DEPARTMENT OF VETERANS AFFAIRS

Veteran's Last, First Name: _____ **Last 4 SSN:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

TRICARE Affirmation

Please fill in the section below if you elect to use your TRICARE benefits for this visit/appointment. In order to utilize your TRICARE benefits, you must elect to use them at each "episode of care." An "episode of care" is defined as the managed care provided by a health care facility or provider for a specific medical problem or behavioral condition or specific illness during a set time period. An episode of care can be a short period of care or care on a continuous basis or it may consist of a series of intervals marked by one or more brief separations from care. An episode of care consists of all clinically related services for one patient for a discrete diagnostic condition from the onset of symptoms until treatment is complete.

I _____ agree and elect to use my TRICARE benefits for an appointment
(Insert Veteran's Full Name)

on _____. I understand that any associated ancillary services (such as x-rays, laboratory, etc.) related
(Insert Date)

to this visit are considered to be a part of this "episode of care" and will also be billed to TRICARE. I understand that the US Department of Veterans Affairs (VA) medical facility where treatment is performed will submit claims on my behalf to TRICARE and that I am responsible for any cost shares, co-pays, and deductible amounts, which are listed on the TRICARE Explanation of Benefits. I also understand that if I have Other Health Insurance (OHI), VA will bill my OHI as my primary insurance carrier, and then bill TRICARE as my secondary payer. I further understand that:

- **If I am a dual-eligible (VA/Department of Defense) Veteran seeking care for a service-connected condition in a VA medical facility, I must receive that care using my Veteran's benefits and TRICARE will not be billed.**

When TRICARE is billed the cost shares, co-pays and deductible amounts cannot be waived and it becomes my responsibility to pay such cost shares, co-pays, and deductible amounts in full to _____
(Insert Name of the Appropriate Medical Treatment Facility)
when I receive the VA Patient Statement.

_____ _____
Patient's Signature **Date**