party Collection Program (TPCP) – Record of Other Health Insurance*	1. File here unless military treatment facility (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, outdated 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 Personally Identifiable Information 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, family member prefix, Last 4 of Sponsor's social security number, 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
Form Number and Title	Special Instructions

	electronic forms database. Obsolete or outdated electronic forms may be deleted/destroyed in accordance with 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-empaneled 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 Composite Health Care System (CHCS) computer generated form)*	Copy of original, or similar document used by the United States Army, United States Navy, or Department of Veterans Affairs medical facilities.
Form Number and Title	Special Instructions

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.
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 7

ARRANGEMENT OF FORMS IN THE AF FORM 2100A SERIES, HEALTH RECORD OUTPATIENT SECTION 2

Table A7.1. Arrangement of Forms in the AF Form 2100A Series, 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*	
OF 178, *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 the health record.
Note: Ensure inter-related documents for the same episode of care or subsequent referral care documents are filed on top of the initial encounter document.	

Attachment 8

ARRANGEMENT OF FORMS IN THE AF FORM 2100A SERIES, HEALTH RECORD OUTPATIENT SECTION 3

Table A8.1. Arrangement of Forms in the AF Form 2100A Series, 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.
DD Form 2992, *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 DD Form 2992, the SF 88, or any other form prepared in conjunction with DD Form 2992. Keep all supporting documents even though the DD Form 2992 may be destroyed. Remove the DD Form 2992, specifically prepared for annual or incoming clearance, from the record and destroy when it expires. Remove and destroy any DD Form 2992 excusing, grounding, or disqualifying an individual for flying or special operational duty after the new DD Form 2992 returning the individual to medically approved/cleared status is filed.
AF Form 1418, *Recommendation for Flying or Special Operational Duty – Dental*	
Form Number and Title	Special Instructions

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 disclosure.
Disclosure Accounting Record (continued)	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 9

ARRANGEMENT OF FORMS IN THE AF FORM 2100A SERIES, HEALTH RECORD OUTPATIENT SECTION 4

Table A9.1. Arrangement of Forms in the AF Form 2100A Series, 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 United States Army, United States Navy, Air National Guard (ANG), and United States Air Force Reserve (AFR).
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*	
USAFSAM Form 1527-1, *Annual Report of Individual Exposure to Ionizing Radiation*	
USAFSAM Form 1527-2, *Cumulative Occupational Exposure History to Ionizing Radiation*	
AF From 1753, *Hearing Conservation Examination*	

AF Form 2755, *Master Workplace Exposure Data Summary*	
Form Number and Title	Special Instructions
AF Form 2769, *Supplemental Data Sheet*	
AF Form 895, *Annual Medical Certificate*	
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 Armed Forces Health Longitudinal Technology Application (AHLTA), print the information from the CD-ROM and file in the appropriate outpatient records department.
Advance Directives (Self Determination Act forms), durable Power of Attorney forms, organ donor forms	

Attachment 10

ARRANGEMENT OF FORMS IN THE INPATIENT RECORD

Table A10.1. Arrangement of Forms in 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.
*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 ER; 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*	
Form Number and Title	Special Instructions

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*	
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)*	
Form Number and Title	Special Instructions
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*	
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*	
Form Number and Title	Special Instructions
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 legally authorized representative. Admitted patients or legally authorized representative 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 11

SERVICE TREATMENT RECORDS MAILING ADDRESSES FOR OTHER SERVICES

U.S. Army:
AMEDD Record Processing Center
3370 Nacogdoches Road, Suite 116
San Antonio, TX 78217

U.S. Navy:
Navy Medicine Records Activity (NMRA)
BUMED Detachment St. Louis
4300 Goodfellow Blvd, Bldg. 103
St. Louis, MO 63120

U.S. Marine Corps:
Marine STR Processing Center (MRA)
Attn: STRRCC
3280 Russell Road
Quantico, VA 22134

U.S. Coast Guard:
Commanding Officer
USCG Health, Safety, and Work-Life Service Center (MA)
300 E. Main Street, Suite 1000
Norfolk, VA 23510-9109

USPHS – U.S. Public Health Service
Office of Commissioned Corps Support Services
Medical Affairs Branch
5600 Fishers Lane, Parklawn Building, Room 4C-04
Rockville, MD 20857-0001

NOAA – National Oceanic and Atmospheric Administration
U.S. Public Health Service
Commissioned Personnel Center
Attn: CDR Hobson-Powell
National Oceanic and Atmospheric Administration
8403 Colesville Road, Suite 500
Silver Spring, MD 20910

See AFMOA Kx/Health Benefits/STR/STR Guidance for address updates at:
https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx.