Patient Administration and Patient Movement Protocol in a Deployed Setting

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☐ Significant Changes	OPR: CCSG

1. PURPOSE

To establish and implement Patient Administration (PAD) and Patient Movement standard operating procedures (SOP) at all medical facilities (i.e., all roles of care) in support of combat operations throughout the United States Central Command (USCENTCOM) area of responsibility. This document is meant to serve as a baseline protocol in adjunct with applicable DoD Issuances, Joint Trauma System (JTS) Guidelines, Deployed Record Center procedures and other best-practice resources listed in the references section. This document supplements pre-deployment and professional experience/training and clarifies specific nuances of PAD and patient movement in the combined joint operations area (CJOA). All USCENTCOM clinical operating protocols (CCOPs) are posted to the CCSG SharePoint at https://intelshare.intelink.gov/sites/ccsg/SitePages/CCSG-CLNOPS.aspx.

2. APPLICABILITY

This CCOP applies to all USCENTCOM Medical Treatment Facilities. Specific applicability is to PAD and non-PAD trained personnel (e.g. patient administration officers/enlisted personnel, medical receptionists, medical record technicians, DoD and coalition patient movement personnel, and personnel assigned to complete PAD related functions and tasks) assigned/attached, allocated to perform duties at the Role 1, 2, and 3 healthcare medical and dental services involving patient care and movement.

3. REFERENCES

a. AR 40-66, Medical Record Administration and Health Care Documentation, 17 June 2008

b. AR 40-400, Patient Administration, 8 July 2014

c. AFMAN 41-210, TRICARE Operations and Patient Administration, 10 September 2019

d. AFI 48-307 Volume 1, En Route Care and Aeromedical Evacuation Medical Operations 9 January 2017

e. BUMED Instruction 6010.32, Patient Registration Program, 13 June 2017

f. BUMED Instruction 6320.103 Patient Services Program, 8 August 2016

g. USAFCENT Special Instructions xx-01 thru xx-05

h. AFI 41-200, Health Insurance Portability and Accountability Act (HIPAA), 25 July 2019

i. AR 600-8-4, Line of Duty Policy, Procedures, and Investigations, 15 March 2019

j. AFI 36-2910, Line of Duty, Medical Continuation (MEDCON) and Incapacitation (INCAP) Pay, 8 October 2015

k. AR 638-8, Army Casualty Program 23 June 2015

l. USCENTCOM MOD1, Operational Instructions for the Medical Situation Awareness (MSAT) Reporting Protocol, 20 July 2017

m. USCENTCOM FRAGO 09-962, MOD 1 Joint Theater Trauma System (JTTS) Implementation,

n. USCENTCOM Medical Rules of Eligibility (MEDROE), 30 June 2018

o. USARCENT Medical Rules of Eligibility (MEDROE), 15 October 2016

p. USFORA Medical Rules of Eligibility (MEDROE),

q. USCENTCOM MOD 14, Individual Protection and Individual Unit Deployment Policy, 3 October 2019

r. Patient Administration Systems and Biostatistics Activity (PASBA), Consolidation of Deployment Medical Guidance, 15 December 2016

s. Central Command Regulation (CCR) 40-1, Healthcare Operations, 7 September 2018

t. DODI 3020.41 Operation Contact Support, 20 December 2011

u. Third Army/USARCENT/CFLCC Protocol Memorandum SURG-05

v. NATO Standard AMedP-8.2, Basic Military Medical Report, Edition B Version 2, May 2017

w. NATO Standard (STANAG) 2348, Basic Military Medical Record, 15 January 2018

x. DoDI 6000.11, Patient Movement, 22 June 2018

y. AR 40-95, AFI 48-131, SECNAVINST 6401.1B, Veterinary Health Service, 29 August 2006

z. USCENTCOM Policy Letter 106, Repatriation of Deceased Military Working Dogs in USCENTCOM Area of Responsibility, 4 June 2019

aa. DoDI 6040.45, DoD Health Record Life Cycle Management, 16 November 2015

4. **RESPONSIBILITIES**

a. USCENTCOM Command Surgeon (CCSG) establishes and maintains USCENTCOM processes for patient administration consistent with DoD directives, instructions, recommended best practices, and other applicable documents.

b. The Deployed Medical Records Processing Center [currently Patient Administration Systems and Biostatistics Activity (PASBA)] provides additional clarity and technical assistance for all matters related to deployment medical documentation.

c. Medical Task Force Commanders and Component Surgeons ensure all medical units follow this protocol for U.S. and non-U.S. patients.

d. Facility commanders ensure all staff members comply with guidance provided within this SOP.

e. Patient Administration Divisions (PAD), and personnel assigned to complete duties related to patient administration and patient movement, comply with prescribed procedures, educate medical and non-medical personnel regarding these procedures and report non-compliance to appropriate leadership. Task Force (TF) and Role 3 facility PAD staff ensure distribution, compliance, and updates to facilities within their respective footprint.

5. The proponent for CCOP- 05 is the USCENTCOM Command Surgeon.

//Original Signed//

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APPENDIX A: Eligibility and Medical Rules of Eligibility (MEDROE)

1. **Purpose:** To provide guidance on eligibility of care for patients presenting to a military medical treatment facility (MTF) in the USCENTCOM Area of Operations (AO).

Non-US military/DOD/government employees may be subject to separate billing for healthcare provided within the MTF according to USCENTCOM/USAFCENT/USARCENT/CJTF-OIR/USFOR-A policy.

2. **Background:** MTFs receive numerous patients from multiple areas within their Area of Responsibility (AOR). Each patient classification varies based on the individual's occupation or vocation, military service, and nationality. Medical care rendered is based upon established MEDROE.

3. **Procedures:**

a. All patients presenting to MTFs are entitled to **Life, Limb, or Eyesight** emergency care.

b. Determine eligibility each time a patient presents to the MTF.

c. PAD verifies the patient's eligibility to receive treatment in accordance with the published MEDROE and service-specific regulations. Ineligible personnel may receive care on an emergency basis at the discretion of the facility commander. Notify the PAD OIC/NCOIC of all ineligible patients admitted to the MTF. Eligibility will be determined by the following:

(1) Patient's Military ID card or other identification card
(2) General Inquiry DEERs (GIQD)
(3) Clues of status (i.e., the following):

(a) Arrival by military transportation
(b) Uniform
(c) Military ID tags
(d) Letter of Instruction/Authorization (LOI/LOA)

d. DOD/civilian contractors must possess a Letter of Authorization (LOA) indicating routine medical care is authorized in order to receive routine medical care at MTFs. Confirm eligibility annotated on LOA for DOD and non-DOD civilian contractors prior to registration and treatment. Contract companies are responsible for providing medical treatment information. DOD /civilians often have issues when they require medivac. GS and contractors need to have medivac insurance or the sponsoring command or company have to understand they are authorizing cost if we are using a Civilian medivac option.

e. Providers at Role 3 facilities may accept non-urgent contractors from Role 1 and Role 2 facilities as patients based upon individual facility protocols and MEDROE. MTFs co-located with diplomatic or host nation facilities may route patients to another facility with a provider to provider hand-off. This may include patient movement by ground, rotary or fixed wing assets.

f. Most Coalition Forces **are authorized** for medical evacuation (MEDEVAC) and aeromedical evacuation (AE). The Patient Administration office must communicate with the respective regional Patient Movement Cell/Medical Regulating Office (Iraq, Afghanistan or Kuwait) or Command element prior to MEDEVAC. See Appendix I Aeromedical Evacuation and En Route Care.

g. MEDROE for named operations may vary on medical care provided and medical evacuation.

