STATEMENT OF INCIDENT

- QUESTIONNAIRE -

DATA REQUIRED BY THE PRIVACY ACT OF 1974

(5 U.S.C., Section 552a)

1. **AUTHORITY:** The Federal Medical Care Recovery Act, 42 U.S.C., Section 651-3, Executive Order 9397, 10 U.S.C., Section 1095, 32 CFR, Part 220.12 (l), 5 U.S.C., Section 301, 44 U.S.C., Section 3101.
2. **PRINCIPAL PURPOSE (S):** To obtain information required enabling the United States to recover the reasonable value of Government-sponsored medical care furnished at its expense from third parties.
3. **ROUTINE USES:** a. Identify injured party and nature of injuries. b. Identify persons involved, including witnesses and other interested parties. c. Determine the circumstances of incidents, which give rise to personal injuries. d. Determine insurance coverage and source(s) of medical treatment. Information may be disclosed to civilian attorneys, insurance companies and other agencies to settle claims, and/or to the Department of Justice for use in litigation, and may be furnished to other components of the Department of Defense as required by regulation.
4. **MANDATORY OR VOLUNTARY DISCLOSURE:** MANDATORY DISCLOSURE. Failure to provide all pertinent information in a timely manner will result in the potential disqualification or suspension of all Government-sponsored health care at the discretion of the Secretary of Defense for Health Affairs, TRICARE, as well as the immediate withholding of military medical records pertaining to the incident from the injured beneficiary and/or their legal representative.

INSTRUCTIONS FOR COMPLETION

You must provide all information, which pertains to the circumstances of your injury. For sections, which do not apply to you, please mark "N/A" (*Not Applicable*) in the space provided. Attach documents supporting your statement. The regulation that requires completion of this form applies equally to active, retired, or separated United States military personnel and/or their family members.

INJURED PARTY

NAME (Last, First, MI)	DATE OF BIRTH	SOCIAL SECURITY #
HOME ADDRESS	**TELEPHONE**	**EMAIL**

INJURED PARTY / MILITARY SPONSOR

BRANCH OF SERVICE			SPONSOR'S STATUS	
(Check One) : USA ☐ USAF ☐ USN ☐ USMC ☐ OTHER ☐			(Check One) : Active Duty ☐ Retired ☐ ETS'd ☐ Deceased ☐ Reserved ☐ National Guard ☐	
NAME (Last, First, MI)			**GRADE/RANK**	**SPONSOR'S SSN**
MILITARY UNIT MAILING ADDRESS (If sponsor is on active duty)				**SPONSOR'S WORK PHONE**

DETAILS OF THE INCIDENT

DATE	TIME _____ AM ☐ PM ☐	COUNTY
STREET (if known)	**CITY**	**STATE**
DID THE POLICE RESPOND? YES ☐ NO ☐ N/A ☐		MILITARY POLICE ☐ CIVILIAN POLICE ☐
IF YES, NAME OF AGENCY	**TRAFFIC ACCIDENT REPORT #**	**ACCIDENT REPORT ATTACHED?** YES ☐ NO ☐
WAS A TICKET ISSUED? YES ☐ NO ☐ N/A ☐	**IF YES, AGAINST WHOM?**	**CITED FOR**

IN YOUR OWN WORDS, please describe *in this block*:

1) *How* your accident occurred: (Please PRINT) :

2) *Who* (if anyone) was at fault and why.

IMPORTANT: COMPLETE ALL APPLICABLE BLOCKS ON EACH PAGE, AND RETURN WITHIN 10 DAYS TO:

OFFICE OF THE STAFF JUDGE ADVOCATE, AFFIRMATIVE CLAIMS
4217 MORRISON STREET, STE 5030 FORT MEADE, MD 20755
FAX: (301) 677-9758

MOTOR VEHICLE ACCIDENTS:

IMPORTANT: Notify your own insurance carrier even though the injured party was a pedestrian, a passenger in another vehicle, a victim of a "hit and run" incident, a bicyclist, or was involved in a one-vehicle accident. Failure to do so may jeopardize any right of recovery you have or the rights of the United States Government. Direct any questions to the military legal office coordinating recovery of the Government's claim.

