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Health Services

PATIENT ADMINISTRATION FUNCTIONS

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This instruction implements AFD 41-2, *Medical Support*. It provides requirements and outlines, activities, policies, and procedures for patient administration. It describes how to manage patient administration functions, including protecting medical information, managing health records, preparing and disposition of medical documentation and managing administration activities supporting patients. Organizational alignment of these functions may vary between medical treatment facilities. This instruction directs collecting and maintaining information subject to the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. This instruction applies to all Air Force medical units and Air Reserve components where functions are performed. System of records notice F044 AF SG E, Medical Record System, applies.

SUMMARY OF REVISIONS

This document is substantially revised and must be completely reviewed.

This instructions format has been completely changed. **Chapter 1 - Chapter 6** have been rearranged and Attachment 2 - Attachment 13 have been deleted and incorporated into new chapters. Entire AFI has been revised into 10 Chapters and 1 Attachment. The following new guidance has been added: Patient Administration Functional Area Responsibilities (**Chapter 1**); Patient Administration Officer/Director/NCO requirements (paragraph **1.3.**); Health Insurance Portability and Accountability Act Privacy Officer requirements (paragraph **1.4.**); Patient Administration Toolkit (paragraph **1.6.**); DoD Policy for Clinical Use of Electronic Mail in Provider to Patient Communications (paragraph **2.7.**); Establishing Eligibility for Care (paragraph **3.1.**); Medical In/Out-Processing requirements (paragraph **3.2.**); Patient Registration (paragraph **3.3.**); Standardized Appointing (paragraph **3.4.**), Referral Management (paragraph **3.5.**); Secretarial Designee program (paragraph **3.10.**); Special Needs Identification and Assignment Coordination (SNIAC) Process (paragraph **3.11.**); The Tumor Registry Program (paragraph **3.12.**); Medical Evaluation Boards and Continued Military Service (**Chapter 10**), which will rescind AFI 44-157, *Medical Evalua-*

tion Boards (MEB) and Continued Military Service. Significant changes have been made to Legal Aspects of Health Records and Release of Information (Chapter 2); Overall Health Records Management (Chapter 4); Inpatient Records Administration (Chapter 5); Outpatient Records Administration (Chapter 6); Admissions and Dispositions (Chapter 7); Birth Registration (Chapter 8); Casualty Reporting and Procedures Relating to Deceased Patients (Chapter 9). The Managing Biometric Data chapter has been deleted and will be placed in a future AFI created by the Population Health Support Division.

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Chapter 1

FUNCTIONAL AREA RESPONSIBILITIES

1.1. General Information. Personnel accomplishing patient administration activities whether assigned to the patient administration element or in a clinical setting must be aware of the contents of this instruction. This is to ensure that they have an understanding of what happens to the patient administratively throughout the health care continuum.

1.2. Patient Administration Overview.

1.2.1. The following activities are a function of patient administration: Admission and Dispositions, Inpatient Records Management, Medical Evaluation Boards administration, Outpatient Records Management, Release of Information, Line of Duty Determinations (LOD), Casualty Reporting, Aero-medical Evacuation (AE) duties, Secretary of the Air Force Designee program, Birth Registration, Death Processing, Family Member Relocation Clearance program, Referral Management, Medical In/Out-Processing, Organ Donor Program, Tumor Registry Program, Health Insurance Portability and Accountability Act (HIPAA) Privacy Compliance, Eligibility Verification, Sensitive Duties Program and Patient Registration .

1.2.2. Patient administration performs the following tasks.

1.2.2.1. Ensures that adequate health records are created and maintained.

1.2.2.1.1. Manages/provides oversight of outpatient records.

1.2.2.1.2. Manages/provides oversight of inpatient records.

1.2.2.1.3. In cooperation with the Military Personnel Flight (MPF), develops procedures for transfer of outpatient records of personnel who have a permanent change of station, separation and/or retirement.

1.2.2.1.4. Receives, reviews, and processes health records and refers incomplete or inadequate records to the responsible provider of care or department chiefs for completion.

1.2.2.1.5. Reviews records of inpatients received by transfer and obtains any missing records.

1.2.2.1.6. Performs duties associated with the medical records review function.

1.2.2.2. Supervises the administrative functions of admission and disposition of patients.

1.2.2.2.1. Assigns patients to inpatient units.

1.2.2.2.2. Arranges for receiving and safeguarding patient valuables, baggage, and clothing when required.

1.2.2.2.3. Initiates preparation of individual inpatient and related administrative records.

1.2.2.3. Advises MPF of service member hospitalization when appropriate, (i.e. assignment to patient squadron).

1.2.2.4. Ensures the proper reporting and recording of births and deaths to the local department of vital statistics.

- 1.2.2.5. Performs patient movement requests and coordinates Aeromedical Evacuation of patients.
- 1.2.2.6. Coordinates healthcare management of personnel participating in the sensitive duties program as outlined in AFI 36-2104, *Nuclear Weapons Personnel Reliability Program*.
- 1.2.2.7. Provides administrative support for Medical Evaluation Boards (MEB), Physical Evaluation Boards (PEB) and for examination of members on the Temporary Disability Retired List (TDRL).
- 1.2.2.8. Provides administrative support for the Family Member Relocation Clearance (FMRC) process and Special Needs Identification and Assignment Coordination (SNIAC) process.
- 1.2.2.9. Runs the tumor registry when histopathology is not authorized in the Military Treatment Facility (MTF), or ensures another MTF assumes this responsibility. When another MTF assumes this responsibility, provides interface and support as required.
- 1.2.2.10. Provides administrative support for Line of Duty (LOD) determinations.
- 1.2.2.11. Provides administrative support to inpatient units through ward clerks when authorized.
- 1.2.2.12. Provides administrative support for the referral management program.
- 1.2.2.13. Performs casualty reporting and procedures relating to death notifications.
- 1.2.2.14. Manages the release of information program and safeguarding protected health information.

1.3. Patient Administration Officer/Director/Noncommissioned Officer (NCO).

1.3.1. Appointed by MTF Commander:

- 1.3.1.1. The MTF Commander will appoint a Patient Administration Officer, Director, or NCO, depending on the size of the MTF, to manage the oversight of all patient administration functions performed throughout the MTF.
- 1.3.1.2. Since patient administration functions are accomplished across squadrons in the MTF this individual will be the single authority on behalf of the MTF Commander to enforce the policies outlined in this AFI.

1.3.2. Responsibilities:

- 1.3.2.1. Patient Administration Officer/Director/NCO will manage functions listed in paragraph **1.2.** when they are aligned within the Patient Administration Flight/Element.
- 1.3.2.2. For those functions that are not aligned within a Patient Administration Flight/Element, (i.e., PCM Team), they will provide oversight only and will be the MTF point of contact for the policy written in this AFI.

1.4. Health Insurance Portability and Accountability Act (HIPAA) Privacy Officer.

- 1.4.1. The HIPAA Privacy rule requires each covered entity, i.e. medical and dental treatment facilities, to appoint a Privacy Officer (PO). The PO oversees all ongoing activities related to the development, implementation, and maintenance of MTF policies and procedures covering the access to and privacy of patient health information. The PO ensures adherence to the Military Health System

(MHS) policies and procedures covering these same areas. The PO also ensures MTF compliance with federal and state laws and the healthcare organization's information privacy practices, and leads initiative to strengthen patient information privacy protections. The PO seeks to address privacy issues by balancing patient needs and the organization's requirements when making decisions related to patient health information. Many activities required by HIPAA privacy overlap with patient administration duties, therefore, it would be appropriate to appoint the Patient Administration Officer/Director/NCO as the HIPAA PO.

1.4.2. HIPAA Privacy Officer Responsibilities.

1.4.2.1. Policy Implementation, Oversight, Auditing and Compliance.

1.4.2.1.1. Develop policy and procedures for local implementation of the DoD HIPAA Privacy regulation requirements after consultation with the local legal office.

1.4.2.1.2. Maintain current knowledge of applicable federal, DoD and state privacy laws, accreditation standards, and DoD and Service regulations. Monitor advancements of emerging privacy technologies to ensure that the MTF is positioned to adapt and comply with these advancements.

1.4.2.1.3. Establish and recognize best practices relative to the management of the privacy of health information.

1.4.2.1.4. Serve as a liaison to the MTF Medical Information Security Readiness Team (MISRT).

1.4.2.1.5. Perform initial and periodic information privacy risk assessment and conduct related ongoing compliance monitoring activities in coordination with applicable Service directives and the TMA HIPAA Office. Report findings as required.

1.4.2.1.6. Ensure a mechanism is in place with the MTF for receiving, documenting, tracking, investigating, and taking action on all complaints concerning the organization's privacy policies and procedures in coordination and collaboration with other similar functions and when necessary, legal counsel.

1.4.2.1.7. Establish a mechanism which tracks access to protected health information, within the purview of organizational policy and as required by law, and allows qualified individuals to review or receive a report on such activity.

1.4.2.2. Education, Training and Communication.

1.4.2.2.1. Oversee, direct, and ensure delivery of initial privacy training and orientation to all employees, and volunteers within 30 days of assignment to the MTF. Record results in compliance with MTF training documentation policies. Ensure annual refresher training is conducted in order to maintain workforce awareness and to introduce any changes to privacy policies.

1.4.2.2.2. Initiate, facilitate and promote activities to foster information privacy awareness within the organization and related entities.

1.4.2.2.3. Serve as the advocate for the patient, relative to the confidentiality and privacy of health information.

1.4.2.3. MTF Integration Activities.

1.4.2.3.1. Understand the content of health information in its clinical, research, and business context.

1.4.2.3.2. Understand the decision-making processes throughout the MTF that rely on health information. Identify and monitor the flow of information within the MTF and throughout the local healthcare network.

1.4.2.3.3. Serve as privacy liaison for users of clinical and administrative systems.

1.4.2.3.4. Review all system-related information security plans throughout the MTF network to ensure alignment between security and privacy practices, and act as a liaison to the information systems department.

1.4.2.3.5. Collaborate with other healthcare professionals to ensure appropriate security measures are in place to safeguard protected health information.

1.5. Registered Health Information Administrator (RHIA), Registered Health Information Technician (RHIT), or Air Force member with equivalent education and experience.

1.5.1. The RHIA or RHIT is credentialed by the American Health Information Management Association and is a civilian rated eligible by the Office of Personnel Management Qualification Standard for the GS 669 series.

1.5.2. Responsibilities:

1.5.2.1. Management of the inpatient records department, coding of inpatient records, Ambulatory Procedure Visits (APVs), medical transcription, and provision of oversight regarding outpatient record documentation and coding.

1.5.2.2. The RHIA or RHIT works closely with the Information System Security Office (ISSO) and Privacy Officer to ensure security of and controlled access to both the paper-based and automated medical records, and to ensure release of information procedures conform to all legal requirements.

1.6. Patient Administration Toolkit.

1.6.1. To assist with the management of patient administration functions personnel should routinely access the patient administration website for information resources and the latest changes. The website address is <https://kx.afms.mil/patientadmin>. Once there, users will need to register to access certain secure pages on the patient administration homepage.

1.6.2. In addition, managers should be familiar with the following Air Force/DoD Instructions and handbooks relating to patient administration.

1.6.2.1. AFI 33-332, Air Force Privacy Act Program.

1.6.2.2. AFI 34-242, Mortuary Affairs Program.

1.6.2.3. AFI 36-2104, Nuclear Weapons Personnel Reliability Program.

1.6.2.4. AFI 36-2910, Line of Duty (Misconduct) Determinations.

1.6.2.5. AFI 36-3002, Casualty Services.

1.6.2.6. AFI 37-138, Records Disposition - Procedures and Responsibilities

- 1.6.2.7. AFM 37-139, Records Disposition Schedule
- 1.6.2.8. AFI 40-301, Family Advocacy.
- 1.6.2.9. AFI 41-101, Obtaining Alternative Medical and Dental Care.
- 1.6.2.10. AFH 41-114, Military Health Services System Matrix.
- 1.6.2.11. AFI 41-115, Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS).
- 1.6.2.12. AFI 41-301, Worldwide Aeromedical Evacuation System.
- 1.6.2.13. AFI 41-302, Aeromedical Evacuation Operations and Management.
- 1.6.2.14. AFJI 41-315, Patient Regulating to and within the Continental United States.
- 1.6.2.15. AFI 44-102, Community Health Management.
- 1.6.2.16. AF Pamphlet 44-155, Implementing Put Prevention Into Practice
- 1.6.2.17. AFI 48-123, Medical Examinations and Standards.
- 1.6.2.18. DoD 6025.18-R, DoD HIPAA Privacy Regulation.
- 1.6.2.19. DoDI 6040.40, Military Health System Data Quality Management Control Procedures
- 1.6.2.20. Physical Evaluation Board Liaison Officer (PEBLO) Guide.
- 1.6.2.21. 4A0X1 Career Field Education and Training Plan.

Chapter 2

LEGAL ASPECTS OF HEALTH RECORDS AND RELEASE OF INFORMATION

2.1. Safeguarding Medical Information.

2.1.1. Information in the health record is personal to the individual and will be properly safeguarded. Take necessary precautions to avoid compromise of medical information during the movement of the record within and outside the MTF and from the facility to any person authorized to receive them. Only medical personnel are authorized access to the information except as noted throughout this chapter. Health records are only released or disclosed to a third party at the written request of patients or their legal representatives, or as specified in this chapter.

2.1.2. Limit access to all open record storage areas and to electronic records, to authorized personnel only. Authorized personnel are defined as personnel who, through a verification process, have presented a valid requirement to access said records. Personnel granted access must be fully aware of the requirements in this AFI on safeguarding Protected Health Information (PHI) maintained in the MTF.

2.1.3. Establish procedures to ensure highly sensitive records and sensitive medical information are safeguarded. This includes copying electronic records for inclusion into the hard-copy record, safeguarding x-rays and fetal monitoring strips. Drug and alcohol abuse, rape, child or adult abuse and possible claims against the government are examples of highly sensitive records. See paragraphs [2.3.6.3.](#) and [2.5.2.](#) for guidance on litigation cases. Information which may affect the patient's morale, character, medical progress or mental health is considered sensitive. To protect the sensitive nature of the information, ensure that sensitive records or documents are only handled directly by medical personnel when advised by the attending physician or MTF Commander.

2.1.4. The MTF may sequester the original medical record or a certified copy when the situation warrants. A notice should be placed on the original record to ensure personnel do not allow the patient to hand carry the record while there is an active claim. If a certified copy is made for sequestering, return the original record to the file room and suspense it for periodic updates.

2.1.4.1. Records will be sequestered under the following conditions:

2.1.4.1.1. When a claim has actually been filed.

2.1.4.1.2. When the patient has tried to tamper, alter, or illegally remove a record from the facility.

2.1.4.1.3. When a request is received from an attorney under circumstances indicating a claim is being considered.

2.1.4.1.4. When an Inspector General (IG) or Congressional Inquiry or Investigation has been initiated.

2.1.4.1.5. When the record becomes relevant to an Office of Special Investigation (OSI) or Security Forces investigation. Annotate sequestered record form with the OSI/Security Forces agents name and case number for annual review process.

2.1.4.2. See AFI 44-119, *Medical Clinical Performance Improvement* for more guidance.

2.1.4.3. It is the MTF Commander's responsibility (with advice from the Quality Services Manager and the Staff Judge Advocate [SJA]) to establish local Operating Instructions on how to

sequester medical records for safekeeping. As a minimum, the records will be kept in a separate, locked location with limited access. If the patient is actively being seen at the MTF, copy the original record for the outpatient records room and annotate on the jacket "Clinic Copy". Create the "Clinic Copy" in CHCS as a unique record type for tracking purposes in the Medical Records Tracking (MRT) module.

2.1.4.4. Place a cover sheet on the original medical record stating the record has been sequestered. Maintain a separate file on why the record has been sequestered, and the date (or occurrence of an event) when the record should be reviewed to determine the need for continued sequestering. Place a charge out in appropriate records room with statement that the record has been sequestered. If a "Clinic Copy" is made, ensure that original documentation is forwarded to the sequestered file and a copy is placed in the "Clinic Copy".

2.1.4.5. Coordinate an annual review of sequestered records with the base claims officer to determine whether the records should continue to be sequestered. In addition, ensure that records are reviewed prior to patient relocation to see if sequestering is still applicable. If sequestering is still required, mail the outpatient records to the gaining MTF. The losing MTF will make a certified true copy of the record before mailing for cases identified in paragraph 2.1.4.1., except for 2.1.4.1.2. Maintain the copy until the claim is resolved with the base claims officer.

2.2. Laws Affecting Disclosure of Medical Information.

2.2.1. Medical personnel must comply with the Privacy Act, Freedom of Information Act, Health Insurance Portability and Accountability Act, Drug Abuse Offense and Treatment Act, and Comprehensive Alcohol Abuse amendments. Each of these laws must be complied with regarding maintenance, access and disclosure of information from health records and related documentation. The Privacy Officer must periodically contact the Staff Judge Advocate's office for changes to directives.

2.2.2. Privacy Act of 1974. (PL 93-579 and 5 U.S.C. 552a)

2.2.2.1. Medical records are maintained within a system of records protected by the Privacy Act. Electronic and hard copy records are covered by the system notice "Medical Record System" (F044 AF SG E), which identifies the records, including secondary files, as inpatient and outpatient records of care received in Air Force medical facilities. Automated records of treatment received and medical/dental test performed on an inpatient/outpatient basis in military medical treatment facilities and of military members treated in civilian facilities are covered by "Automated Medical/Dental Record System (F044 AF SG D). Disclosure to third parties is prohibited, except pursuant to the written consent of the individual to whom the record pertains or in specified limited circumstances as outlined in the Privacy Act (as implemented by AFI 33-332), and the HIPAA.

2.2.2.2. Refer to AFI 33-332, for guidance on the collection, safeguarding, use, maintenance, access, amendment, disclosure of information, and fees for copying records. This AFI explains policy on access, disclosure, time periods, denial authority, judicial sanctions, and accountability of disclosure.

2.2.2.3. DD Form 2005, **Privacy Act Statement - Health Care Records**, eliminates the need for a separate Privacy Act (PA) statement for each medical, dental or related document requiring individual identifying information. The DD Form 2005 is not a consent form. It serves as evidence that, as prescribed by the PA, the individual was informed of the purpose and uses of the informa-

tion collected and was advised of his/her rights and obligations with respect to supplying the data. The patient's signature is not mandatory. When the PA statement is printed on the reverse of AF Form 560, **Authorization and Treatment Statement**, or on the record folder, do not use the DD Form 2005. The patient does not need to sign the DD Form 2005 even though there is a space for signature.

2.2.3. HIPAA (Public Law 104-191, 45 CFR, parts 160 and 164). The Health Insurance Portability and Accountability Act, Public Law 104-91, was enacted August 21, 1996. The purpose of the Act is to improve the portability and continuity of health insurance coverage, improve access to long term care services and coverage, and to simplify the administration of healthcare. A primary component of HIPAA administrative simplification provisions is the protection and privacy of individually identifiable health information. The HIPAA Privacy Rule governs this component and DoD 6025.18-R, implements the requirements of the HIPAA Privacy Rule throughout the MHS.

2.2.3.1. Use of information. Patient's Protected Health Information can only be used for treatment, payment and health care operations without written authorization from the patient or other disclosures required by law.

2.2.3.2. Acknowledgement of Notice of Privacy Practices. Each patient or guardian will receive a copy of the MHS Notice of Privacy Practices. Documentation must be entered on the HIPAA acknowledgement label that is placed on the bottom middle exterior of the health records jacket.

2.2.3.3. Disclosure or release. For example, records can be disclosed for various reasons without authorization by the patient. Complying with subpoena, court order, or public health requirement as well as specific national security requirements are among the allowed disclosures. See DoD 6025.18-R, for additional guidance.

2.2.3.4. Patient rights to access. Patients have the right to access their health record information. The health record is the property of the United States Government; the information contained in the record belongs to the patient. Patients can request copies of information in their record just as allowed in the Privacy Act.

2.2.3.5. Accounting of disclosure. The patient can request an accounting of every disclosure for the previous 6-year period back to 14 April 2003. This is limited to disclosures that are not part of treatment, payment, health care operations or disclosures authorized by the patient. Authorized disclosures must be tracked using a locally generated form, see [Figure 2.1.](#), until DoD implements the use of an automated accounting of disclosure tracking system.

2.2.4. Substance Abuse Records.

2.2.4.1. *Public Health Service Act*, 42 U.S.C. 290dd-2.

2.2.4.2. Regulations implementing the above statutes are set out in 42 Code of Federal Regulations (CFR), part 2.

2.2.4.3. Drug and Alcohol Abuse Laws take precedence over other directives pertaining to access to information.

2.2.4.4. The SJA reviews health records relating to drug and alcohol abuse or rehabilitation determining whether they may be released and provides guidance on the nature of the reply to the request for information. If the SJA determines that the record is not releasable under the Drug and Alcohol Abuse Acts, inform the requester that release of the record is prohibited by law. If a por-

tion of the record is not releasable, provide that portion which can be released. Inform the requester that the records being released are all that are allowed for release by law.

2.2.4.5. A general authorization for the release of medical or other information is NOT sufficient for disclosing information from records containing drug or alcohol abuse, treatment or rehabilitation information. To comply with the federal laws, a consent for release of information must include the following:

2.2.4.5.1. Name of facility to release information.

2.2.4.5.2. Name or title of person or organization to receive and use information.

2.2.4.5.3. Name of patient, sponsors SSAN and patient's date of birth.

2.2.4.5.4. Purpose or need for information.

2.2.4.5.5. Extent or nature of information to be released (for example, narrative summary or outpatient notes and time period to be covered).

2.2.4.5.6. Statement that the consent can be revoked at any time except for that information which has already been released and the specification of the date, event, or condition on which the consent will expire, if revoked.

2.2.4.5.7. Consent expiration date.

2.2.4.5.8. Date consent signed.

2.2.4.5.9. Signature of patient or person authorized to sign for the patient.

2.2.4.5.10. Signature of witness when required by State law.

2.2.4.5.11. Statement that future disclosure of the information without written consent of the person is prohibited.

2.2.4.6. Information relating to drug and alcohol abuse or rehabilitation may be disclosed as follows:

2.2.4.6.1. Within the U.S. Uniformed Services or between the Air Force and those components of the Department of Veterans Affairs providing health care to veterans.

2.2.4.6.2. To medical personnel to the extent necessary to meet a medical emergency.

2.2.4.6.3. To qualified persons for scientific research, management and financial audits, or program evaluation.

2.2.4.6.4. By an appropriate order of a court of competent jurisdiction after application showing good cause.

2.2.4.7. When information is released (except as authorized in paragraph [2.2.3.3.](#)), the disclosure must be accompanied by the following statement: "Prohibition on Rediscovery: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations [42 CFR Part 2 and 42 U.S.C. 290dd-2] prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose."

2.2.5. Freedom of Information Act (FOIA), (PL 93-502 and 5 U.S.C. 552). Information is made available to the public unless disclosure is prohibited. Information from health records is not released if such disclosure would result in a clearly unwarranted invasion of privacy. See DoD Regulation 5400.7/AF Supplement, *Freedom of Information Act Program*, for specific guidance and procedures related to FOIA.

2.2.6. Patient Self-Determination Act (PL 101-508, Sections 4206 and 4751). The Patient Self-Determination Act (PSDA) mandates that health care institutions inform patients of their rights, according to state law, to make decisions regarding their medical care. This includes the right to accept or refuse treatment and the right to prepare advance directives. An “advance directive” is defined as a written instruction by the patient, in the form of what is commonly known as “living will” or a durable power of attorney for health care, recognized under State law (some states require both) and related to the provision for such care when the patient is incapacitated.

2.2.6.1. Each MTF will establish and maintain written policies and procedures to implement patient’s rights to make decisions concerning their medical care. Ensure compliance with State law (whether statutory or as recognized by the courts of the State) respecting advance directives.

2.2.6.2. Provide to all adult patients written information on their rights under the host State’s law to make decisions concerning their medical care, including the right to execute an advanced directive and to give providers the policies to implement those rights.

2.2.6.3. Document in the patient’s medical record whether or not the patient has an advance directive. This is documented on the AF Form 560 for inpatient care, either the DD Form 2766 or AF Form 1480A, **Adult Preventive and Chronic Care Flow Sheet**, for outpatient care, and on the automated cover sheet for ambulatory procedure visit (APV) cases. NOTE: The AF Form 1480A has been superseded by the DD Form 2766. Utilize the DD Form for all new records.

2.2.6.4. Provide for education of the staff and community on issues concerning advance directives.

2.2.6.5. Check with your local SJA for further guidelines.

2.2.6.6. Title 10 USC Sec. 1044c. Advance medical directives of members and family members: Includes an important safeguard for military members and their family members entitled to legal assistance. This law creates “military advance medical directives” that are exempt from any requirements of form, substance, formality or recording required by State law. For example, if an Air Force member has a military living will prepared in Florida, but then becomes severely injured in California, the military living will is honored in California even though the document may not conform to California law.

2.3. General Guidelines on Releasing Medical Information.

2.3.1. Information is released from health records according to the requirements of this chapter, applicable laws and other directives such as DOD 6025.18-R. Information released will be limited to the minimum necessary to accomplish the intended task, identify the requester, and support a valid requirement for the information.

2.3.2. If the information or access to health records is to be provided to nonmedical personnel with a proper and legitimate need, the MTF Commander or designee determines the pertinent information to release to a requester and whether professional medical assistance should be provided during the

record review. Only enough information required to meet the need of the request is provided and the requester must submit the record review request in writing.

2.3.3. If there are doubts or questions as to whether the requester has a proper or legitimate need for the information, ask the person to state the purpose in writing for which the medical information is to be used. In appropriate cases, the requester is informed that the information is being withheld until written authorization of the patient or legal representative is furnished.

2.3.4. Original medical documents or records are not released to any person or agency outside the Executive Branch, except in compliance with a valid court order or as otherwise required by law. Always consult the SJA prior to releasing medical information under these circumstances. All disclosures/releases of information authorized by the patient must be documented in the health record.

2.3.5. Health records may contain information from nonmilitary sources. A patient can be referred to a nonmilitary source for diagnosis and or treatment. Documentation from the nonmilitary source which supports the diagnosis and treatment will be filed in the patient's outpatient medical record. Copies of this documentation are releasable to the patient or legal representative.

2.3.6. Obtain written authorization from the patient concerned or his/her legal representative before release of information from the health record to any person or agency, with the exception of those items outlined in paragraph 2.4.3.1. See [Figure 2.2](#). for a sample locally generated authorization form. Use this form until DoD establishes a DD Form to replace it.

2.3.6.1. For deceased persons, the next of kin (NOK) or a court appointed executor or administrator signs written consent and provides proof of death.

2.3.6.2. For unemancipated minors, physically, or mentally challenged persons, a parent or guardian signs written authorization and furnishes a copy of the court order appointing guardianship with the request.

2.3.6.3. If litigation is pending or contemplated, send the request for release to the SJA for advice and appropriate action in accordance with AFI 51-301, *Civil Litigation*. Prepare a locally developed authorization form without assigning a form number. Coordinate the wording with the SJA to ensure conformance with local and state laws.

2.3.7. General rules and individual state laws specify when a power of attorney is required. Refer any questions about power of attorney to the SJA.

2.3.8. File all correspondence regarding the release of information in section 3 of the health record for permanent safekeeping. See paragraph 2.5.2. for special instructions pertaining to release to Department of Defense (DoD) Investigative Agencies.

2.3.9. Fees for copying, certifying and searching health records are listed in paragraph 4.3. AFI 33-332.

2.3.10. Advance payments for information requests from insurance companies and other agencies may be accepted. If the request is for a large volume or requires extensive research, notify the requester of any additional charges.

2.3.10.1. If the payment is incorrect, inform the requesting agency that the information is being provided even though the required fee (specify amount) has not been paid, to avoid possible adverse effect to the patient. Advise the requester to send payment promptly to the medical service account (MSA) office by check or money order payable to the Treasurer of the United States.

2.3.10.2. Send payment to the MSA office with the completed copy of the transmittal letter (see paragraph 2.4.1.) if correct payment is received with the request. If the information cannot be obtained on the day the request is received, complete only the required items and send the form and payment to the MSA office before the ordinary close of business each day.

2.3.11. Records of Newborns Released for Adoption: Take special care releasing information from the records of newborns who have been released for adoption. Delete all references to the child's natural parents. Stamp the inpatient record folders of these newborns, "Release of Information Restricted according to AFI 41-210, **Chapter 2**, paragraph 2.3.11." Do not forward AF Form 560, AF Form 565, **Record of Inpatient Treatment**, SF 502, **Medical Record - Narrative Summary (Clinical Resume)**, or SF 535, **Medical Record - Newborn** included in the outpatient record.

2.3.12. Restrictions on Information: According to HIPAA and the MHS Notice of Privacy Practices, a patient has the right to request restrictions of uses and disclosures of their medical or dental information. However, it does not mandate that the MTF is required to agree to the restriction. The restriction should be denied if the MTF couldn't reasonably accommodate the request, if it conflicts with this instruction or any other applicable DOD or Air Force directive, or for other appropriate reasons. See DOD 6025.18-R paragraph C10.1 for more information.

2.3.12.1. Requests for restrictions must be made in writing, see **Figure 2.3.** for a sample locally generated form. Use this form until DoD establishes a DD Form to replace it. The MTF Commander, or designee, must act on requests to restrict information in a timely manner and do so in writing. No restriction shall be effective above the management authority level that an authorized person agreed to it. No restriction shall be effective unless the person agreeing to the restriction is actually authorized to agree to it and establishes a written record of the restriction.

2.3.12.2. The needs of the patient should be weighted with the burden that would be put on the facility to comply with the request. If granted, the patient should be informed that the restriction is not permanent and only applies to the individual or MTF that grants the request for which it is requested and does not transfer to another individual or MTF.

2.4. Releasing Information to Certain Persons and Agencies.

2.4.1. Insurance Agency, Worker's Compensation and Other Third Parties: Third party authorization forms can be used if they meet the criteria as outlined in DOD 6025.18-R para 5.3 to include the name or organization authorized to make the disclosure (the MTF), the name or organization to whom the MTF is making the disclosure (the third party), the purpose of the disclosure, an expiration date or an expiration event, the signature of the individual, and signature date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual shall also be provided. Otherwise, authorizations are invalid under 6025.18-R. If prepayment has not been received use a locally developed form to identify the fees. Prepare the form in three copies; send the original to the requester, file the second copy in part 3 of the health record with the patient's signed authorization for release of information, and forward the third copy to the Resource Management Office. When answering requests for information on injury cases that appear to involve medical affirmative claims action, send a copy of the form to the SJA.

2.4.1.1. Include this statement in the form: "You are not authorized to release this information to any party without the permission of the patient, his/her legal representative, or this medical facility."

2.4.1.2. Any requests identified as a potential third party liability case must be recorded on an AF Form 1488, **Daily Log of Patients Treated for Injuries**. This includes requests received from an attorney, worker's compensation appeals board, or an insurance company in a case involving work-related injury or disease. Forward these requests to the clinic the patient was seen in to have the AF Form 1488 completed and then have the clinic forward the AF Form 1488 to the Resource Management Office.

2.4.2. Patient or Authorized Representative: Information may be released directly to the patient or authorized representatives of the person concerned upon receipt of a written request from the patient (or legal representative). An abstract of the case (or copies of pertinent pages of the record) may be furnished to the person, or authorized representative when a person departs on a temporary absence from home and requires medical care while away.

2.4.2.1. If a provider determines that direct disclosure to the patient could have an adverse effect on either the physical or mental health, safety, or welfare of the individual, or other persons with whom he/she may have contact, the disclosure will be made to a health care provider named by the individual, or to a person qualified to make psychiatric or mental determinations. See AFI 33-332, paragraph 4.4.2. for additional guidance.

2.4.2.2. Give patients or their designated representatives access to their health records upon written request. The original record is retained at the MTF, but copies will be provided if requested. If access cannot be provided within 15 days after the request, state the reason for the delay and the earliest date when the records will be available.

2.4.2.2.1. Encourage health care providers to discuss with employees the contents of their health records. Health care providers may recommend ways of disclosing health records other than by direct employee access. On occasion, a health care provider may elect to disclose information on specific diagnoses of terminal illness or psychiatric conditions to an employee's designated representative, and not directly to the employee, with the employee's concurrence.

2.4.3. Release to the Public: Always consult the SJA prior to releasing medical information to the public. Only information which does not constitute an invasion of personal privacy is made available to the public, including the news media. If appropriate, notify the next of kin before releasing information to the news media or the public.

2.4.3.1. The following information may be released if the patient does not object: name and rank (if applicable), component occupation or job title, and present medical assessment of condition (i.e., stating condition stable, good, fair, serious, or critical). Office and unit assignment for personnel not assigned to routinely deployable or sensitive units may be released without the patient's consent.

2.4.3.2. The following information CANNOT be released without the patient's specific authorization: marital status (e.g., divorced, single, widowed), base, station or organization of routinely deployable or sensitive units, description of disease or injury, general factual circumstances, and general extent of the injury or disease. Do not specify location or description that may prove embarrassing to the individual or reflect bad taste

2.4.3.3. Do not release information listed in paragraph 2.4.3.2. if the patient is not conscious or is mentally incompetent. If the patient is under age or incompetent, the guardian, or legal representative may make the decision.

2.4.3.4. More specific medical information may be provided by the health care provider if approved by the patient, guardian or legal representative.

2.4.3.5. NEVER release a prognosis or sensitive medical information relating to the admission of the patient, such as sexual assault, criminal actions, drug or alcohol abuse, psychiatric or social conditions, venereal disease, or Acquired Immunodeficiency Syndrome (AIDS) – HIV (Human Immunodeficiency Virus) data or AIDS related syndrome. **NOTE:** In all cases in paragraphs 2.4.3.3. and 2.4.3.4., make the statement “Further details with regard to (individual’s) admission to the hospital are not releasable at this time.”

2.4.3.6. Consult the SJA for assistance with problems relating to the release of information.

2.5. Disclosing or Releasing Information Not Requiring Patient Authorization.

2.5.1. All disclosures that are made that do not require a patient authorization must be tracked in the automated disclosure tracking system and kept for six years.

2.5.2. DoD INVESTIGATIVE AGENCIES: Special agents are granted access to health records when proper identification is provided. The agent must sign a dated statement which contains the identity of the record to be examined, the identity (file number) of the investigation for which the record is being examined, a certification by the examiner that the examination is required as part of the official investigation, identification of any copies of material furnished to or copied by the agent, and a signed receipt. (**NOTE:** Do not file the statement in the patient’s health record. Maintain the statement in a separate folder in the general correspondence files until the investigation is concluded. At that time, annotate disclosure in the disclosure accounting system).

2.5.2.1. Before providing investigative agencies access to the records, the request and the records will be reviewed by the MTF Commander or designee. Special agents should seek an interview with a health care provider when clarification or interpretation of medical documentation is necessary. These actions are taken as quickly as practical so as not to delay the investigation.

2.5.2.2. Although the OSI has the right to seize Government records for investigation, OSI agents will not seize original medical records without SJA written approval. If such approval is received, copies of the seized records will be left with the medical facility. Generally giving the OSI a certified true copy of the original records will suffice. Consult with the SJA if questions arise.

2.5.3. Litigation Cases: Refer requests for release of medical information required for pending litigation to the SJA for advice or action.

2.5.3.1. When mailing out medical records concerning medical malpractice claims use certified mail return receipt.

2.5.4. Government Departments and Non-DoD Agencies: Medical information is released upon request, to other departments and agencies, both Federal and State, that have a proper and legitimate need for the information. For example:

2.5.4.1. Release protected health information to the Department of Veterans Affairs (DVA) to process a claim in which the person’s medical history is relevant or upon the separation or discharge of the individual from uniformed service for the purpose of a determination by DVA of the individual’s eligibility for or entitlement to benefits.

2.5.4.2. Release protected health information to Federal and State hospitals and prisons for further medical treatment of a person in their custody. Give the First Sergeant or prisoner escort the original health records of active duty members when processing a patient to go to a corrections facility.

2.5.4.3. Release protected health information to the Occupational Safety and Health Administration to help detect, treat, and prevent occupational injuries and diseases.

2.5.4.4. Release protected health information to the Air Force Reserve or Air National Guard Air Reserve Component (ARC) medical personnel when required to determine the medical qualification for continued military duty of a spouse or other beneficiary who is a Reservist or Guardsmen.

2.5.4.5. Release the protected health information of foreign military personnel to their appropriate foreign military authority using the same guidelines as outlined in paragraph 2.5.6.

2.5.4.6. All disclosures of information must be documented in the medical record or the automated disclosure tracking system.

2.5.5. RESEARCH PURPOSES: Release protected health information upon the request of medical research or scientific organizations or other qualified researchers when, in the opinion of the releasing authority, its release is legal and in the public interest. This also includes release of information to present or former members of the uniformed services who need it for private study or research to advance their professional standing. Where possible, de-identify the records by removing names and SSNs of individuals and other unnecessary demographic information. Counsel the researcher that the information must be held in confidence and that any published reports must not identify in any way the individuals whose health records were examined. Do not release the information if it violates existing laws.

2.5.5.1. Access may be granted to review records for research purposes in MTFs and facilities of the General Services Administration (e.g., National Personnel Record Centers (NPRC)). Hard copy medical records will not be removed from the MTF or other facility. Space will be furnished to review the medical record.

2.5.5.2. MTF Commanders, with concurrence of an Institutional Review Board (IRB) or Privacy Board, will approve requests from personnel under their command whose research projects involve medical records maintained at that facility when individual patient authorizations are not practical.

2.5.5.3. Submission of research requests. All requests from outside and within the Department of the Air Force will be made through channels to:

AFMSA/SGOZ

2509 Kennedy Circle

Brooks City-Base, TX 78235-5116

2.5.5.4. Requests will include the following:

2.5.5.4.1. Name and address of researcher and any assistants.

2.5.5.4.2. List of the professional qualifications of the researcher and any assistants.

2.5.5.4.3. Description of the researcher's project or field of study.

2.5.5.4.4. Reason for requesting the use of Air Force records.

2.5.5.4.5. Identification of the specific records required and their location.

2.5.5.4.6. Provide inclusive dates when access is desired.

2.5.5.4.7. Signed agreement from each person named in the request listing the following conditions:

2.5.5.4.7.1. Information taken from Air Force medical records will be treated according to the ethics of the medical and dental profession.

2.5.5.4.7.2. Identities of people mentioned in the records will not be divulged without their written authorization, and no photographs of a person or of any exterior portion of his or her body will be released without his or her written consent.

2.5.5.4.7.3. The researcher understands that permission to study the records does not imply approval of the project or field of study by the Air Force Surgeon General.

2.5.5.4.7.4. All identifying entries concerning a person will be deleted from abstracts or reproduced copies of the records. Published reports will not identify in any way individuals whose health records were examined.

2.5.5.4.7.5. Any published material or lectures on the particular project or study will contain the following statement: "The use of Air Force medical records in the preparation of this material is acknowledged, but it is not to be construed as implying official Department of the Air Force approval of the conclusions presented."

2.5.5.5. Proof of access authorization: Any approval letter from the Surgeon General allowing access to records will be shown to the proper authority (custodian of the medical records) when requesting access to records at the MTF level.

2.5.6. Access to Active Duty Member Health Records by Commanders or Commander Designee.

2.5.6.1. The Privacy Act, 5 U.S.C 552a, contains an exception in section (b)(1), which provides for disclosure to "those officers and employees of the agency which maintains the record who have a need for the record in the performance of their duties." Likewise, HIPAA allows for a specific military exception as governed by DOD 6025.18-R paragraph C7.11 to "assure the proper execution of the military mission."

2.5.6.1.1. A commander is defined as an officer that has command authority over the patient. A commander's designee includes Vice Commander, Deputy Commander, First Sergeant or commanders support staff.

2.5.6.2. Access, however, must be balanced with the recognized sensitivity of medical records, which often contain information of a very private nature. Therefore, before a Commander or designee gains access to an individual's protected health information, he or she must establish a need for those records IAW DoD 6025.18-R, paragraph C7.11 and receive the concurrence of the SJA. Keep disclosure of information to a minimum as necessary to meet their needs and annotate the disclosure on the disclosure tracking form or automated system.

2.5.6.3. The MTF Commander or designee provides a summary of the pertinent records to the requesting Commander or designee. A request from or the consent of the individual concerned in the review is not required (See 5 U.S.C. 552a[b]1).

2.5.6.4. The actual record will be provided only if specifically requested for clarification purposes or other clear need. For actual records release in this section, the requester shall document in writing to the MTF Commander the need for the actual record and why a summary per paragraph 2.5.6.3. is not sufficient. When appropriate, such review shall be conducted with the assistance of a provider who can advise on medical record data that might otherwise be misinterpreted.

2.5.6.5. Commander or designee must not release or discuss the medical records except as directed in this section.

2.5.6.6. For release of information for Personnel Reliability Program (PRP) purposes refer to paragraph 2.4. in AFI 36-2104.

2.6. Sending/Receiving Medical Information via Telephone Facsimile (Fax).

2.6.1. Although most regulatory and accreditation requirements do not specifically address the use of fax machines in relation to transmission of health information, you must be aware of any specific state laws and regulations, including hospital licensure laws, which address requirements for original records or fax transmission.

2.6.2. Previously listed guidelines pertaining to the release of information apply regardless of the method of release.

2.6.3. To protect patient privacy, only use fax transmission when the original record or mail-delivered copies will not meet requirements for immediate patient care. Only fax sensitive information when urgently needed for patient care or when required by a third-party payer for ongoing certification of payment for a hospitalized patient.

2.6.4. Limit fax transmission to only that documentation necessary to meet the requester's needs. Utilize regular mail or messenger service for routine disclosure of information to insurance companies, attorneys or other legitimate users.

2.6.5. The cover letter sent with the documentation transmitted will include (See [Figure 2.4.](#)):

2.6.5.1. Date and time of fax transmission

2.6.5.2. Sending facility's name, address, telephone and fax numbers

2.6.5.3. Sender's name

2.6.5.4. Receiving facility's name, address, telephone and fax numbers

2.6.5.5. Authorized receiver's name

2.6.5.6. Number of pages transmitted including cover page

2.6.5.7. Confidentiality notice, including instructions on re-disclosure and destruction

2.6.6. Maintain the signed release authorization and the original cover letter with a notation of the disclosed information, date, and identity of the employee making the disclosure. File these in the patient's health record.

2.6.7. If the documentation is received by anyone other than the intended recipient, the burden is on the sender to remedy that error. Frequently used destination numbers should be preprogrammed into the fax machine to eliminate misdial errors.

2.6.8. If the transmission does not reach the intended recipient's system, check the internal logging system of the facsimile machine to determine where the transmission was sent. Send a request to the incorrect number explaining that the information was misdirected and asking for return of the documents via mail. See [Figure 2.5](#) for a sample cover letter to accompany the request. Notify the Risk Management department and follow their instructions for any other action to take.

2.6.9. The receiver of the documentation is bound by all of the laws and requirements governing the use and release of medical documentation.

2.6.10. To help protect confidentiality, establish specific policies and procedures for handling documents received via facsimile. Include the following:

2.6.10.1. All fax machines used to transmit and receive PHI must be located in a secure or supervised location.

2.6.10.2. Remove documents as soon as the transmission completes

2.6.10.3. Count pages to ensure transmission of all intended information. Check for legibility and notify sender of problems

2.6.10.4. Read the cover letter and comply with instructions for verifying receipt

2.6.10.5. Process the documents, if appropriate, or notify the authorized recipient that a facsimile transmission has been received. Seal the documents in an envelope and deliver to the authorized recipient or hold for pickup

2.6.11. Unless otherwise prohibited by state law, documentation received via fax can be included in the patient's health record.

2.6.12. The use of a fax machine to transmit physician's orders is permissible. To verify their authenticity, the provider should sign the orders prior to transmission. If the orders were not signed, do not carry them out until the ordering physician verifies them. Unless otherwise required by state law or regulation, the facsimile copy does not require countersignature.

2.6.13. Documentation transmitted on thermal paper will fade over time. If your fax machine uses thermal paper, make a photocopy of the document and place that copy in the record. Destroy the thermal paper document after making the photocopy.

Figure 2.2. Sample Authorization for Disclosure of Medical or Dental Information Form.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION		
<p>The purpose of this form is to provide the MTF/DTF/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information. Guidelines regarding use of this form are contained in DOD Regulation 8025.18-R.</p> <p>This form will not be used for authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.</p> <p>Privacy Act of 1974 applies.</p>		
PATIENT DATA		
Name (Last, First, MI)	Date of Birth (YYYYMMDD)	Patient SSN
Period of treatment (YYYYMMDD - YYYYMMDD)	Type of Treatment: <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/> Both	
DISCLOSURE		
<p>I authorize _____ (Name of MTF/DTF/TRICARE Health Plan) to release my patient information to:</p> <p>Name _____</p> <p>Address _____ City _____ State _____ Zip _____</p> <p>Phone _____ Fax _____</p>		<p>Reason for Request/Use of Medical Information:</p> <input type="checkbox"/> Personal Use <input type="checkbox"/> Insurance <input type="checkbox"/> Continued Medical Care <input type="checkbox"/> School <input type="checkbox"/> Legal <input type="checkbox"/> Retirement/Separation <input type="checkbox"/> Other (please specify) _____
Information to be Released:		
Authorization Start Date (YYYYMMDD):	Authorization Expiration: <input type="checkbox"/> Date (YYYYMMDD) _____ <input type="checkbox"/> Action Completed	
RELEASE AUTHORIZATION		
<p>I understand that:</p> <p>a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.</p> <p>b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.</p> <p>c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.</p> <p>d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.</p> <p>I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.</p>		
Signature of Patient/Parent/Legal Patient Representative	Relationship to Patient (if applicable)	Date (YYYYMMDD)
For Staff Use Only-(To Be Completed only Upon Receipt of Written Revocation)		
<input type="checkbox"/> AUTHORIZATION REVOKED		Revocation completed by _____ Date ____/____/____
Imprint of Patient Identification Plate When Available	Sponsor Name: Sponsor Rank: FMP/Sponsor SSN: Branch of Service: Phone Number:	

Figure 2.3. Sample Restrictions Authorization Form (Back).