4. **Resources:** Below are the MEDROEs for USCENTCOM, USARCENT and MEDROE Annexes for USARFORA. The most current MEDROE is available through CJTF/TF Command Surgeon Cell.


Medical Rules of Eligibility-CENTCOM (


USARCENT MEDROE.docx


USAFORA MEDROE ANNEX A.pdf


USAFORA MEDROE Annex C.pdf

5. **NATO Countries, Patient Categories (PATCAT) and Family Member Prefixes (FMP):**

a. The table below lists NATO countries' forces to ensure the proper registration of NATO and non NATO military services:

Table 2 NATO countries' forces (PATCAT K72) ***For*** most current list of NATO countries see https://www.nato.int/cps/en/natolive/nato_countries.htm**.**

Bulgaria	Hungary	Poland
Canada	Iceland	Portugal
Czech Republic	Italy	Romania
Denmark	Latvia	Slovakia
Estonia	Lithuania	Slovenia
France	Luxembourg	Spain
Germany	Netherlands	Turkey
Greece	Norway	United Kingdom
Albania	Belgium	Macedonia
Montenegro	Croatia	United States of America

b. The most commonly used PATCATs are for Active Duty, Reserve and National Guard personnel; K72 for NATO forces, K74 for non-NATO coalition forces, K65 for contractors (government as well as non-government contractors), and K53 for Department of Defense/State (DoD/DoS) personnel and K91 local civilians/local unknown (HN). Lesser used are K78 for Detainees. DO NOT use PATCAT 41 or 43 in contingency operations unless clarified and approved for use by USCENTCOM**.**

Table 3 Patient Categories (PATCAT) and Corresponding Family Member Prefix (FMP)

BENEFICIARY CATEGORY DESCRIPTION	**PATCAT**	**FMP**
ACTIVE DUTY		
ARMY	A11	20
AIR FORCE	F11	20
MARINE	M11	20
NAVY	N11	20
COAST GUARD	C11	20
RESERVE		
ARMY	A12	20
AIR FORCE	F12	20
MARINE	M12	20
NAVY	N12	20
COAST GUARD	C12	20
NATIONAL GUARD		
ARMY	A15	20
AIR FORCE	F15	20

MISCELLANEOUS		
STATE DEPARTMENT EMPLOYEE	K51	20
DoD EMPLOYEE (OVERSEAS – Federal agencies other agency beneficiaries of the government overseas)	K53	20
CONTRACT EMPLOYEE (US GOVT, NON-US GOVT)	K65	20
NATO MILITARY	K72	20
NON-NATO MILITARY	K74	20
FOREIGN CIVILIAN (NON-HOST NATION)	K76	20
EPW/DETAINEE/INTERNEE	K78	20
CIVILIAN IN DETENTION	K78	20
LOCAL NATIONAL/LOCAL CIVILIAN/LOCAL UNKNOWN (HN)	K91	99
U.S. CIVILIAN EMERGENCY	K92	98
PATIENT NOT ELSEWHERE CLASSIFIED (OVERSEAS) i.e., U.S. MILITARY FAMILY MEMBER – **VERY LIMITED USE**	K99	99

The most current list of Defense Health Agency (DHA) Patient Categories (PATCAT) may be accessed at the following website: https://www.health.mil/Military-Health-Topics/Business-Support/Uniform-Business-Office/Patient-Categories

c. Family Member Prefix (FMP) codes are shown in the table below (not all-inclusive).

Table 4 Family Member Prefix (FMP) codes

Category	Description
01	OLDEST CHILD OF SPONSOR
02	SECOND OLDEST CHILD OF SPONSOR
20	**SPONSOR – PRIMARY BENEFICIARY**
30	FIRST SPOUSE/FORMER SPOUSE
31	SECOND SPOUSE/FORMER SPOUSE
98	**NON-SPONSOR PERSON BROUGHT TO MTF IN AN EMERGENCY**
99	ALL OTHER, NOT ELSEWHERE CLASSIFIED

Appendix B: Patient Registration

1. **Purpose:** To prescribe the procedures necessary for patient registration in the Medical Communications for Combat Casualty Care (MC4) system ensuring complete and accurate demographics for all patients treated at an MTF to prevent duplicate patients and ensure continuity of care.

2. **General:** Proper registration requires sufficient staffing in the PAD office or of other personnel responsible for patient registration. Accurate, complete patient registration prevents duplicate patients in MC4 and ensures continuity of care.

3. **Responsibilities:** PAD Clerks (or personnel designated to register patients) ensure complete full registration in MC4 system of record (AHLTA-T all roles of care/HALO select Role 1s and TC2 for MTFs with inpatient capabilities) when the patient is not already registered in the MC4 system. Ensure patient meets MEDROE prior to registration.

4. **Procedures:**

a. Medical personnel notify PAD a patient is not in the MC4 system.

b. A PAD clerk (or other designated staff) verifies the patient is not in the MC4 system specifically TMDS, AHLTA-T/HALO and TC2. If a patient is not in MC4, the clerk will complete patient registration in AHLTA-T using the following guidelines.

(1) Scan the barcode on the BACK side of the patient's CAC and select Done. (Scanning the FRONT side of the CAC may result in inaccurate transfer of patient data.)
(2) Verify all information for accuracy.
(3) Select drop down menu options even if information is pre-filled.
(4) Select correct information if pre-filled data is inaccurate. Pay specific attention to *SSN*, *Service*, Patient Category (*PATCAT)*, Family Member Prefix (*FMP) and Date of Birth (DOB)*. These are the most frequently inaccurate fields creating duplicate patients.
(5) Save.

Note: MC4 coding errors may inaccurately transfer data into various fields. Verify demographic data, especially PATCAT, prior to saving to ensure accuracy. PAD personnel should apply for access to DEERS GQID prior to arrival in theater and use this system to verify demographic data of a patient prior to registration.

Table 5 Required AHLTA-T Registration Fields

Last Name	Date of Birth	Gender
First Name	Deployed Unit	Religion
SSN/DoD ID	Unit Identification Code (UIC)	Marital Status
Branch of Service	Rank	Race
Patient Category (PATCAT)	Family Member Prefix (FMP)	

c. Refer to PATCAT and FMP tables in Appendix A. Refer to Appendix C for patients requiring pseudo SSNs and trauma names. Refer to Appendix P for Military/DoS/Contract Working Dogs registration.

d. MTFs utilizing HALO provide minimal demographic information at registration including: full name, SSN, FMP, date of birth, and gender. Additional demographics that can be added include Sponsor SSN, DoD ID, Service, UIC, blood type, unit and grade.

e. MTFs with inpatient care complete full registration in TC2.

(1) Scan the patient's CAC.
(2) Verify accuracy of information, including UIC and allergies.
(3) Save.

f. Notify medical staff when patient registration completed. They will then be able to initiate an electronic encounter, order labs, medication, x-rays, etc. and document care.

g. Make every effort to obtain patient's true identity PRIOR to issuing a pseudo name and pseudo SSN. The exception to this is host nation (HN) and third country national (TCN) personnel. Follow patient trauma name (PTN) and pseudo SSN (PSSN) conventions as outlined in Appendix C.

h. Ensure correct gender. Incorrect gender limits the ICD-10 codes which can be used.

i. Correct any incorrect demographic information and merge duplicate patients/records as needed. Section/flight leadership must request these additional privileges from MC4 support staff upon arrival to theater. Merging duplicate patient privileges will be restricted to select personnel. Merge duplicate patients only after discharge from the facility. Contact the MC4 support staff for assistance with merging duplicate patients/ records.

j. Some Special Operations patients are entered based on their true name. However, this is based on the reason for the visit and whether or not this is a result of a classified mission. Detainees are registered based on their ISN and VIPs are entered based on their true name unless advised otherwise.

