

EMERGENCY CIVILIAN MEDICAL/DENTAL CARE CLAIM

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 8013, Secretary of the Air Force; powers and duties; delegation by.

PURPOSE: Information required to determine responsibility for payment of medical services performed by civilian providers.

DISCLOSURE IS VOLUNTARY: If information is not provided, individual will be responsible for payment.

NOTE: The below information is required to determine responsibility for payment and for preparation of SF Form 1034, Public Voucher for Purchases and Services Other than Personal.

| | | | | |
|------------------------------------|--|-------|-----|-------------------|
| NAME (Last, First, Middle Initial) | | GRADE | SSN | ORGANIZATION/UNIT |
|------------------------------------|--|-------|-----|-------------------|

| | | | |
|------|----------------|----------------|--|
| BASE | DUTY PHONE NO. | HOME PHONE NO. | STATUS <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> AFRES <input type="checkbox"/> ANG <input type="checkbox"/> OTHER _____ |
|------|----------------|----------------|--|

| | | |
|--|--------------------|--------------|
| ARE YOU A STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GRADUATION DATE _____ | DATE OF SEPARATION | GAINING BASE |
|--|--------------------|--------------|

TYPE OF CARE RECEIVED

EMERGENCY ROOM DOCTOR HOSPITAL AMBULANCE REIMBURSEMENT
 PHARMACY R OTHER _____

| | | | |
|------------------|-----------------------------------|------------------|----------------|
| NAME OF PROVIDER | ADDRESS AND PHONE NO. OF PROVIDER | DATE OF SERVICES | AMOUNT CHARGED |
|------------------|-----------------------------------|------------------|----------------|

| | | |
|--|---|--|
| HAVE BILLS BEEN PAID? (Attach original receipt and/or cancelled check) <input type="checkbox"/> YES <input type="checkbox"/> NO | WAS THIS AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | STATUS AT TIME OF ILLNESS/INJURY(TDY, leave, off-duty etc) |
|--|---|--|

STATE THE CIRCUMSTANCES OF ILLNESS/INJURY:

WHAT:
 WHEN:
 WHERE:
 HOW:

| | |
|--|---|
| DID YOU ATTEMPT TO OBTAIN CARE AT A FEDERAL/MILITARY FACILITY?(if NO, explain why) <input type="checkbox"/> YES <input type="checkbox"/> NO | LIST NEAREST FEDERAL/MILITARY FACILITY AND DISTANCE |
|--|---|

THIRD PARTY LIABILITY CLERK REVIEW. THIS IS / IS NOT A THIRD PARTY LIABILITY.

COMMENTS:

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

| | |
|-----------------|------------------------|
| DATE (YYYYMMDD) | SIGNATURE OF APPLICANT |
|-----------------|------------------------|

| | | |
|------|---|------------------------|
| DATE | <input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED | SIGNATURE OF 82 MG/SGH |
|------|---|------------------------|

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The traditional Field-by-Field creation process is extremely ineffective and slow.

The only realistic option to create high-quality forms is the Insert-Text-Anywhere-on-Page (ITAOP) method.

The field creation process is about 10,000 times faster than the traditional method; the list of ITAOP features is not even available for the traditional method.

ITAOP savePDF method proved to be very simple and completely reliable for millions of users all over the world (incl. individuals, companies, organizations, government employees).