(Continued) Use this space to specify medical information to be restricted:

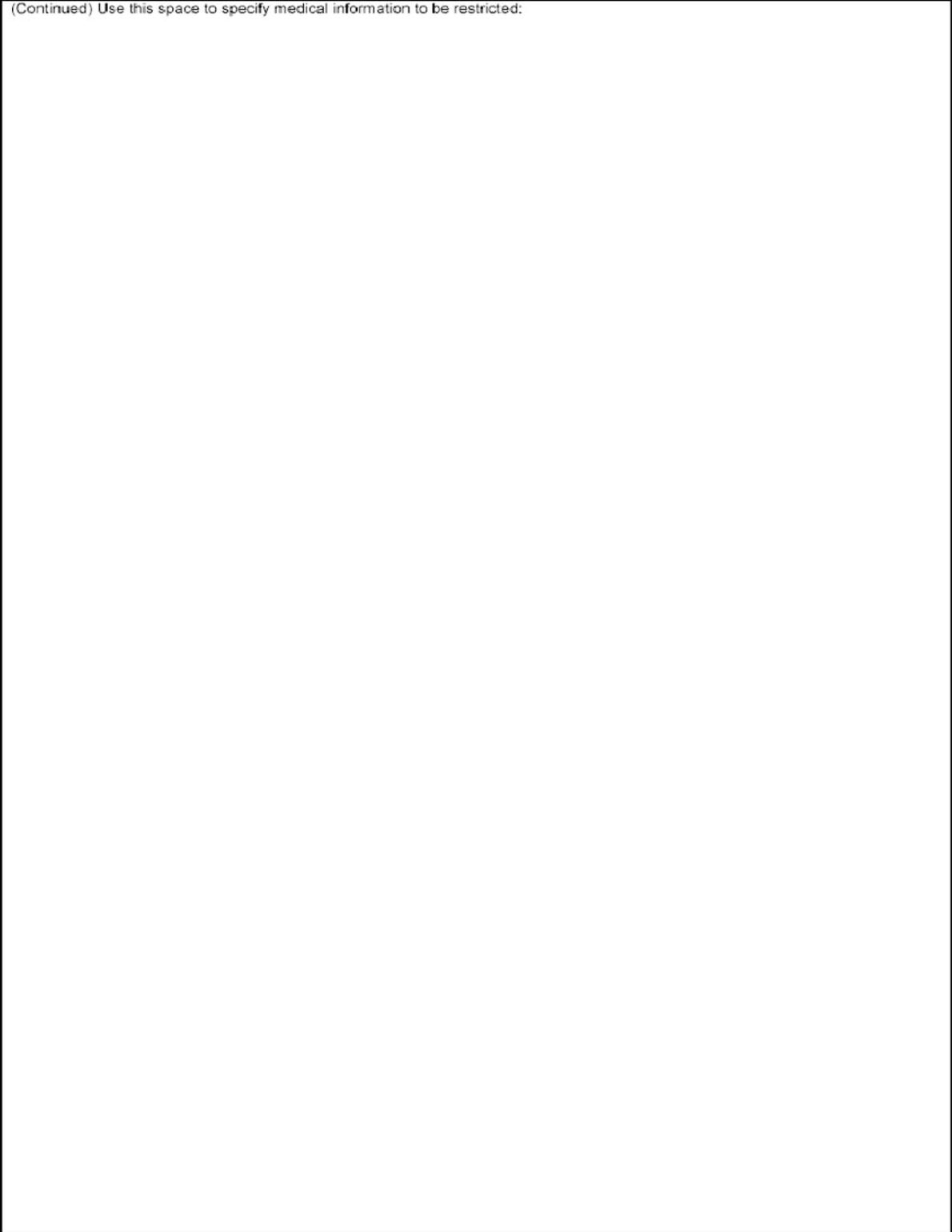


Figure 2.4. Sample Format –Facsimile Cover Letter.

FACSIMILE COVER LETTER	
[sending facility name]	
[address]	
[city, state, zip code]	
[telephone number]	
[facsimile number]	
DATE: _____	TIME: _____ NO. OF PAGES: _____
TO: _____	(name of authorized receiver)
_____	(name and address of authorized receiver's facility)
TELEPHONE: _____	FAX: _____
(of receiver)	(of receiver)
FROM: _____	(name of sender)
TELEPHONE: _____	FAX: _____
(of sender)	(of sender)
COMMENTS:	
*****CONFIDENTIALITY NOTICE*****	
The documents accompanying this telefax contain confidential information belonging to the sender may contain protected health information. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law.	
If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telefax in error, please notify the sender immediately to arrange for return of these documents.	

NOTE: This is a sample form. It should not be used without review by your organization's legal counsel to ensure compliance with local and state laws.

Figure 2.5. Sample Format—Misdirected Facsimile Cover Letter.

<p>Misdirected FACSIMILE COVER LETTER</p> <p>[sending facility name]</p> <p>[address]</p> <p>[city, state, zip code]</p> <p>[telephone number]</p> <p>[facsimile number]</p> <p>DATE: _____ TIME: _____ NO. OF PAGES: _____</p> <p>TO: Recipient at 999/999-9999</p> <p>FROM: _____ (name of sender)</p> <p>TELEPHONE: _____ FAX: _____ (of sender) (of sender)</p> <p>COMMENTS:</p> <p>We believe that information on one of our patients was transmitted to you in error. This is confidential information, belonging to <i>[name of sender]</i> that may contain protected health information. Please return these documents to us immediately by mail. Thank you.</p> <p>*****CONFIDENTIALITY NOTICE*****</p> <p>The documents accompanying this telefax transmission contain confidential information belonging to the sender that may contain protected health information. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party and is required to destroy the information after its stated need has been fulfilled, unless otherwise required by state law.</p> <p>If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this telefax in error, please notify the sender immediately to arrange for return of these documents.</p>

NOTE: This is a sample form. It should not be used without review by your organization's legal counsel to ensure compliance with local and state laws.

2.7. Clinical Use of Electronic Mail in Provider to Patient Communications.

2.7.1. Providing quality health care depends on a provider's ability to adequately communicate diagnosis and treatment programs, as well as furnish appropriate health education information. Today, electronic mail (email) has begun to augment both written and verbal (face-to-face and telephonic) communications that have traditionally been the primary mechanisms for communicating health information.

2.7.2. Since email automatically creates a written record, it presents clear advantages for documenting patient care. However, a message can also easily contain data that can be considered as individually identifiable health information. Currently the MHS does not have an email system in place that can protect individually identifiable health information. Therefore, use of email to transmit this information is prohibited until a viable system is developed for use by the MHS.

2.8. Power of Attorney.

2.8.1. The Staff Judge Advocate (SJA) provides the rules regarding the need for a sponsor or patient to get a power of attorney. Ensure all hospital and clinic personnel are made aware of the power of attorney rules.

2.8.2. Call the base SJA or medical law consultant at the nearest medical center on unusual cases.

Chapter 3

ADMINISTRATION OF PATIENTS

3.1. Establishing Eligibility For Care.

3.1.1. The local Military Personnel Flight (MPF) is ultimately responsible for establishing an individual's eligibility for medical care in the Defense Enrollment Eligibility Reporting System (DEERS). AFH 41-114 and AFI 41-115, provide additional information.

3.1.2. Eligibility Verification Process.

3.1.2.1. Eligibility verification is a two-step process. Designated medical facility personnel ensure all patients, including those in uniform, show a valid ID to confirm the patient's identity before they provide routine care, ancillary, or administrative services and do a DEERS check to verify entitlement.

3.1.2.2. Verify a person's eligibility status by performing a DEERS check via CHCS or other proof of eligibility such as a Secretarial Designee Letter, valid Orders, completed Line of Duty (Air Force and Army) or Notice of Eligibility (Navy and Marine Corps). MTFs will perform DEERS checks on all beneficiaries presenting for care.

3.1.2.3. If the beneficiaries eligibility cannot be verified via a DEERS check in CHCS, check Native DEERS (NDEERS) for eligibility status.

3.1.2.4. If the beneficiaries eligibility cannot be verified through any of the above steps, fill out a locally developed form, see [Figure 3.1.](#), and counsel the patient that they must return with verification of eligibility within 30 days or they will be billed for care rendered.

3.1.3. Eligibility questions should be directed to the TRICARE Flight Commander or other MTF-designated personnel.

Figure 3.1. Sample Form-Proof of Eligibility.

MEMORANDUM FOR _____

Date

FROM: OFF SYM

SUBJECT: Proof of Eligibility

1. Per AFI 41-210, Patient Administration, paragraph [3.1.](#), all Military Treatment Facilities (MTF) must verify a patient's eligibility status when they present for care. This verification is accomplished by the patient presenting a valid ID card and the MTF staff performing a DEERS check.

2. When presenting for care today, your eligibility could not be verified through this process. Verification of your eligibility must be received by _____. *(no later than 30 days from date care is rendered)* If verification is not received by this date, you may be held liable for the cost of your care.

3. If you have any questions regarding this policy, please contact the Medical Service Account office at XXX-XXXX. Thank you.

3.2. Medical In/Out-Processing.

3.2.1. The DoD has established policy that all military service members will be apprised of their health care benefits as they move from one assignment to another. Specifically, members must be informed of the scope of their benefits; how to access health care in their local community; how to access care while away from home or enroute to a new duty station; and how to get problems resolved should they arise.

3.2.2. All MTF commanders will establish medical in/out-processing programs. At a minimum, the following information must be reviewed for each program.

3.2.2.1. In-processing:

3.2.2.1.1. How to change Primary Care Manager (PCM) at new location.

3.2.2.1.2. Choosing your new PCM and how to contact your PCM.

3.2.2.1.3. Benefits of enrolling in TRICARE Prime, including Point of Service.

3.2.2.1.4. Local policies on TRICARE Prime enrollment and CHCS registration data collection.

3.2.2.1.5. How to enroll family members in the dental plan.

3.2.2.1.6. MTF/lead agent/Managed Care Support Contract/TRICARE Service Center points of contact.

3.2.2.1.7. Exceptional Family Member Program/Family Advocacy Program (EFMP/FAP) services available and enrollment information.

3.2.2.1.8. Policy on obtaining TRICARE cards.

3.2.2.1.9. How to schedule/cancel appointments.

3.2.2.1.10. Out of area care procedures.

3.2.2.1.11. Services available at local MTF(s).

3.2.2.1.12. How to access services not available at the local MTF and after hours.

3.2.2.1.13. Services available in the network.

3.2.2.1.14. Local/AF medical record custody policy.

3.2.2.1.15. Life Skills Support Center services.

3.2.2.1.16. Local prescription services.

3.2.2.1.17. Preventive Health Assessment (PHA) policies.

3.2.2.1.18. Completion of mini-medical review and Health Enrollment Assessment Review (HEAR) completion.

3.2.2.1.19. Recommended preventive services for Prime enrollees.

3.2.2.1.20. Immunizations review and update.

3.2.2.1.21. PRP procedures.

3.2.2.1.22. Use of self-care books.

3.2.2.1.23. How to file a civilian medical/dental claim.

3.2.2.1.24. Contact information for the Beneficiary Counseling and Assistance Coordinator/Debt Collection Assistance Officer (BCAC/DCAO).

3.2.2.1.25. Co-payments and deductible fees for care outside the direct care system.

3.2.2.2. Out-processing:

3.2.2.2.1. Ensure all laboratory and radiology results and category 2 e-mails are printed and filed in the individual's health record NLT 10 days prior to final out-processing appointment for PCS, separation or retirement. For individuals in the Family Member Relocation Process print and file results in their health records prior to the screening required in paragraph [3.11.3.1](#).

3.2.2.2.2. Health records control.

3.2.2.2.3. Claims for care while in transit.

3.2.2.2.4. Scheduling appointments in transit.

3.2.2.2.5. Locating a TSC/MTF at new assignment.

3.2.2.2.6. Prescription services while in transit.

3.2.2.2.7. Transferring/changing your PCM to a new MTF.

3.2.2.2.8. Customer satisfaction "feedback" on services at losing base.

3.2.2.2.9. How to avoid point of service charges while in transit.

3.2.3. MTF commanders will ensure that all MTF staff are aware of these requirements and actively participate in the dissemination of TRICARE benefits.

3.3. Patient Registration.

3.3.1. The Patient Administration function has oversight of registration of patients. If other sections such as Pharmacy, Lab and Emergency Department have the ability to register patients in CHCS, patient administration personnel will provide training and will be the approval authority to allow access to registration capability.

3.3.2. All patients should be registered upon in-processing or enrollment, whichever comes first. Full registration will be accomplished except when not feasible such as a reference lab where a specimen is being processed. At a minimum, the following information must be captured:

3.3.2.1. Patient's name.

3.3.2.2. Patient's sponsor.

3.3.2.3. Sponsor's SSN.

3.3.2.4. Patient's relationship code.

3.3.2.5. Patient's date of birth.

3.3.2.6. Patient's gender.

3.3.2.7. Patient's Service (sponsor only).

3.3.2.8. Patient's station/unit (sponsor only).

3.3.2.9. Patient's rank (sponsor only).

3.3.2.10. Organ donor declaration (yes or no). See AFI 44-102, for more information on the organ donor program.

3.3.2.11. Third party insurance information.

3.3.2.12. MTF where record is maintained.

3.3.3. Potential Duplicate Patient Report. Run this report to identify potential duplicate patients at least monthly. Research each error and develop a process to correct. Use as a training tool when specific personnel continuously create duplicates.

3.4. Standardized Appointing.

3.4.1. MHS Standard Appointment Types and Access Criteria. MTFs will use one of the following nine MHS Standard Appointment types:

3.4.1.1. PCM: Initial primary care only (30 days).

3.4.1.2. SPEC: Initial specialty care only (28 days).

3.4.1.3. ACUT: Acute appointment (24 hours).

3.4.1.4. ROUT: Routine appointment (7 days).

3.4.1.5. WELL: Wellness, health promotion (30 days).

3.4.1.6. PROC: Procedure with designated time allotment (provider designated duration).

3.4.1.7. EST: Established patient follow-up (provider designated duration).

3.4.1.8. TCON: Telephone consult.

3.4.1.9. GRP: Group/class appointment (provider designated duration).

3.4.1.10. OPAC: Open Access.

3.4.2. Standard Location (Clinic Names).

3.4.2.1. Each MTF will have the option to use as many or as few of the clinic names as necessary.

3.4.2.2. Providers will use Clinical (CLN) orders and Consult (CON) orders to facilitate the assignment of the right provider or clinic.

3.4.3. Booking Authority.

3.4.3.1. The dollar (\$) sign will be used as the last character in the appointment type field to indicate MTF Book Only, e.g. PCM\$, ROUT\$.

3.4.3.2. The \$ suffix is a short term solution. Eventually the MTF and the MCSC will have a partnership that provides all parties with the availability to book all appointments.

3.4.4. Patient Access Types. All MTFs will have the capability to reserve appointment slots according to a patient access type as follows:

3.4.4.1. Active duty.

- 3.4.4.2. Prime.
- 3.4.4.3. Graduate Medical Education.
- 3.4.4.4. No Active Duty.
- 3.4.4.5. No Prime.
- 3.4.4.6. No Active Duty, No Prime.
- 3.4.5. MHS Enterprise Appointment and Referral Business Rules.
 - 3.4.5.1. The order of search precedence for appointments by the location of the appointment is:
 - 3.4.5.1.1. For Prime patients seeking primary care:
 - 3.4.5.1.1.1. PCM: Provider based in any place of care where the PCM practices.
 - 3.4.5.1.1.2. PCM: Any PCM group member providing service in the enrollee's place of care.
 - 3.4.5.1.2. For Prime patients seeking specialty care:
 - 3.4.5.1.2.1. MTF based provider or clinic requested by PCM.
 - 3.4.5.1.2.2. Next available MTF (based provider) within access standards.
 - 3.4.5.1.2.3. Network provider within access standards.
 - 3.4.5.1.2.4. Non-network provider within access standards.
 - 3.4.5.1.3. For Non-Prime patients seeking primary care:
 - 3.4.5.1.3.1. Primary Care provider – civilian or MTF.
 - 3.4.5.1.3.2. Next available MTF.
 - 3.4.5.1.3.3. Network provider.
 - 3.4.5.1.3.4. Non-network provider.
 - 3.4.5.1.4. For Non-Prime patients seeking specialty care:
 - 3.4.5.1.4.1. Closest MTF.
 - 3.4.5.1.4.2. Next available MTF.
 - 3.4.5.1.4.3. Network provider.
 - 3.4.5.1.4.4. Non-network provider.
- 3.4.6. Specialty Care and Referral Process.
 - 3.4.6.1. All prime patients seeking specialty care will have a referral from their PCM except in the case of a medical emergency. Limited Self-Referral will be permitted for certain known and predictable conditions. See paragraph 3.5. for guidance on referral management.
 - 3.4.6.2. All referral requests will be electronic via CHCS (or other approved system).
- 3.4.7. Patient's Rights.
 - 3.4.7.1. Prime enrollees (except active duty service members) may elect to use the Point of Service Option.

3.4.7.2. Beneficiaries may waive the distance access standard for specialty care.

3.4.7.3. The patient may waive the time access standard and request appointments outside of access standards for convenience reasons even though appointments are available within access standards.

3.4.7.4. The patient's refusals and waivers will be documented electronically in CHCS (or other approved system).

3.4.8. Booking.

3.4.8.1. Clinic appointment templates, other than acute, will be open for booking at least 30 days ahead at all times (on a rolling calendar).

3.4.8.2. Basic CHCS Patient Demographic information, at a minimum, name, address, and telephone number will be updated at the time of appointment booking.

3.4.8.3. Delinquent and non-count appointments must be resolved by CHCS end-of-day processing daily.

3.4.8.4. An appointment slot may be reserved using one of the patient access types listed in paragraph [3.4.4](#).

3.4.8.5. Associated Appointment Process Business Rules.

3.4.8.5.1. MCSC and MTF (government) appointment clerks will be able to view all available appointments in CHCS or other approved system.

3.4.8.5.2. One telephone number will function as the beneficiaries' point of access for all appointing and referral needs. The beneficiaries' call will be appropriately routed to the right telephone extension if the first point of contact is unable to serve the beneficiary's health care information or appointment needs. The routing will occur without requiring the patient to make an additional telephone call.

3.4.8.5.3. The appointing process will work under the assumption of "PCM by Name" enrollment where applicable.

3.4.9. Associated CHCS (or other approved system) Requirements.

3.4.9.1. Scheduling.

3.4.9.1.1. Scheduling supervisors will be able to assign a patient access type to each appointment slot on a provider schedule.

3.4.9.1.2. Valid patient access type entries will be those in a common file having the same controls as the provider specialty file.

3.4.9.1.3. These entries will be five alphanumeric characters.

3.4.9.1.4. Future "No Active Duty" and "No Active Duty, No Prime" patient access types will indicate slots reserved for patients to be seen through resource sharing agreements.

3.4.9.2. Booking.

3.4.9.2.1. Managed Care Program (MCP) users will be able to search for appointment slots based on patient access types.

3.4.9.2.2. Users with appropriate authority may override the patient access type or age restrictions on a slot and book the appointment for a patient with a different patient access type of age.

3.4.9.2.3. The clinic has the responsibility to define access on a continuous basis, (how many appointments are designated by which enrollment status).

3.4.9.2.4. Each MTF has the ability to designate when the appointment will be released and what the new appointment definition will be.

3.4.9.3. Age Delineation.

3.4.9.3.1. A high and low age range will be recorded on each provider's profile to indicate the ages of the patients that the provider is credentialed to treat.

3.4.9.3.2. When searching for available appointments for a patient, CHCS will highlight appointments with providers who treat patients of that age.

3.4.9.4. Time. Providers are able to define the amount of time required per appointment or procedure.

3.4.9.5. Appointment Detail Field.

3.4.9.5.1. The Appointment Detail Field is permanent and searchable.

3.4.9.5.2. Scheduling supervisors will be able to assign up to three appointment detail values to each appointment slot on a provider schedule.

3.4.9.5.3. Valid detail entries will be those in a common file having the same controls as the appointment type file, see [Table 3.1](#).

3.4.9.5.4. These entries will be up to 10 characters in length.

3.4.9.5.5. MCP users will be able to search for appointment slots based on appointment detail entries.

3.4.9.5.6. The system will allow additional locally defined detail coded if deemed necessary for appointment specificity.

3.4.9.5.7. Detail values will not be used by sites to indicate specialty care at the Medical Expense and Performance Report System (MEPRS) 4th level. Specialty care at the fourth MEPRS level should be designated by the creation of a clinic name to indicate that care.

Table 3.1. Appointment Detail Field Table.

Code	Definition
+PPD	Positive Purified Protein Derivative (PPD) or other tuberculosis test evals
>BF	Weight exceeding body fat standards
ADHD	Attention Deficit and Hyperactivity Disorder or Attention Deficit Disorder
Anger	Anger management education – no PCM referral required
Asthma	Asthma evaluation or education appointments
BCP	Birth Control
BEPC	Birth and Early Parenting Class

Code	Definition
BFC	Breast Feeding Class
BK	Back pain or problem
BTL	Bilateral tubal ligation
Chol	Cholesterol
Circ	Circumcision
Colpo	Colposcopy – abnormal pap required
DM	Diabetes
DSGCH	Dressing/bandage change
E&I	Female Endocrine and Infertility patients only
EFMP	Exceptional Family Member Program
EyeDz	Eye disease
FlexS	Flexible Sigmoidoscopy
Flt	Flight Physical Exam
GDb	Gestational Diabetes patients only
Head	Headache education
HTN	Hypertension patients
IUD	Removal or possible placement of an IUD
MC	Medicare eligible
MEB	Evaluation Board Physical Exam
NoPaP	Gynecology appointments only, not Paps
NOR	Removal or possible placement of Norplant
NPCL	New Prenatal Class
NST	Non-Stress Test
Nutr	Nutrition education – no PCM referral required
OB	Pregnancy or obstetrics
OSS	Overseas Screening
PAP	Pap Smear patients
PDS	Pathfinding/Drill Sergeant test
PE	Physical Exam
PFT	Pulmonary Function Tests/Spriometry
PP	Post-Partum patient only
PRT	Physical Readiness Test Screens
PVR	Post-Void Residual
RET	Retinal Screening
Sch	School Physical

Code	Definition
Scoli	Scoliosis
SEA	Sea Duty Screening
Inject	Shot only
SPE	Separation or retirement physical exam
Stress	Stress management education program – no PCM referral required
TobCes	Tobacco Cessation - no PCM referral required
UroGyn	Urology or Gynecology
Vas	Vasectomy
Vert	Vertigo
WB	Well-Baby

3.5. Referral Management Process.

3.5.1. MTFs will develop policies for managing referrals to and from providers outside of the MTF per paragraph 3.4.6.2. These policies should:

3.5.1.1. Adhere to current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards or National Committee for Quality Assurance (NCQA) standards, when applicable.

3.5.1.2. Be developed and executed in concert with existing contracts with the regional Lead Agent and Managed Care Support Contractor (MCSC).

3.5.1.3. Ensure that patients who are referred to civilian health care sources (network or non-network) are informed of any potential costs related to receiving care, and that a mechanism is in place for the appropriate agent to pay associated health care bills. Referral policies should be coordinated with the MCSC.

3.5.1.4. Ensure that patients are informed of resources available to assist with scheduling appointments, receiving authorizations, obtaining covered services or supplies, resolving claims-related issues, filing appeals or grievances, or seeking TRICARE customer service.

3.5.1.5. Ensure that patients are aware of any limits on the scope of care, applicable access standards, the number of visits and/or the length of time covered by the referral.

3.5.1.6. Ensure that MTFs have a tracking mechanism for referrals that tracks the patient's appointment date, when results are received, sent to the referring provider, and filed in the patient's record. Tracking mechanism should identify those results not received within the established MCSC timelines to allow for appropriate follow-up action to ensure all results are received.

3.5.1.7. Ensure that all referrals include a copy of sufficient clinical, administrative and authorization information to allow the consulting provider to appropriately evaluate the patient, contact the referring provider and complete the appropriate claims/billing paperwork. As a general rule do not send the original medical record.

3.5.1.8. Ensure that a feedback mechanism is in place to provide the referring provider with the clinical results of the referral.

3.5.1.9. Outline a timely and appropriate appeals/grievance process, when applicable.

3.5.1.10. Ensure that a timely process exists to act on referrals into the MTF, and ensure that the MCSC is notified in a timely fashion if a patient referred to the MTF cannot be seen within applicable access to care standards.

3.5.2. Support to Geographically Separated Units (GSU)/TRICARE Prime Remote (TPR) enrollees.

3.5.2.1. GSU members are usually enrolled to a civilian primary care manager (PCM) through the TPR program. However, when a TPR member's medical condition warrants referral to an MTF for either administrative reasons (i.e. LOD, MEB, etc.) or specialty care, the MTF becomes clinically responsible for that patient. If the MTF subsequently refers the patient to the local network, while maintaining clinical oversight of the patient's care, the approval/authorization process rests with the referring MTF. Under no circumstance will the Service Point of Contact (SPOC) at the Military Medical Support Office (MMSO) be asked to place an authorization into the system for a TPR enrolled patient when an MTF initiated the referral. If the patient's clinical needs exceed MTF oversight capability, care management is returned to the civilian PCM through the SPOC. These same guidelines apply to ARC personnel referred to our MTFs for medical and administrative support.

3.5.2.2. The supporting MTF commander has direct control of patient travel funding for GSU members as outlined in AFI 41-101, the Joint Federal Travel Regulation, and AFH 41-114. Specifically, the nearest AF MTF provides AD patient travel reimbursement to AF members. Place of enrollment has no bearing on payment responsibility.

3.5.3. Access to Care and Referral Times

3.5.3.1. Access to Care (ATC) standards state a Prime beneficiary must be provided a specialty care appointment within four weeks or 28 days. Wait time begins the date the patient or referring provider contacts the TSC/Health Care Finder, an MTF, or a provider for an appointment.

3.5.3.2. Patients should be strongly encouraged to contact the MTF or MCSC within seven days after a provider initiates a referral to obtain the needed medical care as promptly as possible. Providers are responsible to inform patients of the necessity to seek timely appointments to ensure continuity of care.

3.5.3.3. The MTF need only offer one MTF appointment within the access to care standards to fulfill its duty to provide care within the access standards. However, if multiple and convenient appointment choices are available, whenever possible the patient should be offered more than one option that meets the ATC standard. Moreover, if the patient is unable to accept the initial appointment offered, the patient should be offered the next available appointment thereafter. Appointing staff should be trained to use ATC measurement features of CHCS to accurately document timeliness of services and patient refusals of appointments within access standards.

3.5.3.4. Once offered an MTF appointment within standards, the non Active Duty patient may choose to exercise their point of service option should civilian care still be desired. The standards are meant to require certain conduct of MTFs and MCSCs for the benefit of the beneficiary.

3.5.3.5. A provider's professional judgment cannot waive the standards. There is no provision for waiving the standards, which are fixed by regulation and incorporated into the MCSC contracts. While the provider cannot relieve any entity of its obligations under the ATC standards, the provider can, exercising his or her professional judgment, advise the patient of his or her opinion that

a condition is amenable to a greater than four-week/28 day wait for an appointment time. If the patient accepts that opinion, the patient has the option of declining timely offered appointment as discussed above.

3.5.3.6. A contractor may request exceptions to the requirement to make specialty services available within the network if they are not sufficiently available in the area to make inclusion practical. However, absent such an exception, the contractor is bound by the network adequacy standards. If the network is legally and contractually adequate, but there still is no ability to provide an appointment in the MTF or network within four weeks/28 days, the appropriate solution is to refer the patient to an out-of-network provider within the ATC standards or to give the patient the option, with the referring provider's concurrence, of waiting for an in-network appointment.

3.5.3.7. MTF and TRICARE authorized providers have the authority to determine what category of care (acute or routine) is required for a given health care need, even if it is different from the patient's original request. In other words, if the patient calls in for an acute appointment and a provider determines, based upon his or her own training, experience, and appropriate criteria that a routine appointment is merited, the routine appointment will be offered. The provider should document the logic behind the decision in the patient's medical record.

3.6. Quarters Status.

3.6.1. Quarters is a full duty excuse provided to active duty uniformed service members receiving medical or dental treatment for a disease or injury that, based on sound professional judgment, does not require inpatient care. A quarter's patient is treated on an outpatient basis, is to remain in their domicile during the quarter's timeframe, and is generally returned to duty within a 72-hour period.

3.6.2. Establish local procedures for program management, including:

3.6.2.1. Notifying patient's commander or designee. Disclose minimum information necessary. Use a local generated form to document notification, see [Figure 3.2](#). Forward a copy of this form to the member's Unit Commanders Support Staff for tracking purposes.

3.6.2.2. Notifying Public Health for communicable disease tracking.

3.6.2.3. How to extend period of quarters.

3.6.3. Other restrictions: Physician assistants/nurse practitioners may not place a patient on quarters for longer than 48 hours without approval by a physician. Obstetrical (OB) quarters is discussed in AFI 44-102.

3.6.4. Unit commanders and supervisors have the authority to grant up to 24 hours sick status at their discretion if a members illness/injury does not require MTF intervention. If the illness/injury persists beyond 24 hours, then the commander or supervisor must refer the member to the MTF for treatment and subsequent quarters authorization.

3.7. Line of Duty (LOD) Determinations.

3.7.1. The attending health care provider decides when an LOD determination is required (see AFI 36-2910, A2.1). An LOD determination is also required in cases when the member dies leaving family members. Initiate a LOD on AF Form 348, **Line of Duty Determination**. Notify HQ ARPC/DRSP, DSN 926-6134, on all LOD determinations initiated on participating Individual Reservists.

3.7.2. In cases where the health care provider has determined a LOD is required for an admission, the admitting clerk obtains the time, place, and manner of occurrence of the incident from the patient or other witness and records the information on the reverse of the AF Form 560.

3.7.3. Full instructions for making LOD determinations (including preparation of the AF Form 348) are available in AFI 36-2910.

3.8. AF Form 570, Notification of Patient's Medical Status for Special Administrative Actions.

3.8.1. Use AF Form 570 when:

3.8.1.1. Reporting communicable diseases to Force Health Management.

3.8.1.2. Reporting patient injuries that occur after admission.

3.8.1.3. Reporting anticipated Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB) action.

3.8.1.4. Indicating probable hospitalization over 90 days.

3.8.1.5. Reporting deaths to initiate casualty notification process.

3.8.1.6. Reporting Very Seriously Ill, (VSI), Seriously Ill (SI), or Incapacitating Illness or Injury (III) patients or removing from or movement between these categories.

3.8.1.7. Reporting any information about a patient's medical status requiring administrative action.

3.8.2. Responsibility for Preparing AF Form 570. The physician or dentist is ultimately responsible for initiating an AF Form 570.

3.8.3. See [Chapter 9](#) for casualty notification and processing death cases.

3.9. Electing Optional Civilian Medical Care.

3.9.1. Active Duty Air Force members must notify the servicing MTF within three days of treatment when receiving civilian medical care at his/her own expense (i.e., in such cases specified in AFI 41-101, paragraph 1.4.). Collect information on the nature of the ailment or illness, treatment received or recommended and any drugs or medication prescribed, and file it in the outpatient medical record.

3.9.2. Ordinary leave for lost time may be required in accordance with AFI 36-3003, *Military Leave Program*. Note: If a member elects childbirth from civilian sources at her own expense (hospitalization or home delivery), she must take ordinary leave to cover any period of time lost from duty before delivery. The attending provider recommends convalescent leave in accordance with AFI's 36-3003 and 44-102.

3.9.3. Active duty members must arrange for the civilian medical facility to send a summary of treatment to the servicing MTF.

3.9.4. Approved organ donors hospitalized in civilian facilities will be considered administrative inpatients. Convalescent leave may be granted by the patient's commander in accordance with AFI 36-3003.

3.10. Secretarial Designee Program.

3.10.1. Refer to AFI 41-115, Chapter 2 for guidance and preparation of Secretarial Designee applications. In addition, the following criteria apply.

3.10.1.1. Each application must have 100% DEERS and ID check.

3.10.1.2. Thoroughly screen application and select appropriate criteria IAW 41-115, paragraph 2.2.

3.10.1.3. Individuals being considered for Secretarial Designee status (not currently eligible for care) will not receive treatment at Air Force MTFs until the Designee status has been approved.

3.10.1.4. Under the Continuity of Care criteria, secretarial designee status may be approved for the following categories by the MTF Commander or designated representative:

3.10.1.4.1. Newborns of eligible family member daughters.

3.10.1.4.2. Pregnant former Active Duty members and their newborns prior to losing eligibility.

3.10.1.4.3. Pregnant spouses of former Active Duty and their newborns prior to losing eligibility.

3.10.1.4.4. Family member daughters who became pregnant prior to losing eligibility, and their newborn. Pregnant family member daughters who elect to lose eligibility through marriage are not eligible for Secretarial Designation.

3.10.1.5. All other categories must be approved by SAF/AA.

3.10.2. Submit applications to the MAJCOM/SG POC 45 days prior to expiration of medical benefits or requested Designee start date. MAJCOM/SG will recommend approval of applications and send to HQ USAF/SGMA. If application is disapproved at MAJCOM/SG level, it will be returned to MTF.

3.10.3. Reciprocal Healthcare Agreements are located at the [TRICARE Military Health System](#) website.

3.11. Special Needs Identification and Assignment Coordination (SNIAC) Process.

3.11.1. The SNIAC process identifies family members with special medical and educational needs to support assignment activities. The Family Member Relocation Clearance (FMRC) Coordinator (4A, 4C, 4N) is assigned by the MTF/CC and provides administrative functioning and forms and record management in the SNIAC process.

3.11.1.1. Each MTF will develop a Medical Group Operating Instruction to identify family members with special needs and provide Family Member Relocation Coordination. The MTF/CC assigns the Special Needs Coordinator (SNC) (Active Duty Medical Officer: MSC, BSC, NC, MC, DC) to provide SNIAC oversight in the MTF.

3.11.2. DoD Criteria for Assignment Limitation Code "Q" determines eligibility for SNIAC. Enrollment is mandatory. Special Needs identification occurs by self-referral, medical provider referral, Child Find and educational referral, and data sharing with TRICARE management and Health Benefits activities.

3.11.3. Family Member Relocation Coordination.

3.11.3.1. All family members of Active Duty Air Force sponsors with an OCONUS assignment requesting travel will be screened within 6 months of Permanent Change of Station for special medical and educational needs. The appropriate AF 1466, **Request for Family Member's Medical/Education Clearance for Travel**, 1466DO, **Dental Health Summary**, DD Form 2792, **Exceptional Family Member Medical and Education Summary**, and Addenda are used.

3.11.3.2. For CONUS travel, only those family members with special medical and educational needs must be screened for travel. The appropriate forms are used.

3.11.3.3. For sponsors on unaccompanied assignments, family member clearance screening is accomplished by the MTF in closest proximity to the family. When special needs exist, the FMRC Coordinator at the MTF in closest proximity to the family assists with coordination of the AF Form 1466, 1466DO, and appropriate DD Form 2792 and Addenda for completion by the MTF or family members' physician, dentist, and/or school. Completed, signed AF and DD Forms and Addenda are forwarded to the sponsors' assigned MTF FMRC Coordinator. The sponsor's MTF FMRC coordinates with the gaining MTF to complete the AF Form 1466, Section VII.

3.11.4. Administrative functions related to record management include:

3.11.4.1. Using the automated, on line tool, Q-Base to develop a chronological log of "Q-coded" sponsors and special needs family members.

3.11.4.2. Compiling the Special Needs Assignment Coordination Record (SNACR), a secondary medical record.

3.11.4.3. Coordinating conjoint medical appointments for the sponsor, family members, Medical Review Officer, and Special Needs Coordinator.

3.11.4.4. Coordinating with the gaining base local school, DDESS, or Department of Defense Dependent Schools (DoDDS) representative for Individualized Education Plans or Early Intervention Services representative for Individualized Family Service Plans.

3.11.4.5. Initiating, reviewing, completing, forwarding, and tracking Facility Determination Inquiries (FDI) package (AF 1466, AF Form 1466 DO, DD Form 2792 and appropriate addenda) for all family members with special needs whose sponsors are in the PCS cycle.

3.11.4.6. Coordinating with the MAJCOM Behavioral Health Consultants on all disapproved FMRC submissions.

3.11.4.7. Processing delayed FMRC submissions.

3.11.4.8. Notifying the sponsor of FDI status and approval or disapproval.

3.11.4.9. Processing an FMRC submission received from a losing MTF.

3.12. The Tumor Registry Program.

3.12.1. All Air Force MTFs that diagnose and/or treat patients with malignancies must have a cancer program and will comply with the requirements of the American College of Surgeons' Committee (ACoS) on Cancer, IAW AFI 44-110, *The Cancer Program* to the extent possible based on the size and services of the facility. The guidance in this chapter applies to patient administration only if your facility does not have a histopathology department.

3.12.2. At a minimum, cancer programs in MTFs must have an institutional cancer committee, a tumor registry and hold timely cancer conferences/Tumor Board meetings. Small MTFs (free-standing clinics and hospitals of fewer than 15 beds) may use the cancer programs and the registry functions of a larger referral MTF with a memorandum of agreement (MOA). Those facilities with the MOA must still continue to do case finding and prevention activities.

3.12.3. The Tumor Registry is the principal database for evaluating the care of cancer patients in the MTF. All MTFs that diagnose and/or treat cancer must maintain a registry. Patient Administration actions will include:

3.12.3.1. Use Automated Central Tumor Registry (ACTUR) to create and track cases.

3.12.3.2. Maintain follow-up information for the lifetime of each patient according to ACoS guidelines.

3.12.4. Release Information to Non-Air Force Tumor Registries. Refer to [Chapter 2](#) on release of information.

Figure 3.2. Sample Quarters Authorization Form.

QUARTERS AUTHORIZATION <i>(This form is subject to the Privacy Act of 1974, see separate PAS, (DD Form 2005))</i>		
SECTION I: DURATION OF QUARTERS		
CIRCLE: 24 Hrs or less 48 Hrs 72 Hrs OB Patient	PATIENT LIVES:	
DATE AND TIME FOR RETURN TO DUTY:	RETURN APPOINTMENT (If applicable):	
PROVIDER SIGNATURE, STAMP/DATE:		PHYSICIAN COUNTER SIGNATURE, STAMP/DATE:
SECTION II: DIAGNOSIS CATEGORIES (Circle one)		
Disease	Aircraft	Motor Vehicle
Battle Casualty	Non-battle Injury	Other _____
SECTION III: PATIENT IDENTIFICATION		
PATIENT NAME:	RANK:	SEX:
SSN:	BRANCH OF SERVICE:	
SECTION IV: UNIT NOTIFICATION		
UNIT:	PERSON CONTACTED & EXT:	

DATE/TIME:

NOTIFICATION MADE BY: (*PRINT Rank and Last Name*):

AFI 41-210 Patient Administration Functions requires that I am informed, and acknowledge in writing, the intent of quarters. The intent of quarters status is to return to my residence/quarters. Only necessary stops (i.e., pharmacy, shoppette or Commissary, dining facilities) should be made enroute or subsequently. I acknowledge receipt of a copy of this quarters authorization and have been instructed to take it to my squadron orderly room when I report back to duty. I authorize the MTF to notify my commander or designee that I am on quarters. Furthermore, I understand this authorization expires on the date/time listed in Section I and that upon expiration, I am to report to duty (normal work shift), or if ill return to the clinic for sick call (0700 hrs). My failure to comply with these instructions can result in administrative actions.

PATIENT SIGNATURE:

DATE:

REMARKS:

FORM 0-XXX. XXX XX (PA)**PREVIOUS EDITIONS ARE OBSOLETE.**

"This document contains information covered under the Privacy Act, 5 USC 552, Health Insurance Portability and Accountability Act, Public Law 104-191, and DoD Directive 6025.18. It must be protected in accordance with those provisions."

Chapter 4

OVERALL HEALTH RECORDS MANAGEMENT

4.1. Managing Health Records.

4.1.1. Health records are the property of the United States Government, not the individual. This designated record set consists of outpatient records, inpatient records, extended ambulatory records (EAR), fetal monitoring strips (FMS), mental health records, and dental records. Maintenance of records at the MTF is required IAW this instruction. Refer to AR 40-66 for additional information on health records maintenance of Army personnel and NAVMAN MED P-117, Chapter 16 for additional information on health records maintenance of Navy/Marine Corp personnel. Inform beneficiaries of this requirement through appropriate media. Initiate action to retrieve records maintained outside the MTF.

4.1.2. Management of medical records includes “assurance” which is the responsibility of administrative, clinical, and information technology staff.

4.1.3. The MTF Commander is the custodian of outpatient and inpatient records and ensures that all health records are prepared, maintained, used, protected, and controlled as required by this instruction. The Commander also ensures that records and loose documents are retired or disposed of according to AFMAN 37-139. Commanders must be knowledgeable concerning the control of health records and protected health information, release of information from the records, and provider of care documentation requirements. They ensure that these important functions are properly supported. The MTF Commander will also manage assurance of paper-based and automated medical records.

4.1.4. The Dental Surgeon is the custodian of the dental records and is responsible to the Commander for that area.

4.1.5. The RHIA/RHIT or Air Force member equivalent is responsible for the management of inpatient records to include the coding of inpatient and Ambulatory Procedure Visit (APV) records, management of medical transcription, and also provides oversight for outpatient record documentation and coding of patient encounters. The RHIA or RHIT works closely with the Information System Security Office (ISSO) and Privacy Officer to ensure security of and controlled access to both the paper-based and automated medical records, and to ensure release of information procedures conform to all legal requirements.

4.1.6. Health care providers (physicians, dentists, and other authorized health care providers) will include in appropriate health records, an accurate, legible, and complete description of all services rendered to patients. This description must adequately address current medical, administrative, and legal requirements. Health care providers will ensure that proper identification information is entered on various forms and that records are returned to the appropriate file as quickly as practical, but NLT 72 hours after treatment is rendered.

4.1.7. Records created and maintained at a joint Department of Defense/Veterans Administration (DoD/VA) facility are shared by the two organizations. Develop local policies to ensure that the needs of both organizations are met. Follow the instructions in AFMAN 37-139 for disposition of records to the National Personnel Record Center (NPRC) in St. Louis, MO.

4.2. Documenting Health Records. Health records are completed to meet the highest possible standards of completeness, promptness, clinical pertinence, and standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Only authorized individuals make entries in the medical record using black or blue-black ink. Dental records are the responsibility of the base dental surgeon. See AFI 47-101, *Managing Air Force Dental Services*, for maintenance of dental records. For care received outside of the Direct Care System ensure that Memorandum of Understanding (MOU) and TRICARE contracts include a mechanism for obtaining documentation (i.e., summaries, operative reports, etc) to be incorporated into the individual's health record.

4.3. Correcting Health Records.

4.3.1. Patients have the right to see their health records and request amendment if they think the documentation is in error. There is no requirement to agree to the amendment and at no time should any documentation be removed from the record unless it is determined that the documentation is not on the patient whose record is in question. The MTF record amendment policy will detail the requirements for patient's requests. Follow these processes upon receipt of a patient's request for amendment.

4.3.2. The request to amend the record must be made in writing, see [Figure 4.1.](#), and be signed by the patient or guardian and filed in section 3 of AF Form 2100A or left side of AF Form 2100.

4.3.3. Reply to the requestor, in writing, within 60 days with either an acceptance or denial of the amendment. If this is not possible, a 30-day extension is allowed. However, the MTF will inform the patient, in writing, about the extension. The letter will include a reason for the delay and a date the response will be provided. Only one extension is allowed per amendment request.

4.3.4. Denial of requests is allowed if any of the following conditions are met:

4.3.4.1. The protected health information is not part of a designated record set available for inspection under HIPAA.

4.3.4.2. The information requested to be amended is actually accurate and complete.

4.3.4.3. The MTF did not originally create the protected health information requested for amendment (e.g., copies of records from treatment at another MTF or civilian facility provider). However, if the requestor can prove that the MTF which originally created the information no longer exists, the MTF will handle the request as if it had created the information.

4.3.5. Upon receipt of a request for record amendment, forward it immediately to the applicable provider for research.

4.3.6. Take the following action when a minor error is identified near in time to the erroneous entry date and the responsible practitioner has current memory of the circumstances.

4.3.6.1. Line through the incorrect data with one straight line. Do not erase, scratch out or otherwise destroy the original data. Amendment of erroneous data should be done by the originating practitioner. If that is impractical, enter a brief explanation of why the originating provider did not make the correction. Enter the correct data next to the lined through data if space permits. Only providers privileged to document patient care will make corrections. The date for all entries or corrections must be the actual date of the notation.

