



**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)