5. **Resources**: MC4 PAD Quick Reference Guide.

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N131_TC2_GUI_PAD_

APPENDIX C: Pseudo SSNs and Naming Convention

1. **Purpose:** To outline CCSG policy regarding patient registration and the utilization for pseudo SSNs (PSSNs), patient trauma numbers (PTNs) and DOBs to prevent assignment of multiple PSSNs and duplicate registration for patient who present for care when their identity is: (a) unknown or (b) if they are foreign citizens who do not possess a nine-digit identity number. Maintain continuity of patient identity between Role 2 and Role 3 medical treatment facilities (MTFs).

2. **Responsibilities:**

a. Medical Task Force Commanders and Component Surgeons will ensure all medical units follow this policy for non-U.S. patients.

b. Role 2 and 3 MTF commanders ensure all staff comply with guidance provided in this policy.

c. Role 2 and 3 Patient Administration Divisions or personnel assigned with patient administration duties will:

(1) Validate PSSN has not been previously used in TMDS, AHLTA-T, and TC2 to alleviate duplicate patients.

(2) Track chronologically and maintain a PSSN log book to include name and DOB for historical data and future reference.

(3) Ensure all medical documentation transferred with a patient contains the correct patient demographic information by validating demographic information in appropriate databases (i.e., DEERS, JLV, GIQD DEERS).

(4) Ensure all demographic information in TMDS, AHLTA-T and/or TC2 is corrected and merged when necessary upon discharge.

(5) Ensure patient receives the PSSN for future medical care.

3. **PTN & PSSN Procedures:**

a. Make every effort to obtain patient's true identity PRIOR to issuing a pseudo trauma name (PTN) and pseudo SSN (PSSN) unless patient is host nation (HN) or third country national (TCN).

b. PTN Assignment

(1) Assign/admit using a PTN when patient is non-DoD, non-NATO/coalition [i.e., Host Nation (HN), Third Country National (TCN)] OR patient is incoherent, unconscious and does

not have a valid photo identification documentation. Only assign a PTN to U.S. and NATO/coalition service members if unable to establish identity at time of initial treatment.

(2) Originating medical facilities assign PTNs. Role 3 facilities provide PTNs to Role 2 MTFs within their respective geographical cache. **Do not change PTNs when transferring patients to another MTF.** Role 3 PAD updates patient information if/when the patient's name is later identified.

(3) PTN is used for record keeping continuity purposes. If patient name is known, medical personnel are encouraged to use patient known name when corresponding with the patient.

c. PSSN Assignment and Construction Convention

(1) PSSNs are artificial nine-digit numbers assigned to patients who present for care when their identity is unknown (John/Jane Doe) OR if they are foreign citizens who do not possess a U.S. generated nine-digit identity number. Special Forces/civilian staff unable to provide actual SSN and name due to security/safety concerns will present pseudo information upon receiving medical care.

(2) Role 3 facilities provide PTNs and PSSNs to Role 2 facilities within their respective geographical cache. Role 2 facilities not within the cache of an MTF and/or assigned a PSSN prefix construct PSSN utilizing designated PSSNs as outlined in this SOP. Role 2 MTFs consult with the Role 3 PAD to ensure proper formatting and usage of PSSNs for their facility. Once assigned, patients retain the PSSN for subsequent treatment at any MTF. Ensure patients have their PSSN upon discharge and understand the purpose of the PSSN at MTFs. This enables providers to view all patient encounters at all MTFs and PAD to link patient records in the event duplicate records exist due to name spelling, DOB, SSN variations.

(3) The MTF will assign a PSSN for patients meeting the above criteria in chronological order. The first three (3) digits are the assigned prefix for a specific MTF. To ensure the PSSNs do not match a US patient's SSN, **MTFs will keep the fourth and fifth digits as 00** and change the third digit of the PSSN when the MTF goes over 9999.

(a) Example: CJTH's pre-determined PSSN is 750-00-xxxx; once CJTH has reached 750-00-9999, the next chronological number is 751-00-0000).

(4) Detainees with assigned internment serial numbers (ISN) are assigned the 890-00- PSSN prefix and the last four numbers contained in the ISN, use the standard PSSN format. For example, if a detainee is admitted and the ISN of USAF-0012345DP, then the PSSN assigned would be 890-00-2345. Once assigned, detainees are referred to by an ISN only for all outpatient encounters and inpatient admissions.

(a) If a detainee is admitted directly from the field prior to being assigned an ISN, use the standard PSSN format. For example, if the detainee is admitted to Dwyer use the chronological order format, 920-00-0001 (first patient), 920-00-0002 (second patient), etc.

(5) Track all PSSNs in a logbook at each MTFs to prevent duplication, as well as for historical data and future reference. Maintain a hard copy of the PSSN logbook. If the MTF closes, forward the hard copy PSSN logbook to the Deployed Medical Records Center.

(6) Verify PSSN has NOT been used by another patient prior to assigning the PSSN to a patient. Check the proposed PSSN in TMDS, AHLTA-T and TC2. If the PSSN has be utilized by another patient, progress to the next PSSN. Keep PSSNs as close to sequential order as possible.

Table 6 PSSN prefixes for Role 2 and 3 MTFs

Facility Name	Facility Prefix	PSSN
CRAIG JOINT THEATER HOSPITAL (CJTH)	BAF	750-00-XXXX
JALALABAD/FENTY (FST)	JAF	790-00-XXXX
DAHLKE	DAH	753-00-0XXX
DAHLKE GST	GHO	758-00-XXXX
CHAPMAN	CHA	710-00-XXXX
H-KIA (KABUL)	HKI	760-00-XXXX
HEADQUARTERS RESOLUTE SUPPORT (HQRS)	HRS	840-00-XXXX
PAMIR	PAM	753-00-5XXX
KANDAHAR	KAF	870-00-XXXX
KANDAHAR GST	GST	873-00-XXXX
SHORAB	SHO	900-00-XXXX
TARIN KWOT	TKW	770-00-XXXX
DWYER	DWY	920-00-XXXX
BDSC	BDSC	100-00-XXXX
ERBIL	NEMU	226-00-XXXX
AL ASAD	AASS	105-00-XXXX
Q-WEST	QWE	368-00-XXXX
GREEN VILLAGE	GV	875-00-XXXX
TAA AL QAIM		250-00-XXXX
LAFARGE CEMENT FACTORY	LCF	772-00-XXXX
RAQQA		745-00-XXXX
USMH-K		820-00-XXXX
AL UDEID		810-00-XXXX
TOWER 22	TOW	XXX-00-XXXX
DETAINEES	DET	890-00-XXXX

Note: PSSN prefix codes are assigned regionally to Role 2 and Role 3 MTFs. Historically Iraq assigned 100s, Afghanistan 700s, and Kuwait 800s.

d. Pseudo Trauma Names (PTN) Naming Convention

(1) Originating MTFs assign PTN (initial MTF where the patient was evaluated. The PTN follows the patient to higher roles of care unless staff later identify patient's official name of a U.S. Service Member or NATO/Coalition member. If the patient is transferred to a higher role of care, pseudo name (PTN) follows the patient to the Role 3 facility. Role 3 MTF PAD update patient's actual name, if known, upon discharge or if patient transferred to Role 4 facility (Landstuhl Regional Medical Center - LRMC). The exception to this is HN local civilians and non-NATO coalition forces including HN military/state agencies. The ONLY time PAD changes this category of patient name is when the patient is evacuated to LRMC. Update patient's official name upon discharge (not a transfer) from MTF. Role 2 facilities under the cache of a Role 3 utilize pseudo names provided by the Role 3 facility.

