MEDICAL PROVIDER FORM		
MEMORANDUM FOR MEDICAL PROVIDER: Your patient is a military member under the Department of the Air Force using federal funds for healthcare. As such, we ask that you type the requested information in sections 2-8 of this form regarding your patient's injury/illness and/or disease, and send this completed form via fax or email to Military Medical Fax/Email (box 1c.). Please complete a separate form for every injury/illness and/or disease your patient reported incurring or aggravating, if applicable. If there is additional relevant documentation available and your patient has signed a release of information, please fax or email the documentation along with this completed form to Military Medical Fax/Email (box 1c.). **MEMORANDUM FOR MEMBER:** Type your information in Member Information (boxes 1a-1c) and upload this form to your provider's online patient portal if possible, or fax or email this form to your provider. For Military Medical Fax/Email (box 1c), type the fax or email of your Reserve/Guard Medical Unit, Primary Care Manager or designated credentialed provider at your Military Medical Treatment Facility.		
Member Information		**(Completed by Member)**
1a. Patient Name:	1b. Military Unit Designation:	1c. Military Medical Fax/Email
Condition Information		**(Completed by Member's Medical Provider)**
2. Condition Type (X one only): ☐ Injury ☐ Illness ☐ Disease		
3. ICD 10 Code:		
4. Diagnosis:		
5. Is this the first time the condition has been diagnosed? Yes ☐ No ☐ If you answered 'No,' is there medical documentation that indicates when the condition was first incurred?		
6. If the injury, illness, or disease is a pre-existing condition, is it your medical opinion that a trauma or the nature of the military service has worsened the condition beyond its natural progression? Yes ☐ No ☐ Explain your response.		
7. Brief statement of member's injury/illness/disease and treatment plan if known:		
8a. PROVIDER NAME	8b. PROVIDER SIGNATURE	8c. DATE
8d. PROVIDER OFFICE ADDRESS	8e. PROVIDER PHONE NUMBER	8f. PROVIDER FAX NUMBER