

CLIENT LEGAL SERVICES  
DIVISION



Military Claims Branch



**DEPARTMENT OF THE ARMY**  
HEADQUARTERS, 8TH ARMY  
OFFICE OF THE STAFF JUDGE ADVOCATE  
UNIT #15237  
APO AP 96205-5237

REPLY TO  
ATTENTION OF:

EAJA-LS

25 June 2010

MEMORANDUM FOR CLAIMANTS AGAINST THE UNITED STATES GOVERNMENT

SUBJECT: Procedures for Filing Tort Claims

1. Welcome to the Client Legal Services Division, USAG-Yongsan, Korea. Enclosed are instructions and forms explaining how to file a tort claim against the United States for wrongful death, personal injury, and property damage.
2. It is unfortunate that you have suffered a loss or injury. Our goal is to investigate and fairly settle your claim as quickly as possible. Please understand, however, that Congress and the Department of the Army have placed restrictions on our authority to pay claims of this nature. To ensure that we can pay you the full amount of money to which you are entitled under the law, it is important that you read and carefully follow the enclosed instructions, that you carefully complete all applicable claims forms, and that you submit all the required documentation to substantiate your claim.
3. A claims survey form is attached to this letter. We are genuinely interested in your comments regarding our service to you and welcome any suggestions for improvements. Please return this form at the time you file your claim or fold it in half and mail it postage-free through the MPS. If you have additional comments at a later time, extra survey forms are available at the Client Legal Services Division.
4. The Claims Office is open Monday, Tuesday, Wednesday and Friday from 0900 to 1630, and on Thursday from 1300 to 1600. We are closed Thursday mornings for training. If you need assistance at any stage in the claims process, please do not hesitate to contact us at (02) 7918-8212/8108 (commercial) or DSN 315-738-8212/8108.

Encls  
as

MARC W. ZELNICK  
CPT, JA  
Chief, Client Legal Services Division

## TORT CLAIM CHECKLIST (Medical)

The following is **required** to process a military tort claim for medical injury:

\_\_\_\_\_ **Original SF 95** (sample form & blank form enclosed).

- Complete blocks 1 – 19 (if not applicable, write “NA”)
- Statements such as “See Attached” are not acceptable entries
- Use personal mail address, NOT local Korean residential address

\_\_\_\_\_ **Documentary evidence to support your claim.**

\_\_\_\_\_ **Release for Use of Medical Records under HIPPA.**

\_\_\_\_\_ **Insurance Settlement (if insurance company paid any funds associated with injury).**

\_\_\_\_\_ **US Military stationed or TDY in Korea (and accompanying dependents): PCS/TDY orders to Korea, with amendments, pinpoint assignment orders, and extensions (FSTE/AIP).**

\_\_\_\_\_ **US Civilian Employees stationed or TDY (and accompanying dependents): Employment documentation for current position (i.e. SF50 (DoD), DA Form 3434 (NAF), USFK Form 700-19A-E & Accreditation Letter (Invited Contractor), etc), along with extension paperwork, or TDY order.**

**NOTE: If the above document does not reflect that you have a return rights, living quarters allowance, transportation agreement, etc., provide your original passport showing VISA/SOFA status (passport will be immediately returned upon verification).**

\_\_\_\_\_ **US Personnel visiting Korea (Active Duty: copy of leave form; Civilians: original passport for verification of VISA status (passport will be immediately returned upon verification)).**

\_\_\_\_\_ **Reassignment documentation (if scheduled to depart).**

\_\_\_\_\_ **Original Electronic Fund Transfer Worksheet** (blank form enclosed).

\_\_\_\_\_ **Original Power of Attorney.** You must have this if you are filing for your sponsor, spouse, or someone else.

**NOTE:** Additional documentation or information may be required in the course of the investigation. Failure to provide necessary documentation will result in action based available information.

You have **two years** from the **date of the incident, date injury discovered, or date you should have know the injury to exist, whichever is later,** to file a claim.

If you desire copies of any forms or documents pertaining to your claim, you should make copies prior to coming to the Client Legal Services Division. If you need assistance, feel free to come by our office during normal office hours or call to speak to one of our representative.