(2) Use the abbreviation of the facility and the last four of the next chronological PSSN as the last name. MFTs select first names IAW local procedures. Use judgement and cultural sensitivity when selecting first names for PTNs.

Table 7 PTN Naming Convention Example

First Name	Facility abbreviation	Last PSSN	Complete trauma name
Jodie	JAF	1234	JAF1234, Jodie

e. DOB Assignment

(1) If a patient is incoherent, unconscious or if a patient does not know their date of birth or age, the treating MTF care provider estimates the patient's age. PAD enters the PSSN DOB into TMDS, AHLTA, and the TC2 systems.

(2) The provider annotates in the notes section of the patient chart that the DOB and age are only estimates.

(3) Individual MTFs may have a local SOP with protocol stating to assign all patients with an unknown date of birth the same birthdate i.e., January 1, 1990. If the patient is a newborn, young child or elderly, the birthday must be adjusted to accurately reflect their estimated/actual age to reduce confusion when charting to ensure appropriate care is rendered.

f. Affix preprinted label with assigned PSSN on the ID card of non-U.S personnel (coalition, HN military, etc.). This practice prevents the duplicate patient/re-registration of coalition and other non-US patients who may come in as a trauma patient then get seen as an outpatient. Updating names upon discharge will also assist with preventing duplicate patients and ensure continuity of care.

g. All MTFs include preprinted labels with PSSN/PTN inside Trauma/MASCAL packets as outlined in this policy.

APPENDIX D: Admissions, Dispositions (A&D) and Patient Accountability

1. **Purpose:** To prescribe the procedures necessary for the admission, disposition and accountability of patients.

2. **General:** The Patient Administration (PAD) office maintains accurate accountability, efficient admissions and disposition processing, and reporting capability at all times.

3. **Responsibilities:** After notification of an order placed for admission or discharge into TC2 by the provider, EMT, or ICU/ICW nurse, Patient Administration office completes all required procedures to admit or discharge the patient and ensure accountability.

4. **A&D and Patient Accountability Procedures:**

a. Admission Procedures

(1) Eligibility: PAD verifies the patient's eligibility to receive treatment IAW published Medical Rules of Eligibility (MEDROE) and service regulations. See Appendix A Eligibility

(2) Registration: Enter the patient into TC2 for an assigned registration number. In TC2 enter the following information, at a minimum:

(a) Name
(b) FMP
(c) Gender
(d) DOB
(e) Social Security Number
(f) PATCAT

Note: See Appendix A for FMP and PATCAT codes

(3) Admit Patient:

(a) A PAD representative gathers demographic data in the EMT/ICU/ICW to insure accurate pertinent information for registration within the MC4 System. During the admission process, record the patient's identification, unit information, and demographics on the patient information sheet and upload into TC2/ALTHA-T.

(b) Monitor TC2 for admission order. Verify patient location and admit patient to assigned ward and bed. Ensure diagnosis code, attending physician and other information is correct. Check TC2 for any new orders throughout shift, as necessary.

(4) Personal effects: Collect, label, document and store patient valuables and effects at time of admission. See Appendix T Personal Effects and Patient Trust Fund.

(5) Update hospitalization, bed status and other reports IAW facility policies and Appendix S Reports.

(6) Notify Casualty Liaison Team (CLT) upon admission of U.S .Service Member (SM) or DoD contractor.

b. Accountability: Patient Administration maintains accurate accountability of patients throughout inpatient treatment.

(1) Conduct ward runs, at a minimum, at the beginning and the end of a shift and at least once during a shift. Medical staff will notify PAD upon admission, when transferring a patient between wards, and upon discharge. Maintain patient accountability reference/bed status board IAW facility procedures.

(2) Submit updates to bed status/hospitalization reports IAW facility policies and Appendix S Reports.

c. Disposition Procedures:

(1) The attending physician creates orders for disposition by appropriately completing the Doctor's Orders in TC2, in the Provider Order Entry menu.

(2) The ICU/ICW nurse annotates the patient’s disposition on the patient clearing record. MTFs utilize service- or facility-specific patient clearing records to document the disposition process. The patient's inpatient record remains in ICU/ICW until returned to the PAD after discharge.

(3) PAD personnel discharges the patient in TC2 after order received. Return patient’s personal effects and valuables to the patient, non-medical attendant (NMA) or Command representative depending upon type of discharge (i.e., transfer, return to duty, death).

(4) Collect patient’s chart from ICU/ICW. See Appendix F Inpatient Records for processing procedures.

(5) Notify the facility Casualty Liaison Team (CLT) upon discharge of U.S. patients. Notify the Theater Casualty Assistance Office when CLT personnel are not present at time of discharge.

(6) The PAD clerk annotates the disposition date, time and disposition type in the facility Patient Tracker, Alpha Roster, Bed Status, Hospitalization Report or other facility patient register. Include any additional pertinent comments including evacuation and follow-on care.

(7) Upon discharge, a PAD representative or other designated party coordinates transient billeting, as required. Patients/NMAs schedule return flight arrangements through the PAX Terminal or respective unit liaison (LNO). Notify PAD office upon confirmation of flight including expected date/time group of patient's departure to duty location for tracking purposes. See Appendix I Aeromedical Evacuation.

d. Absent Sick and Outpatient Tracking for Patient Pending Patient Movement

(1) Absent Sick

(a) Role 2 (with inpatient capabilities) and Role 3 MTFs maintain accountability of U.S. military patients admitted to HN facilities for inpatient treatment. Role 3 facilities annotate and account for these patients as absent sick (ABS) on daily hospitalization/bed status reports.

(2) Outpatient Pending for Patient Movement

(a) PAD or En-Route Patient Staging Facility (ERPSF) maintain accountability of outpatients pending movement for medical care. Spreadsheets may be used to track patients and NMAs. Update status/information at least daily.

e. PAD offices not conducting 24 hour operations remain on call in the event of emergencies and after-hours admissions. MTF or base emergency operations centers (EOCs) notify PAD staff of a recall after duty hours. Upon recall notification, PAD ensures patients are registered and/or admitted into TC2, if applicable. PAD will maintain adequate stock of pre-positioned trauma/MASCAL packets in a centralized location. Inform MTF personnel of MASCAL packets location and availability. See Appendix N for MASCAL procedures.

5. **Admission Flowchart & Patient Clearing Record Example**


A4029.pdf


Admissions Flowchart.docx

APPENDIX E: Medical Records in Combat and Contingency Operations – Inpatient Treatment Record, Outpatient/Service Treatment Records, Extended Ambulatory Records, Carded for Record Only (CRO)

1. **Purpose:** This section covers initiating and maintaining inpatient treatment and outpatient records (ITR/OTR), loose hard copy documentation and scanning procedures, ambulatory procedure visits, deployed inpatient records retirement process and carded for record only (CRO) events.

2. **General**: U.S. and NATO standard for documenting medical care is utilization of an electronic system. Where available, utilize MC4 systems to document medical care. TC2 is the primary inpatient documentation system approved for use in the USCENTCOM AOR for US MTFs. AHLTA-T is the outpatient documentation system approved for use in the USCENTCOM AOR for US MTFs. NATO/Coalition MTFs may utilize other electronic medical documentation systems as required by their respective country.