4.3.6.2. If there is not enough space on the record next to the incorrect data to enter the correction, draw one straight line through the entry, initial, date and make a referral note to where in the record the correction is documented. Then enter the correction chronologically as indicated on the referral note. If the correction is not self-explanatory, also enter the reason for the correction. Provider will sign, date, and stamp the new entry. If other practitioners are associated with the patient's care and have a need-to-know concerning the change, inform them of the correction. Major changes may require documentation on a separate form (i.e., a new, blank form). Follow the same procedures stated above and file the corrected information as near as possible to the document containing the lined through information.

4.3.7. Take the following action if an error is identified after a claim or lawsuit has been filed or after a substantial time lapse:

4.3.7.1. Do not automatically amend the record as outlined in paragraph 4.3.6. when the adequacy of care has been challenged by the patient. Any amendment of the actual record is likely to create an appearance and allegation of record tampering. Consult the SJA or area medical law consultant for guidance.

4.3.7.2. The practitioner with personal knowledge of the erroneous data, prepares a separate statement of fact with the assistance of the SJA. The statement becomes a part of the claim or litigation file. Notify all practitioners involved with the patient's care if the erroneous data could affect the patient's future care.

4.3.8. Active duty members who believe their medical records contain erroneous information may apply to the Air Force Board of Correction of Military Records, SAF/MIBR, 550 C Street West, Suite 40, Randolph AFB TX 78150-4742. The MTF will take no action until contacted by the board representatives. See the "Guide to Processing Applications to the Air Force Board for Correction of Military Records (AFBCMR)", dated 20 June 1995.

4.4. Reviewing Health Records.

4.4.1. Record review functions are performed at each MTF by either an established Medical Record Review Committee or incorporated into other committees that review records. These functions will include evaluation of the quality, clinical pertinence, information assurance, and timely completion of inpatient and outpatient records and the assurance that the records are prepared and maintained according to Air Force directives and JCAHO standards. Cross-service representation will be included in the performance of these committees, i.e., representatives of the various clinic services, dental services, nursing services, medical record departments, management and administrative services, and other departments, as appropriate. Responsibilities of this committee will include but not be limited to the following items.

4.4.1.1. An adequate number of both inpatient and outpatient records (representative of the workload of the facility) are reviewed to ensure the highest possible standards of completion, legibility, promptness in documentation, and clinical pertinence are met. Records of recent deaths, hospital infections, complications and unusual problem cases are reviewed. A representative sample of records from every provider will be reviewed throughout the year.

4.4.1.2. Review the monthly medical record availability and accountability rates and report to the Executive Committee of the Medical Staff (ECOMS) or as directed by the MTF commander.

4.4.1.3. Written reports of the review function contain conclusions, recommendations, actions taken and results of actions and are forward to the Executive Committee of the Medical Staff for review.

4.4.2. Committees tasked with records review must approve locally overprinted Standard Forms (SF) filed in health records. SAF/AAIP granted a waiver to AFI 33-360V2, *Forms Management Program*, permitting overprinting on SFs. This waiver concerns overprinting only and does not grant authority to reprint existing SFs at the local level. Overprints are authorized only when the material added does not conflict with the purpose for which the form was intended. See AFI 33-360V2 for further instructions on the authorized use of overprinted forms.

4.5. Automation of Health Records. The Military Health System is transitioning from a paper-based health record to a computer-based patient record system. Automated health data and record systems are a part of the overall military health records system and are protected under the Privacy Act of 1974. Computer-based patient records, at a minimum, must meet the same standards and guidelines as the paper-based record. They must also meet required data security and medical privacy rules under the HIPAA Act of 1996. Until such time as a completely computerized medical record is available, a process must be in place to ensure electronic information is printed when patients are referred for further medical care, separating, retiring or being discharged from the military, transferring to another duty station, or if the archived record is about to expire.

4.6. Electronically-Generated Forms (EF).

4.6.1. Use only the AF-approved forms package. Word processing packages are directly forbidden because there is no method of locking the form so that it cannot be changed by the user, see AFI 33-360V2. Most Air Force and some Standard and Optional Forms can be downloaded from the Air Force [e-Publishing Home Page](#). There is also the [DoD Forms Program](#) web site for DoD forms, Standard and Optional forms, and other federal agency electronic forms.

4.6.2. The only exception to the policy in [4.6.1.](#) is with forms for which the Interagency Committee on Medical Records (ICMR) has identified standard data elements.

4.6.3. For these forms, the standard elements are required but mirror imaging of the paper form is no longer required. Additional data elements that would change the meaning of the form cannot be added. Standard patient information is required on these forms.

4.6.3.1. Patient information blocks on outpatient forms will include the following elements. Under Patient Information, include Name (last, first, middle), Sponsors SSN/FMP, Sex, Date of Birth, Rank/Grade, Department/Service Where Records Maintained, and Relationship to Sponsor. Under Sponsor Information, include Name (last, first, middle) and SSN/Identification Number. Under Facility Information, include Name of MTF.

4.6.3.2. Patient information blocks on inpatient forms will include the following elements. Under Patient Information, include Name (last, first, middle), Sponsors SSN/FMP, Sex, Date of Birth, Rank/Grade, Department/Service Where Records Maintained, Relationship to Sponsor, Register Number, and Ward Number. Under Sponsor Information, include Name (last, first, middle) and SSN/Identification Number. Under Facility Information, include Name of MTF.

4.6.4. To date, the forms for which standard data elements have been identified for the body of the form are: SF 93, SF 505, SF 506, SF 509, SF 526, SF 551, SF 558, SF 559, SF 600, and OF 523B.

Contact AFMSA/SGOZ for a list of the identified standard data elements for these and any subsequent forms for which standard data elements have been identified.

4.6.5. Optional Form (OF) 275, **Medical Record Report**, may be used in lieu of Standard forms, Air Force forms and DoD forms. OF 275, if used, must show the form number and title of the form being replaced. Information entered on the form must include all of the same information as the form it represents. File the OF 275 in the same location as the form it replaces. This form is not to be used for the creation of local forms.

4.6.6. If a MTF desires to create a local form in lieu of a form which already exists, a waiver must be requested from the ICMR via AFMSA/SGZZ, Brooks City-Base, TX

4.7. Overprinting of Forms. AFDPO/PPPF granted a waiver to AFI 33-360V2, permitting overprinting on Standard Forms, as well as other forms listed in this attachment and the list of prescribed forms in the table of contents. The specific overprint must be approved by the local body responsible for the medical record review function, recorded in the minutes of that body, and approved by the MTF Commander. Overprints are authorized only when the material added does not conflict with the purpose for which the form was intended (Federal Property Management Regulation 101.11.804.1). Follow instructions in AFI 33-360V2 concerning inclusion of the name of your organization followed by "overprint" in the lower right margin of the form; for example, 20th MDG Overprint. This waiver concerns overprinting only and does not grant authority to reprint existing Standard Forms at the local level.

4.8. Recording Videotaped Documentation of Episodes of Medical Care.

4.8.1. In order to provide a uniform approach to the documentation of telemedicine, these guidelines are proposed:

4.8.2. If the patient is identifiable, he/she must provide written consent before encounter is videotaped, unless the taping is for documentation for neglect or abuse.

4.8.3. Written documentation of consultation by providers at both ends of the encounter will be filed in the patients record.

4.8.4. Permanent video images will be erased after written documentation is complete. (Exception: Cases with exceptional educational value, or required for other specific reasons may be retained for a specified interval. Any MTF, which chooses to keep images on file for educational purposes, will have a standard operating procedure or policy on how the images will be maintained. Review this guideline periodically and update as necessary.)

4.8.5. In those cases where adverse administrative, non-judicial, or judicial proceedings may be contemplated because of possible criminal activity, consult with the local judge advocate before erasing the videotape.

4.8.6. Final documentation by provider will indicate whether or not the image was erased, or where the videotape will be maintained if not erased.

4.8.7. Duration of storage of electronic/video images is not yet defined.

4.8.8. There is currently no clear medico-legal determination on whether a videotaped procedure or consultation will become part of the patient's medical record. Contact the medical law consultant for the most recent guidelines.

4.8.9. The decision on whether or not to retain the videotaped image must be carefully made. If videotapes are available for some patients but not for all, absence of a videotape may create the perception of purposeful destruction of evidence.

4.9. Retirement of Health Records.

4.9.1. Disposition (Transfer or Retirement) of Records to National Personnel Records Center (NPRC), the Department of Veterans Affairs (DVA) or the Civilian Personnel Office (CPO).

4.9.2. Active Duty Outpatient Records. Transfer health record groups (outpatient and dental record) along with a photocopy of the DD Form 214, **Certificate of Release or Discharge from Active Duty** and the DD Form 2697, **Report of Medical Assessment**, for active duty members separating, retiring or being discharged **after** 1 May 94 to the DVA, Records Management Center, P.O. Box 5020, St. Louis, MO 63115-0020 (Reference AFI 36-2101, *Classifying Military Personnel (Officers and Airmen)*, paragraph 2.20.1). NOTE: Members separated, retired or discharged before 1 May 94 had their records transferred to NPRC. If these records need to be retrieved contact NPRC for instructions.

4.9.2.1. For those members separating under Palace Chase or Palace Front, send the records to the gaining reserve or guard unit.

4.9.2.2. If the member is filing a claim for disability at the time of separation, send the records to the Veterans Administration Regional Office (VARO) of the state where the member intends to reside. (NOTE: A new policy encourages individuals **prior** to separation or retirement to set up an appointment through the Veterans Administration for physicals and disability processing. Individuals should take their records to these appointments, which will probably be occurring in the area from which they are retiring.)

4.9.2.3. Within 5 workdays after the member's Date of Separation (DOS), the MTF will forward the records and any loose documentation to the Military Personnel Flight. If this is not accomplished within the time frame, the MTF is responsible for forwarding the records to the appropriate office within the military or the DVA (as stated in this section). NOTE: Any loose documentation must be placed into an appropriately labeled outpatient folder before it is forwarded.

4.9.3. NATO Military Personnel and Family Member Outpatient Records. Deliver outpatient records of NATO military personnel and their family members in a sealed envelope to the individual concerned upon transfer to another U.S. military base. Upon return of personnel to the NATO country, transfer records to the specific national military medical authority.

4.9.4. Non-NATO Foreign Military Personnel Outpatient Records. Retire outpatient records for non-NATO foreign military personnel to NPRC 2 years after the end of the calendar year of the last date of treatment, in accordance with AFI 37-138 and AFMAN 37-139.

4.9.5. Non-military and Retired Personnel Outpatient Records. Retire outpatient records for nonmilitary and retired personnel to the NPRC, 111 Winnebago Street in St. Louis, MO 2 years after the end of the calendar year of the last date of treatment, in accordance with AFI 37-138 and AFMAN 37-139.

4.9.5.1. Screen records according to the date of last treatment. Records are maintained at the MTF for two years after the year in which the last treatment occurred and then retired. This does not pertain to medical records on ARC member's that are being maintained by MTFs. Contact the appropriate POC at the ARC unit for disposition instructions when a question exists on whether or not

an ARC member is still actively participating. If a local POC is unknown, then contact the appropriate ARC/SG.

4.9.5.2. If the sponsor is still assigned to the base, records of eligible family members should be retained if the family is still in the area, even if they did not receive care during the year.

4.9.5.3. Retain the outpatient records for an entire family as long as one family member is receiving medical care.

4.9.6. Civilian Air Force Employee Outpatient Records. The Civilian Employee Medical Folder (EMF) is a chronological, cumulative record of occupational and non-occupational information pertaining to the health of a civilian employee during the course of employment. This record consists of personal and occupational health histories, exposure records, medical surveillance records, Office of Worker's Compensation Programs (OWCP) records, and the documented notes, evaluations and tests results generated by health care providers in the course of examination, treatment and counseling. Maintain outpatient records of civilian Air Force employees until the employee is transferred to another activity within the Federal government or is separated from the Federal Service. Upon employee transfer or separation, place the record in SF 66D, **Employee Medical Folder**, and forward to the Military Personnel Flight (MPF), Civilian Personnel Section within 10 days of transfer or separation. It is the responsibility of the MPF to forward the EMF to the appropriate custodian.

4.9.7. Retirement of Inpatient Records, Extended Ambulatory Records (EARs), and Fetal Monitoring Strips (FMS) to NPRC. (NOTE: For discharges in CY 03 and previous years, filing of multiple same patient episodes in a single folder is acceptable, i.e, multiple inpatient records in the same folder, multiple EARs in the same folder. However, beginning with discharges as of 1 Jan 04, each separate inpatient record and EAR episode must be filed in separate folders.)

4.9.7.1. Inpatient Records. Retire inpatient records of all personnel, with the exception of NATO military personnel and their family members (see paragraph 4.9.1.6.1.4.), to NPRC, 111 Winnebago Street in St. Louis, MO, in accordance with AFMAN 37-139.

4.9.7.1.1. Retire inpatient records according to the year of hospitalization discharge, not admission.

4.9.7.1.2. Teaching facilities will retire records 5 years after the end of the calendar year of the last date of treatment; Non-teaching military treatment facilities (MTF) will retire records 1 year after the end of the calendar year of the last date of treatment; Non-fixed medical facilities, Expeditionary Medical Support (EMEDS), will transfer completed records to the home base MTF that had facility oversight during the period of patient hospitalization not later than 1 year after completion of the records or upon return of the EMEDS to home base, whichever is first.

4.9.7.1.3. Follow these same rules for retirement of inpatient records of non-NATO foreign military personnel.

4.9.7.1.4. Deliver inpatient records of NATO Personnel and their family members in a sealed envelope to the individual concerned upon transfer to another U.S. military base. Upon return of personnel to NATO countries, transfer records to the person's national military medical authority. This is required IAW NATO Standard Agreements.

4.9.7.2. Extended Ambulatory Records (EARs). The rules for retirement of EARs are the same as those for inpatient records (i.e., five years after the end of the calendar year of the last episode in the folder or one year after).

4.9.7.2.1. Retire the EAR folder to NPRC along with the inpatient records and any applicable fetal monitoring strips (i.e., in the same box.)

4.9.7.2.2. Place the EAR folder behind any fetal monitoring strips for that patient, or behind the applicable inpatient record folder if there are no fetal monitoring strips

4.9.7.2.3. If the patient does not have an inpatient record but does have an EAR, the EAR is still included in the shipment of inpatient records.

4.9.7.3. Fetal Monitoring Strips (FMS). Retire the FMS to NPRC in accordance with AFMAN 37-139, (NOTE: Digitized, or other format, fetal monitor strips that can be printed out on an 8 1/2"X 11" sheet of paper are filed in the infant's inpatient record or the mother's if the infant is still-born and are retired as a part of the inpatient record.)

4.9.7.3.1. Retire the fetal monitoring strips to NPRC using the same disposition schedule as that for inpatient records (i.e., either five years after the end of the calendar year of birth or one year after)

4.9.7.3.2. Attach the envelopes containing the fetal monitoring strips to the inside of an appropriately labeled folder (only two envelopes per patient per folder).

4.9.7.3.3. Annotate the outside of the folder with the name and register number of the infant, sponsor's name and SSN, name of the MTF and date of infant's birth.

4.9.7.3.4. File these folders in the same box as the applicable inpatient record (baby's or mother's) directly after that record.

4.9.8. Prepare shipment indices of records being retired to NPRC. There will be one index for outpatient records and one index for inpatient records. (The inpatient records, FMS, and EAR records will all be included on the same index.)

4.9.8.1. MTF users who will transmit retirement indices to NPRC must register with NPRC by completing VA Form 9957, **ACRS Time Sharing Request Form**. Sample of the form is available in **Figure 4.2.** and **Figure 4.3.** An electronic copy of the form along with the instructions for completion can also be obtained at the following NPRC website: <http://www.archives.gov/facilities/mo/st-louis/military-personnel-records/customer-service.html>. Look under "Medical Registry System."

4.9.8.2. Follow the applicable tables and rules in AFM 37-139 to determine record retirement eligibility.

4.9.8.3. Utilize the step-by-step instructions provided in the Medical Record Tracking, Retirement, and Retrieval (MRTR²) User Guide to set up the CHCS record rooms, create pull lists of retirement eligible records, and to create the final shipment index. A copy of this User Guide can be obtained from the Patient Administration website: <https://kx.afms.mil/patientadmin>.

4.9.8.4. The CHCS system will maintain shipment indices until all records listed have been destroyed or transferred to the National Archives, or when no longer needed, whichever is later. It

is recommended that you also print out and maintain a copy of each index for future use. This information is invaluable when determining whether or not a record has been retired to NPRC.

4.9.8.5. Forward a copy of each shipment index to the Base Records Management Office for their files.

4.9.9. Requests for Medical Records from NPRC.

4.9.9.1. When requesting records retired to NPRC prior to CY 2003, utilize the DD Form 877-1, **Request for Medical/Dental Records**. This form contains space for the minimal information required by NPRC to institute a search for the requested record.

4.9.9.2. For records retired to NPRC CY 2003 and later, utilize the NPRC on-line query system (Medical Registry System (MRS)) to request the record. This system can be accessed through a web interface. Users who will access the MRS for record inquiries or ordering must register with NPRC by completing VA Form 9957 as stated in paragraph [4.9.2.1](#).

4.9.9.3. Utilize the step-by-step instructions provided in the Medical Record Tracking, Retirement, and Retrieval (MRTR²) User Guide to access the MRS for record inquiries and ordering. A copy of this User Guide can be obtained from the Patient Administration website:

<https://kx.afms.mil/patientadmin>.

4.9.9.4. When requesting records from another MTF or Veterans Administration facility, utilize the DD Form 877-1, or some other form as desired.

4.10. Base Closures and Medical Records Management.

4.10.1. Inpatient Records are retired to the NPRC upon inactivation of the hospital (or upon downsizing to a clinic) in accordance with AFMAN 37-139.

4.10.2. If early retirement is desired (i.e., out of cycle), the MTF Commander must request early retirement from HQ USAF/SCMI, 1250 Air Force Pentagon, Washington, DC 20330-1250. Coordinate the request with the local Information Management Office before submission.

4.10.3. Submit requests for early retirement as soon as possible because of the time required for approval. The request is coordinated with NPRC who will notify the MTF Commander of the decision. The request must include the following:

4.10.3.1. Reason for request

4.10.3.2. Closure date (or date realigning to a clinic)

4.10.3.3. Type(s) of records to be retired

4.10.3.4. Number of records (volume) involved

4.10.3.5. All information normally included on the shipment index when requesting an accession number from NPRC

4.10.4. Outpatient records of active duty members and their family members are transferred to the member's gaining base.

4.10.5. Outpatient records of retirees and others.

4.10.6. If another MTF is identified by the patient as the new facility of treatment, forward the medical records to that facility with a cover letter explaining why the records were forwarded.

- 4.10.7. If a civilian MTF is identified as the new treatment facility, copy pertinent portions of the record for the patient to take to that facility. Retire the original record to NPRC in accordance with AFMAN 37-139. Maintain an AF Form 1942, **Clinic Index**, for six months or until the base closes, whichever comes first, then destroy.
- 4.10.8. For sequestered records, each Major Command (MAJCOM) will designate repository bases within the command to administer medical records involved in projected or actual litigation.
- 4.10.9. If an actual medical malpractice claim was filed for active duty family members, forward the original inpatient or outpatient record (as applicable) to the Risk Manager or Hospital Administrator at the gaining MTF. **Do not** allow the patient to handcarry the record. In addition, send a letter explaining why the records are being forwarded.
- 4.10.10. Use the following guidance if an actual medical malpractice claim was filed for a retiree or other patient.
- 4.10.10.1. If the continued care will be provided at an Air Force MTF, forward the original record with the appropriate letter of explanation.
 - 4.10.10.2. If the care will be provided by a civilian or non-Air Force MTF, provide the patient with a copy of the record and forward the original with the appropriate letter to the Risk Manager or Medical Facility Administrator at the designated repository.
- 4.10.11. Use the following guidance for potential claims.
- 4.10.11.1. If there is a potential claim in reference to inpatient records, forward the original inpatient record with the accompanying letter of explanation to the Risk Manager or Quality Services Manager at the gaining Air Force MTF or designated repository base.
 - 4.10.11.2. If there is a potential claim in reference to outpatient records, as a general rule, follow procedures outlined in this section. Coordinate special concerns and circumstances with the local base Staff Judge Advocate.
- 4.10.12. Closure bases must establish a "Chain of Custody" document which lists each patient's name, SSN and location to which the medical record was forwarded. Forward a copy of the Chain of Custody document to the MAJCOM.
- 4.10.13. On inactivation of the MTF, the old retained SF 135s, **Records Transmittal and Receipt** (these were produced prior to CY 03) and copies of the CHCS shipment indices (produced CY 03 and later) will be forwarded to the next higher records management office (i.e., the MAJCOM).

Figure 4.1. Sample Request for Amendment or Correction of the Medical Record Form.

REQUEST FOR AMENDMENT OR CORRECTION OF THE MEDICAL RECORD

[Name of MTF]

Patient Name: _____ Date of Birth: _____

FMP and Social Security Number: _____

Address: _____

Phone Number: _____

After review of my medical record, I do not feel that the original documentation made by _____ accurately reflects my treatment, condition, or diagnosis on the following date _____ and should be supplemented with clarifying information in the form of an addendum or correction to my medical record.

I understand that my physician or health care provider may or may not supplement my record with an addendum or correction based on my request. I understand that my physician or other health care provider is allowed to alter the original documentation in my record as outlined in AFI 41-210. I understand that my request for amendment or correction will be made a permanent part of my medical record and will be sent to any future authorized medical record request for information.

I understand that [Name of MTF] will provide a response to this request no later than sixty (60) days from the date of my request. I understand I have the opportunity to provide a statement of disagreement should my physician or health care provider deny my request.

Reason for amendment: _____

I request the following amendment/correction be made on my medical record: _____

Signature: _____ Date: _____

PHYSICIAN OR HEALTH CARE PROVIDER RESPONSE

q In response to your request, an amendment/correction will be made part of your permanent record.

q Your request has been denied; however, your request is made part of your permanent medical record. The reason your request is denied is as follows: _____

Signature: _____ Date: _____

Date response sent to Patient: _____

Figure 4.2. Sample VA Form 9957 ACRS Time Sharing Request Form.

 Department of Veterans Affairs		ACRS TIME SHARING REQUEST FORM	
<p>PRIVACY ACT STATEMENT: The information is solicited under authority of Title 38, United States Code and Executive Order 9397 and is necessary to accomplish the action requested by the requester, including establishing, modifying or deleting a Time Sharing Customer Account. Furnishing the information on this for, including your Social Security Number, is voluntary; however, if the information is not furnished, we will be unable to take further action on your request.</p>			
<p><i>NOTE: Information from this form is used to establish a Time Sharing Account.</i></p>			
<p>1. ACTION REQUESTED (Check only one of the three items)</p> <p> <input type="checkbox"/> CREATE NEW CUSTOMER <input type="checkbox"/> MODIFY EXISTING CUSTOMER <input type="checkbox"/> DELETE EXISTING CUSTOMER </p>			
2. CUSTOMER INFORMATION			
A. NAME		B. TIME SHARING CUSTOMER ID	C. SOCIAL SECURITY NUMBER
D. TELEPHONE NUMBER (Include Area Code)		E. FACILITY (STATION) NUMBER/SUFFIX OGA	F. MAIL ROUTING SYMBOL OR STOP CODE
G. JOB TITLE			H. SUBSYSTEM APPLICATION FUNCTION CODE (SAFC) 26D2
I. IF FOR CONTRACTOR, OR IF TEMPORARY ACCESS, SHOW EXPIRATION DATE (Month, day, year)		J. EMPLOYER (For Contractor or Other Government Organization)	
K. OFFICE ADDRESS (Street, City, State, Zip Code, for Contractor or Other Government Organization)			
Proxy Server Address:			
<p><i>NOTE: See reverse for instructions.</i></p>			
3. FUNCTIONAL TASKS			
CHECK APPROPRIATE BOX ADD DELETE		FUNCTIONAL TASK CODES	CONCURRING SYSTEM MANAGER OF RECORD (SMR) DESIGNEE SIGNATURE & TITLE (If required)
		1NARA84—FTP MRS	
		1NARA85—MRS Record Order	
		1NARA86—MRS Look-up only	
4. SIGNATURES			
REQUESTING OFFICIAL & TITLE			DATE
APPROVING OFFICIAL & TITLE			DATE
SECOND APPROVING OFFICIAL & TITLE (If required)			DATE
FACILITY POINT OF CONTACT			DATE

Figure 4.3. Instructions for VA Form 9957 ACRS Time Sharing Request Form.

 Department of Veterans Affairs		ACRS TIME SHARING REQUEST FORM	
<p>PRIVACY ACT STATEMENT: The information is solicited under authority of Title 38, United States Code and Executive Order 9397 and is necessary to accomplish the action requested by the requester, including establishing, modifying or deleting a Time Sharing Customer Account. Furnishing the information on this for, including your Social Security Number, is voluntary; however, if the information is not furnished, we will be unable to take further action on your request.</p>			
<p><i>NOTE: Information from this form is used to establish a Time Sharing Account.</i></p>			
<p>1. ACTION REQUESTED (Check only one of the three items)</p> <p> <input checked="" type="checkbox"/> CREATE NEW CUSTOMER <input type="checkbox"/> MODIFY EXISTING CUSTOMER <input type="checkbox"/> DELETE EXISTING CUSTOMER </p>			
2. CUSTOMER INFORMATION			
A. NAME Enter your name		B. TIME SHARING CUSTOMER ID Leave this blank	C. SOCIAL SECURITY NUMBER Enter your SSN
D. TELEPHONE NUMBER (Include Area Code) Enter your office telephone		E. FACILITY (STATION) NUMBER/SUFFIX OGA	F. MAIL ROUTING SYMBOL OR STOP CODE AF users enter: 061 AR and Navy users enter: 062
G. JOB TITLE Enter your job title		H. SUBSYSTEM APPLICATION FUNCTION CODE (SAFC) 26D2	
I. IF FOR CONTRACTOR, OR IF TEMPORARY ACCESS, SHOW EXPIRATION DATE (Month, day, year) Leave this blank		J. EMPLOYER (For Contractor or Other Government Organization) Enter Army, Navy or Air Force	
K. OFFICE ADDRESS (Street, City, State, Zip Code, for Contractor or Other Government Organization) Enter Your Office Address		Proxy Server Address: Enter Your Proxy Server Address (Contact your System Administrator for the Proxy Server address through which your Internet traffic flows. If there is none at your MTF, enter the IP address of your worksite computer.)	
<p><i>NOTE: See reverse for instructions.</i></p>			
3. FUNCTIONAL TASKS			
CHECK APPROPRIATE BOX ADD DELETE	FUNCTIONAL TASK CODES	CONCURRING SYSTEM MANAGER OF RECORD (SMR) DESIGNEE SIGNATURE & TITLE (If required)	
	1NARA84--FTP MRS	Check the ADD box if the user will FTP index files	
	1NARA85—MRS Record Order	Check the ADD box if the user is authorized to look up and to ORDER records from the MRS	
	1NARA86—MRS Look-up only	Check the ADD box if the user is <u>only</u> authorized to LOOK UP records on the MRS but may not submit record orders	
		Send the completed form to:	
		National Personnel Records Center	
		Attn: NRPS-Rademacher	
		9700 Page Ave., Room 2076	
		St. Louis, MO 63132	
4. SIGNATURES			
REQUESTING OFFICIAL & TITLE Obtain your boss's signature/title		DATE Enter date	
APPROVING OFFICIAL & TITLE Obtain approving official's signature/title		DATE Enter date	
SECOND APPROVING OFFICIAL & TITLE (If required)		DATE	
FACILITY POINT OF CONTACT		DATE	

Chapter 5

INPATIENT RECORDS ADMINISTRATION

5.1. Creating Inpatient Records.

5.1.1. Develop and maintain inpatient records using guidelines in this chapter and the JCAHO standards. Prepare an inpatient record for the following episodes:

5.1.1.1. Patients admitted to an inpatient unit of an Air Force MTF, including patients admitted and discharged before midnight on the day of admission regardless of the type of discharge.

5.1.1.1.1. Reactivate the record of hospitalization if the patient is readmitted before midnight on the same day as discharged for the same reason as the first admission. The attending provider annotates the reason for readmission and the hospitalization is considered as one continuous period.

5.1.1.1.2. If the patient is readmitted after midnight, or the reason for readmission is different from that of the previous admission, create a new record.

5.1.1.2. Active duty personnel admitted to non-Federal hospitals and others for whom administrative responsibility is assumed. See paragraph 5.8.2. for documentation guidance.

5.1.1.3. Live births occurring in an Air Force MTF. **NOTE:** Do not create a separate record on stillbirths under 22 weeks.

5.1.1.4. Patients who die in transit. The MTF receiving the remains processes the records and completes the AF Form 565 as if the patient had transferred in.

5.1.1.5. All patients admitted to an EMEDS facility or fixed contingency hospital during deployment. See paragraph 5.8.3. for instructions.

5.1.2. A “canceled admission” may be appropriate in some instances. Annotate the admission work sheet with the reason for cancellation and place all paperwork generated by the admission (e.g., History and Physical, progress notes, laboratory and x-ray reports, etc.) in the patient’s outpatient record folder. Record and code the episode as an outpatient visit.

5.2. Creation of the Master Patient Index (MPI).

5.2.1. The MPI serves as an alphabetical index of all hospital patients and patients for whom administrative responsibility is assumed (e.g., active duty military in non-federal medical treatment facilities). **NOTE:** Do not destroy - maintain for 50 years.

5.2.2. The MPI is created by and stored in the current automated system.

5.2.3. MTFs without automated A&D functions will maintain either hard-copy index cards or readily accessible and properly maintained DD Forms 739, **Register of Patients**, as they are a source for locating prior admission data.

5.3. Preparing Inpatient Record Folders.

5.3.1. Number folders according to the social security number (SSN) as follows:

Table 5.1. Preparing Inpatient Record Folders.

If the patient is:	Use SSN of:
Active Duty/ARC	Member
Family Member	Sponsor
Civilian Employee	Employee
Retired military	Member
Civilian Emergency	Patient
Foreign national, allied or neutral military member without SSN	Construct a pseudo SSN

5.3.2. See **Chapter 6**, paragraph **6.1.5.**, for guidance on constructing a pseudo SSN whenever the actual SSN cannot be determined.

5.3.3. Select an AF Form in the 788A-788J series, as appropriate, according to the last two digits of the applicable SSN. Enter patient identification information on the front of the folder.

5.3.3.1. Print the first name, middle initial, and last name of the patient in the space provided with a black pen, felt-tip marker, or embossed card. Address labels prepared by the Personnel Data System may be used to provide names of military personnel. **DO NOT** use pencil for any entry. Always place information in the upper right-hand corner of the cover in the patient ID area.

5.3.3.2. Enter the sponsor's SSN in the preprinted blocks in the upper right-hand corner of the record.

5.3.3.3. Enter the family member prefix in the two circles next to the SSN.

5.3.3.4. Blot out the ½-inch square block, along the right edge of the back leaf of the folder, containing the same digit as the last digit of the SSN, with a black ink pen, felt-tip marker, or black tape.

5.3.3.5. Mark through the current year with a felt-tip marker or pen to indicate the latest year the non-active duty patient was treated.

5.3.3.6. Indicate the patient's status in the appropriate block on the front.

5.3.3.7. Attach the CHCS MRT bar code label to the inpatient record folder. See the MRTR² User Guide for instructions on label requirements. See paragraph **4.9.2.3.** for web address.

5.3.4. Documents placed in the folder may be held together with a 3-inch fastener or fastened into the folder. When records are retired to the NPRC, documents are permanently affixed to the folder.

5.4. Contents of Inpatient Records.

5.4.1. On disposition of the patient, arrange paper copies of forms in the order listed below as applicable to the case. **NOTE:** Upon development of the computer-based patient record, the arrangement of data in the electronic record may vary from the guidance provided here. An asterisk "*" denotes that the form may not be filed in the order listed. See instruction column for proper filing location. Command and locally developed medical forms should be filed in the appropriate order as according to purpose.

Table 5.2. Arrangement of Forms in Inpatient Record.

Form Number and Title	Instructions
AF Form 565, Recrod of Inpatient Treatment	Original, typed, or electronic
AF Form 560, Authorization and Treatment Statement	Original
SF 569, Patient's Absence Record	
*AF Form 618, Medical Board Report	With attachments as a complete package when prepared.
SF 502, Medical Record-Narrative Summary (Clinical Resume)	Unless included in Medical Board package.
SF 503, Medical Record-Autopsy Protocol	
DD Form 1322, Aircraft Accident Autopsy Report	When used instead of SF 503 for reporting autopsies performed on aircraft accident fatalities.
SF 504, Clinical Record-History Parts I and II	
SF 505, Clinical Record-History Parts II&III	
SF 506, Clinical Record-Physical Examination	
SF 539 (or DD Form 2770), Medical Record-Abbreviated Medical Record	When used instead of, or in addition to SF 504-506.
SF 558, Medical Record-Emergency Care and Treatment	When patient is admitted through the Emergency Room; Original.
*SF 507, Clinical Record Report On _ or Continuation of SF Report _____	Always file as an attachment to the form to which it pertains. Do not separate from that form.
*OF 275, Medical Record Report	When used in lieu of a SF, AF or DD form, file in place of that form.
SF 535, Clinical Record-Newborn	
SF 509, Medical Record-Progress Notes	When appropriate place preadmission SF 600s in front of SF 509
SF 513, Consultation Report	
DD Form 2161, Referral for Civilian Medical Care	
SF 515, Medical Record-Tissues Examination	If an AFIP report is prepared, file it beneath the SF 515 to which it pertains
SF 516, Clinical Record-Operation Report	
OF 517, Medical Record-Anesthesia Recovery Room Record	
AF Form 1864, Preoperative Nursing Record	
OF 522, Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures	Or locally approved form (check with State Requirements).
SF 533, - Medical Record – Prenatal and Pregnancy	Prenatal record is filed as a whole package with all forms pertaining to prenatal treatment filed chronologically between the SF 533 and AF Form 3915.
AF Form 3915, Labor and Delivery Flow Sheet	
AF Form 1302, Request and Consent for Sterilization	
AF Form 1225, Informed Consent for Blood Transfusion	
SF 523, Medical Record-Authorization for Autopsy	
OF 523B, Medical Record-Authorization for Tissue Donation	

(Table continued on next page)

Form Number and Title	Instructions
SF 519B, Medical Record – Radiological Consultation Request Report	
OF 520, Medical Record-Electrocardiographic Record	
SF 546, Chemistry I	
SF 541, Medical Record-Gynecologic Cytology	
SF 547, Chemistry II	
SF 548, Chemistry III (urine)	
SF 549, Hematology	Facilities having Coulter Counter Model S, use AF Form 1976-Hematology instead of SF 549.
SF 550, Urinalysis	
SF 551, Serology	
SF 552, Parasitology	
SF 553, Microbiology I	
SF 554, Microbiology II	
SF 555, Spinal Fluid	
SF 557, Miscellaneous (NOTE: Laboratory Reports may be computerized)	
DD Form 741, Eye Consultation	
AF Form 1412, Occupational Therapy Treatment Record	
AF Form 1535, Physical Therapy Consultation	
AF Form 1536, Physical Therapy Consultation Continuation Sheet Record	
SF 521, Medical Record-Dental	
SF 524, Medical Record-Radiation Therapy	
SF 525, Medical Record-Radiation Therapy Summary	
SF 526, Medical Record-Interstitial/Intercavitary Therapy	
SF 527, Medical Record-Group Muscle Strength, Joint R.O.M., Girth and Length Measurements	
SF 528, Medical Record-Muscle Function by Nerve Distribution: Face, Neck and Upper Extremity	
SF 529, Medical Record-Muscle Function by Nerve Distribution: Trunk and Lower Extremity	
SF 530, Medical Record-Neurological Examination	
SF 531, Medical Record-Anatomical Figure	
AF Form 3066 (or 3066-1), Doctor's Orders	
AF Form 3069, Medication Administration Record	
AF 3068, PRN Medication Administration Record	
AF 3067, Intravenous Record	

AF Form 3241, Adult Admission Note	
AF Form 3242, Adult Patient Care Plan	
AF Form 3244, Pediatric Admission Note	
AF Form 3245, Pediatric Patient Care Plan	
AF Form 3247, Neonatal Admission Note	
AF Form 3248, Neonatal Patient Care Plan	
AF Form 3250, Obstetric Patient Care Plan	

Form Number and Title	Instructions
AF Form 3252, Mental Health Patient Care Plan	
AF Form 3254, Patient Care Plan	
AF Form 3256, Patient/Family Teaching Flow Sheet	
SF 511, Medical Record-Vital Signs Record	
SF 512, Medical Record-Plotting Chart	
SF 512A, Medical Record-Plotting Chart-Blood Pressures	
DD Form 792, Twenty-Four Hour Patient Intake and Output Worksheet (if local requirements to file)	
Other prescribed nursing forms	
AF Form 570, Notification of Patient's Medical Status	
AF Form 1122, Personal Property Inventory	
AF Form 1122A, Personal Property Inventory (Continuation Sheet)	
Birth Certificate and Worksheet	
Death Certificate	
AF Form 438, Medical Care - Third Party Liability Notification	
DD Form 2569, Third Party Collection Program Insurance Information	
Other command and local administrative forms	
Other release of information forms	
Correspondence Records received with transferred patients	
*DD Form 602, Patient Evacuation Tag	File beneath the SF 502 from the transferring MTF.

NOTE: Interfile preadmission paperwork with its corresponding documentation.

5.4.2. Problem Oriented Medical Record (POMR). If a MTF elects to use the POMR format, develop local directives to prescribe which cases will use this format, the method by which the forms are used and the manner in which the forms will be filed.

5.4.3. Self-Determination Act (Advance Directive) Documents. When provided by the patient (at each admission), the documents (which may include the living will, durable power of attorney and organ donation paperwork) will be filed with the other administrative documents in the record. After

discharge, the patient may take the documents home with them and bring them back if admitted again at some future date.

5.5. Forms and Identification.

5.5.1. Inpatient records consist of the original copy of the forms listed in [Table 5.2](#), as applicable to the case. Each form filed in the inpatient record must contain, at a minimum: Patient name (last, first, middle), Register Number, patient's FMP, patient's and sponsor's SSN, MTF of treatment name and name of MTF where the outpatient records are maintained.

5.5.2. Standard Forms Available on World Wide Web. Many Standard Forms are now available at the [GSA - Forms Library](#) website. These forms are in "pdf" format and must be downloaded with the adobe reader, available on the website. Forms not available on the website must be ordered from:

GSA-FSS
General Products Commodities Center
ATTN: 7FSM
819 Taylor Street
Fort Worth, TX 76102

5.5.3. See [Chapter 4](#) for guidance on overprinted and electronically generated forms.

5.5.4. Dictated and Transcribed Medical Forms. Include the dates and times of dictation and transcription, the clinical specialty or subspecialty of the health care provider preparing the report and their Air Force Specialty Code (AFSC), if appropriate, with the appropriate suffix on all transcribed reports, such as SFs 502, 504-506, 516, etc.

5.6. Filing Inpatient Records.

5.6.1. Preparation of folders, arrangement of content, and record filing methodology is consistent throughout Air Force medical treatment facilities.

5.6.2. File records in terminal digit format by SSN.

5.6.3. For discharges in CY 03 and earlier, records of previous admissions may be brought forward and filed, as a separate entity, in the folder of the current admission record.

5.6.4. Beginning with discharges as of 1 Jan 04, file each admission in a separate folder. There is no requirement to re-file admissions in a separate folder for discharges occurring prior to 1 Jan 04.

5.6.5. Only authorized personnel at the MTF may access inpatient records. Substitute an AF Form 614, **Charge Out Record**, for the inpatient record when removed from the file and charge out record in the MRT module of CHCS.

5.6.6. Fetal Monitoring Strip (FMS) Filing Procedures. Maintain the FMS on the obstetrical unit with the prenatal record until delivery.

5.6.6.1. After discharge of the infant, send the FMS to the inpatient record section for maintenance until retirement to the NPRC. Annotate the envelope with the name and register number of the infant, sponsor's name and SSN, name of the MTF, and date of infant's birth.

5.6.6.2. Place strips in envelopes that will be filed in record folders when retired to NPRC. NOTE: Digitized, or other format, FMS which can be printed out on an 8 1/2" X 11" document are

filed in the infant's inpatient record or the mother's if the infant is stillborn. Attach the CHCS MRT bar code label to the folder. See paragraph [5.3.3.7](#).

5.6.6.3. When an undelivered patient is transferred, send all FMS prepared with the copy of inpatient records to the receiving MTF.

5.6.6.4. Send the FMS with the patient, when a newborn is transferred to another MTF during initial hospitalization.

5.6.6.5. File FMS for stillborn infants, those under 22 weeks gestation, under the register number of the mother.

5.6.6.6. When it cannot be determined that prenatal care terminated in hospitalization or delivery, send the outpatient fetal monitoring strips to the inpatient record section.

5.6.6.7. All FMS will be retired to NPRC in the same shipment as the inpatient records and the EARs.

5.7. Documentation Guidance.

5.7.1. Provider's Social Security Numbers will not appear anywhere in the patient's inpatient record. The only place where the provider's SSN (or other identification number) is required is on the Pharmacy's copy of orders for Schedule II medications.

5.7.2. AF Form 560 - Use this form as a work sheet for admitting the patient and for recording final diagnoses and procedures.

5.7.2.1. Demographic information can be entered directly into the current automated system, without duplicate entry of the same information on AF Form 560. It is not necessary that the final automated coversheet be an exact copy of the AF Form 560.

5.7.2.2. The appropriate health care provider completes AF Form 560 at discharge and authenticates the entry and identifies himself or herself by signature, initials and use of a name stamp.

5.7.2.3. Upon receipt of the inpatient record, inpatient records personnel review the entire record to ensure completeness and accuracy of diagnostic and procedure information on the AF Form 560. If a question arises, consult the provider for clarification. The provider completing the form makes the final decision regarding additions and deletions of diagnoses and procedures.

5.7.2.4. Sequence and code the diagnoses and procedures using the current version of the International Classification of Disease. Prepare the final cover sheet (AF Form 565 or automated equivalent) after all information has been checked and completed.

5.7.2.5. Complete an AF Form 560 for active duty military personnel hospitalized in a non-military MTF. A complete copy of the inpatient record from the treatment facility is not necessary. See paragraphs [5.8.2](#) and [7.3](#), for further guidance.

5.7.2.5.1. When the patient is discharged to duty, complete the AF Form 560 with the diagnostic and procedure information obtained from the non-military MTF and file a copy in the member's outpatient record.

5.7.2.5.2. If the patient is transferred to your MTF, enter the Source of Admission and dates of treatment in item 40 of the current AF Form 560. Do not create a separate form; the entire period of treatment is covered with one AF Form 560.

5.7.2.6. Disposition of the AF Form 560.

5.7.2.6.1. The original worksheet is filed in the inpatient record

5.7.2.6.2. A copy of the AF Form 560 is placed in the outpatient record when used in lieu of a AF Form 565.

5.7.3. AF Form 565. Use this form or automated equivalent as the final cover sheet of each record to provide an administrative and clinical summary of each admission.

5.7.3.1. The appropriate health care provider will sign the provider's attestation statement on the final cover sheet. This statement is used to show that the provider agreed with the identification of the principal diagnosis and procedure, any co-morbidities or complications, and the sequencing of the diagnoses and procedures.

5.7.3.2. A locally designated health care provider will sign the AF Form 565, in an administrative capacity only, for a military member hospitalized in a nonfederal hospital. (The current automated system requires the name of a health care provider in order for the record to be entered.) At local MTF option, in addition to the provider's signature, a stamp indicating that the record was created for administrative purposes only may also be used.

5.7.3.3. Use AF Form 565 in death cases for persons who are inpatients at the time of death.

5.7.3.4. Disposition of AF Forms 565.

5.7.3.4.1. Insert the original AF Form 565 in the inpatient record.

5.7.3.4.2. Insert a copy of AF Form 565 in the outpatient record after final disposition of the case.

5.7.3.4.3. File a copy of the AF Form 565 in the outpatient record of patients being transferred to another facility.

5.7.4. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) states that "a concise discharge summary providing information to other caregivers facilitating continuity of care includes the following: the reason for hospitalization; significant findings; procedures performed and care, treatment, and services provided; patient's condition at discharge; and instructions to the patient and family as appropriate." Consideration should be given to instructions relating to physical activity, medication, diet and follow-up activity, medication, diet and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved." When preprinted instructions are given to the patient or family, the record should so indicate and a sample of the instruction sheet in use at the time should be on file in the medical record department.

5.7.4.1. The health care provider dictates a concise clinical resume (narrative summary) which is transcribed on the SF 502 for:

5.7.4.1.1. Patients hospitalized 8 days or longer.

5.7.4.1.2. Patients received by transfer from another MTF for further medical treatment regardless of the length of stay.

5.7.4.1.3. Patients who die after admission.

5.7.4.2. The narrative summary may be handwritten on the SF 502 if the patient has been hospitalized less than 8 days.

5.7.4.3. When a patient is transferred to another medical facility for further care, a handwritten summary will be completed. If, for expediency's sake, a quick transfer note is written, a written or dictated summary will follow.

5.7.4.4. Final progress notes on SF 509 may be substituted for narrative summaries on patients with minor problems requiring less than a 48-hour stay, normal newborn infants or uncomplicated obstetrical deliveries. Include any instructions given to the patient or family in the final progress note. Insert a copy in the patient's outpatient record.