**SAMPLE**

<b>CLAIM FOR DAMAGE, INJURY, OR DEATH</b>		<b>INSTRUCTIONS:</b> Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.			FORM APPROVED OMB NO. 1105-0008	
1. Submit to Appropriate Federal Agency: HQ, EUSA, Office of the SJA ATTN: Military Tort Claims Unit 15237 APO AP 96205-5237				2. Name, address of claimant, and claimant's personal representative if any. (See instructions on reverse). Number, Street, City, State and Zip code.  Enter your name and mailing address		
3. TYPE OF EMPLOYMENT MILITARY    CIVILIAN	4. DATE OF BIRTH Self-Explanatory	5. MARITAL STATUS Self-Explanatory	6. DATE AND DAY OF ACCIDENT Self-Explanatory	7. TIME (A.M. OR P.M.) Self-Explanatory		
8. BASIS OF CLAIM (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary).  You are responsible to describe your claim in a clear and concise statement that specifies exactly how the agency involved was responsible for your damage, injury or loss, by describing what you believe was the negligent act that was committed.  An SF95 that simply states "A government employee was negligent", "my vehicle was damaged", or "see attached MP report", is not a proper claim.						
9. PROPERTY DAMAGE						
NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code). Complete if applicable, otherwise enter "NA".						
BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF THE DAMAGE AND THE LOCATION OF WHERE THE PROPERTY MAY BE INSPECTED. (See instructions on reverse side). Complete if applicable, otherwise enter "NA".						
10. PERSONAL INJURY/WRONGFUL DEATH						
STATE THE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE THE NAME OF THE INJURED PERSON OR DECEDENT.  Complete if applicable, otherwise enter "NA".						
11. WITNESSES						
NAME			ADDRESS (Number, Street, City, State, and Zip Code)			
Self-Explanatory			Self-Explanatory			
12. (See instructions on reverse). AMOUNT OF CLAIM (in dollars)						
12a. PROPERTY DAMAGE Enter US currency only	12b. PERSONAL INJURY Enter US Currency only	12c. WRONGFUL DEATH Enter US Currency only	12d. TOTAL (Failure to specify may cause forfeiture of your rights). Total blocks 12a, 12b & 12c			
I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.						
13a. SIGNATURE OF CLAIMANT (See instructions on reverse side).			13b. PHONE NUMBER OF PERSON SIGNING FORM Self-Explanatory	14. DATE OF SIGNATURE Self-Explanatory		
<b>CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM</b>  The claimant is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729).			<b>CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS</b>  Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)			

# SAMPLE

## INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of the vehicle or property.

15. Do you carry accident insurance?  Yes If yes, give name and address of insurance company (Number, Street, City, State, and Zip Code) and policy number.  No

If you have private insurance, you must enter the complete address of the insurance company. You are NOT required to file a claim with your insurance company, but may file through your insurance company and then file a claim for the deductible.

16. Have you filed a claim with your insurance carrier in this instance, and if so, is it full coverage or deductible?  Yes  No 17. If deductible, state amount.

Self-Explanatory

Self-Explanatory

18. If a claim has been filed with your carrier, what action has your insurer taken or proposed to take with reference to your claim? (It is necessary that you ascertain these facts).

If you filed a claim with your insurance company, you must annotate what action your insurance company took regarding your claim, and provide documentation evidence to support the action they took.

19. Do you carry public liability and property damage insurance?  Yes If yes, give name and address of insurance carrier (Number, Street, City, State, and Zip Code).  No

If you have private insurance, you must enter the complete address of the insurance company. You are NOT required to file a claim with your insurance company, but may file through your insurance company and then file a claim for the deductible.

## INSTRUCTIONS

**Claims presented under the Federal Tort Claims Act should be submitted directly to the "appropriate Federal agency" whose employee(s) was involved in the incident. If the incident involves more than one claimant, each claimant should submit a separate claim form.**

**Complete all items - Insert the word NONE where applicable.**

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE, AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY

Failure to completely execute this form or to supply the requested material within two years from the date the claim accrued may render your claim invalid. A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

If instruction is needed in completing this form, the agency listed in item #1 on the reverse side may be contacted. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplementing regulations. If more than one agency is involved, please state each agency.

The claim may be filled by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with the claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file for both personal injury and property damage, the amount for each must be shown in item number 12 of this form.

DAMAGES IN A **SUM CERTAIN** FOR INJURY TO OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN **TWO YEARS** AFTER THE CLAIM ACCRUES.

The amount claimed should be substantiated by competent evidence as follows:

- (a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of the injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.
- (b) In support of claims for damage to property, which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.
- (c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.
- (d) Failure to specify a sum certain will render your claim invalid and may result in forfeiture of your rights.

## PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. **Authority:** The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

- B. **Principal Purpose:** The information requested is to be used in evaluating claims.
- C. **Routine Use:** See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.
- D. **Effect of Failure to Respond:** Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid."