3. **Responsibilities:**

a. Facility and TF Medical commanders ensure all medical personnel establish and maintain access to, received training for and utilize USCENTCOM directed electronic documentation systems.

b. Medical personnel document care electronically in TC2 and include paper-based documents in ITR.

c. Health Information Systems Officers (HISO) and MC4 support personnel assist medical personnel establish and maintain systems access accounts.

d. Patient Administration office maintains US Military and Coalition Forces Medical records for care provided to patients within the area of responsibility (AOR).

(1) Ensure all outpatient treatment properly documented in AHLTA-T. Outpatient treatment includes outpatient clinic visits, urgent care and any evaluation or treatment provided in an emergency room (ER) or trauma bay. Role 1 and 2 facilities primarily use AHLTA-T. Role 3 ERs also document care in AHLTA-T.

(2) PAD will maintain custody of all inpatient records and prepare for retirement to Patient Administration Systems and Biostatistics Activity (PASBA) at Fort Sam Houston, Texas.

(3) Role 3 and Role 2 Patient Administration (PAD) offices with inpatient capabilities create, maintain and retire inpatient treatment records (ITRs); maintain and retire dispose of outpatient treatment records according to service specific policies/regulations.

4. **Medical Documentation Procedures:**

a. Electronic health records (EHR)

(1) Defense Health Agency (DHA), USCENTCOM and NATO require MTFs document all medical care provided to all patients. Electronic documentation is the primary documentation method.

(2) Paper based documentation is the alternate documentation method. Upload all paper documents into a patient's electronic health record (EHR) – either AHLTA-T or Theater Medical Data Store (TMDS). Facilities without scanning capabilities utilize higher roles of care with scanning capabilities to ensure completion of scanning into patient's EHR.

(3) Medical providers and staff record the following information electronically in TC2 (not a comprehensive list):

(a) Detailed admission notes (this does not replace nor done in lieu of completing the Trauma form/Resuscitation record)
(b) Operative note(s)
(c) Radiology dictations, pharmacy entries and laboratory results
(d) Physician/provider note(s) and orders
(e) Nursing notes
(f) Detailed discharge summary

(4) Medical providers and staff record all outpatient care in AHLTA-T. Medical providers may access care provided outside AOR via TC2 GUI. Evaluation and treatment care record consists of the following (not a comprehensive list):

(a) Primary, secondary, tertiary diagnosis
(b) Symptoms and examination notes
(c) Radiology dictations, pharmacy entries and laboratory results
(d) Treatment plan
(e) Detailed disposition and follow-up

(5) PAD ensures all medical documents are uploaded into a patient's EHR in AHLTA-T for outpatient care and TMDS for inpatient care. If unable to scan outpatient documents directly into AHLTA-T, scan documents into TMDS.

(6) Naming convention for uploaded documents into TMDS/AHLTA-T is as follows:

a. Role 3/Role 2 with inpatient care: FACILITY ABBREVIATION_DOCUMENT TYPE_LAST NAME_ LAST 4 SSN_DATE OF ADMISSION [Role 3 inpatient treatment ONLY including Extended Ambulatory Records (EARs) i.e., Ambulatory Patient Visit (APV), Behavior Health (BH) or Observation (OBS).

(1) Example: BAF_Inpatient Chart Part A_Johnson_1234_1 Nov 2019

b. Role 1 and 2: FACILITY ABBREVIATION_DOCUMENT TYPE_LAST NAME_LAST 4 SSN_DATE OF ENCOUNTER (Role 2 outpatient treatment ONLY)

(1) Example: HKIA_SF 600_Johnson_1234_1 Nov 2019

(7) Direct questions or issues with electronic health care systems to MC4 support staff, systems administrator or HISO.

(8) MTFs without scanning capabilities request assistance from an MTF with scanning capabilities. Annotate documents sent to MTF for scanning on deployed outpatient documentation list spreadsheet (see Resources at end of this annex). MTF confirms receipt of documents and notifies sending MTF when scanning completed.

b. Inpatient Records (ITRs)

(1) Electronic documentation is the primary charting method. Paper documentation is authorized when electronic means via TC2 are not available. Patient records remain on the wards (ICU/ICW) until a patient is discharged from the MTF.

(2) Upon discharge, PAD arranges all documents in the inpatient treatment record (ITR) in accordance with service specific regulations and obtains any required signatures. PAD staff conduct a quality control check on the record then upload the record into TMDS. PAD office conducts a audit of at least 10% of the inpatient treatment record (ITR) monthly prior to shipping to the Deployed Record Center [Patient Administration Systems and Biostatistics Activity (PASBA)] for retirement.

(3) Provide a copy of ITRs for patients evacuated to another treatment facility.

(4) A copy of ITRs accompanies deceased patients.

(5) Complete quality control review on each ITR prior to scanning into TMDS. File, box and ship ITRs to Deployed Records Center every quarter. See Appendix I Deployed Records Retirement Process.

c. Outpatient/Service Treatment Records (OTRs/STRs) & Outpatient Documentation

(1) Do not request permanent hard copy medical records of SMs PCD'd to deployed environments. Maintain OTR/STRs at most recent CONUS/OCONUS duty station (not in contingency operation AO) IAW service specific policies. In the event a permanent party SM brings their permanent health record into theater forward OTR/STR to previous duty station.

(2) For paper-based outpatient documents, annotate patient demographic data on each page and conduct quality control check prior to scanning. Scan paper-based documents into AHLTA-T/TMDS depending upon system capabilities/availability.

(3) MTFs without scanning capabilities utilize adjacent or higher roles of care with scanning capabilities to upload documents into TMDS. Include the deployed outpatient documentation list with documents shipped to another facility for uploading.

(4) Destroy paper-based documents for outpatient medical care IAW facility or service specific procedures only after viewing in the patient's permanent electronic health record (i.e., AHLTA-T/TMDS) and confirming the document(s) are legible, complete and in the correct patient record.

(5) Maintain DD 2766 Deployment Health Records for deployed SMs at the installation Role 1 or Role 2 health clinic IAW unit and facility policies. File hard copy documents inside the 2766 after uploading into TMDS. Units may maintain DD 2766 instead of at the local Role 1 or Role 2 clinic. SMs' 2766s accompany personnel upon redeployment.

(6) Loose documents for Coalition Forces

(a) Return hard copy documentation for coalition forces to respective country liaison or national military medical authority after scanning documents into TMDS. Contact regional operation Task Force Medical element or Surgeon Cell for assistance, as needed.

(b) NATO country medical POC information attached in this appendix under resources; NATO STANAG AMedP 8.2 Annex A List of National Military Medical Authorities.

d. Extended Ambulatory Records (EARs)

(1) EARs capture medical care provided for extended ambulatory encounters including Ambulatory Procedure Visits (APVs) and Observation (OBS).

(2) APVs are outpatient surgical procedures generating inpatient documents. OBS are periods of observation not requiring in-patient medical care. Time frames for observation vary. APVs and OBSs are documented in AHLTA-T.

(3) Scan any paper based documents into TMDS or AHLTA-T.

(4) Create a record following same procedures as an inpatient record. Annotate as an ABV/OBS and NOT as an inpatient record.

(5) If patient has inpatient as well as APVs or OBS documents, file documents according to respective service regulations.

e. Carded for Record Only (CRO)

(1) CRO cases account for deaths occurring outside inpatient care including, but not limited to, the following deaths:

(a) in the emergency department,
(b) outside the MTF requiring documentation of death
(c) during a MASCAL

(2) PAD ensures completion of DD 2064, Overseas Death Certificate and DA 2985 Admission and Coding Sheet or TC2 equivalent.