I WAS A:	DRIVER ☐	PASSENGER ☐	PEDESTRIAN ☐	BICYCLIST ☐	OTHER ☐

	YEAR	MAKE	MODEL
YOUR VEHICLE			

NAME OF DRIVER	**ADDRESS**
NAME OF OWNER (if different than the driver)	**ADDRESS** (if different than the driver)
INSURANCE COMPANY	**ADDRESS**
NAME OF CLAIMS ADJUSTER	**CLAIMS ADJUSTER'S TELEPHONE NUMBER**
POLICY NUMBER:	**CLAIM NUMBER:**
IS A COPY OF THE AUTO POLICY ATTACHED? :	**Y E S ☐ N O ☐**

TYPES OF POLICY COVERAGE: Check [✔] those which apply and indicate coverage amounts:	☐ Personal Injury Protection (PIP) Coverage Amount? $ _____	☐ Medical Payments (Med Pay) Coverage Amount? $ _____	☐ Uninsured/Underinsured Motorist (UM/UIM) Coverage Amount? $ _____

	YEAR	MAKE	MODEL
THE *OTHER* VEHICLE			

NAME OF *OTHER* DRIVER	**ADDRESS**
NAME OF *OTHER* VEHICLE'S OWNER (if known)	**ADDRESS**
***OTHER* DRIVER'S INSURANCE COMPANY**	**ADDRESS**
***OTHER* DRIVER'S CLAIMS ADJUSTER**	**CLAIMS ADJUSTER'S TELEPHONE NUMBER**
POLICY NUMBER OF *OTHER* DRIVER:	**CLAIM NUMBER OF *OTHER* DRIVER:**

TYPES OF POLICY COVERAGE **FOR *OTHER* VEHICLE**: List specific coverage amounts.	**LIABILITY COVERAGE**: (Per Person/Per Accident) $_____/$_____	* * * **NOTE:** * * * IF THIS WAS A MULTIPLE VEHICLE ACCIDENT, PLEASE LIST INFORMATION CORRESPONDING TO ANY AND ALL ADDITIONAL VEHICLES ON A SEPARATE SHEET.

ON-THE-JOB INJURY - & - WORKER'S COMPENSATION CLAIMS:

NAME OF BUSINESS/ORGANIZATION	**ADDRESS**
EMPLOYER'S INSURANCE COMPANY	**ADDRESS**
NAME OF CLAIMS ADJUSTER	**CLAIMS ADJUSTER'S TELEPHONE NUMBER**
WORKER'S COMPENSATION CLAIM NUMBER:	**OTHER INFORMATION:**

OTHER TYPES OF INCIDENTS:

INJURY OCCURRED AT:	MY HOME ☐	OTHER RESIDENCE ☐	SCHOOL ☐	PUBLIC PROPERTY ☐	PRIVATE PROPERTY ☐

NAME OF PROPERTY OWNER	**ADDRESS**
NAME OF INSURANCE COMPANY	**ADDRESS**
NAME OF CLAIM ADJUSTER	**CLAIM ADJUSTER'S TELEPHONE NUMBER**
INSURANCE POLICY NUMBER:	**INSURANCE CLAIM NUMBER:**

YOUR MEDICAL CONDITION

WERE YOU INJURED IN THE ACCIDENT? YES ☐ NO ☐ **IF "YES," WHAT WERE YOUR INJURIES?**

DESCRIBE HERE:

IMPORTANT: (Please *be specific* when describing the nature and severity of your illness/injuries, being careful to include "*Left*" or "*Right*", when specifying the body location. Also indicate if any surgeries or tests have been performed or *will be* performed).