## PAPERWORK REDUCTION ACT NOTICE

This notice is solely for the purpose of the Paperwork Reduction Act, 44 U.S.C. 3501. Public reporting burden for this collection of information is estimated to average 6 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Director, Torts Branch, Attention: Paperwork Reduction Staff, Civil Division, U.S. Department of Justice, Washington, DC 20530 or to the Office of Management and Budget. Do not mail completed form(s) to these addresses.

**CLAIM FOR DAMAGE,  
INJURY, OR DEATH****INSTRUCTIONS:** Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.FORM APPROVED  
OMB NO. 1105-0008

1. Submit to Appropriate Federal Agency:

HQ, EUSA, Office of the SJA  
ATTN: Military Tort Claims  
Unit 15237  
APO AP 96205-5237

2. Name, address of claimant, and claimant's personal representative if any. (See instructions on reverse). Number, Street, City, State and Zip code.

3. TYPE OF EMPLOYMENT

 MILITARY  CIVILIAN

4. DATE OF BIRTH

5. MARITAL STATUS

6. DATE AND DAY OF ACCIDENT

7. TIME (A.M. OR P.M.)

8. BASIS OF CLAIM (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary).

9. **PROPERTY DAMAGE**

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF THE DAMAGE AND THE LOCATION OF WHERE THE PROPERTY MAY BE INSPECTED.  
(See instructions on reverse side).10. **PERSONAL INJURY/WRONGFUL DEATH**

STATE THE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE THE NAME OF THE INJURED PERSON OR DECEDENT.

11. **WITNESSES**

NAME

ADDRESS (Number, Street, City, State, and Zip Code)

12. (See instructions on reverse).

**AMOUNT OF CLAIM** (in dollars)

12a. PROPERTY DAMAGE

12b. PERSONAL INJURY

12c. WRONGFUL DEATH

12d. TOTAL (Failure to specify may cause forfeiture of your rights).

\$

\$

\$

\$

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side).

13b. PHONE NUMBER OF PERSON SIGNING FORM

14. DATE OF SIGNATURE

**CIVIL PENALTY FOR PRESENTING  
FRAUDULENT CLAIM**

The claimant is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729).

**CRIMINAL PENALTY FOR PRESENTING FRAUDULENT  
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Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

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In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of the vehicle or property.

15. Do you carry accident insurance?  Yes If yes, give name and address of insurance company (Number, Street, City, State, and Zip Code) and policy number.  No

16. Have you filed a claim with your insurance carrier in this instance, and if so, is it full coverage or deductible?  Yes  No 17. If deductible, state amount.

18. If a claim has been filed with your carrier, what action has your insurer taken or proposed to take with reference to your claim? (It is necessary that you ascertain these facts).

19. Do you carry public liability and property damage insurance?  Yes If yes, give name and address of insurance carrier (Number, Street, City, State, and Zip Code).  No

**INSTRUCTIONS**

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**Complete all items - Insert the word NONE where applicable.**

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**Failure to completely execute this form or to supply the requested material within two years from the date the claim accrued may render your claim invalid. A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.**

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- (c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.
- (d) **Failure to specify a sum certain will render your claim invalid and may result in forfeiture of your rights.**

The claim may be filled by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with the claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

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**Release for Use of Medical Records under HIPAA  
Use of Medical Records**

As evidenced by my signature below, I, \_\_\_\_\_, (name of patient, natural or legal guardian or estate representative) have read the attached explanation of my privacy rights under the Health Insurance Portability and Accountability Act (HIPAA). I hereby grant authority to the United States Army claims representatives to obtain, copy and release for review, protected information (PHI), including medical and dental records, whether civilian or military, for the purpose of evaluating a claim I have filed against the United States.

I understand that PHI in the possession of the Army claims representative may be copied and disclosed to other agencies, civilian entities, experts, or consultants for purpose of investigating and evaluating the claim.

A photostatic copy of this document shall be valid as the original. This authorization will remain in effect until such time that a final resolution of the administrative claim for compensation has been determined.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Patient's Social Security Number

\_\_\_\_\_  
Signature of Patient  
(If Signed by a Legal Representative,  
List Relationship to Patient)

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Date Signed

**Provided Medical Records of \_\_\_\_\_**  
**Claim Number \_\_\_\_\_**

1. Military Records:

Dates of Treatment    Name of Military Treatment Facility

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

2. Radiology films (MRI/CT Scans, slides or electronic images):

Dates of Treatment    Name of Military Treatment Facility

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. Civilian Records:

Dates of Treatment    Civilian Records

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. Radiology films (MRI/CT Scans, slides or electronic images):

Date of Treatment    Name of Treatment Facility

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## Explanation of Privacy Rights under HIPAA Effective April 14, 2003

1. **Disclosure Notice:** Protected Health information (PHI) about you may be used and disclosed to investigate and evaluate your claim. You have the right to approve or refuse the release of your PHI, except when the release is required or authorized by law or regulation. Failure to approve this use could result in denial of the claim based on the Army's inability to investigate or determine liability. Any suit filed subsequently to the denial or expiration of six months from date of filing of the claim may be contested on the basis that no administrative claim has been filed, which is a jurisdictional prerequisite to filing a suit.

