MEDICAL CARE - THIRD PARTY LIABILITY NOTIFICATION

For use of this form, see AR 40-400; the proponent agency is the OTSG

1. IMPRINT OR TYPE PATIENT DATA *(Same as items 2 thru 28, DA Forms 3647, 3647-1 or its equivalent)*

2. HOME ADDRESS *(Include ZIP code)* AND TELEPHONE NUMBER *(Non-military patients)*

ITEMS MAY BE CONTINUED ON REVERSE (Identify by item number)

3. RECOVERY JUDGE ADVOCATE	4. NAME AND ADDRESS OF FACILITY SUBMITTING NOTIFICATION

5. TYPE OF NOTIFICATION

☐ TRANSFER ☐ REQUESTED BY THE RJA SF 502 SUBMITTED TO THE RJA ☐ YES ☐ NO

6. DISPOSITION OR STATUS OF PATIENT	7. FEDERAL AGENCY SPONSORING PATIENT

8. DIAGNOSIS(ES)

9. CAUSE OF INJURY *(How, when, and where)*

10. PROGNOSIS *(Include probable length of hospitalization and number of expected outpatient visits)*

COMPUTATION OF CHARGES

11. MILITARY HOSPITAL CARE

TOTAL DAYS *a*	DAYS ABSENT *b*	NET DAYS *c*	RATE *d*	TOTAL *e*	PAID *f*	BALANCE *g*

12. MILITARY OUTPATIENT CARE

VISITS *a*	RATE *b*	TOTAL *c*	PAID *d*	BALANCE *e*

13. CIVILIAN SOURCE CARE

TYPE CARE *a*	NAME AND ADDRESS OF CIVILIAN SOURCE *b*	DATE *c*	CHARGE *d*

14. GRAND TOTAL *(11g + 12e + 13d)*

DATE	TYPED NAME AND GRADE OF PATIENT ADMINISTRATOR	SIGNATURE