LIST BELOW THE NAMES OF **MILITARY FACILITIES** & DATES YOU WERE TREATED FOR THE ACCIDENT

LOCAL MILITARY FACILITIES	CLINIC(S) TREATED AT	OUTPATIENT (Dates of Visits)	INPATIENT (Dates of Stay)
Kimbrough Ambulatory Care Ctr, Fort Meade	Which Clinic(s)?	*Please see page 6*	
Walter Reed Army Medical Center, DC	Which Clinic(s)?	*Please see page 6*	
National Naval Medical Center – Bethesda	Which Clinic(s)?	*Please see page 6*	
Malcolm Grow U.S. Air Force Medical Center	Which Clinic(s)?	*Please see page 6*	
DeWitt Army Community Hospital, Fort Belvoir	Which Clinic(s)?	*Please see page 6*	
Kirk U.S. Army Health Clinic, APG, MD	Which Clinic(s)?	*Please see page 6*	
Other Military Facility (*Please specify*):	Which Clinic(s)?	*Please see page 6*	

LIST BELOW THE NAMES OF **CIVILIAN FACILITIES** & DATES YOU WERE TREATED FOR THE ACCIDENT:

CIVILIAN FACILITIES (or Doctor's Name)	CLINIC (S)	OUTPATIENT (Dates of Visits)	INPATIENT (Dates of Stay)

HAVE THE CIVILIAN MEDICAL BILLS BEEN PAID? NO ☐ YES ☐ (IF "*Yes*," please specify *by whom*) :	ME ☐	ARMY ☐	TRICARE (CHAMPUS) ☐	INSURANCE ☐	ATTORNEY ☐	OTHER ☐

IMPORTANT: Initial here if you received –NO– civilian medical treatment for this incident: _____
[initials]

MISCELLANEOUS INFORMATION (Required)			PLEASE SPECIFY:
Do you *handcarry* your medical record?	YES ☐	NO ☐	If "No", Where *is it on file?*
Are you still receiving treatment?	YES ☐	NO ☐	If"No", *When were you released? [date]:*
Have you signed any release form?	YES ☐	NO ☐	If "Yes", *For whom?*
Has property damage been paid?	YES ☐	NO ☐	If "Yes", *By whom?*
Has personal injury been paid?	YES ☐	NO ☐	If "Yes", *By whom?*
Were you placed on Quarters? [*]	YES ☐	NO ☐	If "Yes", *List dates:*

[*] NOTE: *Active Duty* members who missed entire duty days –**MUST**- submit a copy of their **Leave and Earning Statement** (**LES**) *and* complete a "**CERTIFICATION STATEMENT** *of Military Services Lost Due to Third Party Incident*" – attached).

ATTORNEY REPRESENTATION

NAME OF LAW FIRM	ADDRESS
ATTORNEY/PARALEGAL EMAIL	ATTORNEY'S TELEPHONE NUMBER & FAX NUMBER

CHECK THIS BOX: IF YOU HAVE –NOT- RETAINED THE SERVICES OF AN ATTORNEY CONCERNING THIS INCIDENT, INITIAL HERE: _____

INJURED PARTY'S STATEMENT AND SIGNATURE

UNDER PENALTY OF PERJURY, I CERTIFY THAT THE FORGOING INFORMATION IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I hereby acknowledge receipt of the "*Advice to Injured Party*" form and understand that use of this information is authorized by law in pursing medical claims in favor of the U.S. Government.

DATE SIGNED	INJURED PARTY'S SIGNATURE (Parent's Signature, if injured party is a minor.)

PLEASE ATTACH ANY & ALL AVAILABLE DOCUMENTS FOR REVIEW BY THE RECOVERY JUDGE ADVOCATE ATTORNEY:

- **Traffic Accident Report**
- **Auto Accident Diagram**
- **Leave & Earning Statement (LES) [*]**
- **Handcarried Military Medical Record Copies**

MEDICAL RELEASE AUTHORIZATION

DATA REQUIRED BY THE PRIVACY ACT OF 1974

(5 United States Code, Section 552a)

1. **AUTHORITY: The Federal Medical Care Recovery Act, 42 U.S.C., Section 2651-3, 10 U.S.C., Section 1095, 32 CFR, Part 220.12(I), 5 U.S.C., Section 301, 44 U.S.C., Section 3101.**

2. **PRINCIPAL PURPOSE(S): Authorization for release of medical record excerpts in order to document the claim of the United States Government against third parties for medical care recovery costs.**

3. **ROUTINE USES: Information may be disclosed to civilian attorneys, insurance companies and other agencies to settle claims, and/or to the Department of Justice for use in litigation, and may be furnished to other components of the Department of Defense as required by regulation.**