5.7.4.5. Disposition of SF 502:

5.7.4.5.1. File the original in the patient's inpatient record.

5.7.4.5.2. File a copy in the patient's outpatient record.

5.7.4.5.3. Send one copy to the Commandant (G-KMA), U.S. Coast Guard, Washington DC 20590, when U.S. Coast Guard members on active duty are discharged.

5.7.4.5.4. Upon disposition of a uniformed services member who is already on the Temporary Disability Retirement List (TDRL) when admitted, send a copy of the AF Form 565 and SF 502 to the parent service as indicated below:

Air Force:

HQ AFPC/DPAMM
550 C Street West, Suite 26
Randolph AFB TX 78150-4728

Navy:

Department of the Navy
Bureau of Medicine and Surgery (MED-25)
2300 E St., NW
Washington DC 20372-5300

Public Health Service and National Oceanic Atmospheric Administration:

Medical Affairs Branch
ATTN: Dr. David Hooper
Department of Health and Human Services
5600 Fishers Lane, Rm 4C-06
Rockville, MD 20857

5.7.5. For an active duty patient pending final disposition of Permanent Change of Station (PCS) to home or transfer to a VA hospital, place all additional copies of the AF Form 565 (or AF Form 560 when used in lieu of) and SF 502 in a suspense file. Keep the patient in a change-of-status category until final disposition of the case. Upon disposition, patient administration personnel complete the administrative data on the final cover sheet (i.e., regarding type of disposition, etc.) and file the forms as specified in paragraph [5.4](#).

5.7.6. SF 504, SF 505, and SF 506.

5.7.6.1. Health care providers complete the history and physical examination records within 24 hours after admission.

5.7.6.1.1. Completion of any part of the history or physical examination by a medical student/physician's assistant student does not relieve the attending health care provider of the responsibility to ensure that an adequate history and physical examination is performed and documented. (See AFI 44-102 for procedures concerning histories and physicals conducted by medical/physician's assistant students.)

5.7.6.1.2. The certified nurse midwife completes the history and physical examination on obstetrical patients for whom he/she is responsible.

5.7.6.1.3. A properly credentialed oral surgeon completes the physical examination for patients admitted for dental services.

5.7.6.1.4. Podiatrists complete the history and physical as applicable to the podiatry problem.

5.7.6.2. If an adequate history and physical examination is sent with transfer-in patients, the provider may document an interval note on SF 509 stating no changes. The provider will document any important changes.

5.7.6.3. Enter a note in the SF 509 referring to the previous history and physical examination for patients readmitted within one month to the same MTF for the same condition. Document any changes. If desired, place a copy of the previous history and physical in the current record.

5.7.6.4. If a history and physical examination was performed within 30 days before admission, such as in the physician's office, place a durable, legible copy in the inpatient record and document any changes in the SF 509.

5.7.7. DD Form 2770, may be used for the following:

5.7.7.1. Hospitalizations of five days or less for minor medical conditions normally treated on an ambulatory basis when care in the patient's residence is inadequate.

5.7.7.2. Hospitalizations of two days or less for minor surgical procedures performed under local or peripheral nerve block anesthesia. This includes stable anesthesia Class III or IV with minor procedure under local or regional anesthesia with or without IV sedation.

5.7.7.3. Hospitalizations of five days or less for delivering obstetric patients whose intrapartum and postpartum course is uncomplicated, provided that a complete prenatal record is included in the inpatient record.

5.7.7.4. Hospitalizations of 48 hours or less for surgeries when the patient is clearly anesthesia Class I or II, regardless of type of anesthesia used.

5.7.8. SF 535. Prepare SF 535 in duplicate for all newborn infants. Include the original in the newborn's inpatient record. File a copy in the newborn's outpatient record.

5.7.9. SF 509. Record the patient's diagnosis, treatment and care on the SF 509 to chronologically describe the clinical course of the patient.

5.7.9.1. Determine the frequency of the notes based on the patient's condition. Make daily notations for the following: the first five days after a patient has undergone a major operation; if the patient is seriously ill.

- 5.7.9.2. Record the postoperative note on the SF 509. The form may be overprinted locally to provide a format.
- 5.7.9.3. Document the informed consent on the SF 509. See AFI 44-102 for instructions.
- 5.7.10. SF 516. Report surgical operations, including those performed in the ambulatory surgery unit, on SF 516.
- 5.7.10.1. According to JCAHO, surgeons will dictate the report immediately following surgery.
- 5.7.10.1.1. If immediate dictation is not feasible, dictate the report no later than 24 hours following the end of the surgical procedure.
- 5.7.10.1.2. If the operative report is not placed in the medical record immediately after surgery, immediately prior to the patient being released from the Recovery Room enter an operative note providing pertinent information to ensure continuity of care.
- 5.7.10.2. Annotate the date and time of dictation and transcription on the form.
- 5.7.10.3. Include in the report a description of the findings, the technique used, the tissue removed or altered, estimated blood loss, as indicated, the postoperative diagnosis, the condition of the patient at the end of the operation, and the name of the primary surgeon and assistants.
- 5.7.11. Prenatal Records. Prenatal documentation is maintained in the OB/GYN clinic until the mother delivers.
- 5.7.11.1. If delivery is in your MTF, maintain the documents, as a package, with the inpatient documentation and file in the mother's inpatient record. See paragraph [5.4](#).
- 5.7.11.2. If the delivery was not performed in your MTF, file the prenatal package (as a whole package with prenatal treatment documents filed chronologically between the SF 533 and AF Form 3915) in the mother's outpatient record.
- 5.7.12. Laboratory and Radiology reports. When a computerized or automated summary of all laboratory and radiology report results compiled during the patient's hospitalization is provided, file only the cumulative final report with the exception of preadmission labs and x-rays. Destroy all previous duplicated computerized/automated report results. For inpatient records unlike outpatient, all laboratory and radiology results must be filed in the record upon discharge from the hospital.
- 5.7.13. AF Form 3066 or 3066-1. A provider signs and dates orders on the AF Form 3066 or 3066-1, or enters the information into the current automated system.
- 5.7.13.1. When a hardcopy AF Form 3066 or 3066-1 is utilized, maintain the original with the patient's inpatient record.
- 5.7.13.2. When medications are ordered, send a copy to the Pharmacy. The provider's SSN (or other identification number) is only required in the provider's stamp on the Pharmacy copy of prescription for controlled substances (See AFI 44-102).
- 5.7.13.3. A verbal or telephone order may be given to a registered nurse. Each verbal order is dated by the individual taking the order and identifies the names of the individuals who gave and received it. In such cases, the provider confirms the order, signs, dates, and stamps it within 24 hours.
- 5.7.14. Reverse of AF Forms 3068 and 3069.

- 5.7.14.1. The reverse of these forms contain a section for the initials and signatures of nursing staff administering the medications. Instead of signing the reverse of these forms, utilize a separate sheet which contains the names, signatures and initials of the nursing staff.
- 5.7.14.2. When there is a separate sheet with the names, signatures and initials, the nursing staff is only required to initial the reverse of the AF Form 3068 and 3069 when administering medications.
- 5.7.14.3. File the sheet after the AF Form 3068 or 3069.
- 5.7.15. Maintain inpatient records received with a transfer-in patient as a component part of, and attached to, the current inpatient record. Do not break up the transfer record and interfile its forms among the forms of the current record. **NOTE:** If the original record was sent, copy and maintain the pertinent portions, returning the original record to the transferring MTF.
- 5.7.16. Extended Ambulatory Records (EAR). The EAR is a folder that contains information on treatment received during an Ambulatory Procedure Visit (APV), an observation stay, Emergency Room Death (ERD), Dead on Arrival (DOA), or other similar status.
- 5.7.16.1. Maintain each occasion of treatment as a separate episode within the EAR similar to the way multiple admissions are maintained within a single inpatient record folder. Starting 1 Jan 04 create a separate folder for each episode. **NOTE:** There is no requirement to re-folder episodes created before 1 Jan 04.
- 5.7.16.2. Maintain the EAR folder in a method similar to the inpatient record, using the inpatient record folder (AF Form 788A-J). Annotate the folder with the patient's name, Family Member Prefix (FMP), and sponsor's Social Security Number (SSN). Attach the CHCS MRT bar code label to the folder. See paragraph 5.3.3.7. The EAR will be filed by the sponsor's SSN (same as the outpatient and inpatient records).
- 5.7.16.3. The EAR will be maintained in a limited access area to allow for risk management and quality improvement purposes.
- 5.7.16.4. Although the paperwork for these cases is filed in the EAR folder, these episodes are actually coded as an outpatient episode in the appropriate ambulatory data collection system.
- 5.7.17. Creation, Maintenance, and Disposition of APV Records.
- 5.7.17.1. File original documentation on a patient seen during an APV episode in the EAR folder.
- 5.7.17.2. Create an APV record for those cases when a patient is seen in the Emergency Room or specialty procedure room, an APV procedure is performed, and the patient is discharged within 23 hours and 59 minutes of the time the patient was checked in by the nurse for preliminary work-up for the procedure.
- 5.7.17.3. Maintain the record in a limited access area (preferably in the inpatient records section) for risk management and quality improvement purposes. The APV record will be filed by the sponsor's Social Security Number, (same as the outpatient and inpatient records).
- 5.7.17.4. Clinical Application of APV Records.
- 5.7.17.4.1. The medical record documentation for the APV must meet the standards of documentation similar to the short-term stay (abbreviated medical record). The record documentation must comply with JCAHO standards. At a minimum, the record must include an

abbreviated history and physical, progress notes, doctor's orders, patient's informed consent, operative report, tissue report (if any), anesthesia record, summary of care, to include discharge instructions and any Advanced Directive. Copies of the summary, operative report, and any tissue reports are forwarded to the outpatient record.

5.7.17.4.2. Physicians must sign and stamp an automated cover sheet or ambulatory encounter summary form for the APV records. All diagnoses and procedures are to be written in full, without symbols or abbreviations, in acceptable terminology.

5.7.17.4.3. The following forms are recommended for use in APV records:

5.7.17.4.3.1. AF Form 560 or automated coversheet

5.7.17.4.3.2. DD Form 2770

5.7.17.4.3.3. SF 509

5.7.17.4.3.4. SF 516

5.7.17.4.3.5. OF 522, or locally produced form

5.7.17.4.3.6. OF 517

5.7.17.4.3.7. AF Form 3066 or 3066-1

5.7.17.4.3.8. AF Form 3069

5.7.17.4.3.9. AF Form 3068

5.7.17.4.3.10. AF Form 3067

5.7.17.4.4. Until such time as Standard, Air Force or DD Forms are developed, each MTF may elect to develop local forms, as an alternative to the established forms listed in paragraph [5.7.17.4.3.](#) to integrate documentation requirements into the comprehensive records. All locally developed forms will be approved by the MTF's Medical Records Function before use in APV medical records. The MTF may utilize an ambulatory encounter summary form.

5.7.17.5. Coding of APVs.

5.7.17.5.1. Code diagnoses according to International Classification of Diseases (ICD)-9-CM diagnoses coding references or current government approved coding classification system.

5.7.17.5.2. Code procedures/operations according to Current Procedure Terminology (CPT) coding references. Assign an Evaluation and Management (E&M) Code according to CPT coding references (until such time as the system requirement for an E&M code can be deleted).

5.7.17.5.3. Utilize the Ambulatory Data Module (ADM) in CHCS I or CHCS II to capture the coded information on each APV.

5.7.17.5.4. Utilize the ADM Patient Encounter Forms or the automated APV form used for coding in the APV record for auditing and quality assurance purposes.

5.7.17.6. Admission of APV Patients.

- 5.7.17.6.1. Admit as an inpatient an APV patient that stays beyond the time limit of 23 hours and 59 minutes. Time commences when the patient is checked in for preliminary work-up for the procedure.
 - 5.7.17.6.2. Do not backdate or change the time of the admission date and time to the point when the patient's APV episode began. Use the date and time when the actual admission to the hospital occurs. Enter the following statement in the administrative section of the cover sheet **"Patient admitted from APU. Information on the APV procedure is maintained in the APV record."**
 - 5.7.17.6.3. Do not combine the original APV documentation with the inpatient record but maintain it separately in the EAR folder.
 - 5.7.17.6.4. Include copies of the ADM Patient Encounter Form or automated cover sheet, the abbreviated history and physical, operative report, and any other pertinent documentation in the inpatient record, as applicable.
 - 5.7.17.6.5. Code the inpatient record with the reason that caused the admission.
- 5.7.18. Observation Records. Observation patients are outpatients with acute or chronic medical problems who require assessment monitoring or diagnostic evaluation in order to determine final disposition. The decision to place a patient in observation status is based upon the complexity, intensity, and duration of care required.
- 5.7.18.1. Outpatient observation stays generally should not exceed 23 hours and 59 minutes. However, up to 48 hours may be authorized when medical necessity has been clearly demonstrated.
 - 5.7.18.2. Observation patients may be cared for in either dedicated observation units or in any designated bed space. Appropriate JCAHO standards will apply.
 - 5.7.18.3. Documentation of Observation Records.
 - 5.7.18.3.1. Documentation for an observation patient must meet the standards for a short-term stay (abbreviated medical record) and must comply with the current JCAHO documentation standards
 - 5.7.18.3.2. Standard Forms (SF), or other forms as noted, are recommended for use in observation records. At a minimum, the documentation in the medical record will include:
 - 5.7.18.3.2.1. Summary of pertinent diagnostic findings.
 - 5.7.18.3.2.2. A plan of care to include reasons for observation, diagnoses, and risks of complication, patient education, release instructions, medication orders, and plans for follow-up care.
 - 5.7.18.3.2.3. SF 558
 - 5.7.18.3.2.4. SF 509
 - 5.7.18.3.2.5. All diagnostic reports (e.g., laboratory, radiology, or electrocardiogram) as applicable
 - 5.7.18.3.2.6. AF Form 3066 or 3066-1
 - 5.7.18.3.2.7. AF Form 3069 as applicable

5.7.18.3.2.8. AF Form 3068 as applicable

5.7.18.3.2.9. AF Form 3067 as applicable

5.7.18.3.2.10. Advanced Directive

5.7.18.3.3. File all documentation related to an observation stay in the EAR folder. See paragraph [5.7.16](#).

5.7.18.3.4. Forward the following documents to the outpatient treatment record: Release note with summary of pertinent diagnostic findings, Status of patient upon release, and Release instructions with plans for follow-up care

5.7.18.4. Coding of Observation Records.

5.7.18.4.1. Code diagnoses according to ICD-9-CM diagnoses coding references or current government approved coding classification system.

5.7.18.4.2. Code procedures/operations according to the Current Procedure Terminology (CPT) coding references. Assign an Evaluation and Management (E&M) Code according to CPT coding references.

5.7.18.4.3. Utilize the Ambulatory Data Module (ADM) in CHCS I or CHCS II to capture the coded information on each observation episode, except when an observation patient is admitted.

5.7.18.5. Admission of Observation Patients. When a patient is admitted from an observation status, file the observation documentation in the EAR folder. Place copies of pertinent documentation in the inpatient record.

5.8. Inpatient Records Maintenance.

5.8.1. Patients discharged without definitive diagnosis. The inpatient records section maintains, in a suspense file, records which the provider has indicated should be held pending pathology reports, laboratory test results, or other confirmations. Never maintain the records in suspense longer than one month after the month of disposition. Process the record with whatever information is available. The record may be corrected at a later date if information which alters the final diagnosis is received.

5.8.2. Assuming Administrative Responsibility for Military Members Hospitalized in Nonmilitary Medical Facilities.

5.8.2.1. Create an inpatient record on active duty members, for which your MTF has administrative responsibility, who are admitted to non-military medical facilities. Request a complete summary of the patient's treatment while under the care of the civilian health care provider after the patient has been discharged.

5.8.2.2. Code the inpatient record based on the diagnostic and procedural information obtained from the non-military medical facility.

5.8.2.3. Transmit, within 30 days of discharge, a Standard Inpatient Data Record (SIDR) on active duty members admitted to non-military medical facilities. However, the complete summary is not required before the SIDR can be transmitted. If the narrative summary is not obtained in a timely fashion, complete the coding using whatever diagnostic and procedure information has been obtained. A corrected SIDR can be transmitted if information is received that alters the data.

5.8.3. Management of Inpatient Records Created at Deployed EMEDS Facilities and Contingency MTFs.

5.8.3.1. The EMEDS facility maintains the inpatient records while deployed. Upon return of the facility to home base, give these records to the inpatient records section at the parent facility for maintenance as a separate record group. DO NOT send the records to the MTF where the member is based, if different than facility's parent unit. The home base will retire the records in accordance with AFMAN 37-139. Retire the records in a separate shipment than those of records created at the home base facility.

5.8.3.2. Treat records created at Military Operations Other Than War (MOOTW), i.e., contingency facilities, similarly to guidance included in paragraph 5.8.3.1. At those facilities where the management rotates between the three military Services and also between the Air Force medical treatment facilities, maintain the records until the management rotates (either to another Air Force MTF or another Service). Upon rotation of management, return the records to the parent unit's inpatient record department for maintenance as a separate record group. DO NOT send the records to the MTF where the member is based, if different than facility's parent unit. The parent unit will retire the records in accordance with AFMAN 37-139.

5.9. Disposition of Inpatient Records.

5.9.1. When transferring patients to another MTF, send a complete and legible copy of the current inpatient record, original outpatient record, and copies of any previous admissions pertinent to the patient's current condition. If complete and legible copies cannot be made in time for the patient's transfer, send the original current inpatient record. **NOTE:** The receiving MTF returns original records to the transferring MTF when they have served their purpose. Also, send any x-ray films and duplicate slides or surgical specimens when the findings have a direct bearing on the diagnosis and treatment.

5.9.2. The admitting facility notifies the originating MTF of patients admitted while on directed convalescence, PCS home, or AWOL from another medical facility while in patient status. If the patient will remain at the new MTF, the initial facility transfers the individual to the new MTF and forwards the patient's records.

5.9.3. When transferring patients to nonmilitary medical treatment facilities, a transcript or copy of pertinent pages may accompany the patient. Never release the original records; however, pertinent x-ray films are furnished to the receiving nonmilitary MTF as required.

5.9.4. Send a copy of the current inpatient record and any x-ray films when an active duty patient is transferred to a VA hospital pending separation or retirement from the uniformed services.

5.9.5. Send original records of NATO (North Atlantic Treaty Organization) military personnel and their family members (including x-ray film and medical examination reports) in a sealed envelope with the individual concerned upon transfer to another MTF. When the individual is discharged, return the record to the parent country. (See AFMAN 37-139, Table 41-11, Rule 13.) Retain copies of pertinent records necessary for quality assurance review.

5.9.6. Handle inpatient records of non-NATO military personnel and their family members the same as any other inpatient record.

5.9.7. When mailing records pertinent to litigation cases, mail medical records and claims files via certified mail/return receipt.

5.10. Medical Transcription.

5.10.1. Responsibilities of Medical Transcription: Medical transcription services provide timely and accurate transcription of dictation dealing with inpatient and ambulatory patient care. It is a patient administration responsibility and is usually managed by the supervisor or QAE/COTR of inpatient medical records department.

5.10.2. Production Goals: Each medical transcription center should produce an acceptable quantity and quality of medical transcription in a timely manner. Normally, these services are employed to generate transcription services for inpatient episodes of care. If transcription staffing and inpatient workload allow, transcription services can be expanded to ambulatory and outpatient clinic services. Inpatient and Ambulatory Procedure Visit (APVs) dictated operative reports must be transcribed and filed in medical record immediately following surgery. MTFs need to generate clear policy/guidance to all providers in their facility regarding the scope of medical transcription services they intend to offer in accordance with Joint Commission on Accreditation of Healthcare Organizations (JCAHO). NOTE: The American Association of Medical Transcriptionists (AAMT) states that there is no national average productivity level due to multiple variables. Although the American Health Information Management Association and Medical Transcription Industry Alliance agree that one line of dictation equals 65 characters, the AAMT does not support this. This issue has the industry divided. That is why the current AFI 41-210 does not state a requirement for number of lines a transcriptionist should produce per day.

5.10.2.1. Quantity: Suggested production goals for medical transcriptionist are 800 lines per day per transcriptionist. The senior transcriptionist or supervisor in a smaller medical transcription center contributes to the work center output, but these goals are lower than those established for other medical transcriptionist and decrease as the size of the medical transcription center and supervisory responsibilities increase. Personnel in training should be able to achieve the production goals within a reasonable period of time, not to exceed 1 year.

5.10.2.2. Counting and Reporting: Medical transcriptionist count and record their output according to the following suggested instructions. (Output is reported daily to the senior transcriber or supervisor.)

5.10.2.2.1. Margins should be adjusted to ensure full lines that average 80 strokes. Narrative lines of 80 strokes should average 13 words. Count each typed line with six words or more as a line; any narrative line with five words or less is not counted.

5.10.2.2.2. Form-style typing:

5.10.2.2.2.1. Count each line with two or more names, dates or words as one line.

5.10.2.2.2.2. Physicians' signature elements are counted as two lines when a two-line signature element is used, and one line when a one-line signature element is used.

5.10.2.2.2.3. Patient identification data is counted as two lines.

5.10.2.2.3. The senior transcriptionist or supervisor reports individual production to the supervisor or QAE/COTR of inpatient records.

5.10.2.3. Quality: The supervisor or QAE/COTR of inpatient records, through the senior transcriptionist or supervisor, monitors the quality of all medical transcription. When medical transcriptionist are required to retype work which does not meet quality standards, do not include lines retyped in production counts.

5.10.2.4. Timeliness: Work should normally be completed within 24 hours of receipt of dictation. Transcribed narrative summaries and operative reports should be filed in the medical record prior to inpatient/APV coding to provide complete documentation and ensure accurate coding.

Chapter 6

OUTPATIENT RECORDS ADMINISTRATION

6.1. Creation of Outpatient Record Folders. Creation of folders, arrangement of content, and record filing methodology is consistent throughout Air Force medical treatment facilities. Number folders according to the social security number (SSN) as follows:

Table 6.1. Preparing Outpatient Record Folders Table.

If the patient is:	Use SSN of:
Active Duty/ARC	Member
Family Member	Sponsor
Family Member and ARC Member	Sponsor (see 6.1.4.)
Civilian Employee	Employee
Retired Military	Retired Military
Civilian EmergencyPatient	

6.1.1. Normally only one medical record will be established and maintained for each individual in the MTF. If a member has multiple eligibility, cross reference the individual's SSAN on the front of the medical record as indicated in paragraph 6.2.10. The military medical record for ARC members will be maintained as described in paragraph 6.4.4.

6.1.2. If a beneficiary has received medical care under a previous social security numbers (SSN), as a result of remarriage to another military sponsor, record forms filed under the former SSN should be consolidated under the current sponsor SSN. Once the patient has been registered in CHCS under the current sponsor's SSN, merge the old and new patient file. For future inquiries, a cross-reference from the old number to the new number should be indicated in the outpatient files as well as in the current automated system.

6.1.3. If a beneficiary has received medical care under multiple SSNs as the result of dual eligibility status (person eligible for care as family member of active duty, ARC member, or as a retiree), then a cross-reference of the SSNs should be indicated in the outpatient files as well as in the current automated system.

6.1.4. A pseudo-SSN is created for beneficiaries without a SSN. This process occurs in the Defense Eligibility and Enrollment Reporting System (DEERS) when the personnel technician issues an ID card or enrolls the beneficiary. Either a Foreign Identification Number (FIN) or a Temporary Identification Number (TIN) is generated.

6.1.4.1. When issuing an ID card, the DEERS gives the personnel technician a choice to enter an SSN, FIN or TIN. When FIN is selected, DEERS automatically assigns a 900-00-000F. This number is assigned to categories of eligible NATO and non-NATO foreign military members, their family members, for foreign nationals employed in positions overseas that result in DoD benefits and entitlements, and for authorized non-US personnel who are not under our Social Security Administration System, and will not receive a Social Security Number (SSN).

6.1.4.2. A TIN is assigned and automatically generated by the DEERS (800-00-000D) for categories of beneficiaries who are awaiting a SSN (such as newborns) or for those who do not have a

SSN. The TIN is used as a method to record the beneficiary as a potential patient on DEERS while awaiting a SSN. Foreign nationals who are the spouse of a U.S. citizen will be issued a TIN if they are awaiting or will be receiving a SSN. If they are not required to have an SSN, they are issued a FIN. Foreign National spouses who have been issued an Individual Taxpayer Identification Number (ITIN) by the Social Security Administration will be able to use those numbers after the DEERS release in October 2003.

6.1.5. Select the appropriate AF Form 2100A series according to the last two digits of the applicable SSN. **Note:** File outpatient civilian emergency records by SSN in a manila folder. Maintain folders separately from the main file if desired. However, they must be interfiled by SSN with the rest of the records when retired to NPRC.

6.1.6. Maintain civilian employee medical records in manila folders or SF 66D. Place the record in SF 66D when the employee transfers to another Federal agency or is separated from Federal Service. Send the record to the civilian personnel office (CPO). Civilian employees [including Air Reserve Technicians (ARTS)] who are also members of an ARC will have one medical record maintained as indicated in paragraph 6.4.4. The only exception will be if the individual is not employed as a civilian at the same base where his/her ARC unit is assigned. In these cases, a civilian medical record will be maintained as described in the beginning of this paragraph.

6.2. Preparing File Folders:

6.2.1. AF Forms 2100A, 2110A, 2120A, 2130A, 2140A, 2150A, 2160A, 2170A, 2180A and 2190A, **Health Record – Outpatient.**

6.2.2. Select an AF Form in the 2100A series according to the last two digits of the applicable SSN:

Table 6.2. Terminal Digit Table

Last two digits of SSN:	Use AF Form:
00-09	2100
10-19	2110
20-29	2120
30-39	2130
40-49	2140
50-59	2150
60-69	2160
70-79	2170
80-89	2180
90-99	2190

6.2.3. Print the first name, middle initial, and last name of the patient in the space provided with a black pen, felt-tip marker, or embossed card. Address labels prepared by the Personnel Data System may be used to provide names of military personnel. DO NOT use pencil for any entry except rank. Always place information in the upper right-hand corner of the cover in the patient ID area.

6.2.4. Enter the sponsor's SSN in the preprinted blocks in the upper right-hand corner of the record.

- 6.2.4.1. Enter the family member prefix in the two circles next to the SSN. Check DEERS for the DEERS Dependent Suffix (DDS) for the patient or if not available, number in birth date order for family member children.
- 6.2.4.2. The family member prefix does not change as long as it remains with the same sponsor and SSN.
- 6.2.4.3. When a military member marries a person with children, assign family member prefix numbers in sequence following the last family member prefix already assigned to children of the sponsor (if any). Assign the oldest the next number in numerical sequence, etc.
- 6.2.4.4. Assign the family member prefix "30" to the first spouse authorized care in accordance with AFI 41-115. The former spouse also retains the SSN of the sponsor. Assign subsequent spouses who are also authorized care FMP 31-39.
- 6.2.5. Do not make any entries in the small preprinted, numbered blocks, the "R" and "S" blocks at the top of the folder, or the "R" block on the side of the folder (these are for Army use only).
- 6.2.6. Blot out the ½-inch square block, along the right edge of the back leaf of the folder, containing the same digit as the last digit of the SSN, with a black ink pen, felt-tip marker, or black tape. **NOTE:** Use red instead of black to identify the folder of an individual assigned to the Sensitive Duty Program. Green tape may be used for personnel on mobility. Cover the red or green tape with black tape when the member is removed from either program. Stamp or label "PRP" in two-inch block letters on the left hand side of the front of the folder for persons in the Personnel Reliability Program.
- 6.2.7. Records that can be maintained in aerospace medicine services include but are not limited to air crew members, missile launch members, air traffic control personnel, physiological training personnel, parachute duty personnel, weapons control personnel and empanelled family members.
- 6.2.7.1. Mark these folders with a strip of black tape on the side of the folder, extending from immediately below block "9" to the bottom of the folder. If file cabinets are used, apply another strip of black tape to top of folder, immediately to the left of the last four digits of the SSN. Never cover the prefix or SSN.
- 6.2.7.2. Use black ink or a suitable marking device if black tape is not available. Stamp "FLY" in two-inch block letters in the upper left-hand corner of the front of the folder.
- 6.2.8. Mark through the current year with a felt-tip marker or pen to indicate the latest year the non-active duty patient was treated. **NOTE:** Attach AF Form 2700L **Health Record Year Grid**, to AF Form 2100A series. Do not prepare new folders.
- 6.2.9. Blacken in the "outpatient" block for all records.
- 6.2.10. Indicate the patient's status. Enter the Service and rank for active duty and retired military personnel. Enter the country for non-U.S. military personnel. Use pencil for rank only. For family members who are also members of an ARC, enter the family member's **own** SSAN here as well as their status as a member of the Air Force Reserve or Air National Guard as appropriate.
- 6.2.11. If the person is a food handler, the Force Health Management enters the date of the current food handler examination in pencil on the appropriate line of the preprinted format.
- 6.2.12. At points of entry into the Air Force, note "Antibodies: Measles_____, Rubella_____". Use a stamp or pen.

6.2.12.1. Enter the test results after “Measles” or “Rubella”. For example, if the patient is susceptible, mark “-“ after the disease named; if not susceptible, (therefore immune), mark “+”.

6.2.12.2. Enter date of serotesting in the left column.

6.2.12.3. Note in the same way the records of medical personnel and others who have had an antibody screen against measles and rubella.

6.2.13. If the patient is allergic to medication, display this information prominently under the patient identification data on the right-hand side of the folder.

6.2.14. Attach the CHCS MRT bar code label to the health record folder in the upper right-hand corner. See the MRTR² User Guide for instructions on label requirements. See paragraph 4.9.2.3.

6.2.15. Acknowledgement of Notice of Privacy Practices Procedures. See [Figure 6.1](#). (Each patient will receive a copy of the MHS Notice of Privacy Practices and acknowledgement of receipt must be documented in the outpatient health record.)

Figure 6.1. Acknowledgement of Military Health System Notice of Privacy Practices Procedures.

NOTE: Have copies of the MHS Notice of Privacy Practices and Acknowledgement Labels available at medical records/clinic check in areas. You can order these items from the TMA Smartsite at [TRICARE SMART](#). There is no fee for ordering the products, but quantities ordered each day are limited.

Procedures:

1. Medical records technician/clinic check-in personnel checks back outside cover of outpatient health record to see if acknowledgement label is present/signed. See figure 1.
2. If none present, place label centered near the bottom on the outside of the back cover of the record.
3. Ask the patient or their representative if they have received the MHS Notice of Privacy Practices in the mail and ask patient/representative to fill out Name, Date, FMP/SSN and sign. Have MHS Notice of Privacy Practices available to give to patient if they did not receive or do not remember receiving it in the mail.

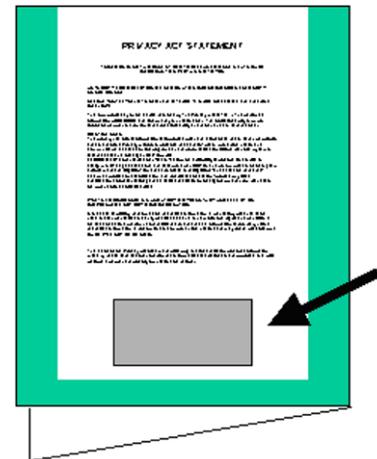


Figure 1

4. If the patient needs MHS Notice of Privacy Practices in a different language, download it from the TMA website at [HIPAA: Health Insurance Portability & Accountability Act](#). The following foreign language versions are available:

Spanish	Japanese	French	English--Large Print Edition
German	Chinese	Portuguese	Braille (call MHS HIPAA Office)
Italian	Korean	Tagalog (Philippines)	

5. If the patient or their representative refuses to sign for any reason, fill in the date, Patient Name, FMP and SSN, check the block that the patient/representative declined to sign, and initial the label.

Acknowledgement of Military Health System	
Notice of Privacy Practices	
The signature below only acknowledges receipt of the Military Health System Notice of Privacy Practices, effective date <u>14 April 2003</u> .	
_____	_____ date
_____	_____ <i>Name</i>
_____	_____ <i>relationship to patient (if applicable)</i>
FMP/SSN: _____ / _____ - _____ - _____	
Patient/Representative declined to sign _____ MTF staff initials	

6.3. Contents of the Outpatient Record.

6.3.1. Outpatient records must contain enough information to identify the patient, support the diagnosis/condition, justify the care, treatment, and service, accurately document the results of care, treatment and service rendered, and promote continuity of care. Documents will contain the name and location of the MTF maintaining the record to ensure the document is sent to the proper MTF. The documents will also contain the name of the outpatient record location.

6.3.2. Use embossed plastic cards or other tracking methods to record patient identification information on forms. Each document in the record contains, as a minimum, patient’s name, family member prefix, full SSN under which the record is to be filed, name of the MTF maintaining the patient’s record, and name of the outpatient record location. An exception is the display sheet on which laboratory and x-ray slips are filed. Since the individual slips contain the necessary data, it is not necessary to repeat identification information on the sheet. The patient’s mailing address may be added to any document.

6.3.3. Electronically generated forms (when used in place of SF, DD, or AF forms) must be a mirror image of the non-automated form and contain the statement “SF, DD or AF Form XXXX (EF) [name and producer/vendor (if any) of the software used].” See **Chapter 4** for guidance on overprinted and electronically generated forms.

6.3.4. Document in the patient’s record whether or not the patient has an advanced directive. Annotate the DD Form 2766 or AF Form 1480A, to indicate an advanced directive is filed and the date it was filed.

6.3.5. AF Form 2100 Series, **Health Record - Outpatient (Two-part folder)**. (Although no longer in print, there may still be some outpatient records that are filed in this style folder. This is acceptable. However, at such time the folder needs replacement, the AF Form 2100A Series (four-part) folder will be used. Additionally, the AF Form 2100A Series will be used to create folders on new patients.)

6.3.5.1. **Right Side:** Arrange documents on the right side of the folder in the following descending order:

6.3.5.1.1. AF Form 745. This form identifies the records of individuals assigned to the PRP and the Presidential Support Program (PSP). File the form so it is the uppermost item on the right side of the record. **NOTE:** Individuals may participate in more than one program. Facilities will circle the initials of the appropriate program on AF Form 745 (PRP and PSP). Removal of the AF Form 745 depends on the number of programs with which the individual is associated. For example:

6.3.5.1.1.1. For single program participants, the AF Form 745 will be removed and destroyed when the MTF program manager is notified by a base official the individual is no longer a participant.

6.3.5.1.1.2. For dual program participants, do not remove the form unless notification has been received that the individual is removed from both programs. Line out only the affected program initials in black. In the case of reentry, replace the form and circle the initials. Destroy the old form.

6.3.5.1.2. AF Form 966, **Registry Record**, is filed on top of the right side and under AF Form 745, if used.

6.3.5.1.3. Patient signed informed consent to the use of an E-mail format of communication with his/her provider.

6.3.5.1.4. SF 600, **Health Record – Chronological Record of Medical Care**. This form documents outpatient treatment. Enter the patient's name, family member prefix, SSN, facility name, and the name of the facility maintaining the record.

6.3.5.1.4.1. Use SF 600 to document the diagnoses, treatments, notes, disposition of cases, and other information about the patient. Document any health education provided to the patient. Entries on the SF 600 will be dated, signed and stamped.

6.3.5.1.4.2. As additional SFs 600 are prepared, place each on top of the earlier one so the latest report of treatment is on top.

6.3.5.1.5. OF 558, **Medical Record-Emergency Care and Treatment**, is used to document the diagnosis and care a patient receives in the Emergency Room. Interfile OF 558 with SFs 600 in date order.

6.3.5.1.5.1. Facilities using the ER to provide routine follow-up treatment may use SF 600 instead of OF 558. MTFs using this option should prepare a directive explaining the process.

6.3.5.1.5.2. Send the original OF 558 to the inpatient unit and file in the inpatient record if the patient is admitted. File the original OF 558 in the outpatient record if the patient is treated as an outpatient. File the second copy of the form in the ER. Give the third copy to

the patient. Establish local procedures to safeguard the ER copies of OF 558 pertaining to highly sensitive issues.

6.3.5.1.6. DD Form 2161, **Referral for Civilian Medical Care**, or SF 513. DD Form 2161 or SF 513 is filed on top of the SF 600 to which it belongs.

6.3.5.1.7. Laboratory Reports – mount on white bond paper arranging the forms to ensure that the results are readily visible without requiring the removal of staples. Patient ID is not needed on the bond paper.

6.3.5.1.8. SF 519B, **Medical Record – Radiological Consultation Request Report** is filed in chronological order by date with the most recent on top.

6.3.5.1.9. OFs 520, **Medical Record-Electrocardiographic Record**, (or automated EKG report), are filed together in chronological order by date (the most recent on top), except when OFs 520 attached as documentation to reports, are filed with other reports. Filing a copy of the inpatient electrocardiograms (EKGs) in the outpatient record is optional. MTFs shall develop local policy to inform outpatient physicians of abnormal results of EKGs performed while a patient is in an inpatient status. Ensure OF 520 is filed so that the tracing can be read by the health care provider. Facilities with computer generated EKG reports may destroy OF 520 after the test has been ordered and if all patient identification is on the automated report.

6.3.5.1.10. SF 78, **Certificate of Medical Examination**, (applies to civilian employees only) is kept in the employee's medical folder (SF 66D). When the employee is transferred, separated, or retired, send the entire record in a sealed envelope marked with the appropriate identification, to the CPO for inclusion in the employee's official personnel folder.

6.3.5.2. **Left Side:** Arrange forms on the left side of the folder in chronological sequence by the date of the most recent action. Folders with the preprinted Privacy Act Statement on the back will not have DD Form 2005 filed inside the record.

6.3.5.2.1. DD Form 2766 or AF Form 1480A, **Adult Preventive and Chronic Care Flow-sheet** – Always file this form as the TOP FORM on the left side of the outpatient record. **EXCEPTIONS:** ANG Medical Squadrons may file the (NGB Interim) Form 1480 on top for Air National Guard Members not Extended Active Duty or military family members. **NOTE:** The AF Form 1480A has been superseded by the DD Form 2766. Some records may have the older AF form. There is no requirement to transfer the information from the AF form 1480A to the DD form 2766. However a DD Form 2766 will be utilized for new patients and when a new form is needed.

6.3.5.2.1.1. This form provides the caregiver in the field with expanded medical data and ensures standards-of-care are met. The priority populations to receive this form are mobility personnel, active duty, and adult beneficiaries, respectively. Utilize the hard stock version of the form for the active duty population. For all others, local reproduction of the electronic version will be used.

6.3.5.2.1.2. All documentation will be completed in ink, except in sections III, *Medications*, and VII, *Screening Exams*. Section III may be completed in pencil. Section VII may be completed in pencil for the date the exam is ordered and ink when the exam is completed and the results are written.

- 6.3.5.2.1.3. Information will be transcribed from the AF Form 1480 onto the DD Form 2766 or AF Form 1480A in accordance with the AFPAM 44-155, Implementing Put Prevention Into Practice, 1 Feb 99, Chapter 4, paragraph 4.1.2.7. After transcribing the data, draw a line through the information and write the word "*Transcribed*" along the line with the date, full name, rank and AFSC of the transcribing individual. The AF Form 1480 will remain with the medical record. Place it behind the Health Enrollment Assessment Review for Primary Care Managers (HEAR PCM) Report.
- 6.3.5.2.2. DD Form 2766C or AF Form 1480B, **Adult Preventive and Chronic Care Flow-sheet - Continuation Sheet**. This form is used as a continuation form for documenting information that cannot fit on DD Form 2766 or AF Form 1480A, or for local requirements. An automated version of the form is also utilized by the Air Force Complete Immunization Tracking Application (AFCITA), for documentation (reserved for documenting immunizations). Each time a member receives an immunization, the AFCITA will print an updated automated form. Discard the previous form after ensuring the latest contains all the immunization information.
- 6.3.5.2.3. DD Form 2796, **Post-Deployment Health Assessment**.
- 6.3.5.2.4. DD 2569, **Third Party Collection Program – Insurance Information** – original.
- 6.3.5.2.5. **Health Enrollment Assessment Review for Primary Care Managers (HEAR PCM)** - original. The HEAR-PCM questionnaire is a required survey/questionnaire sent to the patient which requests information about clinical preventive tests. The patient is responsible for completing the survey and returning it to the individual's Primary Care Manager. The results are compiled in a format which provides recommendations of preventive health services.
- 6.3.5.2.6. **Results from HEAR**
- 6.3.5.2.7. AF Form 1480, **Summary of Care** – original.
- 6.3.5.2.8. AF Form 3922, **Adult Preventive Care – Flow Sheet** - original. Transcribe the AF Form 3922 information in the same way as the AF Form 1480. File this form after the AF Form 1480.
- 6.3.5.2.9. AF Form 3923, **Child Preventive Care – Flow Sheets** – original.
- 6.3.5.2.10. AF Form 565, **Record of Inpatient Treatment**, (or CHCS computer generated form) – copy of original (or similar document used by U.S. Army, U.S. Navy, or Department of Veterans Affairs).
- 6.3.5.2.11. AF Form 560, **Authorization and Treatment Statement**, used for cancelled admissions and for nonmilitary hospital dispositions at clinics without automated A&D function. Previously filed AF Forms 560 will not be removed.
- 6.3.5.2.12. SF 502, **Medical Record – Narrative Summary (Clinical Resume)** – copy of original report.
- 6.3.5.2.13. SF 509 - copy of original, when used as a final discharge note or discharge instruction.

- 6.3.5.2.14. SF 515, **Medical Record – Tissue Examination** – copy of original if inpatient report, original if outpatient report.
- 6.3.5.2.15. SF 516, **Medical Record – Operation Report** – copy of original if inpatient report; original if outpatient report.
- 6.3.5.2.16. OF 517, **Clinical Record – Anesthesia** – copy of original inpatient report if there was an anesthetic incident; original if outpatient report.
- 6.3.5.2.17. Copy of all documentation relating to ambulatory surgery, including OF 522, **Medical Record – Request for Administration of Anesthesia and for Performance of Operations and Other Procedures**.
- 6.3.5.2.18. SF 602, **Health Record – Serology Record** – original.
- 6.3.5.2.19. SF 601, **Health Record – Immunization Record** – original (used by U.S. Army, U.S. Navy, Air National Guard, and U.S. Air Force Reserve).
- 6.3.5.2.20. AF Form 618, **Medical Board Report** – signed copy of original and associated documents.
- 6.3.5.2.21. AF 1721, **Spectacle Prescription** – copy of original.
- 6.3.5.2.22. A copy of the current AF Form 1042, **Medical Recommendation for Flying or Special Operational Duty**, AF Form 1418, **Recommendation for Flying or Special Operational Duty – Dental** – a copy of all AF Forms 1042 returning the individual to flying status, and a copy of any permanent suspension. File with the AF Form 1042, the SF 88, or any other form prepared in conjunction with AF Form 1042. Keep these supporting documents, even though AF Form 1042 may be destroyed. Remove the AF Form 1042 prepared for annual or incoming clearance from the file and destroy when it expires. AF Form 1042 excusing, grounding, or disqualifying the individual may be removed and destroyed when the AF Form 1042 returning the individual to flying status is filed.
- 6.3.5.2.23. SF 88, **Report of Medical Examination** – signed copy of each report. When DD Form 2161 or any other form is prepared in conjunction with the SF 88, it is filed with the SF 88.
- 6.3.5.2.24. SF 93, **Report of Medical History** – signed copy of each report. File civilian employee's SF 93 in his/her health record.
- 6.3.5.2.25. DD Form 2216, **Hearing Conservation Data**, DD Form 2215, **Reference Audiogram**, and AF Form 1671, **Detailed Hearing Conservation Data Followup** – original of each.
- 6.3.5.2.26. Occupational environmental forms: AF Form 190, **Occupational Illness/Injury Report**; AF Form 1527, **History of Occupational Exposure to Ionizing Radiation**; AF Form 1527-1; AF Form 1527-2; (**Note: Need Titles of Forms**) AF Form 2755, **Master Workplace Exposure Data Summary**; AF Form 2769, **Supplemental Data Sheet**;
- 6.3.5.2.27. AF Form 348, **Line of Duty Determination**, (active duty military).
- 6.3.5.2.28. AF Form 422 **Physical Profile Serial Report**, (active duty military). The original AF Form 422 and all revisions of AF Form 422, whether temporary or permanent.

