**DEPARTMENT OF VETERANS AFFAIRS**

**Veteran's Last, First Name:** _____ **Last 4 SSN:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

# TRICARE For Life Affirmation

**Please fill in the section below if you elect to use your TRICARE For Life benefits for this visit/appointment. In order to utilize your TRICARE For Life benefits, you must elect to use them at each "episode of care." An "episode of care" is defined as the managed care provided by a health care facility or provider for a specific medical problem or behavioral condition or specific illness during a set time period. An episode of care can be a short period of care or care on a continuous basis or it may consist of a series of intervals marked by one or more brief separations from care. An episode of care consists of all clinically related services for one patient for a discrete diagnostic condition from the onset of symptoms until treatment is complete.**

I _____ agree and elect to use my TRICARE benefits for an appointment
*(Insert Veteran's Full Name)*

on _____. I understand that any associated ancillary services (such as x-rays, laboratory, etc.) related
*(Insert Date)*

to this visit are considered to be a part of this "episode of care" and will also be billed to TRICARE For Life. I understand that the US Department of Veterans Affairs (VA) medical facility where treatment is performed will submit claims on my behalf to TRICARE For Life and that I am responsible for any cost shares, co-pays, and deductible amounts, which are listed on the TRICARE For Life Explanation of Benefits. I also understand that if I have Other Health Insurance (OHI), VA will bill my OHI, (i.e., Medigap, as my primary insurance carrier, and then bill TRICARE For Life as my secondary payer. I further understand that:

- **If I am a dual-eligible (VA/Department of Defense) Veteran seeking care for a service-connected condition in a VA medical facility, I must receive that care using my Veteran's benefits and TRICARE For Life will not be billed.**

When TRICARE For Life is billed the cost shares, co-pays and deductible amounts cannot be waived and it becomes my responsibility to pay such cost shares, co-pays, and deductible amounts in full to _____ when I receive the VA Patient Statement.
*(Insert Name of the Appropriate Medical Treatment Facility)*

_____ _____
**Patient's Signature** **Date**