(3) Retain a copy of all medical documents and scan into TMDS along with DD 2064 and Admission and Coding Sheet/TC2 equivalent. Original documents accompany remains.

(4) Create and retire record following same procedures as inpatient records. Annotate CRO on record jacket. Include copies of all documentation annotating medical interventions and/or resuscitative care.

(7) See Appendix M Decedent Affairs for detailed procedures on processing deaths.

f. Point of Injury Care Documentation

(1) Unit Surgeon at BN level is responsible to ensure point of injury care (DD 1380/TCCCC AAR form) is entered into Theater Medical Data Store (TMDS) within 72 hours of injury for any service member injured (battle/non-battle injury) when a patient requires: evaluation at a Role 2/3 and/or requires evacuation out of theater for injuries/illness.

(a) Establish procedures for collecting documents from local Emergency Management Service (EMS) providing point of injury (POI) care and movement to Emergency Department (ED). Upload documents into TMDS/AHLTA-T and create an encounter to link the documents with care received at MTF.

g. Linking Patients and Documented Care

(1) Link patients registered multiple times due to name spelling, SSN and DOB variations in TMDS. Verify patient demographic information (i.e., ID card, GIQD, Joint Legacy Viewer) prior to linking patient records.

(2) MTFs with MC4 capabilities will create an outpatient encounter to “link” care to scanned documents. MTFs without MC4 (AHLTA-T) capabilities will create a TMDS patient encounter annotating the diagnosis, treatment/interventions, and disposition. This encounter will appear under the Medical Events History tab of the Patient Summary.

h. Medical Records Translation Services

(1) Medical record translation services can be requested through International SOS by TRICARE Overseas Program (TOP) Prime Remote beneficiaries. Valid translation requests include items listed in (a) through (f) below.

(a) Physician treatment notes
(b) Consultation results
(c) Claims and supporting documentation
(d) Hospitalization and operative summaries
(e) Physician letters summarizing care
(f) Emergency treatment results

(2) Routine translations will be processed within 10 business days after acceptance. Urgent translations will be processed within two business days after acceptance. Timelines and certification only apply to the following languages: German, Dutch, Flemish, French, Italian, Spanish, Portuguese, Arabic, Turkish, Greek, Polish, Hungarian, Bulgarian, Czech, Romanian, Russian, Japanese, Korean and Tagalog.

(3) TOP Prime Remote beneficiaries can submit translation requests directly through the secure medical record translation portal. Facilities may appoint a representative to request translation services, as needed, for patient records instead of the patient requesting the services. Upload translated documents into TMDS as all other outpatient/inpatient records.

Translation services website: http://www.tricare-overseas.com/beneficiaries/resources/medical-records-translation.

(4) TOP Prime beneficiaries should request medical record translations through their military hospital or clinic or primary care manager.

(5) To learn more, download the Beneficiary User's Guide for the International SOS Medical Records Translation Portal. Or, click here to download useful frequently asked question (FAQs). **Note:** To ensure optimal usability of the Medical Records Translation Portal, please confirm you are using the newest supported version of Microsoft® Internet Explorer, Mozilla Firefox, or Google® Chrome.

i. Patient Safety Concerns

a. All patient safety concerns or incidences (i.e., near misses, etc.) are documented in the online Joint Patient Safety Report System at https://patientsafety.csd.disa.mil. Information for patient safety may be located at https://jts.amedd.army.mil/index.cfm/PI_CPGs/pi/patient_safety.

5. **Resources:**

NATO STANAG
AMedP 8.2 (Basic Mili

Deployed Outpatient
Documentation List.xls

APPENDIX F: Deployed Records Retirement Process

1. **Purpose:** To prescribe the procedures necessary for retiring inpatient medical records.

2. **General:** Inpatient medical records are managed differently than outpatient medical records. Military medical treatment facilities (Role 2E and Role 3) providing inpatient care retire inpatient records quarterly to the Deployed Medical Records Processing Center (PASBA). PASBA retires inpatient records to the National Personnel Records Center (NPRC).

a. NPRC archives military personnel, health and medical records (i.e., inpatient medical records) for patients treated at all MTFs. NPRC is one of the National Archives and Records Administration's (NARA) largest operations.

3. **Responsibilities:**

a. PAD initiates, compiles, quality check and ships inpatient records quarterly to the Deployed Medical Records Processing Center for retirement.

b. Deployed Medical Records Processing Center (PASBA) processes all deployed inpatient records IAW NARA retirement schedule.

4. **Records Retirement Procedures:**

a. Retire **all** inpatient records quarterly. Mail all inpatient medical records NLT 30 days after the end of each quarter. Scan all paper-based documents into TMDS prior to retirement. Facilities may utilize the 30 days following the quarter to conduct provider peer review of records. Provider peer review will not interfere with mailing records for retirement. Utilize the following records retirement schedule:

Table 8 Inpatient Record Retirement Schedule

Months in Quarter	NLT Shipment Date
January – March	1 May
April – June	1 August
July – September	1 November
October – December	1 February

b. At the time of records retirement, log inpatient records on internal tracking log IAW local SOP and on the Deployed Medical Records Processing Center (PASBA) retirement sheet (see template under Resources). Review and quality check all records and place in a record filing box according to the following three (3) categories: **(1) Active Duty Service Members (i.e., MWD), (2) ALL Others** (this includes, but is not limited to, Contractors, DoD Civilians, State Department, Host Nation (HN) military/civilian, NATO/Coalition Forces, Third Country

National (TCN), etc.) and **(3) Detainee/EPW/Internee records. Ship each category separately.**

c. Place records inside the respective shipping box in the following manner:

(1) In terminal digit order **AND**
(2) In the same order as they appear on the retirement spreadsheet

d. Inpatient records (ITRs) will include a records jacket, all paper-based documents, and other documents listed below. Records shipped for retirement must contain the following:

(1) DA 3444 series Medical Record Jacket
(2) DA 2985 or AF 506 (Admission & Disposition Coding Sheet) computerized or manually generated. Computer generated form is preferred and has the patient registration number preprinted on the form.
(3) Narrative or Discharge Summary
(4) AF 3899 Patient Movement Request (for patient air evac'd)
(5) DA 3647 (Army) or AFI 565 (AF) **Navy form** Final Disposition
(6) Any additional hand-written documentation for an inpatient record (ensure documents scanned into TMDS to include SF 600, SF 558, any point of injury care documents)
(7) Memorandums explaining any of the following:
a. Admission errors
b. Missing hospitalization register numbers
c. Missing provider signatures
d. Missing provider orders
e. Open encounters
f. Corrections to medical documentation (i.e., incorrect SSN, name, trauma name, psuedo name/SSN for correction)
e. Any other discrepancies in the record

e. Print the following (hand written or on a label) on the top right hand corner of the medical record jacket:

(1) Patient label with demographic data (Name, SSN/PSSN, DOB)
(2) PATCAT
(3) Registration number
(4) Gender
(5) Admission Date
(6) Facility name

f. Complete quality checks for accuracy and completeness. Refer to the "Quality Assurance Retirement Process" in attachments. Quality check (QC) all records inside the boxes. Recommend two people conduct a quality check of the inventory lists and the records together (i.e., one person reads the list while the other person checks for the physical record).

g. The lead box contains the master roster of all records shipped. Subsequent boxes contain rosters of contents within that specific box.

h. Each shipment starts with BOX 1 out of total shipment in each prescribed patient category (for example Active Duty Box 1 of 5; Others 1 of 2).