- 6.3.5.2.29. A copy of any document affecting aeronautical rating, designation, or flying status for medical reasons.
- 6.3.5.2.30. Prenatal forms will be maintained in the OB-GYN clinic until the mother delivers. After delivery in the MTF, the prenatal forms will be filed as a package in the inpatient record. If the mother delivers in a civilian facility the forms will be filed in the outpatient record.
- 6.3.5.2.31. Other SF, DD, or AF Forms.
- 6.3.5.2.32. Other command or local health care forms approved by the command surgeon or medical facility commander.
- 6.3.5.2.33. Other correspondence pertaining to the health care of the patient.
- 6.3.5.2.34. AF Form 1352, **Hyperbaric Patient Information and Therapy Record** - original if treatment was on an outpatient basis.
- 6.3.5.2.35. Copy of reports of health care requested from civilian sources (after being reviewed by the military provider).
- 6.3.5.2.36. AF Form 1446, **Medical Examination – Flying Personnel** – signed original.
- 6.3.5.2.37. AF Form 895, **Annual Medical Certificate (AMC)**.
- 6.3.5.2.38. AF Form 137, **Footprint Record**.
- 6.3.5.2.39. DD Form 2005, **Privacy Act Statement Health Care Records**. If not printed on the back of the medical folder.
- 6.3.5.2.40. Advanced Directive (Self Determination Act forms), durable Power of Attorney forms, organ donor forms.
- 6.3.5.2.41. The last document filed on the left side will be a “Disclosure Accounting Record.” The purpose of the document is to maintain a record of patient information released. This document will contain the following information: individual’s name (i.e., patient); requestor’s name and address; nature of disclosure; individual’s consent with a block for annotating “Yes” or “No, not required”; and date of disclosure. Until such time as this form is printed on the AF Form 2100A series folder, each MTF will develop a local form containing space for the requested information with space for entry of multiple requests.
- 6.3.6. AF Form 2100A Series, **Health Record – Outpatient (Four-part folder)**. The AF Form 2100A series is divided into four sections. Section 1 is located on the left side of the folder immediately inside the front cover, with the fastener at the bottom. Sections 2 and 3 are located on the middle flap of the folder, with fasteners at the top. Section 4 is located inside the back cover, with the fastener at the bottom. Folders are prepared for new patients, or when the present folder no longer protects the contents. Do not reaccomplish usable AF Form 2100 series folders (two-part folder).
- 6.3.6.1. Arrange forms in section 1 in chronological sequence by the date of the most recent action. **Exceptions:** DD Form 2766 or AF Form 1480A is always the top form.
- 6.3.6.1.1. DD Form 2766 or AF Form 1480A
- 6.3.6.1.2. DD Form 2766C or AF Form 1480B
- 6.3.6.1.3. DD Form 2796

- 6.3.6.1.4. DD 2569 unless reported in electronic format in an automated system.
 - 6.3.6.1.5. Health Enrollment Assessment Review for Primary Care Managers (HEAR PCM) - original.
 - 6.3.6.1.6. Results from HEAR
 - 6.3.6.1.7. AF Form 1480
 - 6.3.6.1.8. AF Form 3922
 - 6.3.6.1.9. AF Form 3923
 - 6.3.6.1.10. AF Form 565 (or approved CHCS computer generated form) - copy of original, or similar document used by the U.S. Army, U.S. Navy, Department of Veterans Affairs medical facilities
 - 6.3.6.1.11. AF Form 560 is used for cancelled admissions and for nonmilitary hospital dispositions at clinics without automated A&D functions. Previously filed AF Forms 560 will not be removed.
 - 6.3.6.1.12. SF 502 - copy of original.
 - 6.3.6.1.13. SF 509 - copy of original, when used as a final discharge note or discharge instruction.
 - 6.3.6.1.14. SF 515 - copy of original if inpatient report, original if outpatient.
 - 6.3.6.1.15. SF 516 - copy of original if inpatient report, original if outpatient.
 - 6.3.6.1.16. OF 517 - copy of original if inpatient report (if there was an anesthetic incident), original if outpatient.
 - 6.3.6.1.17. Copy of all documentation relating to outpatient ambulatory surgery including OF 522.
- 6.3.6.2. Arrange the forms in section 2 as follows:
- 6.3.6.2.1. AF Form 745, when applicable, is always the top form of this section.
 - 6.3.6.2.2. AF Form 966 is placed on top of the documents and under AF Form 745 if used.
 - 6.3.6.2.3. Patient signed informed consent to the use of an electronic mail (e-mail) format of communication with his/her provider
 - 6.3.6.2.4. SF 600 is filed in date order. Utilize both sides of the form.
 - 6.3.6.2.5. Interfile OF 558 with the associated SF 600 in date order.
 - 6.3.6.2.6. File DD Form 2161 and/or SF 513 on top of the SF 600 to which it belongs.
 - 6.3.6.2.7. AF Form 1352
 - 6.3.6.2.8. AF Form 1446
 - 6.3.6.2.9. SF 78
 - 6.3.6.2.10. SF 88
 - 6.3.6.2.11. SF 93

6.3.6.3. Arrange the forms in section 3 as follows:

6.3.6.3.1. AF Form 348

6.3.6.3.2. AF Form 422 is filed chronologically with most recent report on top.

6.3.6.3.3. A copy of any document affecting aeronautical rating, designation, or flying status for medical reasons.

6.3.6.3.4. Arrange forms in chronological sequence by the date of the most recent action. **EXCEPTION:** AF Form 137 is filed on top of DD Form 2005. **NOTE:** The September 1988 edition of AF Form 2100A series has the Privacy Act Statement printed on the folder. It is not required to place DD Form 2005 in these folders.

6.3.6.3.5. Prenatal forms will be maintained in the OB-GYN clinic until the mother delivers. After delivery in the MTF, the prenatal forms will be filed as a package in the inpatient record. If the mother delivers in a civilian facility the forms will be filed in the outpatient record.

6.3.6.3.6. AF Form 618

6.3.6.3.7. AF Form 1042

6.3.6.3.8. AF Form 1418

6.3.6.3.9. AF Form 137

6.3.6.3.10. DD Form 2005 for records that do not have a privacy act statement preprinted. The patient is not required to sign the form.

6.3.6.3.11. File all other forms in chronological order by date, including letters and copies of reports of care from civilian sources (reviewed by the military health care provider).

6.3.6.3.12. The last document filed in Section 3 will be a "Disclosure Accounting Record." The purpose of the document is to maintain a record of patient information released. This document will contain the following information: individual's name (i.e., patient); requestor's name and address; nature of disclosure; individual's consent with a block for annotating "Yes" or "No, not required"; and date of disclosure. Until such time as this form is printed on the AF Form 2100A series folder, each MTF will develop a local form containing space for the requested information with space for entry of multiple requests.

6.3.6.4. Arrange the forms in section 4 in chronological order, regardless of the type of report, with the most recent report on the top. Exceptions are as follows:

6.3.6.4.1. Laboratory forms are stapled individually to bond paper. Computer generated reports may be grouped together and filed as the top forms in this section.

6.3.6.4.2. SF 602

6.3.6.4.3. SF 519b.

6.3.6.4.4. OF 520, if used.

6.3.6.4.5. SF 601

6.3.6.4.6. AF Form 1721

6.3.6.4.7. DD Form 2216

6.3.6.4.8. DD Form 2215

6.3.6.4.9. AF Form 1671

6.3.6.4.10. Occupational environmental forms: AF Form 190, AF Form 1527, AF Form 1527-1, AF Form 1527-2, AF Form 2755, and AF Form 2769

6.3.6.4.11. Other tests.

6.3.6.4.12. AF Form 895

6.3.6.4.13. Advanced directives (Self Determination Act forms), durable Power of Attorney forms, organ donor forms.

6.4. Filing Outpatient Records.

6.4.1. All outpatient records, both paper-based and automated will be maintained in a secured location with access granted only to authorized personnel

6.4.2. "Terminal Digit" Filing System: File records by SSN, according to a terminal digit, color-coded and blocked filing system. Divide the central files into 100 equal sections. Establish a minimum of file guides bearing the 100 primary numbers, "00" through "99".

6.4.2.1. Each section contains all the records whose terminal digits (last two numbers) correspond to that section's primary number.

6.4.2.2. File folders in numerical sequence according to their secondary numbers within each section. The secondary number is the pair of digits immediately to the left of the primary number.

6.4.3. All outpatient records and forms are maintained in a single numerical file in a central location except as authorized by the MTF Commander. Use AF Form 614 in the main file to indicate the location of the health record if decentralization is authorized. Records may be filed by organization for units that frequently transfer as a group or for student/trainee records.

6.4.4. Manage ARC outpatient records as follows:

6.4.4.1. Maintain records for members of ARC units (AFRC Cat A; ANG) with their medical unit or element unless a local agreement exists with the collocated MTF to maintain the records.

6.4.4.2. Maintain records for individual mobilization augmentees (IMA) (Cat B) as follows:

6.4.4.2.1. Maintain records for centrally managed IMAs (HC, JA, SG) with active duty unit of attachment MTF.

6.4.4.2.2. Maintain records of non-centrally managed IMAs with active duty unit of assignment MTF.

6.4.4.2.3. Maintain records of IMAs without unit of attachment/assignment MTF at HQ ARPC/SGP, Denver, CO, 80280-5000.

6.4.4.3. Maintain records for participating Individual Ready Reserve (IRR) (Cat E) at HQ ARPC/SGP, Denver, CO, 80280-5000.

6.4.4.4. Conduct an annual inventory of all ARC health records on file as of 31 March.

6.4.4.4.1. Individual ARC units furnish a list for personnel identified in [6.4.4.1](#). Notify local unit in writing if records are not on hand.

- 6.4.4.4.2. HQ ARPC/SGP maintains a registry of IMA/PIRR records/locations, and furnishes a list of the records identified in paragraph 6.4.4.2. and 6.4.4.3. Notify HQ AFPC/SGP if records are not on hand <mailto:arpc.sgpdl@arpc.denver.af.mil>, or if transfer of records (reassignment, retirement) is required.
- 6.4.5. Establish local procedures to annually inventory all Active Duty Air Force records by 31 March. Rosters are obtained from the MPF.
- 6.4.6. Family Advocacy records are maintained by the family advocacy officer for each individual in the family advocacy program. These files are separated from the outpatient record and are secured. Do not use the AF Form 2100A series for these records.
- 6.4.7. ROTC, AFIT, USAF Recruiting Service, and GSU/TPR personnel and their family members may maintain their own medical records when the nearest MTF is not easily accessible. However, if they are enrolled to an MTF near their location, the records must be maintained at the MTF of enrollment.
- 6.4.8. Records of PRP and PSP personnel are maintained in a separate, secured location and are cross referenced using AF Form 614.
- 6.4.9. Special Cases.
- 6.4.9.1. Dual Status Patients. A person may be eligible for care in more than one status. For example, a person may be treated as a family member of an active duty person and may also receive treatment as a retiree. Maintain a cross-reference in the record files as well as in the patient index when a person is eligible for treatment in more than one status.
- 6.4.9.2. In order to increase file space for outpatient records, it is permissible to split storage of records that consist of more than one volume. Place an AF Form 614 with the current volume to indicate the location of other volumes.
- 6.4.9.2.1. Place outpatient records of deceased personnel in a separate secured file. Place an AF Form 614 in the central file to indicate the location of the record.
- 6.4.9.2.2. Use of AF Form 1942, to manage records is optional; however, prepare and maintain an AF Form 1942 for each record permanently forwarded or hand-carried to another facility. Keep the form in an alphabetical file, after it is signed, for six months and then destroy.
- 6.4.9.3. Record custodians comply with Air Force instructions when maintaining Army and Navy records.
- 6.4.9.4. When personnel from the U.S. Army and U.S. Navy are:
- 6.4.9.4.1. Attached to an Air Force facility for medical care, the Air Force assumes custody of their health records. When patients from other Services are treated in Air Force facilities and require certain Service specific forms be completed and filed in the records, the documents will be filed in the record. The document will be placed in the appropriate section of the outpatient record based on the type of form.
- 6.4.9.4.2. Treated in an MTF but their records are not available, send documents ordinarily included in Air Force outpatient records to the custodian of their records. If unknown, forward these documents using guidelines provided in paragraph 6.6.3.

6.4.9.5. When Air Force personnel are treated at a U.S. Army or U.S. Navy facility, send the documentation to the MTF where the record is maintained.

6.4.9.6. Interfile Army and Navy records with Air Force records. Replace folders with the AF Form 2100A series only if the color and blocking do not permit interfiling.

6.5. Other Documentation Guidance.

6.5.1. Inpatients Seen in Clinics. For inpatients seen in clinics, the clinic service returns medical documents that must be inserted into the inpatient record to the inpatient unit to provide a complete record of the inpatient visit.

6.5.2. Withdrawing Documents. When documents in an outpatient record are relevant to further treatment as an inpatient, the documents may be withdrawn and inserted in the inpatient record. Note the withdrawal on SF 600.

6.5.3. Dead On Arrival (DOA) and Emergency Room Death (ERD). All DOA and ERD encounters will be reported in the automated ambulatory data collection system. Any documents created on these patients will be maintained in an Extended Ambulatory Record in a limited access area (i.e. file in a separate area of the inpatient/outpatient record file rooms).

6.5.4. Variations in the disposition and maintenance of records in clinics are not authorized. The MTF Commander ensures that the health records are maintained as required by current Air Force directives.

6.5.5. Request for Ancillary Services. Clinic personnel will ensure the appropriate ancillary request form is properly completed and shows all patient identification and other data required by directives. Develop local procedures between clinic and ancillary services to correct errors and avoid omissions.

6.5.6. Do not ask patients to complete forms except those forms used for physical examinations (e.g. periodic retirement, flying or employment physicals).

6.5.7. When documentation is received without adequate identification, they will send it back to the originator to complete. The originating clinic completes the required entries and returns the documentation to the proper record section.

6.5.8. Retain copies of documentation created on pay patients who are stationed or enrolled at another MTF and whose medical records are maintained at that MTF. Copies are maintained in order to validate the treatment rendered.

6.6. Outpatient Records Maintenance.

6.6.1. Quality Control of Outpatient Records Maintenance. The medical records are the property of the United States Government. The information contained in the record belongs to the patient. IAW the Privacy Act of 1974 and HIPAA of 1996, the patient has the right to the information in the record. However, the maintenance of the record at the MTF is a legal requirement and there is an increasing requirement that these records be available to the many accrediting and auditing agencies who review records. The lack of medical records and medical record documentation may adversely impact JCAHO accreditation. In any case, record availability is paramount to facilitate the most appropriate health care for patients.

6.6.1.1. Establish a methodology to retrieve medical record of enrolled population upon arrival on station.

6.6.1.2. Establish custody of the health record upon the patient's initial visit.

6.6.1.3. Implement a system to retrieve health records, when possible, from those patients who hand carry them and verify where the record should be maintained.

6.6.1.4. Effort should be made to ensure patients do not leave the MTF with their records.

6.6.1.5. Patients may request a copy of pertinent sections of their records; however, the original should not be relinquished except in rare occasions when an exception is required. In this case, appropriate procedures must be followed, see paragraph 6.7.8.

6.6.1.6. Establish a system that allows for delivery of records to clinics for scheduled appointments, and for walk-ins to the greatest extent possible.

6.6.1.7. Staff members will not return the record to the patient's control after the visit unless the record label states that it is maintained at another MTF or deployable unit and is verified that this is the records file location.

6.6.1.8. All loose documents must contain sufficient patient identification information to allow for proper filing IAW paragraph 6.3. Additionally, these documents must have the outpatient records location and the MTF where the record is maintained.

6.6.1.9. Under normal circumstances the record must be returned to the record section by the end of the day. However, records can be charged out by the requester for an extended period if they know it will take longer to accomplish the task.

6.6.2. Filing Outpatient Computer Generated Clinical Encounter Results. Daily filing of outpatient test results is no longer a requirement as the result of on-line capability through clinical results retrieval. Develop local policies and procedures to ensure complete cumulative test results are printed and inserted in the outpatient records upon referral of patient to a civilian provider for medical care, on PCS of individual, and in other appropriate instances where necessary. Develop methods to ensure all test results (including archived results) are retrieved and filed when the record is retired to the National Personnel Records Center, the Department of Veterans Affairs, or the MTF deems it necessary for the record to contain the hard copy test results. MTFs discontinuing the daily filing of outpatient laboratory and radiology test results will follow these guidelines:

6.6.2.1. Determine if there are state laws that require the maintenance of hard copy test results or that prohibit the storage of these results in electronic media only. There are no federal laws prohibiting the storage of test results in electronic media. The MTF may implement this practice if there are no state laws.

6.6.2.2. Consult and obtain agreement with the professional staff. Providers must have access to all test results on demand. The professional staff must comprehend they will no longer find hard copy test results in the outpatient records on a routine basis. Instead, authorized users may obtain the results from the CHCS interactive computer terminals. Ensure confidentiality of the data by following all applicable DoD and Air Force security regulations. The system manager at each MTF is responsible for controlling and issuing accounts giving authorized users access to test results or other patient data.

6.6.2.3. It is essential that the outpatient record section coordinate with the MTF CHCS Administrator to determine the optimal time and retrieval methods for on-line and archived data. Make arrangements for systems personnel to be on hand to assist in the retrieval of the archived data.

Make every effort to ensure complete documentation is obtained on the cumulative printouts, especially archived data.

6.6.2.4. Test results are archived after a facility specified time (usually 18 months). Test results will be printed and filed in the patient's outpatient record before the archived files are disposed of or pass their retention data. Retrieval of archived data is a lengthy process and best performed on weekends. Take these time considerations into account when preparing records for retirement, transfer, or appointments made with providers who do not have access to CHCS.

6.6.3. Handling Loose Medical Documentation. File loose documents in the outpatient record as soon as possible. Documents received after the record is charged out are placed temporarily in the pocket of the charge out guide.

6.6.3.1. Proceed as follows when loose documents are received and there is no charge out guide or record in the file:

6.6.3.1.1. Active Duty Air Force. Maintain and be on requirement for the CD-ROM Personnel list of active duty and retired personnel in the outpatient records section. To be placed on the requirements list, send an e-mail request to <mailto:tab@randolph.af.mil>. Provide the name of the product requested and a valid mailing address including applicable suite/room number and a 9-digit zip code. Review the list and if the person is included, forward the documents to the new unit servicing MTF or MPF at the base to which the patient is assigned. Send any documents or records for separating or retiring Air Force personnel to the local MPF no later than five duty days after the member's DOS. If more than five duty days, send the health records and/or loose documentation for members not filing a claim directly to the Department of Veterans Affairs, 4300 Goodfellow, Building 104, St. Louis, MO 63115-0020. Send health records and/or loose documentation for members who are filing a claim to the VA Regional Office (VARO) where the member has filed for compensation or pension. Prepare DD Form 675, **Receipt for Records and Patient's Property**, to forward records and loose documents to the VARO or VA Records Management Center. Coordinate with the MPF to determine where health records and/or loose documents are to be sent. The Department of Veterans Affairs requires that when sending loose documentation it must be filed in an outpatient health record folder before it is sent to them.

6.6.3.1.2. Family Members, Retired, and Other Non-Military Personnel. Records of Air Force active duty family members are usually maintained at the MTF where the sponsor is assigned unless it is an unaccompanied tour. Check the CD-ROM Personnel Locator to ascertain where the sponsor is assigned. If it can be determined that the sponsor's family members receive care at the MTF, forward the loose documents for inclusion in the outpatient record. In all other cases where the record cannot be located, file the loose documents in a charge-out guide. If the record is not located within three months, place the documents in a manila folder annotated with the patient's identification, and file in place of the charge out guide. These records will be retired in accordance with AFI 37-138.

6.6.3.2. Return a document with incomplete patient identification to the originating clinic for completion.

6.6.3.3. Develop local procedures between clinic and ancillary services personnel to correct errors and avoid omissions. Do not ask the patient to return an improperly completed form to the originator.

6.6.3.4. If the clinic cannot sufficiently identify the documents for filing, notify the committee responsible for medical records review, the chief of the medical staff, or the MTF quality review committee in order to resolve the problem. Unidentifiable medical documentation may be destroyed at the direction of either.

6.6.4. Forwarding Loose Documentation or Medical Records After Members Departure From Your Base. Use these procedures if loose documents or complete outpatient records are found after the member has left:

6.6.4.1. Send U.S. Air Force records or documentation as follows:

6.6.4.1.1. Active duty personnel. Review the local CD-ROM Personnel Locator and forward to the new unit servicing MTF or MPF. **NOTE:** If the location on the CD-ROM Personnel Locator is data masked, or the records were returned from the base due to member not arriving, send to HQ AFPC/RMIQL, 550 C Street West, Suite 50, Randolph AFB, TX 78150-6001.

6.6.4.1.2. Reserve or Guard personnel. Send to HQ ARPC/SG, 6760 E Irvington Place, Denver CO 80280-0001.

6.6.4.1.3. Retired or separated personnel. Send to the Department of Veteran Affairs, 4300 Goodfellow, Building 104, St. Louis MO 63115-0020.

6.6.4.2. Send U.S. Army records or documents as follows:

6.6.4.2.1. Active duty officer, warrant officer, and enlisted records to the Commander, U.S. Army Enlisted Records and Evaluation Center, ATTN: PCRE-RP, 8899 East 56th Street, Indianapolis, IN 96249-5301.

6.6.4.2.2. Records for retired personnel to the Commander, ARPC, 9700 Page Boulevard, St. Louis MO 63132-5200.

6.6.4.3. For U.S. Navy records and documents, send a letter with the active duty member or retiree sponsor's name and SSN to the Department of the Navy, Navy Personnel Command, PERS-312F, 5720 Integrity Drive, Millington, TN 38055-3120 or fax to (901) 874-2700, DSN 882-2766. In addition to providing the most recent address, the Navy Worldwide Locator Service (<http://www.navy.directory.smartlink.navy.mil>) will be able to advise if the documents should be retired to NPRC or the DVA RMC. Dispose of records of family members and retired Navy personnel in the same manner as AF family members and retirees.

6.6.4.4. For U.S Marine Corps active duty members, forward the stray or lost medical records or forms to the USMC Worldwide Locator Service, Commandant of the Marine Corps, Headquarters USMC, 2008 Elliot road, Suite 215, Quantico, VA 22134.

6.6.4.5. For Public Health Service or Coast Guard commissioned corps records or forms with a complete name and SSN, forward to Medical Branch, 5600 Fishers Lane, Parklawn Building, Room 4-35, Rockville, MD 20857-0435.

6.6.4.6. For National Oceanic and Atmospheric Administration (NOAA) records of forms with a complete name and SSN, forward to Commissioned Personnel Center, NOAA (ATTN: CP01), 11400 Rockville Pike, Room 108, Rockville, MD 20852-3004.

6.6.4.7. For ARC records or documents, if the member's ARC unit is unknown, contact the appropriate ARC/SG for further instructions.

6.6.4.8. For Individual Mobilization Augmentee records or documents, forward to HQ ARPC/SGP, 6760 East Irvington Place #7200, Denver, CO 80280

6.6.4.9. For Air National Guard members records or documents, forward to HQ ANG/SGPS, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157.

6.6.4.10. For unit assigned reserve members, send records and documents to HQ AFRC/SGP, 155 Second Street, Robins AFB, GA 31098-1635.

6.6.4.11. For inactive guard and reserve, send records to:

6.6.5. Missing/Lost Records. An Air Force facility-wide search may be conducted upon request for any missing/lost records. The following information should be faxed to AFMSA/SGOZ at DSN 240-5167 or Commercial (210) 536-5167:

6.6.5.1. Name

6.6.5.2. Sponsor's SSN

6.6.5.3. FMP (20, 30, 01, 02, etc.)

6.6.5.4. Pay Grade

6.6.5.5. Status (AD/AF, Dep Ret/USN, USNR, etc.)

6.6.5.6. Location and date where record was last seen

6.6.5.7. Point of contact should record be located (name and phone number)

6.7. Tracking of Records.

6.7.1. All MTFs with CHCS must fully utilize the Medical Records Tracking (MRT) function to include bar code scanning and electronic AF Form 250, **Health Record Charge Out Guide Request**. All others must establish a manual tracking system.

6.7.2. The MRT will be used to charge in and charge out records at every requesting and receiving location in the MTF to ensure proper tracking of the record. Build borrowing locations in MRT for all locations that request records.

6.7.3. Accomplish a monthly review of charged-out records and establish a methodology to retrieve those records charged out. Report the results to the Health Records Review Committee.

6.7.4. Availability and Accountability: MTFs will implement a system to ensure 90% point of service availability and 95% accountability (goal is 100%) of outpatient medical records. Availability is defined as the physical presence of that record for use at the point of service or for review. Accountability is defined as the ability to pinpoint the specific location of the record as located in the medical records room or documented as checked out with an AF Form 250 or in the CHCS MRT module.

6.7.4.1. Availability standard methodology -- Sum total of all records delivered at the time of request divided by the number of hard copy and electronic AF Form 250s. Maintain daily statistics and compute monthly average for each records room and aggregated for the overall MTF average.

6.7.4.2. Accountability standard methodology -- Use the process outlined in DODI 6040.40 Enc. 1 paragraph C.6.

6.7.4.3. Report monthly availability and accountability rates through the records review function at the MTF up to the Executive Committee of the Medical Staff or as directed by the MTF commander.

6.7.5. Education:

6.7.5.1. Upon inprocessing and at least annually, brief all MTF staff on their responsibilities in health records management or maintenance based on their role in the MTF. Topics will include but not be limited to control, release, availability and accountability of health records.

6.7.5.2. All PCM team members and additional clinical staff will receive medical record maintenance training.

6.7.5.3. Training will be documented in the Career Field Education and Training Plan.

6.7.5.4. Just as important as the availability of records is the completeness of the documentation in those records. Therefore, MTFs will establish procedures to ensure that records contain accurate and complete documentation of outpatient visits.

6.7.5.5. Patients will be educated on the importance and reasons why medical records must be maintained by the MTF (e.g. Town Hall meetings with patients, patient newsletters, etc.)

6.7.6. Using Charge Out Guides. Use AF Forms 885, 886, and 887. **Medical Record Charge Out Guides**, and AF Form 250, to show the location of an outpatient record removed from the file. Use of the MRT module in CHCS is required as a tool to track movement of outpatient records. It also enhances the management of records accountability and availability.

6.7.7. Loaning Records to Clinics/Units. Establish strict procedures to manage the loaning of records. These procedures will:

6.7.7.1. Limit access to all outpatient records areas to only authorized personnel.

6.7.7.2. Require consistent use of charge out guides and accurate, complete information on AF Form 250 and in the CHCS MRT module.

6.7.7.3. The outpatient records section and clinic personnel will ensure the outpatient record is available prior to patient's appointment.

6.7.7.4. If the record is not present at the clinic when the patient arrives, an AF Form 250 or other appropriate form is prepared/entered into the MRT module in CHCS. This completed form is presented to the Records Section and the patient's record is removed from the file, charged out to the destination clinic in the MRT module and sent to the clinic. Do not use the patient to hand carry the record. If the record is not available, the provider should make an entry on the form used to document care that the record was not available for review.

6.7.7.5. If a record is involved in a potential claim, do not give the original record to the patient. See paragraph [2.1.4](#).

6.7.7.6. Establish specific time criteria for records return and follow-up actions to retrieve delinquent records.

6.7.7.7. Require that retirees' and family members' outpatient records be retrieved and maintained in the MTF.

6.7.8. DoD Records Control Policy. Health records are the property of the United States Government and their maintenance and availability at the MTF is key to appropriate medical care and legal and administrative proceedings.

6.7.8.1. Patients requesting their records should be informed of DoD's policy of not allowing patients to hand carry their record. Patients may have a copy of their records reproduced upon request IAW para [2.4.2.2](#). If a record is needed for a consult or appointment outside of your MTF, make a copy of pertinent section IAW para [3.5.1.7](#). If record is needed for an appointment in your facility, use the steps outlined in para [6.7.7](#).

6.7.8.2. When it is known that the patient has custody of their record, take the following actions to retrieve the record from the patient:

6.7.8.2.1. Contact the patient and inform them that the record is the property of the United States Government and must be returned immediately. Inform them that they may have a copy of the record but the original must be maintained in your MTF.

6.7.8.2.2. If the patient does not return the record after contact, take the following actions:

6.7.8.2.2.1. Active Duty and their Family Members: Contact the sponsor's chain of command for assistance in retrieving the medical record. Inform their chain of command of your attempts to have the record returned and that IAW this AFI of the requirement that they must be maintained in your MTF. If, after contacting the sponsor's chain of command, the patient still has not returned the record, send a certified letter notifying the patient that they may have a copy of the record, but the original is the property of the United States Government. Recite all previous attempts to have the record returned and their repeated refusals to do so. Make a request to have the record returned within 10 days and that failure to comply will result in notification of the Security Forces for further action and criminal investigation for theft of United States Government property.

6.7.8.2.2.2. For all other beneficiaries enrolled to your MTF: If, after following paragraph [6.7.8.2.1](#), the patient does not return the record, send a certified letter notifying the patient that they may have a copy of the record, but the original is the property of the United States Government. Recite all previous attempts to have the record returned and their repeated refusals to do so. Make a request to have the record returned within 10 days and that failure to comply will result in notification of local law enforcement through the Security Forces for further action and criminal investigation for theft of United States Government property.

6.7.8.3. Clinic clerks are responsible for obtaining records for patients treated in their clinics. Clinic clerks must complete an electronic AF Form 250 to check out a record.

6.7.9. Clinic personnel must keep outpatient record entries up-to-date and use the following disposition rules:

6.7.9.1. As a general rule, records are to be returned to the Outpatient Records location at the end of the duty day associated with each episode of care. Any clinician requiring extended use of a record to complete care/documentation should re-charge the required record to their clinic for additional 3-day increments (as required) in the Medical Records Tracking module in CHCS to ensure records accountability. Do not give records to the patient to keep in their possession, or to

hand carry to the outpatient record section. Throughout the day, records of patients who have completed their visit are gathered and returned to the outpatient records section.

6.7.9.2. Admission to Hospital. Send the outpatient record to the designated inpatient unit. Clinic personnel update MRT to reflect that the record is being sent to the appropriate inpatient unit.

6.7.9.3. Transfer of Patient to Another Military Facility for Treatment. Clinic personnel update MRT to reflect that the record is being sent to the appropriate MTF.

6.8. Partial Hospitalization.

6.8.1. Partial hospitalization is defined as a facility or unit that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility. Patients would spend a portion or majority of a day (less than 24-hour daily care) in a hospital setting and then return to their homes or places of residence in the evening. They would then return to the facility on the following day.

6.8.1.1. Partial hospitalizations are characterized by structured, daily supervised, outpatient activities over a prolonged period (usually 2-6 weeks) tailored to treat or rehabilitate individuals with generic-like illnesses, dependencies or psychological profiles. Partial hospitalization may be used for crisis stabilization, treatment of partially stabilized mental health disorders for adults and adolescents, chemical dependency treatment programs, or as a transition from an inpatient program when medically necessary.

6.8.1.2. All documentation for partial hospitalization must comply with the current JCAHO documentation standards. Standard Forms (SF), or other forms as noted, are recommended for use in the partial hospitalization records. At a minimum, the documentation in the medical record will include:

6.8.1.2.1. SF 504, Parts I and II

6.8.1.2.2. SF 505, Parts II and III

6.8.1.2.3. SF 506

6.8.1.2.4. Nursing assessments and interventions

6.8.1.2.5. SF 509, written daily, which reflects a brief summary of the therapeutic activity, observation of the patient's status and responses in the course of the therapeutic contact and the therapist's plans for any subsequent therapeutic contact.

6.8.1.2.6. AF Form 3066 or 3066-1

6.8.1.2.7. AF Form 3069, as applicable.

6.8.1.2.8. Supporting documentation such as case management notes, treatment team notes, weekly progress summaries, and physician summaries including physician supervision, evaluation, and certification.

6.8.1.2.9. Patient education, release instructions, and plans for follow-up care.

6.8.1.3. All documentation related to the partial hospitalization stay will be filed as a package in the Mental Health record or section 3 of the health record, as applicable. Illnesses related to mental health will be filed in the Mental Health record.

6.9. Geographically Separated Units (GSU).

6.9.1. Active duty service members and their family members assigned to a GSU residing more than 50 miles or approximately one hour of driving time from the nearest military medical facility adequate to provide the needed care are eligible for care at civilian and VA medical facilities. Refer to AFI 41-101 for the guidance and requirements for obtaining alternative medical and dental care. The Air Force MTF Commander or GSU Commander will ensure mechanisms are in place for documentation (i.e., summaries, operative reports, etc) to be incorporated into the individual's health record. Personnel preparing to leave their duty station will request a complete record from their Primary Care Manager or provider no later than 30 days before the scheduled departure date.

6.9.2. Loose medical documentation generated by an MTF on GSU members and their family members should be forwarded to the member's home address as indicated in DEERS if they are maintaining their own records. If the records are maintained by an MTF, forward the loose documentation to the records section of the MTF for filing in the outpatient health record.

6.10. Mental Health Records.

6.10.1. Mental health records are a separate category of records that contain detailed psychiatric notations of evaluations, consultations, tests, and treatment provided on an outpatient or inpatient status. Do not use AF Form 2100 or 2100A series for records kept in the mental health clinic. These records must be kept in properly secured files in the mental health clinic. See AFI 44-109, *Mental Health and Military Law*, paragraph 3., for guidance on the Limited Privilege Suicide Prevention (LPSP) Program. Effective implementation of this program requires special handling of records generated while a patient is covered under that privilege to protect from unauthorized disclosure and to meet the Government's burden during court-martial proceedings of proving that those records were not used inappropriately.

6.10.1.1. Place an AF Form 745 on the top right side in the mental health record of any individual involved with a sensitive duty.

6.10.1.2. On each outpatient visit the outpatient record is requested from the records section and an entry is made into the outpatient record in sufficient detail to enable health care providers in other clinics to provide effective continuing care to the patient. Changes in diagnosis, profile, therapy or medication require a specific note detailing such changes in the outpatient record. Personal information disclosed in therapy should not be entered into both the outpatient and mental health records.

6.10.1.2.1. Missed appointments should be documented.

6.10.1.2.2. An outpatient note is required when medication is prescribed, renewed, changed, or discontinued.

6.10.1.2.3. There should be an annual summary, if applicable, and a brief termination summary when the patient leaves treatment. This should be entered into both the outpatient and mental health records. See [Figure 6.3.](#) and [Figure 6.4.](#)

6.10.1.3. Mental health record documentation must be sufficiently detailed and organized to enable the practitioner responsible for the patient to provide continuing care to the patient, determine later what the patient's condition was at a specific time and review the diagnostic and therapeutic procedures performed and the patient's response to treatment.

6.10.1.4. Mental health clinics must review all active records every 6 months. Mental health and outpatient records of patients who have not had an appointment at the clinic for the past 3 months and who have not been formally terminated should be referred to the provider so that a termination summary can be entered in both the mental health and outpatient records.

6.11. Prenatal Records.

6.11.1. Prenatal records may be maintained separately by the prenatal clinic and then must be incorporated into the inpatient record at the time of delivery. For exceptions, see the following:

6.11.1.1. If a patient is transferred or relocates before delivery, the prenatal record should be given to the patient to hand carry to the next MTF. If the patient does not expect to deliver in a MTF, copies of the prenatal record should be given to the patient and the original documents filed in the patient's outpatient record.

6.11.1.2. Prenatal records should be screened quarterly. When the expected date of delivery has passed or there is no indication that the patient is being followed, the prenatal record should be withdrawn from the prenatal file and forwarded to the outpatient records section for inclusion in the patient's outpatient record. If no outpatient record is available, prepare one.

6.12. Family Advocacy Program (FAP) Records.

6.12.1. When a FAP record is opened, entries are required in outpatient medical records each time a patient is seen in the Family Advocacy department. These entries are made by the Family Advocacy Staff.

6.12.1.1. Each entry on a SF 600 or equivalent form will be preceded by "FAP" and include the appropriate signature and signature stamp.

6.12.1.2. Documentation of a family member's initial interview will indicate the family member "was seen IAW AFI 40-301 due to an allegation of family maltreatment."

6.12.1.3. The synopsis will include the following:

6.12.1.3.1. A statement addressing results of a suicidal/homicidal assessment.

6.12.1.3.2. A statement addressing initial risk/safety assessment.

6.12.1.3.3. The statement "This case will be presented to the FMCMT."

6.12.1.4. When a FAP record is not opened, the only documentation placed in the outpatient medical record will be the request for consultation (DD Form 2161 or equivalent).

6.12.1.5. On subsequent Family Advocacy department contacts with family members for maltreatment cases, the outpatient medical record entry will reflect at least "Individual seen IAW AFI 40-301."

6.12.1.6. FMCMT reviews will be documented in the outpatient medical record **only** when there is a significant change in the family situation or the intervention plan, or when deemed necessary for continuity of medical care.

6.12.1.7. FMCMT decisions on retiree cases WILL NOT BE documented in the outpatient medical record of retiree clients since services to retirees are voluntary.

6.12.1.8. All family members receiving FAP services will have a termination note when treatment services are terminated.

6.13. Guidelines for Documentation in Graduate Medical Examination (GME) Programs. Documentation requirements will be as outlined by the Accreditation Council for Graduate Medical Education (ACGME) in their common and specific program requirements.

6.14. Management of Records for Personnel in the Nuclear Weapons Personnel Reliability Program (PRP). Medical records for individuals on PRP require special handling to maintain the integrity of the program. Instructions for special preparation of PRP records is located in paragraph 6.2.6. and 6.3.5.1.1. PRP program requirements are located in AFI 36-2104.

6.15. Other Secondary Records. There may be specialty clinics (e.g. Oncology Clinic) that need to closely monitor their patient's response to therapy and choose to keep a copy of their clinic records available to them in the clinic. This is acceptable as long as there is ONE complete record in the MTF where all original patient documentation is available for all caregivers. Once treatment is completed the specialty clinic is responsible for ensuring all original documentation is filed in the health record and the secondary record is destroyed.

6.16. Management of Outpatient Records Pre and Post Deployment.

6.16.1. The original medical records on deployed active duty and ARC personnel will remain at the home base MTF. Prior to deployment, photocopy the DD Form 2766 or AF Form 1480A (whichever form is in the record) and keep the copy in the original medical record which remains at the home base MTF. For individuals on PRP, a copy of AF Form 745 will be placed in the DD Form 2766 or AF Form 1480A upon deployment. Stamp "PRP" in 2-inch letters on the cover of the DD Form 2766 or AF Form 1480A when individual is deployed.

6.16.1.1. Records will be maintained and managed (to include information assurance) by the MTF in the area of operation responsible for providing primary medical care to the member.

6.16.1.2. Deployed records will be managed to ensure that all medical documentation, both paper and electronic, is captured and that the documentation is returned for filing in the original medical record once the member returns to the MTF. If the deployed member receives medical care or testing, all medical documentation is placed in the bracket inside the DD Form 2766 or AF Form 1480A folder (e.g., SF 600, AF Form 422, or ancillary reports, etc.)

6.16.1.3. When the member returns to the home base after deployment, ensure that the deployed record is returned to the home base MTF.

6.16.1.4. Upon return of the member to the home base (after deployment), remove the medical documentation (except for the DD Form 2766c or AF Form 1480B) from the DD Form 2766 or AF Form 1480A folder and place it in the proper order within the patient's original medical record. Also file the DD Form 2766 or AF Form 1480A in the medical record. Remove and shred the photocopied DD Form 2766 or AF Form 1480A upon filing the original in the medical record. File the DD Form 2766C in the prong of the DD Form 2766.

6.16.1.5. Medical documentation created during deployment must be filed into the member's outpatient record within 30 days of the member's return to home base.

6.17. Transferring Outpatient Records.

6.17.1. Upon receipt from the MPF of a list of active duty personnel PCS'ing, outpatient records personnel are responsible for forwarding of all health records and/or loose medical documents to arrive at the MPF by their established suspense date. Send a letter to the MPF, see [Figure 6.2](#), if the record is not available. See paragraph 6.6.3.1.14. for forwarding health records and/or loose medical documents for separating or retiring members. The patient may be given an abstract of the case, or copies of pertinent pages, if the provider believes future medical care is needed. If it is determined that the person's physical or mental health would be injured if he/she reviews the record, place the record in a sealed envelope stamped or otherwise marked "Sensitive Information, For Eyes Only of New MTF Commander". Inform the MPF that the records are not to be handcarried by the person concerned (see AFI 36-2608, *Military Personnel Records Systems*).

6.17.2. Forwarding Nonmilitary and Retired Military Outpatient Records.

6.17.2.1. The provider may authorize copies or prepare an abstract of pertinent medical documents to be given to the patient. Mail the original record to the gaining MTF.

6.17.2.2. Do not release a copy or abstract of an adult family member or emancipated minor record to anyone else except as authorized by AFI 33-332.

6.17.3. Transferring Outpatient Records by Mail:

6.17.3.1. Mail outpatient records to another DoD MTF upon receipt of a DD Form 2138, DD Form 877, or other valid request.

6.17.3.2. Initiate the DD Form 2138 for active duty and retired members and their family members if a record is mailed. The individual delivers the form to the new MTF. The receiving MTF completes the remaining sections of the form and sends to the losing MTF.

6.17.3.3. Insert a charge out guide with a copy of PCS orders, DD Form 877, or DD Form 2138. File all loose medical documents in the appropriate charge out guide. Store loose documents no more than 90 days, then mail to the receiving MTF.

6.17.3.4. When individuals who are not attached to the base are receiving medical care on base (for example, AFIT students), identify their records by entering their status on the record folder, in pencil. Do not forward these records except at the patient's specific request.

6.17.3.5. When mailing records pertinent to litigation cases, medical records and claims files will be mailed via certified mail/return receipt.

6.17.4. Transfer of Mental Health Records. The Mental Health Flight will secure through the Military Personnel Flight a monthly listing of individuals identified for PCS. Mental health staff, including Life Skills Support Center, Alcohol and Drug Abuse Prevention and Treatment (ADAPT) office, and the Family Advocacy Office, will check clinic files for records of transferring personnel. When clinic records are identified, each case will be reviewed to determine appropriate action as outlined below. ADAPT and Family Advocacy programs have unique requirements with regard to records management, but will ensure procedures for managing cases at transition points such as PCS are at least as stringent as those defined below for managing cases in Life Skills Support Centers (LSSC).

6.17.4.1. Open Cases. For all open LSSC cases, the provider shall contact a privileged provider at the gaining base, communicating patient status and needs in transition and establishing an appointment for follow-up to ensure continuity of care. Prior to the patient's PCS, the provider at the los-

ing base will also complete and forward to the gaining provider a summary of treatment outlining the basis for initial contact, identified problems, diagnostic assessment, risk assessment, treatment plan (including medications and therapeutic interventions), progress in relation to identified goals, referrals (if any), and status at the time of transfer, see [Figure 6.3.](#), Sample Mental Health Record Transfer/Termination Summary.. An abbreviated version of this summary will be placed in the outpatient medical record, see [Figure 6.4.](#), Sample Outpatient Medical Record Transfer/Termination Summary. Document both summaries on a SF 600.

6.17.4.1.1. All patients will be briefed on the possible need for transfer of information upon PCS as part of the initial orientation to the LSSC, ADAPT program, or Family Advocacy program. This briefing will be provided verbally, documented in the clinic record, and will also be incorporated as part of the initial confidentiality/consent to treatment paperwork reviewed and signed by the patient. Prior to departing for the new duty station, the patient will be informed of the transfer of information and shall be given the name of a provider at the gaining base, contact information, and an appointment. Although consent by active duty members for transfer of information to the provider at the gaining base is not required, every effort shall be made to involve the patient in this process. Written consent from family member beneficiaries and retirees will be required prior to contacting a mental health provider at the gaining base or forwarding mental health information.

6.17.4.1.2. The contact with gaining provider and the patient, the provision of contact information, and the transfer of information will be documented in both the mental health record and the outpatient medical record.

6.17.4.1.3. In the event a patient fails to show for the scheduled appointment at the gaining base, the identified mental health provider at the gaining base will follow up to determine the cause and to reschedule, if appropriate. If the patient is diverted in route, the provider scheduled to deliver follow on services will notify the referring mental health provider at the losing base. Mental health personnel at the losing base retain responsibility for coordinating follow-on services if the patient does get diverted in route. The provider at the losing base will work with the MPF in tracking the patient and, once the new base of assignment has been determined, will contact the appropriate MH clinic to provide necessary information and ensure appropriate follow up.

6.17.4.2. Closed Cases. The decision to close a case should be based solely on clinical grounds and clearly reflect client status and progress in relation to identified treatment goals. The provider will document the decision to close a case with a termination note in the mental health chart and the outpatient medical record. See [Figure 6.3.](#), and [Figure 6.4.](#)

6.17.4.2.1. All closed cases will be reviewed to assess risk of adverse mission impact. Particular attention should be given to review of cases involving a diagnosis of substance dependence, substantiated (but closed as unresolved) cases of family maltreatment, or previous suicide attempt. Reviewing providers will apply operational and clinical judgment in assessing risk of adverse mission impact, basing their assessment on their understanding of the member, the member's potential response to pressures associated with PCS, and the demands likely to be encountered in the new working and living environment. When a reviewing provider cannot adequately assess the stressors likely to be encountered in a new working or living environment, the provider should query his counterpart at the gaining base in order to determine appropriate action. If it is determined the risk of adverse mission impact warrants mental

health intervention, the provider at the losing base will follow the same procedures noted above (see paragraph 6.1.7.2.) for transferring open cases.

6.17.4.3. During the review of either open or closed cases, if the current risk for adverse mission impact is deemed severe enough to warrant a potential cancellation of PCS, the mental health provider will notify the member and his/her current commander.

6.17.4.4. The mental health provider at the gaining base may request a copy of the mental health record from the losing base.

6.17.4.5. Release of information to the gaining command will be based on the gaining provider's assessment of the risk of adverse mission impact. Release of mental health information to command shall occur in accordance with AFI 44-109.

Figure 6.2. Sample Format—Letter to MPF Concerning Missing Outpatient Medical Records.

(MTF Letterhead)

MEMORANDUM FOR APPROPRIATE MPF/DPMUO

FROM: (Insert the appropriate hospital designation here.)

SUBJECT: Missing Outpatient Records

The outpatient records for _____ (name, rank, SSN) of _____ (organization) are not available at this time. A thorough search will be conducted and the records will be forwarded to your office if found prior to the member's estimated departure date. We will contact your office to determine appropriate disposition.