2. **Medical Records:** PHI includes, but is not limited to, inpatient records, out-patient records, office notes, history and physical examination notes, consultation notes, admission and discharge summaries, order and progress notes, laboratory results, nurse notes, emergency room records, operative records, imaging films and study results (including x-ray, CT, MRI, and PET studies) medical bills, health insurance bills, Medicaid, Medicare, Tricare, Department of Veteran Affairs and civilian records, concerning any medical treatment that the patient received, as well as all such records kept in the regular course of business and are contained in the medical records file, to include records regarding mental health, psychiatric, chemical dependency, or HIV.

3. **General Rule: No Use or Disclosure:** The Army claims representatives must not use or disclose protected health information (PHI), except as HIPAA privacy policies and procedures permit or require.

4. **Acknowledgements and Optional Consent:** Army claims representatives will obtain a written acknowledgement of receipt of our **Notice of Privacy Policy and Procedures** from other Government agencies, civilian entities, experts, or consultants before we disclose your PHI for the purpose of investigating and evaluating your claim against the United States. Any disclosure carries the potential for unauthorized disclosure. However, the following procedures will be followed to preclude such disclosure.

5. **Release to Experts and Consultants:** Army claims representatives will use or disclose PHI to other governmental or civilian experts or consultants in accordance with HIPAA privacy, policies and procedures. As an example, we may release your records to a consultant for review of your medical care, or a health care provider should you undergo an independent medical examination.

6. **Verification of Identity:** Army claims representatives will always verify the identity of a person, unknown to us, who request PHI before disclosure of PHI to that person and obtain satisfactory assurances in the form of a written contract that our consultants and experts will appropriately safeguard and limit their use and disclosure of PHI we disclose to them. The contracts utilized contain the terms that federal law requires to be included in each contract.

**7. Required Disclosures:** Army claims representatives will disclose PHI to you and your attorney, if appropriate, to the extent you have a right to access of the PHI.

**8. Disclosure Limited to Minimum Necessary:** Army claims representatives will make reasonable efforts, or request of another covered entity, to disclose only the minimum necessary PHI to accomplish the intended purpose.

**9. Right to an Accounting of Disclosures.** You may request that we provide you with an accounting of the disclosures we have made of your PHI for the purposes other than those described in this notice of Privacy Practices. The disclosure must have been made after April 14, 2003, and no more than six years from the date of request.

**10. Federal Privacy Laws:** This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accounting Act (HIPAA). There are several other privacy laws that also apply including the Freedom of Information Act, the Privacy Act and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act.

**11. Complaints:** If you believe these privacy rights have been violated, you may file a written complaint with the U.S. Army Claims Service, 4411 Llewellyn Ave., Fort George G. Meade, Maryland 20755-5360, or the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

**12. Right to Revoke:** The authorization may be revoked provided a written signed notice is filed with the U.S. Army claims office processing the claim.

**MANUAL CEFT INPUT INFORMATION**

Payee Name \_\_\_\_\_

SSN \_\_\_\_\_ EIN \_\_\_\_\_

Corporate Status Code (see attached list) \_\_\_\_\_ 2J \_\_\_\_\_

Payee MAILING Address \_\_\_\_\_

Payee Phone: \_\_\_\_\_

Payee Email Address \_\_\_\_\_

EFT Format: CTX

**FINANCIAL INSTITUTION INFORMATION**

ACH Bank Name \_\_\_\_\_

ACH Bank Address \_\_\_\_\_

\_\_\_\_\_

ACH Bank Telephone Number \_\_\_\_\_

ACH Nine-Digit Routing Transit Number \_\_\_\_\_

Depositor Account Number \_\_\_\_\_

Type of Account (checking or savings) \_\_\_\_\_

Account Holder's Name \_\_\_\_\_

Account Holder's Signature \_\_\_\_\_

**NOTE: Failure to annotate legibly, or provide all required information, will delay processing of your claim payment.**



**MPS**

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**HQ, 8th Army  
Office of the Staff Judge Advocate  
ATTN: Chief, Military Claims  
Unit #15237  
APO AP 96205-5237**