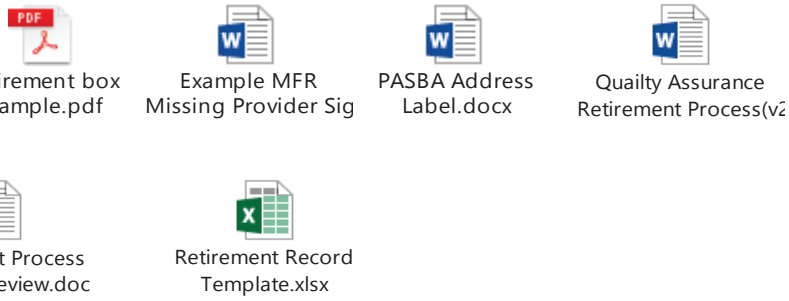
i. Prior to shipping records, notify Deployed Medical Records Processing Center via email of pending shipment. Await approval prior to shipping.

j. Tape the first and last records identifier on the front of the box (e.g. 0001 – 0008) prior to taping the boxes closed. Tape address label on top of the box. Ship boxes IAW local facility Official Mail policies. Some locations may require a hard copy of the Official Mail Appointment Letter, Request to send Official Mail Letter, and/or an Open Parcel Exception Letter.

k. Each box receives a separate tracking number. The top half of the tracking sticker will be placed on the box and bottom half will be given to the shipper (PAD representative). DO NOT MIX UP THE TRACKING NUMBERS. Log tracking numbers IAW facility PAD tracking procedures. Facilities may use a service specific digital tracking mechanism or facility generated tracking spreadsheet.

l. Once shipment is complete save the retirement record spreadsheet in designated share folder on local drive by quarter (Example: Inpatient Tracker Jan-Mar 2019) then start a new tracker.

5. **Resources:** Reference the below documents to complete the retirement records process.



APPENDIX G: Computer Systems and Access

1. **Purpose:** To prescribe the procedures necessary for establishing accounts and access to computer systems necessary to complete PAD functions at MTFs.

2. **General:** PAD personnel, and others assigned in those roles, require access to multiple computer systems and applications to ensure patient accountability, complete electronic health documentation and facilitate patient movement.

3. **Responsibilities:**

a. Facility commanders ensure sufficient number of staff establish and maintain access to, receive training for and utilize health care systems including MC4 (AHLTA-T/HALO/TC2) and patient movement systems (TRAC2ES/mIRC) to ensure electronic documentation of evaluation, treatment, reporting at and patient movement between MTFs.

b. Health Information Systems Officers (HISO)/Medical Information Systems and MC4 support personnel assist medical staff establish and maintain access to MC4 systems with appropriate user roles. They also provide training and technical assistance with electronic healthcare systems, as needed.

c. Information Technology Systems (IT) personnel assist staff establish network access (NIPR/SIPR/CENTRIX).

d. PAD personnel complete necessary training, apply for systems access, utilize systems appropriately and maintain proficiency levels for systems used.

4. **Procedures:**

a. Complete pre-requisite training prior to arrival to theater or as soon as possible upon arrival; i.e., HIPAA, AHLTA-T and TC2, JKO TRAC2ES course, etc.

b. Request: network access, MC4 (AHLTA-T all roles of care and TC2 for Role 2E/3, MTFs with inpatient capabilities), Medical Situation Awareness Tool (MSAT), Theater Medical Information Program (TMIP-J), and Theater Medically Data Store (TMDS) with Protected Health Information (PHI) access. Role 2 and 3 facilities without an Aeromedical Evacuation Liaison Team (AELT) or En-Route Patient Staging Facility (ERPSF) also need access to TRAC2ES for submitting and monitoring patient movement requests (PMRs).

d. See additional details and instructions for specific systems access, required documentation and point of contacts.

5. **Resources:**

Patient
Administration Divisio

APPENDIX H: Medical Evacuation (MEDEVAC/9 Line)/ Patient Evacuation Coordination Cell (PECC) and Patient Movement Cell (PMC) Operations

1. **Purpose:** To outline the requirements for management of Rotary Wing (RW) Medical Evacuation (MEDEVAC) missions by the Patient Movement Cell (PMC), Patient Evacuation Coordination Cell (PECC), Medical Regulating Office (MRO) or Patient Administration (PAD).

2. **General:** US military, NATO and/or Coalition forces may operate in patient movement roles and coordinate care for all personnel entering the military/civilian health care system to receive medical care. Patients are routed to the closest medical facility (US military, coalition forces, host nation (HN) military/civilian) with capability and capacity. Consistent and timely coordination of MEDEVAC missions for patients within the Combined Joined Operations Area (CJOA) ensure patients receive appropriate interventions and ensure continuity of care. Each operation within theater has procedures specific to their respective AO.

3. **Responsibilities:**

a. PMC, PECC, MRO coordinates RW and ground ambulance (EMS) from point of injury (POI) to closest MTF within their respective AO with capacity and capabilities.

b. Requesting MTF staff utilize a RW checklist to ensure all necessary preparations are completed prior to movement i.e., 9 Line request, command notification, Non-Medical Attendant (NMA), etc. MTF ensures sufficient staffing to move patient from facility to aircraft. The attending physician coordinates with an accepting provider prior to movement to a higher level of care unless the patient is moving from point of injury (POI).

c. Receiving MTF staff completes any country requirements (i.e., Visitor Pass) prior to patient arrival. Facility ensures sufficient staffing to move patient from facility to aircraft.

4. **MEDEVAC Procedures:**

a. MTF/Entity Requesting MEDEVAC

(1) Gather information needed for submitting 9 line MEDEVAC/Patient Movement Request (PMR) including MIST report information (see example under Resources). Coordinate with medical staff/providers as needed i.e., provider to provider hand-off.

(2) Contact regional PECC, PMC or MRO IAW operation SOP (i.e., CJTF-OIR, USAFOR-A, etc.) and submit MEDEVAC/ request. Notify patient's Command of pending MEDEVAC and coordinate for a non-medical attendant (NMA) from patient's unit, if required.

(3) Monitor estimated time of arrival (ETA) and prepare patient for movement. Brief NMA and patient (if practical) on MEDEVAC/movement process. Ensure necessary documentation accompanies patient and is uploaded into AHLTA-T encounter or TMDS.

b. MTF Receiving MEDEVAC

(1) Alert staff of incoming MEDEVAC i.e., provider and ambulance crews, as needed.

(2) Monitor notification of wheels up from sending facility.

(3) Prepare for arrival of patient. Pre-register patient in AHLTA-T and TC2 (if patient demographics provided) and print labels for chart, labs, etc.

(4) Receive patient and process IAW SOP.

c. Entity Processing MEDEVAC (PMC/PECC/MRO)

(1) Each AO has specific nuances affecting patient movement. Refer to local SOP for additional guidance.

(2) To coordinate care needed at a higher role of care, Role 1 to Role 3 MTFs utilize regional PMC/PECC/MRO to submit intra-theater patient movement requests (PMRs) IAW local SOP.

(a) The PMC/PECC/MRO uses standard NATO 9 Line formats and MIST to track all patients moving in and out of their respective AO.

(b) Complete MEDEVAC request to PMC/MRO. PMC/MRO requesting element "drops" the 9 line in mIRC chat or Chat Surfer (certain ARCENT entities). Once movement validated with DUSTOFF/MEDEVAC, PMC/MRO notifies sending element/unit and receiving MTF of expected movement time frame including projected wheels up/down times.