(Appropriate duty title of individual signing the letter, i.e., NCOIC, Outpatient Records)

Figure 6.3. Sample Mental Health Record Termination/Transfer of Care Summary.**MENTAL HEALTH RECORD****TERMINATION/TRANSFER OF CARE SUMMARY**

(Purpose: To provide documentation for continuity of care and disability/suitability evaluation by subsequent mental health providers. It is important that the individual clinician use judgment in regard to what information is included in the final summary so as not to jeopardize the patient's privacy or confidentiality.)

Identifying information (Specify name, FMP/SSAN, duty position)

Date case opened and date of last interview

Brief description of course of treatment, status and prognosis (Basis for initial contact, presenting symptoms, diagnostic information, identified problems, abnormal physical findings, abnormal laboratory/imaging results, psychological testing results, referrals and consultations [including but not limited to those within mental health, e.g. ADAPT, FAP, Clinical Health Psychology], relevant information obtained from collateral sources, type of treatment, biological treatment [details of prior medication trials and current medication, duration, dose, response, side effects], psychological and social interventions, risk assessment and interventions taken to reduce risk, response to treatment/changes in patient's condition to include status at time of termination of care and prognosis).

Diagnoses (Specify all five Axes)

Impact on military (Profile changes and current profile, duty impact and restrictions during course of treatment, currently, and anticipated at next assignment, MEB actions taken, information impacting security clearance [omit personal details], duty position of patient at termination [this is to support profile decisions in the event the patient is transferring from one job where profile was not needed to another position where it might be], summary of commander-directed evaluations)

Reason for termination or transfer (Specify whether completed treatment, no show/cancel, PCS, separation from the military, unknown, other)

Recommendation for follow-up (Specify details of recommendations including need for follow up [e.g. clinically indicated, at discretion of patient], type of follow up recommended, medication prescribed and special instructions, name/agency to whom patient's care is transferred, and indicate whether patient expressed understanding of the recommendations and accepted or declined recommendations.)

Therapist's signature and date

Figure 6.4. Sample Outpatient Medical Record Termination/Transfer of Care Summary.

OUTPATIENT MEDICAL RECORD

TERMINATION/TRANSFER OF CARE SUMMARY

(Purpose: To provide documentation for continuity of care and disability/suitability evaluation while maintaining psychotherapist-patient confidentiality. It is important that the individual clinician use judgment in regard to what information is included in the final summary so as not to jeopardize the patient's privacy or confidentiality.)

Identifying information (including name, FMP/SSAN, duty position)

Date case opened and date of last interview

Brief description of course of treatment, status and prognosis (Omit personal and psychological information. Briefly summarize evaluation and course of treatment. *E.g., Self referred for treatment of depression, which has been in remission on Prozac 20mg for eight months. Successfully completed Health Thinking and Depression Management. Iron-deficiency anemia identified with screening CBC was corrected with iron supplement prescribed by PCM. Excellent prognosis.*)

Diagnoses (Specify all five Axes)

Reason for termination or transfer (Specify whether completed treatment, no show/cancel, PCS, separation from the military, unknown, other)

Profile and duty restrictions

Recommendation for follow-up (Specify details of recommendations including need for follow up [e.g. clinically indicated, at discretion of patient], type of follow up recommended, medication prescribed and special instructions, name/agency to whom patient's care is transferred, and indicate whether patient expressed understanding of the recommendations and accepted or declined recommendations. *E.g., Requires medication management. Continue Prozac 20mg qd for additional 3-4 months. Since there is no psychiatrist at [gaining base], patient will follow up with PCM at [gaining base] for medication management. Patient expresses understanding of her mental illness and treatment plan and will schedule appointment upon arrival at gaining base.*)

Therapist's signature and date

Chapter 7

ADMISSIONS AND DISPOSITIONS

7.1. Responsibility for Admission Processing.

7.1.1. Unless otherwise specified, patient administration is responsible for administrative needs required for the admission and disposition of patients. All cases that are admitted to the medical facility, Carded for Record Only (CRO), or for which administrative responsibility is assumed, are processed through the admission function of the medical facility. Air Force medical facilities also assume administrative responsibility for service members hospitalized in nonmilitary medical facilities.

7.1.2. Although the administrative aspects of patient admission and disposition are largely the responsibility of patient administration, related procedures take place in clinic services (including dental) inpatient units. Maximum effectiveness in the overall admission and disposition process can be obtained only through close coordination and cooperation of all staff personnel. Patients will be registered, admitted and discharged using the current automated system.

7.2. Administrative Admission of a Patient. The admissions clerk ensures that the patient's eligibility for care has been determined, see AFI 41-115 for questions on eligibility. Complete AF Form 560 Authorization and Treatment Statement. Enter the data into the current automated system. MTFs without automated A&D functions will produce a manual AF Form 560.

7.3. Assuming Administrative Responsibility for Military Members Hospitalized in Nonmilitary Medical Facilities.

7.3.1. The MTF Commander at the nearest Air Force MTF, including clinics, ensures that appropriate tracking and follow-up processes are in place for any Air Force active duty or ARC member referred to or admitted in a nonmilitary MTF. If the patient is referred from the MTF, the referring provider ensures that the Admission and Disposition Office is notified. Ensure the patient signs an authorization to allow the civilian hospital to disclose treatment information to the MTF. Establish a Memorandum of Agreement (MOA)/relationship with local area civilian hospitals to be notified of active duty admissions in their facilities. The Patient Administration Office is responsible for tracking and the Chief, Medical Staff or designee is responsible for follow-up. The decision on whether or not to transfer the patient to a MTF is based on economics and sound medical practice. For example, while it is probably prudent to transfer a "catastrophic" patient, an appendectomy patient should probably continue care at the non-military treatment facility. See also [5.8.2.](#) for additional guidance on creating inpatient records for these admissions.

7.3.1.1. Obtain full patient identification from the facility and promptly notify patient's unit commander by telephone with the patient's name and location immediately upon notification. If the patient is an ARC member and the unit commander is unknown, contact the appropriate ARC/SG listed below.

7.3.1.1.1. HQ AFRC/SG: DSN: 223-3657 or Commercial: (703) 693-3657.

7.3.1.1.2. HQ ANG/SG: DSN: 278-8516 or Commercial: (301) 836-8516.

7.3.1.2. Obtain information on the patient's diagnoses, any procedures performed and prognosis. The civilian hospital is reimbursed for the patient's care based on the Diagnosis Related Group

(DRG). A complete summary of the patient's treatment while under the care of the civilian health care provider is required after the patient has been discharged. A Standard Inpatient Data Record (SIDR) will be transmitted. However, the complete summary is not required before the SIDR can be transmitted.

7.3.1.3. The Military Medical Support Office (MMSO), is responsible to notify the MTF with geographic responsibility of all unscheduled admissions of TRICARE Prime Remote (TPR)/Geographical Separated Unit (GSU) personnel admitted to non-federal medical facilities so that facility may assume administrative and clinical oversight of that patient's care.

7.3.1.4. Prepare AF Form 1488, if applicable, and forward to the Resource Management Flight.

7.3.1.5. Prepare AF Form 348, if applicable. See AFI 36-2910.

7.3.1.6. Complete AF Form 560. Enter the data into the current automated system. MTF's without automated A&D functions will produce a manual AF Form 560. If the narrative summary is not obtained within 10 workdays from the date of discharge, follow up with the local hospital to obtain the diagnostic and procedure information. **NOTE:** Does not apply when the member elects care at his/her own expense unless the member is hospitalized for purposes of being an approved organ donor in accordance with AFI 44-102.

7.3.2. For active duty Air Force or ARC members with emergency admissions in a uniformed services treatment facility (USTF) or VA hospital or for transfers to same from other Service MTF, the commander of the nearest Air Force MTF assumes medical administrative responsibility and arranges transfer to a military hospital in accordance with paragraph **7.3.1.**

7.3.3. If the member was referred to the USTF or VA hospital, the referral MTF maintains medical administrative responsibility.

7.3.4. ARC and other geographically separated units will notify MMSO at 1-888-647-6676 as soon as possible when one of their members is hospitalized in a civilian medical facility. For ARC members, the medical reason for hospitalization must have been determined to be "in line of duty" by the appropriate ARC authority IAW AFI 36-2910.

7.3.5. Upon notification that an Army active duty member is hospitalized in a nearby nonmilitary medical facility, the commander of the nearest Air Force MTF obtains the patient's identifying data and notifies the nearest Army MTF, as appropriate, and the individual's unit commander. Notification of Navy active duty members hospitalized in a nearby nonmilitary medical facility is made to MMSO at 1-888-647-6676. The commander takes prompt action to keep the designated parent service representative informed of the patient's status when requested to assume administrative responsibility of a patient from another Service branch.

7.3.6. Coast Guard, Public Health Service or foreign military personnel admitted to nonmilitary facilities are not admitted as "Absent Sick", not entered into the current automated system, and not reported to higher headquarters.

7.3.7. Notify the base ground safety office in accident cases using AF Form 1488.

7.4. Assuming Administrative Responsibility for Active Duty Air Force Members Hospitalized in Army or Navy Medical Treatment Facilities.

7.4.1. The nearest Air Force MTF commander assumes administrative responsibility and ensures that the following procedures are carried out for Air Force personnel hospitalized in Army or Navy MTF:

7.4.1.1. Coordinates with the Army or Navy MTF on behalf of Air Force patients.

7.4.1.2. Keeps rosters and pertinent data on hospitalized Air Force patients and notifies the member's commander immediately upon notification.

7.4.1.3. Prepares AF Form 348, when applicable, in accordance with AFI 36-2910.

7.4.1.4. See [Chapter 9](#) for seriously ill or death cases.

7.4.1.5. Complies with AFI 41-101 and AFI 41-115.

7.4.1.6. Notifies the base ground safety officer in accident cases.

7.4.1.7. In CONUS reassign patients to the patient squadron of the responsible Air Force MTF in accordance with AFI 36-2110, *Assignments*, if hospitalization of 90 days or more is expected.

7.4.1.8. Prepares AF Form 1488 when applicable and forwards it to the Resource Management Flight.

7.5. Reporting Infants Born Outside the MTF.

7.5.1. Infants born outside the MTF (i.e., at home or enroute to the hospital) are admitted as "Live-born" when admitted with the mother for post-partum care. Admission must occur within a reasonable time period after birth. Verify that delivery in the military hospital was intended and process the same as for infants born in the hospital.

7.5.2. If the admission and birth occurred in a civilian hospital and the mother and baby are later transferred to the MTF, admit the infant as a direct admission (not a "Liveborn".)

7.5.3. When a newborn infant is transferred to another MTF, the receiving MTF admits the infant as a direct admission.

7.6. Admitting Generals/Flag Officers, Colonels, and Prominent Persons.

7.6.1. Definition of Terms:

7.6.1.1. General Officer (GO): Includes all Active Duty, ARC, and Foreign General/Flag Officers (0-7 and above).

7.6.1.2. Colonel: Includes Air Force active duty that are very seriously ill (VSI), seriously ill (SI), expected to be hospitalized greater than 10 days, or given a profile change because of any medical or surgical condition affecting the member's assignment availability. Also includes any colonel that is a member of the Air Force Medical Service (AFMS) that has been admitted as an inpatient.

7.6.1.3. Prominent Persons: Includes Senior Executive Staff (SES), political officials, high-ranking public officials, and current Chief Master Sergeant of the Air Force (CMSAF). Notifications for this category other than the CMSAF require the patient's authorization.

7.6.1.4. Admission and Extended Ambulatory Care: Admission to your MTF or any facility for which your MTF assumes administrative responsibility. This includes inpatient units and other extended care services, i.e. ambulatory patient visits, observation and partial hospitalization.

7.6.1.5. Sanitized information: Patient's name, rank, age, unit of assignment, and admission/treatment date.

7.6.1.6. Comprehensive Medical Information: Patient's name, rank, age, status (i.e. AD, ARC) unit of assignment, date of admission or date of treatment, diagnosis, current medical status and projected length of stay.

7.6.1.7. Information Conduits: Command Posts or Operations Centers at the base or MAJCOM level. HQ AF/SGXO, Air Force Medical Operations Center (MOC) can be reached at DSN 227-9075 or commercial (703) 697-9075.

7.6.2. Local Notification Procedures when a General/Flag Officer, Colonel or Prominent Persons is Admitted.

7.6.2.1. The admission and dispositions section (or locally appointed designee) will provide sanitized information telephonically to the MTF Commander.

7.6.2.2. Notifications will be made as soon as possible and preferably no later than 12 hours after admission.

7.6.2.3. The MTF Commander will notify the Installation Commander via appropriate information conduits as appropriate. Keeping release to the minimum necessary.

7.6.3. HQ USAF Notification Procedure when a General/Flag Officer, Colonel or Prominent Persons is admitted or remains in the MTF.

7.6.3.1. Medical Centers will call by 0600 EST every duty day to include negative replies.

7.6.3.2. Leave only sanitized information on the MOCs password protected phone lines. Include call back phone numbers so the MOC can get comprehensive medical information as needed.

7.6.3.2.1. In unusual circumstances, if the MTF Commander determines AF/SG should be notified during non-duty hours, call the Air Force Operations Center, (DSN 227-6103, commercial (703) 697-6103), and ask for the medical person on call.

7.6.3.3. Medical Operations Center individuals will call back for comprehensive medical information as required.

7.6.4. HQ USAF/Medical Operations Center Responsibilities:

7.6.4.1. The MOC will create two word documents from the information.

7.6.4.1.1. The first document includes sanitized information only.

7.6.4.1.1.1. The sanitized information document is forwarded in password-protected mode only to the Chief, Air Force General Matters Office (GOMO) via his/her Pentagon e-mail address.

7.6.4.1.1.2. HQ USAF/SG/SG2 or his/her representative will receive the information via live brief or in password protected electronic format. HQ USAF/SG/SG2 or his/her representative will provide the information to CSAF.

7.6.4.1.1.3. If the document has an ADAF 0-6 that is seriously ill, expected to be hospitalized greater than 10 days, given a profile change because of any medical or surgical condition affecting the member's assignability, the information will be provided to the Air Force Colonel Matters Office Support Division.

7.6.4.1.2. The second document will include comprehensive medical information and be provided only to HQ USAF/SG/SG2 or his/her representative.

7.7. Reporting Aircraft Accident Admissions.

7.7.1. For specific instructions, see AFI 91-204, *Safety Investigations and Reports*, paragraph 7.4. The command surgeon of the MAJCOM owning the aircraft involved notifies AFMOA/SGZA, DSN 297-4200, of admission resulting from any aircraft accidents (active Air Force, Reserve, or Air National Guard).

7.7.2. Provide the diagnosis, estimated period of hospitalization, and probable disposition of personnel.

7.7.3. During regular duty hours, notify AFMOA/SGZA by telephone. After duty hours, notify HQ USAF/SG Duty Officer through the Air Force Medical Operations Center, DSN 297-9075 or commercial (703) 697-9075. The appropriate MAJCOM also notifies HQ AFMOA of the initial clinic visit, diagnosis, estimated period of treatment, and the probable disposition of personnel who are examined or received treatment for injuries incurred as a result of an aircraft accident.

7.8. Managing Military Patients Expected To Be Hospitalized Over 90 Days.

7.8.1. Notify the patient's servicing MTF and MPF when a patient will be reassigned or hospitalized over 90 days.

7.8.2. The staff at the admitting MTF must advise the local traffic management office (TMO) and MPF of the person's hospitalization and the expected duration when a patient is hospitalized while traveling to a Continental United States (CONUS) port for PCS overseas.

7.8.3. The patient may be assigned to the Patient Squadron. See [Chapter 10](#), paragraph [10.11](#), for further guidance.

7.9. Notifying the VA of Admission of a Veteran Who At Any Time Filed a Claim. Complete two copies of VA Form 21-8359, Notice to VA of Admission to Uniformed Services Hospital, for a veteran admitted as an inpatient. Send a copy of the form to the VA regional office in the state where the veteran resides and file the other copy in the inpatient record.

7.10. Readmission of Patients.

7.10.1. Reactivate the record of hospitalization if the patient is readmitted before midnight on the same day as discharged for the same reason as the first admission. The attending provider annotates the reason for readmission and the hospitalization is considered as one continuous period.

7.10.2. If the patient is readmitted after midnight, or the reason for readmission is different from that of the previous admission, create a new record.

7.11. Canceling Admissions. See [Chapter 5](#), para [5.1.2](#).

7.12. Rank for OSI Agents. When entering the rank for OSI agents into the current automated system, enter the rank for Airman Basic (E-1) regardless of the agent's actual rank. The purpose is to provide a protection mechanism for the agent.

7.13. Disposition of Patients.

7.13.1. Discharge to Duty (Military Patient) or Discharge (Nonmilitary Patient).

7.13.1.1. Review the AF Form 577, **Patient's Clearance Record**, to ensure the patient has cleared all necessary sections. Annotate the form with the date and time of discharge and enter the information into the current automated system. The patient is then released from the MTF.

7.13.1.2. Maintain the AF Form 577 in the Admission and Dispositions Office for a period of three months and then destroy.

7.13.1.3. Remove any pertinent information from the suspense file and place in the patient's inpatient record. For active duty military members, personnel information is sent to the MPF for inclusion in the field personnel records.

7.13.2. Discharging Nonactive Duty Patients Requiring Domiciliary or Custodial Care.

7.13.2.1. Discharge retirees eligible for care in VA facilities as follows:

7.13.2.1.1. Arrange for admission and transportation to a VA medical facility, if acceptable to the patient or Next of Kin (NOK).

7.13.2.1.2. Release retirees declining assistance in getting into a VA facility to the NOK.

7.13.2.1.3. If NOK declines acceptance, contact civil authorities in the patient's state of residence for permission to transfer the patient to their custody. If the original request for permission is disapproved, repeat the procedure with civil authorities of the state where the patient entered the Service (when different from the state of residence).

7.13.2.1.4. Provide complete information from the attending health care provider (in narrative form) on the diagnosis, date the condition started, history of previous hospitalization(s) for the condition, patient's legal residence, place and date of birth, length of patient's military service, and name and address of patient's NOK.

7.13.2.1.5. Coordinate the patient's move, with proper escort, to the NOK or to the civilian authority accepting custody. Advise the accepting party of the expected time of patient's arrival.

7.13.2.2. Discharge other non-active duty patients requiring domiciliary or custodial care following procedures similar to those in paragraph [7.13.1.](#) and [7.13.2.1.](#)

7.13.2.2.1. Discharge alternatives must be acceptable to the patient or NOK.

7.13.2.2.2. Release the patient to the NOK if the arranged or recommended alternatives are declined.

7.13.2.2.3. Request permission to transfer patient custody to civil authorities if the NOK declines acceptance. Contact the SJA if the request is denied.

7.13.3. Discharging Patients Not Eligible for Care at VA Expense.

7.13.3.1. Discharge a military patient who, upon expiration of term of service (ETS), has physical or mental disabilities as follows:

7.13.3.1.1. Contact the NOK to determine whether they are assuming custody of the patient and responsibility for care, see [7.13.4](#).

7.13.3.1.2. The NOK must produce affidavits certifying their willingness to make suitable arrangements for the patient and the financial means to do so.

7.13.3.1.3. See [7.13.2.1.3](#) – [7.13.2.1.4](#) for procedures to follow when NOK declines acceptance.

7.13.3.1.4. Coordinate the patient's move, with proper escort, to the NOK or to the civilian authority accepting custody. Advise the accepting party of the expected time of patient's arrival.

7.13.3.2. Discharge a civilian patient with a physical or mental disability requiring hospital care beyond that authorized in an Air Force MTF in accordance with [7.13.3.1.1](#) if he or she is not a beneficiary under the Federal Employees' Compensation Act. Coordinate proposals to move a civilian employee hospitalized in a medical facility outside the U.S., or to separate him or her for medical or other reasons, with the appropriate Civilian Personnel Officer.

7.13.4. Discharging Patients With Chronic Physical or Mental Conditions. The following instructions apply to a civilian or military member who is separated or retired because of a chronic physical or mental condition.

7.13.4.1. A patient who does not exhibit suicidal or homicidal tendencies may request release to the NOK, see [7.13.3.1.2](#).

7.13.4.2. Discharge a patient who exhibits suicidal or homicidal tendencies as follows:

7.13.4.2.1. Transfer a member or former member of the Uniformed services entitled to treatment by the VA to a location designated by the VA. This requires the request of the NOK and authorization for admission from the hospital concerned.

7.13.4.2.2. Discharge a military or civilian patient not entitled to treatment by the VA to civil authorities who are legally authorized to assume care in such case; to the Federal Bureau of Prisons, if treatment there is authorized; or to an acceptable private hospital at the written request of the NOK. This will also require authorization from the destination hospital.

7.13.4.3. A non-military psychotic patient admitted to an Air Force MTF overseas is handled by the liaison, through the American Embassy and civil authorities, to resolve problems associated with hospitalization and transfer to CONUS.

7.13.4.3.1. By law, the Department of Health and Human Services (HHS) may receive and provide care for nonmilitary mental patients returned to CONUS.

7.13.4.3.2. If the patient is not releasable to the NOK, and is not authorized further Air Force hospitalization, the overseas commander asks local U.S. diplomatic representatives to arrange, through the Department of State, for the HHS to receive the patient upon arrival in CONUS.

7.13.4.4. For instructions on the discharge of psychotic prisoner patients see [7.13.5.1](#).

7.13.5. Disposition of Prisoner Patient. When discharging prisoner patients, the Federal Bureau of Prisons exercises administrative control over prisoners confined in a DoD regional or long-term cor-

rections facility. This agency's responsibility extends to all matters except clemency, parole, restoration to duty and enlistment. When a prisoner is under the administrative control of the Air Force, the Air Force is responsible as follows:

7.13.5.1. If a prisoner, whose sentence includes an executed punitive discharge, has a disabling condition (including psychosis requiring closed unit treatment), hospitalize the prisoner at the nearest DoD hospital which can provide the required care. Move the patient in accordance with AFI 31-205, *Corrections Program* and AFJI 41-315.

7.13.6. Discharging Patients With Communicable Diseases. Notify Force Health Management if a patient has a communicable disease when the term of service ends and he or she elects to separate and be discharged from the hospital.

7.13.7. Discharging Non-active Duty Patients Refusing to Comply with Rules. Contact the SJA for assistance when a non-active duty patient fails or refuses to comply with established rules.

7.13.8. Discharging Patients With Terminal Illness.

7.13.8.1. Transfer non Air Force members according to AFJI 41-315.

7.13.8.2. Final decision on the discharge of the patient depends on MTF capability, demand for services and humanitarian considerations.

7.13.8.3. If the active duty terminal patient is referred to the PEB, follow the procedures in **Chapter 10** and AFI 36-3212, *Physical Evaluation for Retention, Retirement and Separation*.

7.13.9. Discharging Patients Absent Without Leave (AWOL). Report a military patient who is AWOL from a medical facility to the individual's servicing MPF. Do not carry AWOL patients on the Admissions and Dispositions (A&D) list or the census reports more than 10 days. Close out the medical records after 10 days.

7.13.10. Discharging Patients Through Action by MEB and PEB. See **Chapter 10** and AFI 36-3212.

7.13.11. Convalescing Patients. Initiate convalescent leave for military patients in accordance with AFI 36-3003. Convalescent leave is not to be used as an alternative for placing a member in an excused from duty status or when an individual could instead be returned to limited duty without adversely affecting full recovery.

7.13.11.1. MTF commanders may recommend convalescent leave up to a total of 90 days for a single period of hospitalization. Convalescent leave over 30 days requires additional medical review and consent with the exception of obstetrical leave. Convalescent leave in excess of 90 days must be approved by the MTF's MAJCOM Surgeon's Office.

7.13.11.2. The attending health care provider may recommend up to 42 days of postpartum convalescent leave upon discharge, unless the mother's medical condition warrants a longer period.

7.13.11.3. The discharge clerk coordinates all arrangements for an inpatient's departure on leave. AF Form 988, **Leave Request/Authorization**, is cleared through the discharge clerk.

7.13.11.4. For directed convalescent leave, the health care provider completes and signs Block 7 and the chief of service reviews and approves the leave by signing in the "Remarks" section of Block 8 of the AF Form 988. The patient's unit commander completes Blocks 23 through 25.

7.13.11.4.1. The inpatient record remains open while the patient is on convalescent leave and is held in the suspense file in A&D until the patient returns. The record is returned with the patient to the assigned unit or forwarded to the Inpatient Records department upon discharge.

7.13.11.5. For recommended convalescent leave, procedures are the same as in [7.13.11.4.](#), except the patient's unit commander completes Blocks 22 through 25 on the AF Form 988. In addition, the inpatient record is closed out upon discharge to convalescent leave.

7.13.11.5.1. Except as provided in [7.13.11.2.](#), unit commanders may approve initial convalescent leave up to 30 days. Further approval of convalescent leave beyond 30 days requires additional medical review and consent.

7.13.11.5.2. Recommendations for convalescence are also used for outpatients (without related inpatient episode) when the medical condition warrants it.

7.13.12. Retention of Enlisted Patient Beyond the Discharge Date. See AFI 36-3208, *Administrative Separation of Airmen*.

7.13.13. Discharging Persons Refusing Professional Care. See [Chapter 10](#), paragraph [10.1.4.12](#).

7.13.13.1. Notations are placed in the health record documenting the refusal and explaining the risks of refusal that were provided to the patient. Beneficiaries are encouraged to sign the notation.

7.14. Transferring Patients Through the Aeromedical Evacuation (AE) System. See AFI 41-301, AFI 41-302, and AFJI 41-315 for instruction on AE operations.

Chapter 8

BIRTH REGISTRATION

8.1. Birth Registration in the CONUS.

8.1.1. A birth certificate will be prepared for each infant born in an Air Force MTF. Follow State laws with regard to the forms used, format, and number of copies required. File a work copy in the infant's inpatient record. Contact local department of Vital Statistics to obtain a copy of birth certificate.

8.1.2. Updating Personnel Records. Advise parents to report to the Military Personnel Flight to update personnel records and register the child in the DEERS as part of birth registration. This must be accomplished within 120 days or the member will receive a bill for care. When both the parents are active duty, recommend that the same sponsor be identified in CHCS and DEERS in order to eliminate confusion with the records.

8.1.3. Refer parents to the TRICARE Service Center for TRICARE options, including TRICARE Prime enrollment.

8.2. Registering Births Overseas.

8.2.1. Overseas Air Force MTFs must cooperate with consular officers in registering births of infants born to U.S. citizens in areas overseas. **EXCEPTIONS:** Register births in American Samoa, Guam, Puerto Rico, the Trust Territories, and the U.S. Virgin Islands through the special offices of the Vital Statistics Division, Public Health Services, U.S. Department of Health and Human Services, or specified local U.S. Government offices.

8.2.2. Reporting Births. Births are reported to local authorities on the forms provided by U.S. Consular Offices.

8.2.3. Notifying the U.S. Consular Office. Notify the U.S. Consular Office where the Air Force MTF is located no later than 10 days after the birth of an infant whose parent or parents are U.S. citizens.

8.2.4. Completing Department of State Foreign Forms FS-240, **Consular Report of Birth Abroad of a Citizen of the United States of America**. The FS-240 will be completed in four copies. The (U.S. citizen) parent will sign each copy of the forms under oath before a military officer qualified to administer oaths. The officer administering the oath completes the section reading, "This section to be completed by consular officer, notary public or other person qualified to administer oaths" NOTE: Obtain a supply of FS-240s from the nearest U.S. Consular Office.

8.2.5. If the mother is not a U.S. citizen, the U.S. citizen father must sign FS-240 if he is available. If the father is not available (or if there is any question about his citizenship status), ask the parent(s) to get in touch with the U.S. Consular Office.

8.2.6. If the mother dies or is in very serious condition and the father, who is a U.S. citizen, is not available, send the FS-240 to the U.S. Consular Office as soon as the health care provider delivering the infant signs the form to attest the delivery.

8.2.7. Contact the nearest U.S. Consular Office concerning necessary procedures to establish U.S. citizenship when a child is born out of wedlock.

8.2.8. Advise the parents about the following procedures:

- 8.2.8.1. If the U.S. citizen parents have the proper documentation to support entries on FS-240, inform them that they need not go to the U.S. Consular Office in person.
- 8.2.8.2. If the necessary documentation is questionable or not available, send the FS-240 to the U.S. Consular Office and advise the parents to visit the office with documents establishing marriage and citizenship.
- 8.2.8.3. In addition to proving birth fact, the U.S. Consular approved FS-240 is considered full proof of U.S. citizenship in all courts, tribunals and public offices of the U.S. both inside and outside the CONUS; the District of Columbia; and each state, territory, and outlying possession of the U.S. The FS-240 is equal to the certificate of citizenship or naturalization that the U.S. Immigration and Naturalization Service (USINS) issues.
- 8.2.8.4. FS-545, **Certificate of Birth**, (also known as DS-1350 in the U.S.). Obtain information from the FS-240 to prepare the Certification of Birth. This certification is a short form record of birth that the Department of State uses to provide persons born outside the CONUS and its possessions with a birth certificate form similar to those that State Vital Statistics Registration Offices in the U.S. issue. However, this Certification of Birth does not replace the FS-240 in any way.
- 8.2.9. Registration of Birth. Advise the parents that a fee for registering the child's birth will be charged. The U.S. Consular Officer issues them a copy of the FS-240 when the birth is reported, as well as a copy of the FS-545.
- 8.2.10. Additional Copies of FS-240 and FS-545. Parents, or the child at a later date, can obtain additional copies of the FS-240 and FS-545 from the Vital Records Section, Passport Services, 1111 19th Street, N.W., Suite 510, Washington, DC 20522-1705. Contact the State Department Vital Records Services web site for full information on how to make the request, what information to include, and payment of associated fees.
- 8.2.11. Updating Personnel Records. Advise DOD personnel whose children are born overseas to report to the Military Personnel Flight to update personnel records and register the child in the DEERS and passport application as part of birth registration in an overseas area.

Chapter 9

CASUALTY REPORTING AND PROCEDURES RELATING TO DECEASED PATIENTS

9.1. Reporting Patients in Casualty Status.

9.1.1. A patient placed in a casualty status is reported IAW AFI 36-3002. Categories of patients requiring special casualty reports are as follows:

9.1.1.1. Very Seriously Ill (VSI) Patients. A patient is reported as VSI when, the best judgment of the responsible physician or dentist, the patient's physical condition, whether due to illness or injury, is so severe that there is imminent danger to life.

9.1.1.2. Seriously Ill (SI) Patients. An SI patient is one whose illness or injury is so severe that there is cause for immediate concern, but there is no imminent danger to life.

9.1.1.3. Patient Suffering an Incapacitating Illness or Injury (III). A hospitalized patient who is not classified as VSI or SI by competent medical personnel, but whose illness or injury:

9.1.1.3.1. Renders the patient physically or mentally incapable of communicating with their next of kin (NOK).

9.1.1.3.2. Involves serious disfigurement.

9.1.1.3.3. Causes major diminution of sight or hearing.

9.1.1.3.4. Results in a loss of a major extremity or paralysis.

9.2. Assigning Responsibility.

9.2.1. The patient's attending health care provider classifies a patient as VSI, SI or III and records an entry on the AF Form 3066 or 3066-1. This prompts preparation of an AF Form 570, which is sent to the locally designated Casualty Affairs Liaison (CAL).

9.2.1.1. Preparation of AF Form 570.

9.2.1.1.1. Complete section I, II, and III when the report is prepared. When reporting VSI, SI, and III patients, complete Section IV. If the patient is an organ donor, check the appropriate block and indicate organ to be donated. Section V is completed by the CAL. Section VI may be used to continue entries from other sections, provide additional information, or request administrative action.

9.2.1.1.2. Upon receiving the AF Form 570, the CAL completes section V and immediately notifies the installation commander and/or Casualty Assistance Representative (CAR) in accordance with AFI 36-3002. The CAL provides enough information to make the first notification and required progress reports on the patient's status.

9.2.2. For personnel in a VSI, SI, III or NSI casualty status, the attending physician, MTF Commander, member's commander, or designated representative or HQ AFPC/DPWCS notifies the NOK, by telephone if necessary.

9.2.3. When the physician or dentist determines that the status of a patient previously reports as VSI, SI, or III is changed, an AF Form 570 is prepared as described in paragraph [9.2.1.1](#).

9.3. Procedures for Travel of the Next of Kin (NOK) Under the Invitation Travel Order (ITO) Program.

9.3.1. The attending provider provides a recommendation to the MTF Commander that the presence of the NOK is considered beneficial to the patient's recovery. If the MTF Commander approves the request the CAL (or after duty hours the administrative/noncommissioned officer of the day) immediately contacts the CAR, who is responsible for contacting AFPC/DPWCS for authorization/publication of ITOs, providing the information necessary to request transportation. Full explanation of the ITO Program is in AFI 36-3002.

9.3.2. The MTF commander or designee must concur and approve the attending physician's request on AF Form 570 prior to HQ AFPC/DPWCS issuing the ITO.

9.3.3. ITO approval authority may not be delegated.

9.4. Preparing the AF Form 1403, Roster of Seriously Ill/Very Seriously Ill. The CAL prepares AF Form 1403 each day as of midnight to cover the preceding 24-hour period. Negative rosters are not required. Distribute the AF Form 1403 in accordance with local guidance and AFI 37-124, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*.

9.5. Providing Follow-up Information. The CAL provides the installation commander and CAR with information received from the patient's health care provider for follow-up action in accordance with AFI 36-3002.

9.6. Removing Patients from the Roster.

9.6.1. When the attending health care provider determines that the patient can be removed from the Roster of Seriously Ill/Very Seriously Ill prepare AF Form 570 and send it to the CAL.

9.6.2. The CAL will notify the installation commander and CAR once the patient is removed from the roster so that action can be taken in accordance with AFI 36-3002, *Casualty Services*. Notify interested persons or agencies, as defined by local guidance, quickly and complete Section V of AF Form 570. File AF Form 570 in the patient's suspense file. Annotate the remarks section of the work copy of the AF Form 1403 to show the time of removal.

9.7. Processing Imminent Death Cases. Reference the PEBLO imminent death guide for procedures on processing of imminent death cases located at the [Air Force Physical Disability Division - PEBLO Guide Updates](#) web site.

9.8. Responsibility for Preparing Death Cases.

9.8.1. Death of a person while being attended outside the MTF – the attending Air Force medical officer.

9.8.2. Death of a person in an Air Force-owned or leased aircraft – the medical treatment unit serving the base which investigated the accident.

9.8.3. Death of other Air Force personnel who are not patients in a MTF at time of death – the MTF serving the base which investigated the circumstances of death.

- 9.8.4. Death of a nonmilitary person on an Air Force base – the MTF serving the base.
- 9.8.5. Death of a person being staged through an aeromedical staging flight (ASF) – the MTF supporting the ASF.
- 9.8.6. Death of a person while in transit in an inpatient status – the MTF receiving the remains. **NOTE:** Treat as transfer-in patients those who die while in transit (either while in flight or in an ambulance between facilities) or while being staged through an ASF.

9.9. Policies Regarding Deaths.

- 9.9.1. See AFI 34-242 for instructions on preparing, inspecting and shipping remains and completing related forms and reports. **NOTE:** DoD policy requires that when a military member or family member dies outside the U.S., the death must be officially recorded with the local civil authorities.
- 9.9.2. A health care provider verifies all deaths occurring at an Air Force MTF and on an Air Force installation.
- 9.9.3. Do not remove the body without permission of civil authorities when a member of the Uniformed services on active duty dies outside the limits of an Air Force installation.
- 9.9.3.1. The commander consults local civil authorities to develop procedures to follow when Uniformed services personnel die within or beyond installation limits.
- 9.9.3.2. Obtain a transient or burial permit from the proper civil authority before removing a body from an Air Force base for shipment or burial.
- 9.9.3.3. Release remains to mortuary personnel within 24 hours after death unless extenuating circumstances exist. Ensure that the death certificate is completed and signed by the responsible medical officer before releasing the remains. The mortuary representative (military or civilian) taking custody of the remains signs a receipt for the remains. File the receipt in the deceased's inpatient or outpatient record, as appropriate.
- 9.9.4. Initial movement of remains is accomplished as follows:
- 9.9.4.1. A provider pronounces death at the site or the MTF, prepares a death certificate and gains a decision regarding an autopsy. As authorized by the base commander, in deaths occurring on the military installation, if an autopsy is to be performed at the MTF, the MTF provides transportation of the deceased person from the site of death (or presumed death). If an autopsy will not be performed at the MTF then Mortuary Affairs is responsible for transportation of remains.
- 9.9.4.2. Local civil authorities exercise control over the movement of remains in the event of an off-installation death. Once the remains of an active duty member are released from the civil authorities, determine if an autopsy will be performed. If affirmative, medical personnel transport the remains to the MTF. If negative, mortuary services transports the remains to the contract funeral home or government mortuary. **NOTE:** In the event of a military aircraft accident, an autopsy is usually indicated.
- 9.9.4.2.1. For overseas the same procedures in [9.9.4.2.](#) may be used for family members and other eligible beneficiaries.

9.9.4.2.2. In a disaster or multiple death situation everyone available assists in any way possible. The mortuary officer calls the motor pool for transportation to move the remains during search and recovery operations. Remains are placed in body bags for movement.

9.9.5. When a patient dies, notify the CAL or their representative immediately.

9.9.6. Collect and inventory all personal property of the deceased in the presence of a witness as soon as possible following the death of any patient. Send personal effects of a military patient to the summary court officer. Send personal effects of civilians to an executor or administrator, or (if none appointed) to the nearest NOK. The executor, administrator or nearest NOK, as appropriate, signs the inventory as a receipt for effects. File the receipt in the patient's inpatient or outpatient record, as appropriate.

9.9.7. Certificate of Death. Usually the provider pronouncing death prepares a death certificate and sends it to the proper authorities according to state and civil requirements. However, the death certificate can be signed by a physician with knowledge of the primary and contributory cause(s) of death. This may be the pronouncing physician, the patient's primary physician or another member of the medical staff with that knowledge. File one copy of the certificate in the deceased patient's inpatient record. In overseas areas, prepare DD Form 2064, **Certificate of Death (Overseas)**, per AFI 34-242.

9.9.8. Reporting Deaths. The MTF commander reports deaths as required by AFI 36-3002 when a person dies at an Air Force MTF or en route to the MTF. Establish local procedures regarding other required notifications.

9.9.9. Reporting Stillbirths. Prepare a certificate of death and file it as required by state and civil law. File one copy of the fetal death certificate with the mother's inpatient record. Handle remains as for other deaths (as far as is appropriate). In the case of an abortion, send the surgical specimen to the laboratory the same as for other surgical specimens. **NOTE:** Even when not required by state or civil law, a fetal death certificate may be issued if the NOK requests the coroner or medical examiner to do so.

9.9.10. Comply with AFI 34-242 when deceased Uniformed services personnel cannot be identified by local means. Utilize the resources of the Office of Air Force Medical Examiner (OAFME) to the maximum extent possible to support the identification of remains.

9.10. Performing Post Mortem (Autopsy).

9.10.1. File the authorization to perform a post mortem examination in the deceased's inpatient or outpatient record, as appropriate. Perform a post mortem only with the consent of the surviving spouse, NOK, person having right of burial, as specified in DoD Directive 6465.2, or at the request of the local coroner or medical examiner except in the circumstances described in **9.10.4**.

9.10.2. Under normal conditions, complete the post mortem within 24 hours after the remains are received, appropriate records are available and authorization has been granted.

9.10.3. Record the post mortem on SF 503, **Medical Record-Autopsy Protocol**. Except those performed under AFI 91-204. File the original copy with the health records of the deceased. Maintain a completed copy in the clinical laboratory.

9.10.4. Post Mortems on Members of Uniformed services. Perform a complete post mortem when a member of the Uniformed services, called or ordered into active military service for a period of more than 90 days, dies on an Air Force base if any of the following applies:

- 9.10.4.1. Death occurred under circumstances suggesting crime, suicide, or other appearances requiring investigation. Do not exclude a post mortem merely because a superficial examination may suggest a conclusion as to cause of death.
- 9.10.4.2. Cause of death might constitute a menace to public health.
- 9.10.4.3. Cause of traumatic death is other than result of a military accident, but physiological or pathological changes may have precipitated the events leading to death and cannot be determined without a post mortem.
- 9.10.4.4. Death occurred while the person was serving as an aircrew member in a military aircraft. **NOTE:** AFI 91-204 specifies that an autopsy should be performed when practicable regardless of location of crash or incident.
- 9.10.4.5. Physician is unable to establish the cause of death.
- 9.10.4.6. Death occurred while the person was confined in disciplinary custody but had not been punitively discharged from the military service.
- 9.10.4.7. The commanding officer of an installation or command, the investigating officer, other fact-finding body or medical examiner requires the post mortem to determine the cause and manner of death (such as sudden, unexpected death, homicide or suicide); to secure information for completion of military records; to protect the welfare of the military community; or when the service member is an aircrew member and the death occurs during flight operations.
- 9.10.5. Authorization for Post Mortem on U.S. Uniformed services Personnel. The installation commander or Air Force Medical Examiner (AFME) is the approving authority for the post mortem examinations in **9.10.4.** in areas of exclusive Federal jurisdiction and in other areas when the civil authority has released jurisdiction to the Uniformed Services. In areas outside the U.S. and its territories, existing Status of Forces Agreements apply. When the host government relinquishes its authority, the AFME or installation commander authorizes the post mortem. This approving authority may be delegated to the MTF Commander, but must be written and always current.
- 9.10.6. Performing a Post Mortem on a Civilian. Abide by the laws of the state or foreign nation where the Air Force installation is located when performing a post mortem for a deceased civilian.
- 9.10.6.1. Obtain the written, signed permission of the nearest NOK, or an order by an appropriate civil authority if the death occurred in unusual or suspicious circumstances. Develop procedures incorporating the requirements of this instruction, relevant laws, existing legal agreements and other legitimate requirements of local authorities.
- 9.10.6.2. For post mortem purposes, treat as civilians the remains of members of the National Guard, Reserve Officers Training Corps and other reserve components not on active duty for training.
- 9.10.6.3. When consent of NOK is required, check to verify notification and obtain the required consent on SF 523, **Medical Record-Authorization for Autopsy.**
- 9.10.6.4. After deliverance of casualty notice to the family or NOK and confirmation of its receipt, the MTF Commander sends a condolence letter to the family or NOK and requests permission for a post mortem. The consent is filed in the patient's inpatient or outpatient record, as appropriate.

9.10.6.5. At overseas installations, request the family or NOK send the reply to request for post mortem consent to AFMOA/SGOC, Bolling AFB DC 20332-7050. Upon receipt of reply, AFMOA/SGOC will send a priority wire through military message channels advising of the decision and then send the original message by mail to the MTF for filing in the patient's inpatient or outpatient record, as appropriate.

9.10.7. Performing a Post Mortem on Foreign Military Personnel. Use the procedures outlined in **9.10.4.** for deceased foreign military personnel who were in active military service in the CONUS. Obtain permission for post mortem from the military attaché of the foreign embassy. Include this request for permission in the casualty report required by AFI 36-3002.

9.10.8. Organ Disposal After Post Mortem. Return all organs and tissues removed during post mortem to the body, except those organs, tissues and tissue fluids essential to diagnose the cause of death or intended for studies authorized by the family or NOK or required by law (see DoD Directive 6465.2). Dispose of, in a humane and dignified manner, any organs or tissues retained after release of remains to mortuary officials.

9.11. Disposition of Outpatient Records on Deceased Active Duty Personnel. See AFI 36-2608 and AFI 36-3002 for guidance on the disposition of the outpatient record when an active duty member of the U.S. Armed Services expires.

9.12. Deceased Patient Kit.

9.12.1. Compile and keep on hand several packages of all the forms and other documentation needed in case of death of a patient. The packages should be kept in a central location such as Admissions and Dispositions and shall contain, at a minimum, the following forms in the specified quantities:

9.12.1.1. 1- SF Form 523

9.12.1.2. 3-AF Form 146

9.12.1.3. 1- AF Form 570

9.12.1.4. 1- Release of Remains.

9.12.1.5. Request for Postmortem Examination.

9.12.1.6. AF Form 1122

9.12.1.7. 1- Fax Notification

9.12.1.8. 1- Death Certificate Worksheet

9.12.1.9. 1-Death Certificate (Issued by state. If overseas use DD Form 2064)

Figure 9.1. Expired Patient Checklist.

EXPIRED PATIENT CHECKLIST

Use this checklist when notified of the death of a patient.

Name of Patient: _____ Ward: _____ Notified by Whom: _____

Date/Time: _____ Family Members Present: _____ A&D Clerk's Initials: _____

MAKE ENTRY ON THE QUALITY CONTROL CHECKLIST ON DEATH FOLDER AT THIS TIME!!

COMPLETE THE FOLLOWING ACTIONS "BEFORE" GOING TO THE WARD:

1. Get the expired patient's suspense file from the file cabinet.
2. From the computer or patient's file get information needed to fill out the following forms:
 - _____ AF Form 146- Death Tag- Fill in all blocks (except blocks 5 and 8) Must have 3 tags.
 - _____ AF Form 570- Notification of Patients Medical Status- All data in Block I.
 - _____ Death Certificate Worksheet- Blocks 101,102,104,105 and 106.
 - _____ Release of Remains- Date and Name of Deceased.