4. **MANDATORY OR VOLUNTARY DISCLOSURE: Voluntary. However, eligible recipients of Government sponsored medical treatment electing not to provide this information will be required to assign in writing any other claim against any other party as a result of the incident-giving rise to the Government's claim for the recovery of medical care costs.**

Patient's Full Name: _____

Date of Birth: _____

Patient Social security Number: _____

Military Sponsor's Name: _____

Military Sponsor's Social Security Number: _____

I, _____, as the injured party listed above (or parent) request & Authorize you to furnish the Office of the Staff Judge Advocate, Affirmative Claims, 4217 Morrison Street, Ste 5030, Fort George G. Meade, Maryland 20755-5030, any and all medical, dental, psychological and related information, including Prescriptions and x-rays, requested concerning the incident occurring on/around

_____.
Date of accident

It is understood that thin information/ documentation will be used solely and exclusively to the purpose of the recovery of medical care cost for Government- sponsored civilian or military care provided as a result of this incident. Photocopies of this authorization shall have the same validity as the original. This authorization remains in effect until/unless rescinded in writing

_____ **_____**
Date Signed **× Patient's Signature**
(Parent's Signature if Injured Party is a Minor)

CERTIFICATION STATEMENT

OF MILITARY SERVICES LOST
DUE TO THIRD PARTY LIABILITY INCIDENT

STATUTORY AUTHORITY

The Federal Medical Care Recovery Act, 42 United States Code, § 2651 (as amended by Section 1075 of the FY 1997 Authorization Act, Public Law No. 104-201) allows the United States Government to recover the "costs of pay" from an insurer when an active duty member is negligently injured by another and, as a result, is unable or unavailable to perform their assigned military duties (for complete duty days). This amendment also permits such recovery without a finding of tort liability in no-fault jurisdictions. The authority to collect the costs of pay relating to lost military services is pursuant to the amendments made in Section 1075 and applies to costs of pay ("wages") lost by the Government on or after the date of the enactment of this Act, which is September 23, 1996, regardless of whether the incident giving rise to the claim occurs prior to that date. Such a claim for lost military pay/services as a result of this incident is that of the United States, and not that of the injured service member.

IMPORTANT: Send completed form to the military legal office handling assertion of the Government's claim.

INJURED PARTY (Last, First, MI)	**RANK**	**DATE OF ACCIDENT**	**U.S. CLAIM NUMBER**

ITEMIZATION OF DUTY DAYS MISSED

As a result of the above-captioned incident, I, as an active duty service member, was unable and/or unavailable to perform my assigned military duties for complete duty days during the specific time period(s) listed below:

MEDICAL STATUS	**NUMBER OF DAYS**	**DATE(S)**
Quarters Status (*issued by a military physician*)		
"Off Work Excuse" (*issued by a civilian physician*)		
Military Inpatient Hospital Stay		
Civilian Inpatient Hospital Stay		
Same Day Surgery Stay		
Convalescent Leave Status		
Subsisting Elsewhere Status (*pending a Medical Evaluation Board*)		
Individual duty days missed in their entirety due to traveling to, and/or submitting to, necessary medical treatment or tests as a result of the incident:		
OTHER: (Specify) - Soldier unavailable for recall to perform assigned military duties as a result of this incident:		
I LOST NO TIME AWAY FROM MILITARY DUTIES AS A RESULT OF THIS THIRD PARTY LIABILITY INCIDENT (CHECK HERE): ☐		
TOTAL DUTY DAYS MISSED AS A RESULT OF THE INCIDENT:		

I WAS ASSIGNED TO THE FOLLOWING MILITARY UNIT DURING THE TIME PERIOD(S) INDICATED:

(Information will be used to ensure proper return of funds to the appropriation supporting the installation to which the service member was assigned)

NAME OF UNIT	**MAILING ADDRESS**	**TELEPHONE NUMBER**

NAME OF UNIT BUDGET OFFICER	**BUDGET OFFICER'S PHONE NUMBER**

CERTIFICATION STATEMENT

UNDER THE PENALTY OF PERJURY, I have completed this form and certify that the information I have provided is true and complete to the best of my knowledge and belief. I further acknowledge that Federal Laws (18 United States Code, Sections 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States of America. I understand that this information will be used by the Government to pursue and recover the "costs of pay" relating to military services lost as a result of the incident from the legally-responsible party and/or insurance company.

