

DISENGAGEMENT FOR CIVILIAN MEDICAL CARE

NAVMECOMINST 6320.3B

From: _____ / _____ (Date)

 (Physician's Name and Clinical Service)

 (Name and Address of Facility)

To: _____ / _____ (Responsible Family Member's Name)
 (Patient's Name)
 Procedure//Services Required by
 Patient: _____

Patient disengaged:

To receive care under: _____
 (Program, If Known)

To Receive care from: _____
 (Health Care Provider/Source, If Known)

Disengagement: I understand that the above named facility does not have the capability to provide the services required by the patient named hereon. I understand that the Navy will not be responsible for the cost of care obtained through this disengagement. The Navy has not recommended nor directed the patient named hereon to a particular physician or source of care. I acknowledge that I have been counseled concerning this disengagement and its possible cost-sharing provisions under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or other programs that may be responsible for costs associated with this disengagement. I understand that I am to receive a copy of this statement.

Patient or Responsible Family
 Member's Acknowledgement: _____
 (Signature)

Patient's Name: _____ Status: _____
 (Rank/Service/Dep/Ret)

Address: _____

SSN: _____ ID Card No: _____

Phone No: _____ ID Card Issue Date: 15/Apr/1999

DEERS Check: _____ ID Card Effective Date: 15/Apr/1999

(Yes) (No)

ID Card Expiration Date: 15/Apr/1999

DEERS Verifies Eligibility: _____
 (Yes) (No)

Counselor: _____ (Signature) _____ (Date)