3. Print a Blue Stamp Plate.

WITH THE ABOVE FORMS, GO TO THE WARD AND TALK TO (1) THE DOCTOR (2) CHAPLAIN (3) NURSING STAFF (4) THE FAMILY.

1. The doctor will fill in the following information and provide SIGNATURES:

- _____ AF Form 146- Death Tag- All 3 tags, blocks 5 and 8. Give to the ward.
- _____ AF Form 570- Notification of Patient Medical Status- Sections III and IV (STAMP NAME OF PHYSICIAN).
- _____ SF Form 523- Authorization for Autopsy- Must use patient's blue plate to stamp information under patient's identification.
- _____ Request for Postmortem Examination.
- _____ DEATH CERTIFICATE WORKSHEET- Blocks 1,2,3,7,8,107,108,109,110,111,112,113,114,115,116,117,118.
(STAMP BLOCK 118 AND DOCTOR'S PAGER NUMBER).
- _____ HQ AMC FAX NOTIFICATION – Doctor needs to complete the bottom of the form.
- _____ Complete AF Form 1122- Personal Property Inventory- Complete ONLY if family members are NOT present and store property until family arrives in the patient valuables locker.

2. Get the following information from the family:

- _____ Confiscate patient's ID card.
- _____ Release of Remains: (1) Sign the release (2) Name of Funeral Home.
- _____ Authorization for Autopsy: Be sure to get this signature in presence of Physician and yourself.
- _____ Patient Belongings- maintained in patient valuables locker.

UPON RETURNING TO THE OFFICE COMPLETE THE FOLLOWING ACTIONS:

- Make ALL necessary notifications: _____ AF Form 570, Block V _____ Computer/Box/File
 _____ Fax (HQ AMC) _____ Command Post
 _____ CTDN (All deaths--inform of patient's wish to/not to donate organ and/or tissue)
 _____ Medical Evaluation Boards-MEB-(Imminent and/or Active Duty Death
 _____ If patient died within 24hrs of admission or arrival at the hospital call 423-3805. Leave message if no answer.
 _____ Autopsy: If one is required, after obtaining signatures and filling out both forms completely, turn into Pathology the next duty day (unless an Emergency Autopsy is requested).
 _____ Type Death Certificate- Get Doctor's signature, make 3 copies (Original: To Funeral Home, 1st copy: For A&D File, 2nd copy: In the Risk /Quality Management Box, 3rd copy: To Inpatient Records Section.
 _____ Call Funeral Home when Death Certificate is signed and Autopsy is completed.
 _____ Release of Remains: Have the funeral home complete their portion and make a copy for them. The original is filed in the death folder.

Chapter 10

MEDICAL EVALUATION BOARDS (MEB) AND CONTINUED MILITARY SERVICE

10.1. The purpose of the Medical Evaluation Board.

10.1.1. In order to maintain a fit and vital force, the Secretary of the Air Force relies on disability laws to remove active duty and ARC members who can no longer perform their military duties because of a mental or physical defect. The MEB is the first step in the Air Force disability evaluation process to determine who is not worldwide qualified. AFI 48-123, Chapter 7, and Attachment 2, outlines those medical conditions that require a medical board. Air Force Reserve members must be entitled to disability processing to undergo MEB processing. Air Force Reserve members not entitled to disability processing will be evaluated IAW AFI 48-123 and AFRC medical policy guidance. Air National Guard members not entitled to disability processing will be evaluated IAW AFI 48-123 and ANG medical policy guidance.

10.1.2. Responsibilities.

10.1.2.1. It is the responsibility of every Air Force provider to become familiar with the medical standards for continued worldwide duty, and to identify members who are no longer worldwide qualified.

10.1.2.2. Every MTF Commander must establish and maintain a viable Medical Evaluation Board process.

10.1.2.3. HQ AFPC/DPAMM will monitor, evaluate, and provide guidance and oversight to the medical evaluation board process and ensure that all MEBs presented to the Air Force Disability Evaluation System (DES) are comprehensive, consistent, timely, and sufficiently complete so that they may be fairly adjudicated.

10.1.2.4. HQ AFPC/DPAMM is the sole approval authority for Assignment Limitation Code-C (ALC-C), Medical Hold, and non-emergent elective surgery during an active duty service member's final six months of service. HQ AFPC/DPAMM is the office of primary responsibility for implementing HQ USAF/SG policy on medical standards for continued active duty service, and may make exceptions to this instruction unless specifically prohibited by law.

10.1.2.4.1. For ARC personnel, the appropriate ARC/SGP, see paragraph 10.12., is the approval authority for ALC-C, medical hold, and non-emergent elective surgery. AD MTFs should contact the appropriate ARC/SGP when confronted with these issues involving ARC personnel. For ANG personnel, ANG/DP is the approval authority for Deployment Availability Code 42 (DAC-42) and medical hold. ANG/SGP will work in conjunction with ANG/DP when confronted with these issues involving ANG personnel.

10.1.3. Presumption of Fitness. The existence of a physical defect or condition does not of itself necessarily provide justification for or entitlement to an MEB. The law that provides for military disability, Title 10 U.S.C., Chapter 61, is not used to bestow additional benefits upon those approaching retirement or separation. If a member has performed his or her duty satisfactorily prior to scheduled retirement or an approved separation date, a presumption of fitness is established. This presumption of fitness can be overcome only if clear and convincing evidence to the contrary is established by a preponderance of evidence that one of the following exists:

10.1.3.1. Within the presumptive period an acute, grave illness or injury occurs that would prevent the member from performing further duty, if he or she were not retiring, or a serious deterioration of a previously diagnosed condition occurs that would prevent the member from performing further duty immediately prior to or concurrent with the processing for normal retirement.

10.1.3.2. A serious deterioration of a previously diagnosed condition occurs that would prevent the member from performing further duty immediately prior to or concurrent with the processing for normal retirement.

10.1.4. Special Considerations. Mental competency for pay and records requires a medical board if such a determination is warranted for specific medical and/or psychiatric illnesses. The competency determination is made in addition to a worldwide qualification determination. This competency determination is recorded on AF Form 618, Item 23. If the member is declared incompetent for pay and records, add to Item 22, "DFAS DEM 177-373."

10.1.4.1. Unsuitable Conditions. Some psychiatric (and other) conditions will render an individual "unsuitable" for military duty although they do not constitute a compensable physical or medical disability. These individuals are referred to their commander for consideration for administrative separation. See AFI 48-123, Attachment 2, paragraphs 2.12. and 2.20, and DoDI 1332.38, Enclosure 5, *Conditions Not Constituting a Physical Disability*.

10.1.4.2. If a military retiree on the Temporary Disability Retirement List (TDRL) requires a mental competency status determination, it will be accomplished in accordance with DFAS DEM 177-373. HQ AFPC/DPPD will designate a MTF to conduct this board along with the TDRL periodic evaluation.

10.1.4.3. Legal proceedings against a member may require a sanity determination as specified in the Manual for Courts Martial (MCM) or current legal decisions. This determination is conducted by a sanity board. If the psychiatric findings bring into doubt the member's qualification for worldwide service or competency for pay or records, then an MEB must be convened.

10.1.4.4. If an MEB is required on a general officer, the MTF commander or administrator must immediately notify HQ AFPC/DPAMM personnel who will designate an MTF to conduct the board. DPAMM will forward initial notification to AFGOMO and AF/SG by electronic secure transmission or by telephone and provide final notification when the MEB/PEB action is complete.

10.1.4.4.1. The MTF commander will notify the appropriate ARC/SGP when an MEB is required on an ARC general officer.

10.1.4.5. Commanders at all levels and officers who have convening and approval authority for medical boards will not have an MEB or their clinical evaluation and board processing at an MTF that is within their command and control or official influence. HQ AFPC/DPAMM will designate an MTF to accomplish the board.

10.1.4.6. Officers assigned to the MTF staff will not receive an MEB or processing at their own medical facility. The MTF commander may submit a waiver request through HQ AFPC/DPAMM detailing why an MEB should be conducted at their own facility as well as why the commander has no concern for a conflict of interest. A hospital will not conduct an MEB on assigned enlisted staff if that member has been or is currently a disciplinary problem or where there would be concern for a conflict of interest. The case should be referred to HQ AFPC/DPAMM with a comment

as to the nature of the disciplinary problem by the medical group commander. HQ AFPC/DPAMM will send disposition instructions.

10.1.4.7. ARC members who are entitled to disability processing will have MEBs conducted at active duty MTFs. Additional requirements for reserve and guard members are in paragraph [10.12](#).

10.1.4.7.1. ARC personnel, do not “PCS”. They may be “attached” to a patient squadron or the MTF as defined in paragraph for MEB processing.

10.1.4.8. ANG members that are non-eligible for processing under AFI 36-3212, *Physical Evaluation for Retention, Retirement and Separation*, Chapter 8, will have MEBs convened by ANG authority to determine their eligibility for continued duty. Air Force Reserve medical units do not convene MEBs.

10.1.4.9. USAF Academy Cadets are not eligible for disability processing; however, a board may be held at the Air Force Academy to recommend the cadet’s disposition to the Secretary of the Air Force.

10.1.4.10. Members under court martial charges are not eligible for disability processing unless there is a question of mental capacity or responsibility or when member’s sentence of dismissal or punitive discharge is suspended. Refer to AFI 36-3212, paragraph 1.3.1. Members in Absent Without Leave (AWOL), in deserter status, or in the hands of civil authorities, disability processing does not continue until members return to military control and HQ AFPC/DPPD determines eligibility for disability processing. Refer to AFI 36-3212, paragraph 1.4.2.

10.1.4.11. Dual-Action Cases. Cases which are eligible for processing under this instruction and are pending involuntary separation or discharge. These cases are processed under both directives, and the Secretary of the Air Force will make final disposition. Refer to AFI 36-3212, paragraph 1.4.4 and AFI 36-3208, Paragraph 6.3. and 6.3.1, Section E, or AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*, Paragraph 4.15.5.

10.1.4.12. Members who refuse required professional, medical, dental care, and/or other options of treatment will have an MEB if all criteria in DoDD 1332.18, Paragraph 11, Enclosure 5, are met. These criteria are:

10.1.4.12.1. The service member was advised clearly and understandably of the proper course of treatment, therapy, medication, or restriction.

10.1.4.12.2. The member’s failure or refusal was willful or negligent and not the result of mental disease or of physical inability to comply.

10.1.4.13. An MEB must evaluate any military member refusing to submit to medical, surgical, or dental treatment or diagnostic procedures. If the refusal is based on religious grounds, arrange for the appointment of a military chaplain as an advisor of the board. The board determines if:

10.1.4.13.1. The individual needs the procedure in order to properly perform military duties or establish medical qualification for continued service.

10.1.4.13.2. The procedure, according to accepted medical or dental principle, will produce the desired results.

10.1.4.13.3. When the decision on both points is affirmative, the individual is informed that the treatment is required. If the individual still refuses the procedure, send the MEB proceedings to HQ AFPC/DPAM, Randolph AFB TX 78150-5001, for review and disposition recommendations or instructions. **NOTE:** When an emergency diagnostic or therapeutic measure is required to save the patient's life or limb, it may be performed without the patient's permission. It may also be performed when necessary to protect the health of a patient declared mentally incompetent by a qualified psychiatrist.

10.1.4.14. In instances when members have incidental findings or defects and it is not certain if an MEB is needed, the MTF may send a narrative summary (Review-In-Lieu of MEB) with an explanatory cover letter to HQ AFPC/DPAMM for disposition instructions. The Review-In-Lieu of MEB is used to receive a timely disposition when needed, e.g., separation, retirement, pending assignments, etc. The disposition by DPAMM is final, and has the same effect and authority as an MEB. Dispositions are:

10.1.4.14.1. Return to Duty (with or without an Assignment Limitation Code C).

10.1.4.14.2. Direct an MEB.

10.1.4.14.3. Direct an MEB at another MTF.

10.1.4.14.4. Returned without Action (reason will be specified).

10.1.4.14.5. Continued Military Medical Observation and Care.

10.1.4.15. For ARC members, the Review-In-Lieu of MEB narrative summary will be forwarded to the appropriate ARC/SGP. The ARC/SGP will in-turn forward it to HQ AFPC/DPAMM. Cases on ARC members who have been found fit for duty will be returned to the appropriate ARC/SGP by HQ AFPC/DPAMM. The appropriate ARC/SGP will provide final disposition instructions (i.e., assignment of AL C-C, DAC-42, etc.) to the member's supporting ARC and AD medical facility.

10.1.4.16. MEBs may address active duty members of other branches of the Uniformed services and their reserve components who are eligible for processing under Title 10 U.S.C., Chapter 61.

10.1.4.17. Neither the evaluatee nor anyone else shall attempt to influence the outcome or processing of an MEB.

10.1.5. Dispositions for Review of MEBs by HQ AFPC/DPAMM. HQ AFPC/DPAMM will review all MEBs recommending Return to Duty and all MEBs from non-referral medical facilities. DPAMM will evaluate these cases and provide a disposition. This disposition is final and may not be rebutted by the member unless new and compelling evidence or information is presented that would render consideration of a differing decision. The MTFs designated in paragraph **10.6.** are authorized to send MEBs with the recommendation to refer to IPEB directly to HQ AFPC/DPPDS.

10.1.5.1. HQ AFPC/DPAMM disposition decisions are:

10.1.5.1.1. Return to Duty.

10.1.5.1.2. Return to Duty with Assignment Limitation Code C.

10.1.5.1.3. Return to Duty for Disposition under other Directives.

10.1.5.1.4. Refer Case to the Informal Physical Evaluation Board (PEB).

10.1.5.1.5. Direct MEB.

10.1.5.1.6. Direct Member to be boarded at another MTF.

10.1.5.1.7. Continued Military Medical Observation and Care.

10.1.5.1.8. Direct Case be Referred to Member's Commander for Possible Administrative Separation.

10.1.5.1.9. Return Case without Action (reason will be specified).

10.1.6. Duty and Assignment of Members Undergoing MEB. Members who are undergoing MEB processing may be able to perform duties or work in the MTF or elsewhere on base. The members may be outpatients still assigned to their normal unit of assignment, or attached or assigned to the patient squadron. The patient squadron commander is responsible for directing the member to a duty section, ensuring the duties are not medically contraindicated and do not interfere with evaluation and MEB processing.

10.1.6.1. Upon entry into the DES (i.e., MEB sent to AFPC for processing), members who are undergoing MEB processing may not be placed on leave outside the local area or TDY without prior coordination with HQ AFPC/DPAMM, except for emergencies. The member must be available to report within one duty day.

10.2. Establishing The MEB.

10.2.1. Appointment Authority. Members of MEBs are appointed in writing by the MTF commander under the authority of this paragraph. The appointing orders should cite this paragraph and identify specific individuals tasked for MEB duty. The number of appointees should be large enough to convene a three-member board without delay. There must be only one current order at each MTF. New orders are not required for each board that is convened. Appointment orders will be updated when new members are appointed and reviewed annually.

10.2.2. Composition of the MEB. The MEB will consist of three physicians. When mental competency (sanity) is an issue or there is an Axis I diagnosis, one member must be a psychiatrist. A check mark will be used to identify the psychiatrist member on the AF Form 618.

10.2.2.1. The board is made up of active duty Medical Corps officers of the United States Uniformed services (except interns). Civilian consultants and retired medical officers who are employees of the hospital staff may serve as board members, however, at least two active duty Medical Corps officers must serve with them on any given board.

10.2.2.2. The president of the MEB is the senior ranking active duty physician present. The president of the board may not serve as the final reviewing authority.

10.2.2.3. When competency for pay and records is considered, the board must consist of three Air Force medical officers, one of whom is certified by or eligible for certification by the American Boards of Psychiatry, Neurology, or Neurosurgery. Reevaluation of members previously judged to be incompetent requires a psychiatrist on subsequent competency boards.

10.2.2.4. For a comatose patient, three Medical Corps officers will evaluate for competency determinations. If the patient is not comatose and has an organic mental disorder, a psychiatric evaluation is required and a competency board must be convened. A psychiatrist must sit on the convening MEB whenever a psychiatric condition is listed as the primary diagnosis under review.

Further, the psychiatrist must indicate his/her presence as a member of the convening MEB on AF Form 618.

10.2.2.5. When there is a need to determine sanity, the board will include a psychiatrist. A clinical psychologist will not serve on the board.

10.2.3. Review and Approval Authority. The review and approval authority will be the MTF commander, or designee, if a Medical Corps officer. If the MTF commander is not a physician, the commander must delegate this authority in writing to a senior Medical Corps officer on his or her staff. This must be coordinated with AFPC/DPAMM. The MTF commander or designated review authority may not serve on the MEB under review.

10.2.4. Physical Evaluation Board Liaison Officer (PEBLO). The MTF commander will appoint on orders a PEBLO who is an experienced, mature individual suitable to handle the important tasks of counseling military members undergoing this complicated process. Medical facilities will send a copy of the published order to HQ AFPC/DPAMM and HQ AFPC/DPPDS prior to processing an MEB. Within one month of appointment as a PEBLO, member must complete online PEBLO training located at the [Air Force Physical Disability Division PEBLO Training](#) website. Between 3 - 6 months after appointment the PEBLO should attend the in-residence PEBLO course at HQ AFPC, Randolph AFB TX. The PEBLO will counsel the evaluatee in accordance with paragraph 10.8.6. of this instruction.

10.2.5. Administrative Support. Administrative support will be provided by an MEB clerk, who will also serve as the recorder. The clerk's function will be to assemble and provide all pertinent reports and records, schedule the case for hearing, and provide HQ AFPC with a completed AF Form 618 package. It will also be the clerk/recorder's responsibility to ensure the evaluatee or next of kin has an opportunity to read the report, sign it, and be given an opportunity to write a letter of exception or support. Following this, the clerk or recorder will prepare five (six for ARC members) copies of the completed product and forward the original and three (four for ARC members) copies promptly to HQ AFPC/DPPDS or DPAMM for disposition. MEBs on AFRC members will not be submitted directly to HQ AFPC but to AFRC/SGP who will in turn forward it to AFPC. The DoD standard for MEB completion is 30 days from the date the narrative summary is completed.

10.3. Actions Prior to a Medical Evaluation.

10.3.1. Responsibilities. It is the responsibility of all Medical Corps officers to identify service members for MEB whose qualification for worldwide duty is questionable. Refer the member for MEB action within **30 days** after a complete work-up and a definitive diagnosis has been made. During the medical work-up ensure the member is placed on a 4T profile. **NOTE:** Do not mark the MEB block on the 4T profile if the evaluations are incomplete and a determination cannot be made that the member requires a MEB processing. The Medical Corps officer initiates notification of an MEB action via AF Form 570, Notification of Patient's Medical Status, and forwards it to the action officer (PEBLO). He/she must also notify the Force Health Management office or PCM for active duty members and the ARC medical facility for ARC members of the need to complete a 4T profile on the members. When MEB notification is made on an ARC member, the member's supporting ARC medical unit will be notified by the PEBLO to determine the member's entitlement to disability processing. The MEB should arrive at HQ AFPC/DPPD or HQ AFPC/DPPAM (as appropriate) for active duty members or to the appropriate ARC/SGP for ARC members within 30 days from the dictation of the narrative summary. Under no circumstances will a case be accepted for adjudication if any part of the board

package is older than 90 days without a recent update of patient's current medical status. The function of the MEB is to identify those members who are not worldwide qualified. The decision requiring fitness lies with the Air Force DES. Title 10 U.S.C., Chapter 61, provides for full and fair hearing and adjudication by a series of boards, with the Secretary of the Air Force or designee making the final decision on retention or separation.

10.3.2. Eligibility. AFI 48-123, Chapter 7, and Attachment 2, lists the conditions which will require an MEB. Since no listing is all inclusive, competent and experienced military medical judgment is needed. Questionable cases should be resolved through consultation with the MTF's Chief, Aerospace Medicine (SGP).

10.3.2.1. AFI 48-123, paragraph A2.20, lists general and miscellaneous conditions and defects and provides further guidance.

10.3.2.2. DoDD 1332-18, Paragraph D (3) and DoDI 1332-38, *Physical Disability Evaluation*, lists criteria which will not be used to constitute medical disqualification for continued military service.

10.4. Line of Duty Determination.

10.4.1. An AF Form 348, will be completed when misconduct, negligence, or AWOL may have occurred or when a member has a disease or injury which results in an inability to perform military duty for more than 24 hours, or there is the likelihood of permanent disability. AFI 36-2910 provides instruction on LOD determinations. LOD should be initiated by the patients attending provider or PCM.

10.4.2. MEBs do not make LOD determinations. Completed LODs must be included as part of the MEB package. Administrative LODs must be indicated on AF Form 618, Item 23. A record of an administrative LOD is only required in death cases and is recorded in the member's medical record. In cases that include injuries, an administrative LOD will not suffice if there is a potential for a permanent disability.

10.4.3. Each medical facility commander appoints a Line of Duty Medical Focal Point (LOD-MFP). In addition, each medical officer assigned to the medical facility that first provides treatment or is nearest to the non-Air Force facility that first provides treatment:

10.4.3.1. Identifies cases requiring LOD and misconduct determinations.

10.4.3.2. Advises the member's unit commander of the need for an LOD for members of another service first treated at the Air Force medical facility.

10.4.4. The LOD-MFP completes three copies of AF Form 348, ensures the appropriate medical officer signs it and distributes the AF Form 348 as follows:

10.4.4.1. Send the original to the MPF Special Actions Office (MSPPA) serving the member's immediate commander. File one copy in the member's inpatient or outpatient medical record, as applicable. File one copy in the LOD-MFP Office.

10.5. Where MEBs Should Be Accomplished.

10.5.1. As a general rule, MEB candidates receive clinical evaluation and MEB processing at the medical facility at which they are receiving medical care. However, if that facility is not a physical

evaluation board referral hospital (PEBRH) designated in paragraph 10.6. (unless the case is administratively and clinically simple), the case may be referred to a PEBRH for further processing. Referral to a PEBRH is often appropriate if initial work-up indicates referral to a PEB is needed. Each case must be judged individually, realizing that referral to a PEBRH may result in family separation and possible family hardship until a disability determination is made. If the local MTF is able to provide an adequate clinical evaluation, has the requisite MEB staffing, and has an experienced knowledgeable PEBLO to counsel the evaluatee throughout the MEB and subsequent disability processing, then MEB processing at that facility is appropriate. Only PEBRHs will submit cases directly to HQ AFPC/DPPDS. All other MTFs will forward MEBs to HQ AFPC/DPAMM. Smaller MTFs must request PEB direct-referral authority on MEBs accomplished at non-PEB Direct Referral Hospitals.

10.5.2. If the condition of the active duty member requires movement from a civilian hospital to an AF MTF and the MEB cannot be completed, the MTF receiving the patient will complete the MEB and forward to AFPC/DPAMM or AFPC/DPPDS as appropriate.

10.5.3. If an AD member is hospitalized while away from his/her base of assignment, the nearest AF MTF will accept administrative responsibility for the LOD and MEB process. The member's Primary Care Manager should be kept informed of the patient's condition, to include the patient's status when discharged from the hospital. The nearest AF MTF will also be responsible for processing the MEB for AD AF members hospitalized in other services' MTFs.

10.5.4. Support to Geographically Separated Units (GSUs)/TRICARE Prime Remote (TPR) Enrollees In Fitness For Duty (FFD) Evaluation/Medical Evaluation Board Status: These evaluations can be lengthy. As such when it is in the best interest of the patient and the mission, it is appropriate to return the member to their duty station to await final decision. As a result, the ongoing management of their medical care is returned to their civilian PCM. The MTF responsible for processing the FFD/MEB must be kept informed of the patient's medical status at all times. In order to ensure this, the MTF must notify the MMSO Case Management Division 1-888-647-6676 of the patients' return to the civilian PCM and provide the MMSO Case Manager with a point of contact at the MTF, preferably the PEBLO, and the contact information for the patient's civilian PCM. The MMSO Case Manager will then act as a liaison between the MTF and PCM. The MTF POC will notify the MMSO when the FFD evaluation/MEB final determination has been made and the resulting decision.

Table 10.1. Designated PEBRHs:

FACILITY	DMIS IDENTIFICATION CODE
1 st Medical Group, Langley AFB	0120
3 rd Medical Group, Elmendorf AFB	0006
5 th Medical Group, Minot AFB	0094
6 th Medical Group, MacDill AFB	0045
10 th Medical Group, US Air Force Academy	0033
15 th Medical Group, Hickam AFB	0287
18 th Medical Group, Kadena AB	0804
20 th Medical Group, Shaw AFB	0101
42 nd Medical Group, Maxwell AFB	0004
48 th Medical Group, RAF Lakenheath	0633

FACILITY	DMIS IDENTIFICATION CODE
55 th Medical Group, Offutt AFB	0078
56 th Medical Group, Luke AFB	0009
59 th Medical Wing, Wilford Hall Medical Center	0117
60 th Medical Group, David Grant Medical Center	0014
72 nd Medical Group, Tinker AFB	0096
74 th Medical Group, Wright-Patterson AFB	0095
75 th Medical Group, Hill AFB	0119
81 st Medical Group, Keesler AFB	0073
82 nd Medical Group, Sheppard AFB	0113
86 th Medical Group, Ramstein AB	0807
89 th Medical Group, Andrews AFB	0066
92 nd Medical Group, Fairchild AFB	0128
95 th Medical Group, Edwards AFB	0019
96 th Medical Group, Eglin AFB	0042
99 th Medical Group, Nellis AFB	0079
355 th Medical Group, Davis-Monthan AFB	0010
374 th Medical Group, Yokota AB	0640
375 th Medical Group, Scott AFB	0055
377 th Medical Group, Kirtland AFB	0083

10.6. Required Medical Documentation for an MEB.

10.6.1. SF 502, Medical Record Narrative Summary. This summary must be current within 30 days when received by AFPC, and must describe a clear picture of the member's disease process. It must include all of the following: date and circumstance of the occurrence, response to treatment, current clinical status, proposed treatment, prognosis and the extent the condition interferes with the duty performance.

10.6.1.1. Chief Complaint.

10.6.1.2. History of Present Illness.

10.6.1.3. Past Medical History.

10.6.1.4. Review of Systems.

10.6.1.5. Pertinent Family History.

10.6.1.6. Full Physical Exam to Include Right or Left Handed. See also DoDI 1332.38, paragraph E4.A1.1.3.

10.6.1.7. Laboratory and Radiology Findings.

10.6.1.8. Hospital Course.

- 10.6.1.9. Consultations (must not be older than 90 days, unless updated by consultant). All consultations that were accomplished for diagnoses listed on the AF Form 618 should be forwarded to the MEB. Current profile (AF Form 422) should be attached.
- 10.6.1.10. Operations and Procedures.
- 10.6.1.11. Current Medications.
- 10.6.1.12. Other Diagnoses.
- 10.6.1.13. Referring provider's name, duty title, AFSC, and phone number.
- 10.6.1.14. Administrative LOD.
- 10.6.1.15. Worldwide Qualification.
- 10.6.1.16. Current Profile.
- 10.6.1.17. Final Diagnosis/Recommendation.
- 10.6.1.18. Prognosis, follow-up, restrictions and/or limitations involving current assigned military duties without stating fitness for duty.
- 10.6.2. The preparing physician will refrain from making comment (verbal or written) concerning fitness for duty or expected disability process outcome. The SF 502 must be signed, and the preparing physician's AFSC or specialty, DSN phone number, and duty title must be clearly discernible.
- 10.6.3. When non-physician providers prepare narrative summaries for medical board adjudication (optometry, podiatry, clinical psychology, physician assistant, nurse practitioner), they must be reviewed and counter-signed by a physician; e.g., ophthalmologist for optometry, orthopedics for podiatry, and psychiatry for psychology. Board certified family physicians and internists may counter-sign if they are currently holding privileges in fields related to the patient's condition.
- 10.6.4. Letter from the evaluatee's commander is required. This letter should describe the impact of the member's medical condition on the member's ability to perform his or her normal military duties and to deploy or mobilize, as applicable.
- 10.6.5. The Chief of the Medical Staff will submit a statement regarding the current status of medical credentials for any credentialed medical provider undergoing an MEB. A DD Form 2499 is highly recommended if the provider is unlikely to return to full and unrestricted duty.
- 10.6.6. AF Form 1172, if necessary.
- 10.6.7. AF Form 2100 Series, only required for the formal PEB, and ARC.
- 10.6.8. AF Form 565, if available.
- 10.6.9. Other reports as needed or requested for ARC members, see paragraph [10.12](#).
- 10.6.10. The following special consultations and additional information are required for the diseases listed (these consults or updates must not be over 90 days old when received at HQ AFPC):
- 10.6.10.1. *Asthma*: Current pulmonary or allergy consult on complex cases (an experienced Family Practice Physician may accomplish the more routine asthma cases) to include steroid dependence or usage, level of control, exercise induced, or climate or locally induced symptoms, time lost from duty, frequency and severity of attacks, hospitalization, E.R./Acute Care visits, and functional impairment; also medications (including immunotherapy), dosages, and at least three (3)

current pulmonary function tests (pre- and post-bronchodilator, if abnormal, with results within 5% of each other). If asthma diagnosis is in doubt, then a Methacholine or Histamine Challenge Test may be appropriate.

10.6.10.2. *Burns*: Percent of body burned (by degree) and photographs for rating disfigurement. Include measurements of functional impairment, i.e., range of motion of extremities involved.

10.6.10.3. *Collagen Vascular Disease/Rheumatoid Disease*: Rheumatology consult.

10.6.10.4. *Coronary Artery Disease and other Cardiac Diseases*: Cardiology consult and New York or Canadian Heart Association Classification.

10.6.10.5. *Diabetes*: Include evaluation for end organ damage (Optometry or Ophthalmology evaluation required), therapeutic history and level of control (HgA1C). Endocrinology consult for insulin dependent conditions.

10.6.10.6. *Hearing*: Ear, Nose and Throat (ENT) evaluation for hearing and inner ear disease with evaluation of pure tone decibel loss at 500, 1000, 2000, 3000, 4000, and percent of speech discrimination without hearing aids.

10.6.10.7. *Eyes*: Ophthalmology consult to include visual acuity, degree of peripheral constriction, and perimeter charts.

10.6.10.8. *Malignancies*: Dermatology consult for melanoma; neurosurgery and psychiatry consult for brain tumor; ENT on all head and neck cancer, urology for renal, bladder, and testicular cancer; oncology consult on all other cancers. Consider including an oncology consult if patient is receiving chemotherapy.

10.6.10.9. *Multiple Sclerosis*: Neurology consult.

10.6.10.10. *Seizure Disorder*: Neurology consult, EEG and CT Scan (or MRI) to include date of last known seizure. MEB should be accomplished after two months of trial medication.

10.6.10.11. *Neuromuscular Injury*: Orthopedic consult with range of motion strength and functional impairment and EMG if appropriate; also note dominate extremity if applicable.

10.6.10.12. *Renal Disease*: Nephrology consult to include appropriate laboratory studies, i.e., serum BUN, creatinine, and urine chemistries.

10.6.10.13. *Gastrointestinal Diseases*: Gastroenterology consult on complex cases (an experienced family physician or internist may accomplish more routine cases). If endoscopy performed as part of the work-up, that specialist's consult will be included.

10.6.10.14. *Psychiatric*: Psychiatric evaluation, to include degree of social and industrial impairment and impairment for civilian life, and degree of impairment for military service. If a "Return to Duty" determination is anticipated, consider a 45-day trial of medication.

10.6.10.14.1. Special provisions for reporting psychiatric cases: Multi-axial DSM diagnosis reporting is required, all five Axis including personality assessment and global assessment of function (GAF). For the degree of impairment for civilian social and industrial adaptability for all boardable axis I cases are required. "Total," "severe," "considerable," "definite," "mild," or "none" are the only terms used. For degree of impairment for military service, use the degree of the evaluatee's current and projected impairment for military service: "no impairment," "minimal," "moderate," and "marked."

10.7. Conducting the MEB.

10.7.1. Procedures. Composition is as described in paragraph 10.2.1. The most senior medical officer will serve as the Board President. The MTF commander should attempt to have the same board president on every board for consistency of decisions, but this is not mandatory. The board will meet and discuss the medical problems which might render the evaluatee not worldwide qualified and attempt to reach a unanimous decision. If that is not possible, dissenting votes and the reason for the dissent should be recorded by the MEB clerk on the reverse of AF Form 618, and Item 27 marked appropriately. More detailed instructions on how to complete the AF Form 618 and the medical board package are contained in paragraph 10.8.5.

10.7.2. Responsibility. It is the responsibility of the board president and the reviewing officer to ensure that the best available medical information is in the narrative summary. If the narrative summary is deficient in the laboratory or radiology results, or required reports or consults listed in paragraph 10.7.1., the board president or reviewing authority should return the narrative summary to the preparing physician for clarification or updating. The board report must stand alone during the adjudication process at the Informal PEB, Formal PEB, the Secretary of the Air Force Personnel Council (SAFPC), Assistant Secretary of Defense (Health Affairs), and the Physical Disability Appeals Board (PDAB). Any reports, consults, that are over 90 days old and MEB narrative summaries over 30 days old will not be adjudicated and will be returned to the MTF commander for correction.

10.7.3. MEB Recommendations. The medical board may choose from the following two actions:

10.7.3.1. Return to Duty (fully worldwide qualified).

10.7.3.2. Forward to the Informal PEB (continued worldwide qualification is questionable). **NOTE:** Phrases such as “Continued military medical observation and care,” and “Refer to another hospital for evaluation,” will not be used on the AF 618 as these imply that the member was not ready to board, or the facility was not qualified to conduct the board.

10.7.4. Evaluatee Personal Appearance. Personal appearance of the evaluatee is not required, but the board president may allow (at his or her discretion) the evaluatee to appear before the board for statements. There is no right to counsel or to challenge the MEB or its members.

10.7.5. MEB Clerk Responsibility. Following the recommendation of the MEB, the clerk should ensure that Items 1-27 of AF Form 618 are completed, and assemble the entire case in the appropriate order as listed below. The board report is signed by the president and other members and forwarded to the reviewing authority.

10.7.5.1. When an MEB is anticipated, the MEB clerk should ensure an LOD is completed and attached. Verify separation or retirement date and request a physician obtain medical hold from HQ AFPC/DPAMM if the active duty member is within 60 days of ETS or DOS. Contact the appropriate ARC medical facility prior to initiating MEB processing when the individual is a member of the ARC. For ANG members, ANG/DP is the approval authority for medical hold. Obtain all health records, including dental records if needed. Request records held by the Veteran’s Administration if applicable. Notify member of impending MEB and advise member to report to the Family Support Center for Pre-Separation Transition Assistance Counseling as per AFI 36-3022, *Transition Assistance Program*, paragraph 2.9. Notify physician conducting the board of time constraints. Notify MEB members of date, time, and place of the board. Notify member’s commander of leave and TDY restrictions. Ensure a 4-T profile is sent to the military personnel flight.

10.7.5.1.1. **Additional Responsibilities for Imminent Death Processing.** When it is determined that a member's death is imminent, the MEB clerk should notify the PEBLO, the Casualty Assistance Representative, and the Mortuary Services Officer to brief the member or the next of kin immediately. The member or next of kin then requests expeditious processing through the AF DES. See AFI 36-3212, Attachment 2).

10.7.5.2. The proceedings of the MEB, reviewed and signed by the appointing authority and acknowledged by the evaluatee are reported on AF Form 618. All AF Form 618 items must be completed. An entry of "NA" may be used for items that are not applicable. A board member or the reviewing authority must initial any erasures or significant changes.

10.7.5.3. Instructions for completing the AF Form 618.

10.7.5.3.1. **Item 1. Installation at Which Convened.** Identify the MTF where the MEB was convened.

10.7.5.3.2. **Item 2. Date Convened .** State the exact date the MEB convened and not the date the AF Form 618 is typed.

10.7.5.3.3. **Item 3. Name.** Give last name, first name, and middle name or middle initial of the evaluatee.

10.7.5.3.4. **Item 4. Grade.** For USAF and USN members, abbreviate the proper grade (*E5*, *O3*, etc.). For USA members add the member's corps (SSgt, Ord; Capt, Inf etc.).

10.7.5.3.5. **SSN .** Enter social security number. If not otherwise available, it may be obtained from the evaluatee's servicing military personnel flight.

10.7.5.3.6. **Item 6. Component.** Enter Reg AF, ANG, or AFRC for Air Force Regular, Air National Guard, or Reserve Components, and similar abbreviations for US Army and Navy counterparts.

10.7.5.3.7. **Item 7. Department of Service.** Enter USAF, USA, USN, USMC, NOAA, USPHS or USCG. For members of a foreign military service, the nation is shown. For example, French AF, etc.

10.7.5.3.8. **Organization.** Enter the military organization to which the evaluatee is assigned and its location, e.g., 347th CRS, Moody AFB GA. Avoid nonstandard abbreviations.

10.7.5.3.9. **Item 9. Sex.** Enter "M" for male or "F" for female.

10.7.5.3.10. **Item 10. Date of Birth.** Enter year, month, and day of birth. For example, 2000 Jan 25.

10.7.5.3.11. **Item 11. Age .** Enter age at last birthday in years only.

10.7.5.3.12. **Item 12. Separation and Retirement Date.** Enter the evaluatee's established nondisability separation or retirement date. Secure it from the evaluatee's services MPF. Enter "NA" or "none" if none has been established.

10.7.5.3.13. **Item 13. Hospital Initially Admitted .** Enter the name and location of the hospital to which the evaluatee was first admitted due to the condition for which he or she is being evaluated by the MEB. If the same as Item 1, enter "NA."

10.7.5.3.14. **Item 14. Transferred From.** If transferred as an inpatient or outpatient from another hospital, enter the name and location of that hospital. If that hospital is the one identified in Item 13, enter "Same as Item 13." If not transferred, enter "NA."

10.7.5.3.15. **Item 15. Home Address .** This is the permanent address and should not be confused with current military organization or current mailing address. For ARC members include the home, military duty section, and civilian work section phone numbers here also.

10.7.5.3.16. **Item 16. Military Occupational Specialties.** Enter title and number for primary and secondary Air Force Specialty Codes (AFSC) or equivalent other Service code. If not otherwise available, obtain from the servicing MPF. If no secondary AFSC, list primary only.

10.7.5.3.17. **Item 17. Total Years' Military Service.** Separate active service from inactive service. Show in years and in fractions of years. For example: 3 years 5 months will be shown as 3 5/12.

10.7.5.3.18. **Item 18. Date Entered Active Duty Current Tour.** This is the date from which the member has been on continuous duty without a break in service, or the date a member of a Reserve component entered the current period of active duty orders.

10.7.5.3.19. **Item 19. Aeronautical Rating.** Do not abbreviate. Enter "NA" if none.

10.7.5.3.20. **Item 20. On Flying Status on Admission.** This item is to indicate if an evaluatee with an aeronautical rating or designation was on flying status when admitted to the hospital. Temporary removal from flying duty (DNIF, or duty not involving flying) is not removal from flying status. If temporary removal from flying status led to permanent removal from flying status, will be certified by the proper authority.

10.7.5.3.21. **Item 21. Date Relieved from Flying Status.** If the evaluatee has an aeronautical rating (Item 19) and is now on flying status (Item 20), enter the date relieved from flying status. If no aeronautical rating, enter "NA."

10.7.5.3.22. **Item 22. Applicable Directives and Purpose.**

10.7.5.3.22.1. **Column A. Directives:** AFI 48-123 and this instruction are specified for all cases. The Manual for Courts Martial is utilized for sanity cases. DFAS-DSM 177-373 is specified for mentally incompetent members.

10.7.5.3.22.2. **Column B. Purpose:** Check "Continued Active Duty" for members on active duty when separation, discharge, or retirement for non-disability reasons is not pending. Check "EPTS" when a defect existed prior to service and is the principal reason for the MEB. Check "Other" and enter "Sanity" or "Competency" for a sanity or competency case. Enter "ANG Duty" or "AFRES Duty" If the evaluatee is a member of one of these components and is not eligible for disability processing under this instruction.

10.7.5.3.23. **Item 23. Diagnosis and Findings.** These appear in Column A of Item 23. List all diagnoses that contribute or may contribute to disqualification for worldwide duty. Use terminology in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD 9-CM), the current Diagnostic and Statistical Manual of Mental Disorder (DSM). Administrative LOD.

10.7.5.3.24. **Item 24. Sanity Determination.** Complete for sanity cases only.

10.7.5.3.25. **Item 25. Actions Recommended by Board.** Enter only “Return to Duty,” “Refer to PEB,” or “Disposition Under Other Directives.”

10.7.5.3.26. **Item 26. Board Members.** Each member of the MEB signs the original AF Form 618. In sanity or competency cases, place a check mark after the signature of the board member(s) who is/are a psychiatrist(s).

10.7.5.3.27. **Item 27. Minority Report .** If the board recommendation is not unanimous, “Yes” is checked and the minority report with substantiating rationale is entered on the reverse side of AF Form 618 or on an attached sheet. For unanimous recommendation, check “No.”

10.7.5.3.28. **Item 28. MTF Commander or Designee.**

10.7.5.3.29. **Item 29.** Except in mentally incompetent or deleterious cases, the findings and recommendations of the medical board and any subsequent changes by the review authority are explained to the evaluatee. The evaluatee is also advised that if exception is taken to the narrative summary, findings, or recommendation of the medical board, three work days will be allowed to prepare a letter of exception, which will be attached to the board report forwarded to HQ AFPC/ DPPAM or HQ AFPC/DPPDS. By completing A, B, and C of Item 29, the evaluatee acknowledges that he or she has been informed of the findings and recommendation of the board and of the option to submit a letter of exception. The MEB recorder signs opposite the footnote below Item 29 to show that he or she has thoroughly briefed the evaluatee on the findings, recommendation, and options referenced above. If the evaluatee is unable, refuses, or is not available to sign AF Form 618, enter “Signature Unavailable” or “Refuses to Sign” in Item 29B and explain circumstances on the reverse of AF Form 618 with signatures of two additional witnesses to the evaluatee’s briefing and refusal to sign.

10.7.6. Actions Following the MEB.

10.7.6.1. After the MTF commander or physician designee, if commander is not a physician, reviews and approves the MEB report, the MEB recorder or PEBLO ensures the evaluatee has an opportunity to read the MEB report and narrative summary and assists the evaluatee in resolving any questions concerning the content of the report and summary. The PEBLO advises the evaluatee that he or she may submit a signed statement within three workdays for consideration by the disposition authority if the evaluatee takes exception to the content of the board report or narrative summary. The original narrative summary will not be altered in any way at the member’s request without the unanimous agreement of the member’s treating physician, all MEB members and the reviewing authority. The PEBLO obtains evaluatee’s signature on AF Form 618 acknowledging understanding. Within five workdays after the reviewing authority signs, the PEBLO forwards the completed MEB package (original and three copies) to HQ AFPC for active duty members or (original and four copies) to the appropriate ARC/SGP for ARC members.

10.7.6.2. If the evaluatee has been determined to be incompetent (Items 22 and 23 of AF Form 618), or the case has been designated deleterious (AF Form 1172), the MEB recorder or PEBLO addresses the above mentioned actions to the evaluatee’s next of kin (NOK) or legal guardian, who is entitled to the same rights, privileges, and counseling benefits as the evaluatee.

10.7.6.3. When incompetence is determined, additional copies of AF Form 618 are distributed to accounting and finance authorities. This must be done without delay. Failure to safeguard the pay of members declared mentally incompetent to manage their own affairs has caused serious hard-

ship to members and their families. Send copies to: SFAS-CL/ROC, P.O. Box 99191, Cleveland, OH 44 199-1126.

10.7.6.4. Content and Distribution of the MEB Package.

10.7.6.4.1. AF Form 618, with attachments, is assembled into five sets (six for ARC members) and distributed as indicated below.

10.7.6.4.1.1. Original Set:

10.7.6.4.1.1.1. AF Form 618 (original).

10.7.6.4.1.1.2. Evaluatee's letter of exception (original).

10.7.6.4.1.1.3. Commander's letter.

10.7.6.4.1.1.4. AF Form 1185, **Statement of Record Data**.

10.7.6.4.1.1.5. SF Form 502.

10.7.6.4.1.1.6. Consultation or special studies relevant to case (original copies).

10.7.6.4.1.1.7. Copy of SF 88, from original induction physical.

10.7.6.4.1.1.8. Copy of SF 93, from original induction physical.

10.7.6.4.1.1.9. AF Form 348 or NGB 348, or DD Form 261, **Report of Investigation Line of Duty and Misconduct Status** (with all exhibits attached), when LOD applies. (The appropriate LOD form is required for all ARC members undergoing disability processing). For ANG NGB 348 must be signed by ANG/SGP.

10.7.6.4.1.1.10. AF Form 1172, if deleterious.

10.7.6.4.1.1.11. NOK information, if mentally incompetent or deleterious case, include name, address, relationship, and whether advised or not advised that the case is being referred to the PEB, and available or not available for PEBLO counseling. Following PEB action, if NOK is not known or cannot be contacted, provide a complete summary of all attempts made to identify or contact the NOK.

10.7.6.4.1.1.12. Copy of AF Form 618 from prior MEB convened under AFM 177-373 to determine competency, if one had been convened and there has been no change in the evaluatee's mental status since that board was convened.

10.7.6.4.1.1.13. All appropriate health records (required for PEB adjudication, AFRES and ANG personnel).

10.7.6.4.1.1.14. If an enlisted evaluatee has served on active duty in a grade higher than current grade, send a copy of the promotion (to the higher grade) order, document authorizing demotion and the last four enlisted performance reports.