INJURED SOLDIER'S SIGNATURE	**DATE SIGNED**

REMINDER: Please attach a legible copy of a **DFAS Form 702** Leave and Earnings Statement (LES).

MILITARY FACILITY DATES OF TREATMENT

List the names of **military facilities** & **specific dates you were treated** for the accident. Due to the large demand for bills both CONUS & OCONUS, **Military Treatment Facilities (MTF) no longer accept date spans** for treatment dates. You must list each date of service individually. Please be advised that certain procedure codes do not have rates associated with them, therefore the MTF **may not** bill for procedures including but not limited to *radiology*, *physical therapy, laboratory services*, *prescriptions, or telephone consultations*. For a list of treatment dates please contact the MTF's patient administration department.

[*] NOTE: *Active Duty* members who missed entire duty days **-MUST-** submit a copy of their **Leave and Earning Statement** (**LES**) *and* complete a "**CERTIFICATION STATEMENT** *of Military Services Lost Due to Third Party Incident*" -- attached).

UNITED STATES ARMY
AFFIRMATIVE CLAIMS PACKET
ADVICE TO INJURED PARTY

- INFORMATION SHEET -

FOR THIRD PARTY LIABILITY CLAIMS INVOLVING –MILITARY- BENEFICIARIES

As the injured party, (or his guardian, next of kin, personal representative, or the executor or administrator of his estate), who has been, or will be, furnished civilian or military medical treatment directly by, through, and/or at the expense of the United States Government, you are placed on notice of the following:

1. The Fort Meade Claims Division processes claims for the state of **Maryland** and **Pennsylvania**. *As of 01 May 2021, we will also process claims previously belonging to Aberdeen Proving Ground (APG).* To obtain claims forms and jurisdiction information, please visit our website for our *Military Claims Office Finder*. https://home.army.mil/meade/index.php/about/Garrison/staff-judge-advocate

2. Under the Federal Medical Care Recovery Act, Title 42, U.S. Code, Section 2651, and Title 10, U.S. Code, Section 1095, the Government is entitled to independently pursue/recover the reasonable value of medical care furnished or to be furnished you from the person(s) who injured you, or who were otherwise responsible for your injury or disease. This includes those agencies responsible for the payment of medical expenses under your own, or any other, valid insurance contract.

3. If you are an eligible military beneficiary entitled to legal assistance under Army Regulation 608-50, you may seek guidance from a Legal Assistance Attorney regarding any claim you may have for personal injury. The Legal Assistance Office at Fort Meade may be contacted at: (301) 677-9504 or 9536 for an appointment.

4. You are required to cooperate fully in the prosecution of all actions of the Government against the person(s) who injured you. [32 C.F.R., Part 220.12(1)]

5. You are required to furnish a complete, accurate, and timely statement regarding the facts and circumstances surrounding the incident giving rise to the Government claim for the recovery of medical costs of having treated you and/or for lost military services. [28 C.F.R., Part 43.2]

6. You are required to furnish information concerning any legal action brought or to be brought by, or against, the prospective defendant. You must also furnish the name and address of the attorney representing you, along with information concerning all insurance companies and interested parties.

7. Any attorney representing the Government's claim is statutorily prohibited from assessing his/her counsel fees or expenses on the amount of the Government's claim. [Title 5, U.S. Code, Section 3106]. Notify this office immediately if, at disbursement, the Government's claim is not first deducted from your settlement prior to your attorney assessing agreed upon fees and expenses.

8. Although it does not bar the Government from its rightful recovery, you are cautioned not to sign any release or settlement agreement for any personal injury claim which you may have as a result of your injury without first notifying the military legal office for your sponsor's branch of service:

US ARMY	Office of the Staff Judge Advocate, Affirmative Claims, 4217 Morrison Street, Ste. 5030, Fort Meade, MD 20755-5030	
Point of Contact:	**Tarka Loney**	
	Phone: (301) 677-9975	Email: usarmy.meade.usag.mbx.claims@army.mil
	Fax: (301) 677-9758	

IMPORTANT NOTICE TO INJURED PARTY: KEEP **THIS FORM** FOR FUTURE REFERENCE