TRANSFER DOCUMENTATION
MHS ELIGIBLE / NON-ACTIVE DUTY SERVICE MEMBER (NON-ADSM)
MEDICAL TREATMENT FACILITY

1. NON-ADSM NAME	2. NON-ADSM SSN

3. MHS ELIGIBLE NEEDS TRANSFER TO

4. CASE MANAGEMENT REFERRAL ENTERED? ☐ YES ☐ NO	5. ACCEPTED INTO CASE MANAGEMENT? ☐ YES ☐ NO
6. IF NO CASE MANAGEMENT REFERRAL, REFERRAL TO OTHER RESOURCE? ☐ YES ☐ NO	7. OTHER RESOURCE REFERRED TO *(If 6 is Yes)*
8. IS ACTIVE DUTY FAMILY MEMBER ENROLLED IN EFMP? ☐ YES ☐ NO	9. SELF REFERRAL ENCOURAGED? *(If 8 is No)* ☐ YES ☐ NO
10. CHCS / DEERs ELIGIBILITY VERIFIED? ☐ YES ☐ NO	
11. STATE OF RESIDENCE	12. SPONSOR'S DUTY STATION

13. FAMILY INVOLVEMENT / SUPPORT? ☐ YES ☐ NO		
13a. NAME	13b. E-MAIL ADDRESS	13c. TELEPHONE NO.
14. FAMILY CONTACT MADE ☐ YES ☐ NO		
14a. NAME	14b. E-MAIL ADDRESS	14c. TELEPHONE NO.
15. DIAGNOSIS / SPECIALTY NEEDS	16. AUTHORIZATION FOR RELEASE OF INFORMATION OBTAINED? ☐ YES ☐ NO	

17. FACILITY TRANSFERRED TO LOCATION			
17a. NAME	17b. TYPE *(MTF / VAMC / CIVILIAN)*	17c. TELEPHONE NO.	
17d. ADDRESS	17e. CITY	17f. STATE	
17g. CIVILIAN / TRICARE CERTIFIED? ☐ YES ☐ NO	17h. ALTERNATE LEVEL OF CARE		
17i. OTHER			

18. TRICARE REGION LOCATION		
18a. TRICARE REGION		18b. TELEPHONE NO.
18c. ADDRESS	18d. CITY	18e. STATE
19a. PROVIDER TO PROVIDER CONTACT ☐ YES ☐ NO WHY NOT _____	19b. DATE OF CONTACT	

20. TRANSFERRING PROVIDER		
21a. NAME	21b. E-MAIL ADDRESS	21c. TELEPHONE NO.
22. RECEIVING / ACCEPTING PROVIDER		
22a. NAME	22b. E-MAIL ADDRESS	22c. TELEPHONE NO.
23. DATE OF ACCEPTANCE	24. CM VERIFIED FACILITY NOTIFICATION / ACCEPTANCE ☐ YES ☐ NO	

25. PAYOR / AUTHORIZATION

25a. TRANSFER PREAUTHORIZED	25b. PORTABILITY-RECEIVING REGION
25c. SUPPLEMENTAL HEALTH CARE FUNDING	25d. TRICARE REGION STATUS
26. TRANSPORTATION COORDINATED? ☐ YES ☐ NO ☐ N / A	

27. FINAL TRANSFER ARRANGEMENT COMMUNICATED WITH

27a. DISCHARGING MTF?	27b. RECEIVING SITE?	27c. RECEIVING REGION MCSC?
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

28a. CONTINUE TO CASE MANAGEMENT UNTIL PORTABILITY / REASSIGNED TO ANOTHER REGION?

☐ YES ☐ NO

28b. IF NO, STATE REASON

29a. CASE TRANSITION / CLOSE?

☐ YES ☐ NO

29b. IF YES, STATE REASON

30. CASE REFERRED TO	31. REFERRAL DATE
☐ MTF ☐ DoD ☐ VAMC ☐ FEDERAL ☐ STATE ☐ COMMUNITY RESOURCES	

32. REFERRAL COMMENTS

33. OTHER COMMENTS

34. PERSON COMPLETING FORM

34a. NAME (Printed)	34b. E-MAIL ADDRESS	34c. TELEPHONE NO.
34d. SIGNATURE		34e. DATE