10.7.6.4.1.1.15. Copies of military orders placing the ARC member in a military duty status at the time of the injury, illness, or disease. If military orders are not available, then a statement signed by the member's commander verifying that the member was ordered to military status by competent military authority at the time of the onset of the member's medical condition is required.

10.7.6.4.1.1.16. Request for VA bed designation stating possible duration of hospitalization, if VA hospitalization is indicated.

10.7.6.4.1.1.17. Personnel Rip for ARC members.

10.7.6.4.1.1.18. Supporting civilian medical documentation for ARC members.

10.7.6.4.1.1.19. Other items as necessary.

10.7.6.4.1.2. Sets 2, 3, and 4:

10.7.6.4.1.2.1. AF Form 618 (copy).

10.7.6.4.1.2.2. Evaluatee's letter of exception.

10.7.6.4.1.2.3. Commander's letter.

10.7.6.4.1.2.4. AF Form 1185.

10.7.6.4.1.2.5. SF 502.

10.7.6.4.1.2.6. Consultation or special studies relevant to the case.

10.7.6.4.1.2.7. SF 88 and SF 93.

10.7.6.4.1.2.8. AF Form 1172, if needed.

10.7.6.4.1.3. Set 5 (MTF Copy):

10.7.6.4.1.3.1. Same as Sets 2, 3, and 4 with any additional items desired by the MEB, recorder, or PEBLO.

10.7.6.4.1.4. Set 6 (ARC/SGP Copy):

10.7.6.4.1.4.1. Same as Set 1. Do NOT make copies of the military medical record.

NOTE: Determine if other Services requires an original or copy of the medical record.

10.7.7. Reviewing Authority Responsibility. The reviewing official may disapprove the report and change the findings and recommendations but cannot reverse a finding of competency or sanity. On taking any disapproval action, the reason for the action must be attached to the AF Form 618. Following the review, the evaluatee is asked to sign, signifying that he or she has been informed of the findings and recommendations of the MEB. The evaluatee has three working days to submit comments or a letter of exception.

10.7.8. Cases Returned from HQ AFPC/DPAMM or DPPD. The MTF commander is required to respond by endorsement that the requested information was obtained. Since these medical evaluation boards are time sensitive a stringent suspense will be issued.

10.7.8.1. The MTF Commander will advise members of the MEB and examining physician that the case was returned, and the reason for its return.

10.7.8.2. A new MEB is not required unless the case will be over 90 days old when received by HQ AFPC or new information is considered. A new narrative is not required if an addendum will adequately document interim changes.

10.7.9. Recall of Cases from HQ AFPC. Only the MTF commander can request recall of a case from HQ AFPC before the SAF or designated representative has finalized the case. No unsolicited informa-

tion will be accepted after the MEB has entered the PEB system. If unsolicited information is received, HQ AFPC/DPPDS will return the entire case for a new MEB.

10.7.10. Physical Profiles After an MEB. It is the responsibility of the profile officer of the MTF to issue a correct AF Form 422, as described in AFI 48-123, *Medical Evaluations and Standards*. While undergoing an MEB, the member must have a 4-T profile to prevent reassignment. When adjudication of the MEB is completed by HQ AFPC, and the member is returned to duty, the profile must be revised. Neither HQ AFPC, nor the Boards or Council in the DES can direct cross training. This is a member's unit commander responsibility. If the unit commander feels that the member is not capable of performing in current AFSC, that commander may request retraining through the military personnel flight. The correct process to use is detailed in AFI 48-123, paragraph 10.7.3 and AFI 36-2101, *Classifying Military Personnel (Officers and Airmen)*, paragraph 4.1.7. A new MEB is not required.

10.7.11. Medical Hold. Medical Hold is a method of retaining a service member beyond an established retirement or separation date for reason of disability processing, for conditions when presumption of fitness does not apply (DODI 1332.38, Paragraph E3.P3.5.1.). It will not be used for the purpose of evaluating or treating chronic conditions, performing diagnostic studies, elective treatment of remedial defects, non-emergent elective surgery or its subsequent convalescence, civilian employment issues, preservation of terminal leave, or for any other condition which does not warrant termination of active duty. Separation or retirement processing continues until medical hold is approved.

10.7.11.1. The attending physician or PCM may request medical hold by contacting HQ AFPC/DPAMM directly. Medical hold request on ARC personnel will be coordinated with the appropriate ARC/SG. See AFI 48-123, Attachment 10, note 8. The requesting physician should have the following information readily available:

10.7.11.1.1. Date of projected separation or retirement.

10.7.11.1.2. Whether MEB processing is initiated.

10.7.11.1.3. Whether administrative or punitive discharge is pending.

10.7.11.1.4. Servicing Military Personnel Flight (MPF) implementing separation or retirement.

10.7.11.1.5. A projected medical hold release date.

10.7.11.2. If medical hold is approved, the completed MEB must be received by HQ AFPC/DPAMM or the appropriate ARC/SG no later than 30 days from the date of approval of the medical hold action.

10.7.11.3. Enlisted members cannot be forced to remain in service beyond their Expiration of Term of Service (ETS). They must agree in writing to a medical hold. For officers, medical hold does not require their consent.

10.7.11.4. Members sentenced to dismissal or punitive discharge by a court martial, or who are under charges which may result in such sentences, are not eligible for MEB processing. Medical hold is not authorized unless court martial sentences are suspended, or court martial charges are dropped to permit separation or retirement in lieu of court martial, or charges are held in abeyance pending a sanity determination. Refer to AFI 36-3212, paragraphs 1.3 and 1.4.

10.7.11.5. Members having orders for separation or retirement due to disability, who experience a significant clinical change before actual release from active duty, require revocation of orders and reprocessing of MEB. The servicing MTF contacts HQ AFPC/DPPDS

10.8. Assignment Limitation Code-C.

10.8.1. Definition. When an active duty member has been returned to duty by the Air Force DES as fit, HQ AFPC/DPAMM will review the case to determine if an Assignment Limitation Code (ALC)-C (DAC-42 if ANG member) needs to be placed in the Personnel Data System (PDS). This action is taken by the appropriate ARC/SGP when the member is an ARC member. This code will prevent reassignment without prior HQ AFPC/DPAMM or ARC/SGP medical clearance. The intent of the ALC-C (DAC-42 for ANG) is to protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening medical condition and to prevent the assignment of non-qualified personnel to overseas locations. This will further ensure the safe and effective accomplishment of the Air Force mission.

10.8.2. Authority. HQ AFPC/DPAMM is the authority to assign or remove the ALC-C on active duty members and the appropriate ARC/SGP is the authority to assign or remove the ALC-C or DAC-42 for ARC members. Active duty and ARC medical facility commanders are responsible for tracking and keeping wing commanders updated on those members of the command who are on ALC-C or DAC-42 and will assure timely medical review during the birth month of the member or as specified by HQ AFPC/DPAMM during the year indicated. The active duty or ARC medical facility is the focal point for the management of ALC-C or DAC-42 reviews for all members assigned to the installation including those geographically separated.

10.8.2.1. Medical reviews are conducted periodically, as specified by DPAMM, depending on the diagnosis, and are usually due during the member's birth month.

10.8.3. Request for Exception to Policy. Assignment Limitation Codes (Deployment Availability Codes for ANG) are used to protect our service members. Requests for exception to policy of the limitation may be sent to HQ AFPC/DPAMM, 550 C Street West, Suite 26, Randolph AFB, TX 78150-4718 for active duty members. Send requests on ARC members to the appropriate ARC/SGP. All requests will be reviewed on a case-by-case basis, and the individual's well being will be paramount. Request must be endorsed by a general officer, wing commander, or civilian equivalent (preferably from the gaining command) and should state that the individual named is essential for mission accomplishment, and that the member is the best one qualified and available for the job. The request must also indicate that the member will not be going to a mobility position and that adequate medical care has been coordinated with the gaining unit's MTF commander and will be available to meet the member's needs. The memorandum should indicate that the requesting individual is aware of the member's medical assignment restriction. HQ AFPC/DPAMM is the final approval authority for the exception to policy of ALC-C on active duty members and the appropriate ARC/SGP for the exception to policy of ALC-C or DAC-42 for ARC members.

10.8.4. Eligibility of ALC-C (DAC-42) Members for Retention, Retraining, and Separation. Personnel who have a 4-T profile in conjunction with an ALC-C, and are profiled as stated in Paragraph [10.9.2.](#), are eligible for retraining, promotion, and separation if the 4-T profile in question is directly correlated to the ALC-C. Otherwise, the normal limitations will apply. 4-T profiles are not used in conjunction with an ALC-C for Air Force Reserve members. Profiling will be accomplished as indi-

cated in AFI 48-123, Chapter 10, for Air Force Reserve members, and a 3-T profile will be used in conjunction with a DAC-42.

10.8.5. Medical Facility Action for Return to Duty with an ALC-C. The MTF will publish a profile on AF Form 422 appropriate for the member's current condition. Worldwide qualified will be marked "NO." The release date will be dashed or left blank. The "Remarks" section will contain the phrase "Date of release from this profiling action to be determined by HQ AFPC/DPAMM after next review." In addition, the remarks section will have the following statement: "Member has been found fit and was returned to duty by officials within the Office of the Secretary of the Air Force. However, member's condition is considered restrictive and will require an Assignment Limitation Code. Member will not be mobility qualified and will not be assigned (PCS or TDY) overseas except to Alaska (Elmendorf AFB only), Hawaii, or Puerto Rico. HQ AFPC/DPAMM must coordinate on all PCS movements for all members. The appropriate ARC/SGP must coordinate on all Palace Chase/Front assignment actions into the ARC prior to final approval. All Assignment Limitation Code-C personnel will require a narrative summary review or MEB during his/her birth month _____ (year), with specialty evaluation by _____."

10.8.5.1. The appropriate ARC/SGP must coordinate all Palace Chase/Front assignment actions in to the ARC prior to final approval.

10.8.5.2. ARC members are placed on ALC-C or DAC-42 by the appropriate ARC/SGP. The appropriate ARC/SGP will provide profiling instructions and other guidance required to be recorded on AF Form 422.

10.9. Temporary Disability Retired List.

10.9.1. The law, 10 U.S.C 1210, requires reexamination of all members on the TDRL at least every 18 months to determine if there has been a change in the disability that resulted in their placement on the TDRL. The medical facility conducts the examination according to AFI 48-123 and must complete the examination without delay. HQ AFPC/DPPD usually schedules the initial examination 16 months after placing the member on the TDRL so the medical facility can complete it before the end of the 18th month. The examination is usually scheduled at the Air Force medical facility closest to the member's home that has the required capability, or the closest DoD medical facility if indicated by the member's medical condition. Extensive guidance is located in AFI 36-3212, Chapter 7.

10.9.2. Procedures for Periodic Examinations.

10.9.2.1. Approximately 60 days prior to the reporting date, HQ AFPC/DPPD will send the previous TDRL medical records and special instructions to the examining facility and request a TDRL medical examination appointment. The MTF must respond within 10 days and provide date and time of the appointment. If the medical facility cannot conduct the examination, they must return the records within 15 days to HQ AFPC/DPPDS. The member shall provide to the examining physician, for submission to the PEB, copies of all his or her medical records (civilian, VA and all military medical records) documenting treatment since the last examination. If the member fails to report for the examination on the scheduled reporting date, the medical facility must advise HQ AFPC/DPPDS immediately and await further instructions.

10.9.2.2. The commander of the examining facility or designated representative ensures the examination is completed as quickly as possible. The examination should be completed within 1 to 3 duty days after the member arrives at the examining facility. The DoD requirement is to pro-

vide medical reports to HQ AFPC/DPPD within 30 days of examination. Ensure all laboratory studies and consultations have been completed and included in the report. Advise HQ AFPC/DPPD in writing of any delay and provide an estimated date of report completion.

10.9.2.3. If the member was mentally incompetent when last examined and there has been a change in competency since then, or if there is a question as to mental competency, the examining military facility must convene a competency board IAW AFI 48-123, Attachment 2.

10.9.2.4. TDRL members who are imprisoned or confined by civil authorities must also have a periodic examination. HQ AFPC/DPPD request a report of examination and a copy of the commitment order, when appropriate, from the confinement institution.

10.9.3. Travel and Per Diem Allowance. Members traveling to a medical facility for examination, or to Lackland AFB TX for the formal PEB, receive travel and per diem (including meals and lodging) allowance based on their retired grade (10 U.S.C. 1210 and JFTR volume 1, Chapter 7, Part 1). The member is authorized an escort to accompany him or her to the place of examination when the member is not physically or mentally able to travel without help. Approximately 20-30 days prior to the reporting date, HQ AFPC/DPPD sends travel orders to the member. The order shows the exact date, time and place to report and includes the authority for payment of travel costs. The medical facility endorses the order to show whether they examined the member as an inpatient or outpatient, the dates and times the member reported and was released after completing the examination. If the examination was in outpatient status, indicate whether the member occupied government quarters. The examining facility must ensure the member has an indorsed order to submit the claim for reimbursement. The member submits a travel voucher to 12 CPTS/FMFL for reimbursement.

10.10. Patient Squadron Assignment.

10.10.1. Authority. This section contains the authority for assigning patients to an Air Force medical unit. These patients are assigned on official orders to the Patient Squadron. The MTF Commander may appoint an officer under their command as the Patient Squadron Commander. If they choose not to than the patients assigned to the patient squadron will fall under the command of the MTF Commander.

10.10.2. Hospital Admission and TDY. For purposes of this section, the word "attached" signifies the member is an inpatient in the hospital in a TDY status, and "assigned" means the patient is admitted to the Patient Squadron on official orders in a PCA or PCS status. (Exception: ARC personnel are not PCS'd, therefore, attachment to a patient squadron for ARC personnel by use of TDY travel orders is permissible to meet the needs of reserve personnel needing MEB evaluation and "assignment" to a patient unit. Coordination with the ARC/SGP is encouraged to ensure prerequisites of both organizations are fulfilled). Patients who are not assigned to the Patient Squadron remain assigned to their parent unit and the Patient Squadron Commander will return to their control and management when released from the hospital. The MTF commander may publish TDY orders to move patients between hospitals. Overseas patients are moved to CONUS hospitals in TDY status. The gaining CONUS MTF commander or HQ AFPC/DPAMM will determine if PCS to the Patient Squadron is required. A transfer to CONUS hospital is indicated under one or more of the following conditions.

10.10.2.1. Medical care is not available in the overseas area.

10.10.2.2. It is likely the member will be hospitalized for more than 90 days.

10.10.2.3. Member is not expected to return to active duty.

10.10.2.4. Hospitalization beyond DEROS is expected.

10.10.2.5. HQ AFPC/DPAMM directs.

10.10.3. Patient Squadron Assignments. A patient squadron can be established at any Air Force MTF regardless of size. When a patient is to be assigned to an MTF, the MTF commander of the gaining facility requests (by memorandum) the losing military personnel flight to publish PCS or PCA orders, citing this AFI and the MTF commander's memorandum as authority. No assignment action number is required. Reporting identifier for officer's is 93P0, and for enlisted is 9P000. Fund cite is obtained from the servicing accounting and finance officer. Other action, as needed, is in accordance with AFM 36-2622, *Base Level Military Personnel System, Users Manual*. A member may not be assigned to the Patient Squadron if an LOD (formal or informal) is pending. For ARC personnel, assignment requirements under this paragraph are met when published TDY orders to the MTF are accomplished. Coordination to determine best estimation of TDY duration should be done to prevent unnecessary amendments to TDY orders.

10.10.3.1. Officers pending judicial or adverse administrative action may not be assigned to the Patient Squadron unless approved by the court martial convening authority or discharge authority.

10.10.3.2. Airmen pending judicial or adverse administrative actions are attached TDY or assigned PCS without PCA to the Patient Squadron unless PCA is approved by the court martial convening authority or discharge authority.

10.10.3.3. The Patient Squadron commander in each case above is required to continue the administrative or discharge action.

10.10.3.4. Officers or Airmen in a non-Air Force MTF who meet requirements for assignment to a Patient Squadron are administratively attached to the nearest Air Force MTF and must be assigned to the Patient Squadron if warranted.

10.10.4. Assignment from Patient Squadron to Duty. Reassignment of the patient from the hospital when a member is available for duty: The MTF commander coordinates with the military personnel flight and reports the following information to HQ AFPC/DPAMM. NOTE: Members must have PCS retainability.

10.10.4.1. Patient's grade, last name, first name, middle initial.

10.10.4.2. SSN.

10.10.4.3. Date gained to the MTF.

10.10.4.4. Duty AFSC.

10.10.4.5. Other AFSC.

10.10.4.6. Last overseas tour and number of days served.

10.10.4.7. ODS and STRD (overseas duty selection date and short tour return date).

10.10.4.8. Control roster, administrative or judicial action pending.

10.10.4.9. PRP or Special Security Certification.

10.10.4.10. Hospital administrative date.

10.10.4.11. ICD coded disposition.

- 10.10.4.12. AF Form 422. Physical Profile Serial Report with duty limitations.
- 10.10.4.13. Follow-up medical care recommended.
- 10.10.4.14. Assignment preferences.
- 10.10.4.15. Location of dependents and household goods.
- 10.10.4.16. Social security number of spouse if also active duty.
- 10.10.4.17. Leave requested.
- 10.10.4.18. Rated aviation service rating or medical qualification for flying.
- 10.10.4.19. Memorandum of concurrence by unit commander for assignment of member who is retained after recommendation for administrative disposition under other directives has been made.
- 10.10.4.20. When medically cleared by HQ AFPC/DPAMM, officer or enlisted assignments section will send a message to the local military personnel flight with assignment instructions.
- 10.10.4.21. If the member is assigned to the hospital for MEB or PEB action, make no request for orders until the hospital receives a return to duty disposition from HQ AFPC/DPAMM.
- 10.10.4.21.1. Members will not be retained as hospital patients for rehabilitation in order to gain retention on active duty.
- 10.10.4.22. Members will not be placed in the Patient Squadron in order to preserve terminal leave or otherwise to retain a member beyond his or her date of separation or retirement without specific guidance from HQ AFPC/DPAMM. Once a member is placed on terminal leave, he or she is not permitted to change duty status without prior approval for medical hold or admission to a hospital for an emergency.

Table 10.2. Attachment and Assignments of Patients to Hospital.

Rule	If the member is:	Then the member is:
1	Admitted to an MTF and is expected to stay less than 90 calendar days and is expected to be returned to the parent unit.	Attached to the MTF (see notes 1 and 2).
2	Likely to be hospitalized for 90 calendar days or more.	Assigned to the MTF (see notes 1, 2, 3, and 4).
3	Unlikely to return to the unit	Assigned to the MTF (see notes 1,2,3, and 4).
4	Hospitalized as a result of injury in a combat area.	Attach to the MTF (see notes 1 and 2).
5	Hospitalized while PCS en route or otherwise separated from the unit and assignment to the MTF is necessary to ensure efficient personnel management.	Assigned to the MTF (see notes 1,2,3, and 4).
6	Undergoing physical evaluation for retention, retirement, or separation.	Attached to the MTF as determined by the gaining DBMS or as directed by HQ AFPC/DPAMM (see notes 1, 2, 3, and 4).
7	Overseas and must be evacuated to CONUS hospital.	Attach to the MTF as determined by the gaining MTF Commander or as directed by AFPC/DPAMM (see note 1,2, 3, and 4).
8	At or en route to CONUS port for PCS overseas and expected to be disqualified for world wide duty for more than 30 calendar days (time in hospital PLUS convalescence).	Attached to the MTF (see note 5).

NOTES:

1. If an established length of service date of separation or retirement is within 60 calendar days, the MPF tells the MTF who then requests medical hold, if appropriate, from HQ AFPC/DPAMM. If medical hold is approved, the military personnel flight immediately notifies HQ AFPC/DPPRS and the order publishing agency so that the separation or retirement orders may be revoked before the effective date.
2. If a prior to expiration of term of service (PETS) separation is pending, the military personnel flight tells the MTF which then informs the discharge authority about the patient's medical status. The discharge authority may determine if discharge should be delayed.
3. If officer is subject of judicial or adverse administrative action he or she will remain assigned to the unit initiating the action and will be attached to the medical facility.
4. If moved to a non-Air Force hospital by the Global Patient Movement Requirements Center (GPMRC) and assignment to patient squadron is indicated, patient is attached to the non-Air Force hospital but assigned to the nearest Air Force hospital.
5. The MTF patient administration function notifies the servicing MPF and provides brief medical statement from attending physician together with physician's name and telephone number. MTF relays this to the assignment authority and requests assignment instructions.

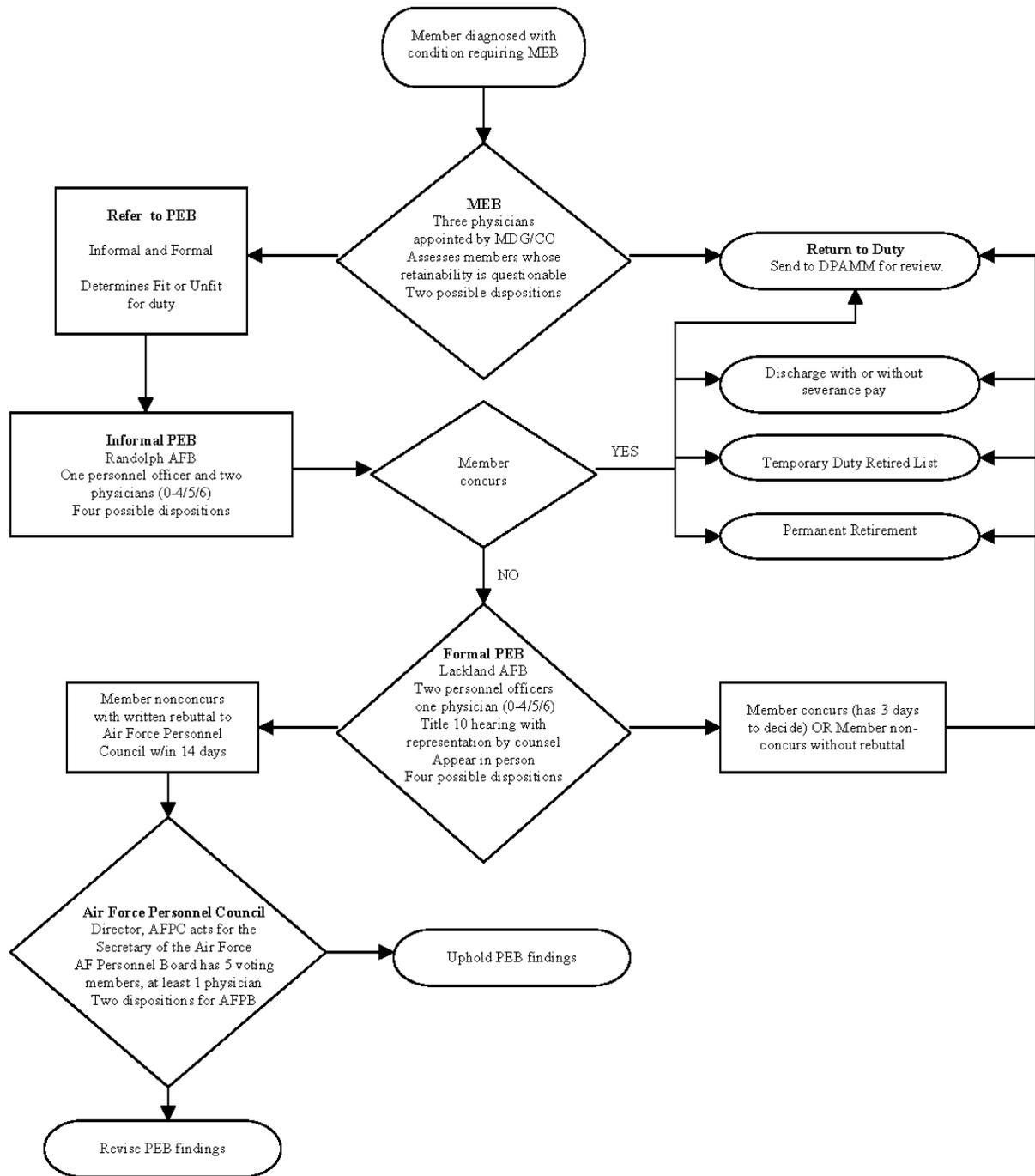
Table 10.3. Administrative Determination to PCS or TDY to Hospital, Patients Assigned Overseas.

Rule	If the member:	And	Then:
1	Has served any length of time.	Cannot be treated in overseas (see note 1).	TDY to CONUS hospital for final PCS determination and disposition (see note 3).
2	Is likely to be hospitalized in excess of 90 calendar days (see note 1).	Is not expected to be retained on active duty.	Assign to CONUS hospital.
3	Can be treated in overseas area and hospitalization is expected to be less than 90 calendar days (see note 1).	Is expected to remain on active duty.	TDY to overseas hospital for treatment (see note 4).
4	Within two calendar days of DEROs (see note 1).	Can be treated in overseas area and return to duty is expected before DEROs (see note 1).	PCS to gaining unit.
5	Can be treated in overseas area (see note 1).	Return to duty is expected after DEROs (see note 2).	PCS to gaining unit with TDY en route to CONUS hospital (see note 3).
6	Cannot be treated in overseas area (see note 1).	Hospitalization is expected to be less than 60 calendar days and is expected to remain on active duty.	TDY to CONUS hospital.

NOTES:

1. Overseas MTF determines.
2. Servicing military personnel flight provides assistance.
3. Air Force MPF servicing medical facility designated by Armed Service Medical Regulating Office provides personnel support.
4. May result in further TDY or CONUS medical facility for final PCS or separation determination.

Figure 10.1. MEB Flowchart.



10.11. Procedures for Air Reserve Component (ARC) Members.

10.11.1. Eligibility. When processing MEBs on ARC members, the PEBLO will first determine if the member is entitled to receive military medical care. Guidance on ARC member's entitlements to military medical care is in AFI 41-115. The PEBLO will also ensure the member has a valid AF Form 348 (NGB 348) or DD Form 261 in the medical record prior to initiation of the MEB. Whenever an ARC member is referred for an MEB, the PEBLO will establish contact with the medical Air Reserve Technician (ART) for unit assigned reservists and Senior Health Technician for guardsmen at the member's supporting ARC Medical Facility or HQ ARPC/SGSP for IMA personnel. The medical ART/SR Health Technician will assist the PEBLO in confirming the member's eligibility for medical care, disability processing, maintaining contact with the member and obtaining all required documentation to be included in the MEB package and administrative orders. The PEBLO will contact the medical ART/SR Health Technician prior to initiating the MEB. If the member does not have a supporting ARC medical facility, or the PEBLO is unable to contact the medical ART/SR Health Technician, the appropriate ARC/SGP will be contacted for assistance.

10.11.2. Line of Duty. ARC members are required to have an AF Form 348 (NGB 348) or DD Form 261 with an **"In Line of Duty"** determination made to be eligible for disability processing. If an AF Form 348 (NGB 348) or DD Form 261 is not in the medical records, or it is unclear if the medical condition was determined to be "Not in the Line of Duty," the member will be referred to his or her supporting ARC medical facility for appropriate disposition. After entitlement to disability processing has been established, only those medical diagnosis(es) which have been determined to be "In Line of Duty" following completion of AF Form 348 (NGB 348), or DD Form 261, shall be identified on the AF Form 618 as the reason for initiation of the MEB processing.

10.11.2.1. All MEBs and reviews in lieu of MEB accomplished on ARC members will be forwarded to the appropriate ARC/SGP for review and action. If it is determined that the member is not entitled to disability processing, then the appropriate ARC/SGP will stop disability processing and initiate the ARC process for evaluating ARC members with disqualifying non-duty related medical conditions. Otherwise, the ARC/SGP will forward the MEB report to HQ AFPC/DPPDS or DPAMM as appropriate.

10.11.3. Medical Records on ARC members undergoing MEB or review in lieu of MEB will be forwarded along with the MEB report, supporting documentation, and the additional information listed below:

10.11.3.1. A copy of the orders or other directives placing a member in a duty status at the time of onset of illness, injury, or disease.

10.11.3.2. A completed and signed copy of AF Form 348 (NGB 348) or DD Form 261, as appropriate.

10.11.3.3. All available medical documentation and medical information unique to Reserve personnel.

10.11.4. Appropriate ARC/SGP:

HQ AFRC/SGP
155 2nd Street
Robins AFB, GA 31098-1635

DSN 497-0603, commercial (912) 327-0603, or 1-800-223-1784, for unit assigned reservists.

HQ ARPC/SGPS

6760 E. Irvington Place #7200

Denver, CO 80280-7200

DSN 926-7236/7237, commercial (303) 676-7236/7237, or 1-800-525-0102, extension 235, for individual mobilization augmentees (IMAs).

HQ ANG/SGPS

3500 Fetchet Avenue

Andrews AFB, MD 20762-5157

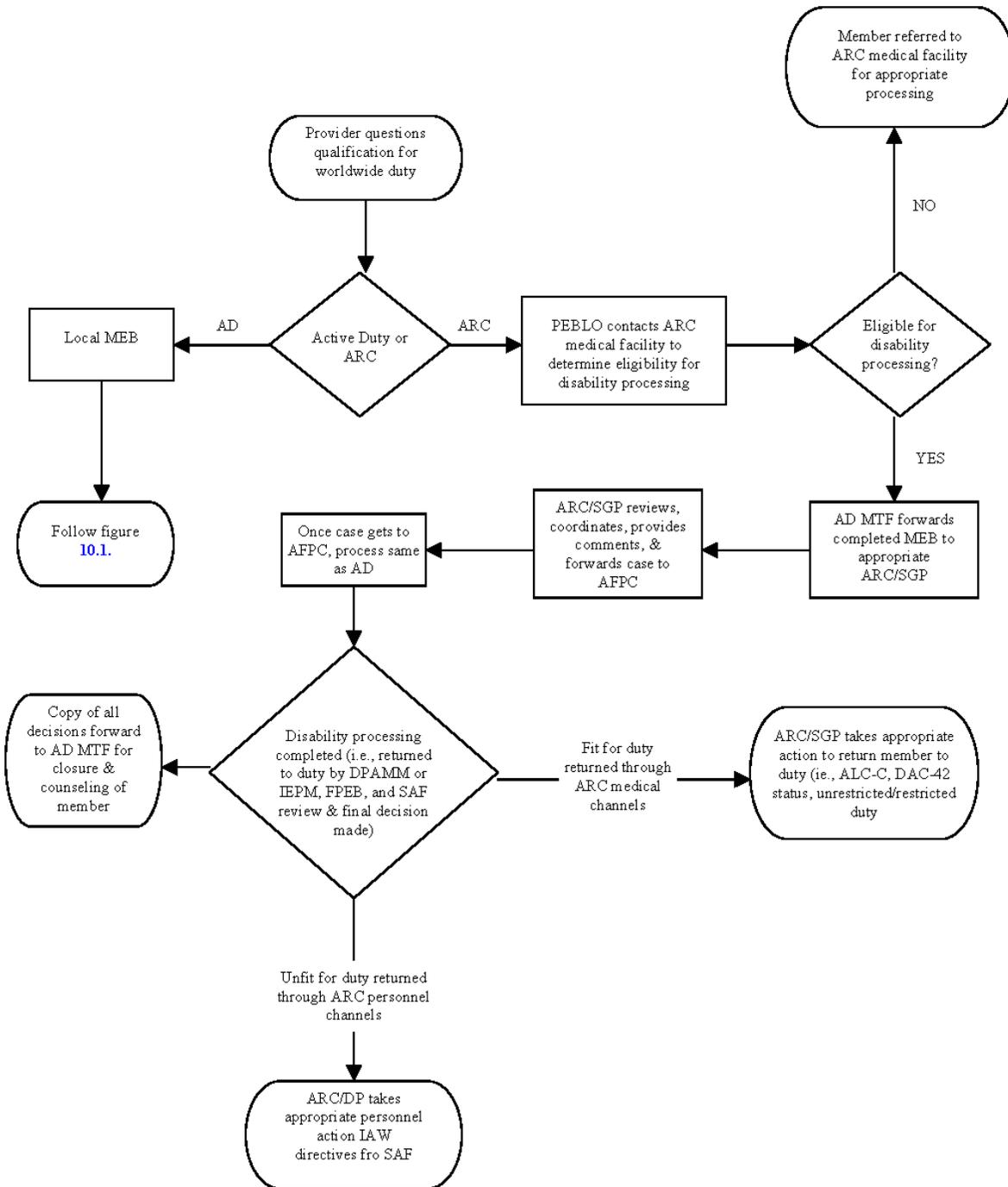
DSN 278-8549 or commercial (301) 836-8549, for guardsmen.

10.11.5. Appropriate ARC Medical Facility.

10.11.5.1. Go to [AFRC NAF/Units Home Page](#) website to determine the appropriate reserve medical facility and POC for unit assigned reservists.

10.11.6. Contact HQ ARPC/SGPS for IMAs.

Figure 10.2. ARC MEB Flowchart.



10.12. TRI-Service Medical Evaluations.

10.12.1. General. Tri-Service MEB processing is permitted under agreements between the Army, Navy, Air Force, Marine Corps, and Coast Guard. When an MEB is completed, it is sent to the nearest PEB referral hospital of the evaluatee's parent service.

10.12.2. **Exceptions.** Exceptions to this policy will be:

10.12.2.1. General Officers - the parent service usually states where the MEB will be conducted.

10.12.2.2. Coast Guard MEBs can be done only at a PEB referral hospital.

10.12.3. Reviewing Authority Responsibility. Once the completed MEB is received, the Air Force MTF commander may do one of the following:

10.12.3.1. Accept the report and process it as written.

10.12.3.2. Accept the report but with a different recommendation.

10.12.3.3. Return the report for more information.

10.12.3.4. Disagree with the report and direct transfer of the member to a PEB referral hospital.

10.12.3.5. Forms used will be those forms used by the service conducting the MEB. The parent service of the evaluatee will provide MEB control and support.

10.12.4. PEBLO Counseling. PEBLO counseling is the responsibility of the parent service unless a joint agreement can be reached. All funds spent for TDY will be obtained from the parent service.

10.13. The Veteran's Administration (VA).

10.13.1. Eligibility for VA Care. Normally members are eligible for VA care if they will soon be released from active duty and have a service connected disability that was incurred while receiving basic pay or was aggravated by LOD circumstances and discharge was anything but dishonorable. The VA may also treat active duty members by means of inter-service agreements.

10.13.2. Request for Bed. A VA bed may be obtained for a service member if prolonged hospitalization will be required. This request is through the TRANSCOM Regulating Command and Control and Evacuation System (TRAC2ES).

10.13.3. Movement of Patient. Movement to a VA bed must not occur until after the member or next of kin concurs with the PEB findings or submits a rebuttal. If movement is critical, the MTF commander must contact HQ AFPC/DPPDS and the PEB referral hospital nearest the VA hospital to which the patient is being moved.

10.13.4. Patient Status. Active duty members who must be treated at a VA Hospital prior to retirement are ordered PCS without PCA. The servicing military personnel flight retains responsibility. If prolonged disability processing ensues, the member may be PCA to the VA hospital, but will be assigned to the patient squadron of the nearest PEB referral hospital.

10.13.5. Required Records. Records transmittal to include all appropriate medical records and completed VA Form 10-1204, **Referral for Community Nursing**.

10.13.5.1. The PEBLO will establish a positive communication link with the VA and follow patient until final Air Force disposition is made.

10.13.6. Spinal Cord Injuries. Significant spinal cord injuries should be moved to a VA spinal cord center as soon as possible, but not later than 12 days post injury. Movement of members should be via the most expeditious means of suitable convenience. GPMRC will assist. Categorize the patient as urgent or priority. Patients are then assigned or attached as described in Paragraph 10.14.3.

10.13.7. Forms prescribed:

- 10.13.7.1. AF Form 230, Request for Patient Transfer
- 10.13.7.2. AF Form 250, Health Record Charge Out Request
- 10.13.7.3. AF Form 560, Authorization and Treatment Statement
- 10.13.7.4. AF Form 565, Record of Inpatient Treatment
- 10.13.7.5. AF Form 569, Patient's Absence Record
- 10.13.7.6. AF Form 570, Notification of Patient's Medical Status
- 10.13.7.7. AF Form 577, Patient's Clearance Record
- 10.13.7.8. AF Form 2700L, Health Record Year Grid
- 10.13.7.9. AF Form 745, Sensitive Duties Program Record Identifier
- 10.13.7.10. AF Form 788A-788J, Inpatient Record
- 10.13.7.11. AF Form 1403, Roster of Seriously Ill/Very Seriously Ill
- 10.13.7.12. AF Form 1480A, Summary of Care
- 10.13.7.13. AF Form 1942, Clinic Index
- 10.13.7.14. AF Form 1976, Hematology
- 10.13.7.15. AF Form 2100A, Health Record – Outpatient
- 10.13.7.16. AF Form 2110A, Health Record – Outpatient
- 10.13.7.17. AF Form 2120A, Health Record – Outpatient
- 10.13.7.18. AF Form 2130A, Health Record – Outpatient
- 10.13.7.19. AF Form 2140A, Health Record – Outpatient
- 10.13.7.20. AF Form 2150A, Health Record – Outpatient
- 10.13.7.21. AF Form 2160A, Health Record – Outpatient
- 10.13.7.22. AF Form 2170A, Health Record – Outpatient
- 10.13.7.23. AF Form 2180A, Health Record – Outpatient
- 10.13.7.24. AF Form 2190A, Health Record – Outpatient
- 10.13.7.25. AF Form 3066, Doctor's Orders (multiple copy format)
- 10.13.7.26. AF Form 3066-1, Doctor's Orders (cut sheet format)

10.13.7.27. AF Form 3068, PRN Medication Administration Record

10.13.7.28. AF Form 3069, Medication Administration Record

GEORGE PEACH TAYLOR, JR., Lt General, USAF, MC, CFS
Surgeon General

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

Public Health Service Act (42 CFR Part 2; 42 U.S.C. 290dd-2)

5 U.S.C. 552, Freedom of Information Act

5 U.S.C. 552a, The Privacy Act

Title 10, United States Code, Section 8013

41 Code of Federal Regulations, Part 2

DoDR 5400.7/AF Supplement, Freedom of Information Act Program

DoDI 6040.40, Military Health System Data Quality Management Control Procedures

AFI 31-205, Corrections Program

AFI 33-119, Electronic Mail (E-Mail) Management and Use

AFI 33-332, Air Force Privacy Act Program

AFI 34-242, Mortuary Affairs Program

AFI 36-2101, Classifying Military Personnel (Officers and Airmen)

AFI 36-2104, Nuclear Weapons Personnel Reliability Program

AFI 36-2110, Assignments

AFI 36-2608, Military Personnel Records Systems

AFI 36-2910, Line of Duty (Misconduct) Determinations

AFI 36-3002, Casualty Services

AFI 36-3003, Military Leave Program

AFI 36-3026(1), Identification Cards for Members of the Uniformed Services, Their Family Members, and Other Eligible Personnel

AFI 36-3208, Administrative Separation of Airman

AFI 36-3212, Physical Evaluation for Retention, Retirement, and Separation

AFI 37-124, The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections

AFI 37-138, Records Disposition – Procedures and Responsibilities

AFI 41-101, Obtaining Alternative Medical and Dental Care

AFI 41-115, Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)

AFI 44-102, Community Health Management

AFI 44-109, *Mental Health and Military Law*

AFI 44-119, *Medical Clinical Performance Improvement*

AFI 47-101, *Managing Air Force Dental Services*

AFI 48-123, *Medical Examination and Standards*

AFI 51-301, *Civil Litigation*

AFI 51-604, *Appointment To and Assumption of Command*

AFI 65-103, *Temporary Duty Orders*

AFI 91-204, *Safety Investigations and Reports*

AFPD 41-2, *Medical Support*

AFH 41-114, *Military Health Services System (MHSS) Matrix*

AFMAN 37-139, *Records Disposition Schedule*

AFJI 41-315, *Patient Regulating To and Within the Continental United States*

Abbreviations and Acronyms

AE—Aeromedical Evacuation

AFSC—Air Force Specialty Code

AIDS—Acquired Immunodeficiency Syndrome

AMC—Annual Medical Certificate

ANG—Air National Guard

APV—Ambulatory Procedure Visit

ARC—Air Reserve Component

ASF—Aeromedical Staging Flight

CAL—Casualty Affairs Liaison

CFR—Code of Federal Regulations

CHCS—Composite Health Care System

CONUS—Continental United States

CPO—Civilian Personnel Office

CPT—Current Procedural Terminology

CRO—Carded for Record Only

DEERS—Defense Enrollment Eligibility System

DOA—Dead on Arrival

DVA—Department of Veterans Affairs

EAR—Extended Ambulatory Record

EMEDS—Expeditionary Medical Support
EMF—Employee Medical Folder
EFMP—Exceptional Family Member Program
ER—Emergency Room
ERD—Emergency Room Death
ETS—Expiration of Term of Service
FAP—Family Advocacy Program
FMP—Family Member Prefix
FMS—Fetal Monitor Strip
FOIA—Freedom of Information Act
GPMRC—Global Patient Movement Requirements Center
GSU—Geographically Separated Unit
HHS—Department of Health and Human Services
HIPAA—Health Insurance Portability and Accountability Act
HIV—Human Immunodeficiency Virus
IG—Inspector General
III—Incapacitating Illness or Injury
ICD-9-CM—International Classification of Diseases – Clinical Modification
ICMR—Interagency Committee on Medical Records
IMA—Individual Mobilization Augmentee
ITO—Invitation Travel Order
JCAHO—Joint Commission on Accreditation of Healthcare Organizations
LOD—Line of Duty
MAJCOM—Major Command
MEB—Medical Evaluation Board
MHS—Military Health System
MOOTW—Military Operations Other Than War
MPF—Military Personnel Flight
MPI—Master Patient Index
MSA—Medical Service Account
MTF—Military Treatment Facility
NOK—Next of Kin

NSI—Not Seriously Injured
NPRC—National Personnel Records Center
OF—Optional Form
OSI—Office of Special Investigation
PA—Privacy Act
PCA—Permanent Change of Assignment
PCS—Permanent Change of Station
PEB—Physical Evaluation Board
PEBLO—Physical Evaluation Board Liaison Officer
PL—Public Law
PO—HIPAA Privacy Officer
POMR—Problem Oriented Medical Record
PRP—Personnel Reliability Program
PS—Presidential Support
PSDA—Patient Self Determination Act
RD—Reinforcement Designees
RHIA—Registered Health Information Administrator
RHIT—Registered Health Information Technician
SADR—Standard Ambulatory Data Record
SAF—Secretary of the Air Force
SF—Standard Form
SI—Seriously Ill
SIDR—Standard Inpatient Data Record
SJA—Staff Judge Advocate
SSN—Social Security Number
TDRL—Temporary Disability Retirement List
TDY—Temporary Duty
TMO—Traffic Management Office
TOL—TRICARE Online
TPR—TRICARE Prime Remote
TRAC2ES—TRANSCOM Regulating Command and Control and Evacuation System
USINS—U.S. Immigration and Naturalization Service

USTF—Uniformed Services Treatment Facility

VSI—Very Seriously Ill

VA—Veterans Affairs

VARO—Veterans Administration Regional Office

WWL—Worldwide Locator

WWR—Worldwide Workload Report

Terms

Appropriate ARC/SG—HQ AFRC/SGP for unit assigned reservists, DSN 497-0603. HQ ARPC/SGS for Individual Mobilization Augmentees (IMA), DSN 926-7237. ANGRC/SGP for guardsmen, DSN 278-8550.

Attending Physician—The physician who has the primary responsibility for the medical diagnosis and treatment of the patient.

Air Reserve Component (ARC)—Members and units of the Air Force Reserve and Air National Guard.

Consent to Release Medical Information—Authorization for the patient or the individual's legal representative to release information. **Note:** A routine, general authorization for the release of information is not adequate for disclosing information from records containing drug/alcohol abuse, treatment, or rehabilitation information.

Convalescent Leave—An authorized leave status granted to active duty uniformed service members while under medical or dental care that is a part of the care and treatment prescribed for a member's recuperation or convalescence.

Domiciliary Care—Inpatient institutional care given to a beneficiary where the patient's family members will not provide the care, not because it is medically necessary, but because care in a home setting is either not available or is unsuitable,.

Highly Sensitive Records—Health records, correspondence (including working papers), and laboratory results, which may have an adverse effect on the morale or character of the patient or other person(s). Highly sensitive records include but are not limited to alleged or confirmed information relating to the treatment of patients for sexual assault, criminal actions (including child or spouse abuse), psychiatric or social conditions, or venereal disease. Claims against the government (including malpractice) are also considered highly sensitive.

Inpatient Records Library—The library provides resources for clinical reference and research, supports specialty training and post graduate programs, provides the means for accomplishing analysis and establishing trends, etc.

Power of Attorney—A legal document authorizing an individual to act as the attorney or agent of the grantor. General rules and individual state laws specify when a power of attorney is required. Refer any questions pertaining to power or attorneys to the legal office.

Sensitive Medical Information—Information which may affect the patient's morale, character, medical progress, or mental health. This includes the specific location or description of illness or injury, which may prove embarrassing to the patient or reflect poor taste. If the patient consents, information relating to the description of disease or injury and general factual circumstances may be released. **NOTE:** To protect

the sensitive nature of the information, records or documents will be sent directly through medical channels when considered advisable by the health care provider or MTF Commander.

Written Authorization—Written consent from the patient or authorized representative allowing release or disclosure of information.