© Movement timelines for MEDEVAC are different than AE. Urgent within 1 hour, priority within 4 hours and routine within 24 hours.

(d) DUSTOFF receives MIST report over SIPR prior to receiving patient. MEDEVAC requests via ground will vary slightly by AOR.

(3) Complete warm hand-off with gaining MTF via SIPR if available. Provide patient registration information, if available. This will prevent duplicate patients.

(4) Note the condition of patient determines the mode of transportation to the airfield – rotary wing, ambulance, shuttle, etc. MEDEVAC to the airfield for onward movement to definitive care may be required.

d. Non-Medical Attendants (NMA)

(1) It is the responsibility of the patient's unit to provide a NMA and ensure the patient and NMA have a government travel card (GTC). Include NMA information on PMR. NMA must be same rank or higher and same gender. Verify NMA possesses required documentation i.e., orders, ID card and passport (foreign/civilian).

(2) All NMAs must possess appropriate travel orders (DD 1610) from the originating MTF authorizing the same category/method of movement as the patient. The MTF, in coordination with the unit of record, prepares the travel orders. The travel orders clearly state reimbursable items, costs and accounting codes as specified in the Defense Travel System (DTS). Return travel must be identified and annotated on the DD 1610.

(3) NMAs may continue with patient for further treatment out of theater to Landstul Regional Medical Center (LRMC). The LRMC Liaison (LNO) coordinates return travel to theater (major hubs only) for NMAs not accompanying a patient to CONUS. The NMA's unit coordinates return travel from CONUS to theater once NMA is released from NMA duties.

(4) At ANYTIME in the patient movement process, the Theatre Validating Flight Surgeon can release the Non-Medical Attendants and their baggage. This happens mostly if the patient travels to CONUS, with consideration of the patients need at the time and the aircraft the patient will be on.

5. **Resources**: MEDEVAC and AE Command notification, NMA policy and other information are similar to Aeromedical Evacuations. Additional templates and information are located under Resources in Appendix I Aeromedical Evacuations.


RW and FW Flow Charts v20190306 cjtf·


A2_Rotary Wing Patient Movement Re(


9-LINE-MIST MASCAL.xlsx

APPENDIX I: Aeromedical Evacuation, En-Route Care and Patient Baggage

1. Purpose: To outline the procedures associated with aeromedical evacuation (AE), en-route patient care, utilization of En-Route Patient Staging Facility/System (ERPF/ERPSS), medical and non-medical attendants and processing patient baggage for intra/inter-theater patient movement.

2. General: USTRANSCOM coordinates all military air (MILAIR/grey tail) patient movement in the AOR. International SOS (ISOS) is the TRICARE contracted agency in the AOR for civilian air ambulance assets. ISOS is utilized when grey tail is not available; patient must be an eligible TRICARE beneficiary. Theater Patient Movement Regulatory Center (TPMRC-E) processes patient movement for military and/or civilian air assets. TPMRC-E may take PMRs via phone as a last resort. Patient Movement (PM) will not be initiated without a validated patient movement request (PMR).

TPMRC-E is the theater regional patient movement center covering USCENTCOM and USAFRICOM. Email box is tpmrc-e.3afsgz@us.af.mil

3. **Responsibilities**:

a. MTF PAD/Medical Regulating Office (MRO)/ Patient Movement Cell (PMC)/Patient Evacuation Coordination Cell (PECC)/En-Route Patient Staging Facility (ERPSF):

(1) submits Patient Movement Request (PMR) via TRAC2ES or through TPMRC-E for military air evacuation or International SOS (ISOS) for civilian air medical evacuation

(2) monitors PMR for corrections, approval and mission assignment

(3) notify unit Commander of need for aeromedical evacuation (AE).

b. Medical provider determines patient evacuation requirements and recommends need for non-medical attendant (NMA) to accompany patient.

c. Medical staff prepares patient medically for movement.

4. Aeromedical Evacuation (AE) Procedures:

a. Provider determines whether patient requires higher role of care and coordinates follow-on care directly with an accepting physician.

b. Provider completes AF 3899 Patient Movement Request (PMR) and submits to PAD/MRO/ERPSS/ERPSF personnel for processing. Urgent patients can move as soon as Flight Surgeon at TPMRC-E validates mission.

(1) PAD/MRO/PECC/PMC ERPSS/ERPSF notify chain of command of need intra/inter-theater evacuation and for non-medical attendant (NMA), if required.

c. PAD/MRO/PECC/PMC/ERPSS/ERPSF create and submit PMR in TRAC2ES. Refer to attachment "Creating a PMR in TRAC2ES" under Resources. Verify PMR validated; periodic correct all error back remarks and resubmit. Follow-up with TPMRC-E via DSN 314-480-8040 or email, as needed.

(1) Required information includes: patient's home address and phone number, forward and rear unit POC information i.e., phone numbers,

(2) MTFs without the ability to submit PMRs directly into TRAC2ES may submit manual PMRs directly to TPMRC-E or regional movement entity (MRO/PECC/PMC) for processing.

d. While waiting for validation, contact patient, NMA and patient's Command; prepare patient for movement.

(1) Outpatient: Provide welcome letter/information with flight information including date and time for reporting to the ERPSS/MTF, checklist of items to bring with them and a checklist of contraband items. See items under Resources.

(2) Inpatient: Contact patient chain of command and provide movement information and request NMA information. Contact NMA and brief on duties.

(3) Maximum allowable baggage is two (2) 70 lb. bags plus a smaller carry-on item. See baggage specifics on TPMRC trifold under Resources. Excess baggage is secured and processed by patient's unit.

e. Once validated, monitor outbound mission information and verify demographics for patient and NMA, if required, on manifest. Missions may arrive earlier or later than scheduled. Complete anti-hijacking, tag patient and NMA baggage. Create packet of patient information required for movement i.e. theater clearance memo, medical documentation, etc.

f. Flight surgeon clears patient for air movement. Update medication and vitals prior to staging. Current vitals and medication are needed as part of patient handoff.

g. Stage and move patients for movement to airfield. Ensure patients and NMA properly cleared through personnel/human resources/PERSCO and host nation immigrations, as required. Ensure patients, NMA(s) and PAD/ERPSS staff accompanying patients and NMA(s) on the flight line possess hearing and eye protection.

h. Conduct patient and baggage handoff with air crew (medical crew director/flight nurse and baggage crew) i.e., verification of baggage tag numbers on the anti-hijacking form. Ensure anti-hijacking statement is completed and signed by PAD and receiving aircrew. Ensure mission manifest is signed by flight nurse/medical crew.

i. Remain on stand-by in case of flight delay or flight return. Follow local timeframe

protocol prior to returning to MTF and discharging patient from the facility.

j. Complete notification of casualty liaison teams/reports, as required for respective facility i.e., notification to Command. Upload final PMR in TMDS.

k. If PMR is for outpatient, 9V, ask TPMRC-E for ULN MEDPAX for patient traveling through a PAX terminal. MEDPAX are usually for patients requiring outpatient care/consults for specialty care. MEDPAX do not require medical care during flight and do not have an NMA. AECT assigns the ULN – this is a guaranteed seat on a MILAIR flight; This information will not appear on the PMR. See example MEDPAX memo under Resources.

l. Military Working Dogs (MWD) are treated as an active duty service member. Kennel required and must be leashed at all times (even if sedated during flight). MWD handler will not be separated during flight. Department of State handler will be separated from MWD and vet tech will be present during flight. See Annex P Military/Contract Working Dogs for additional specifics on movement for MWD.

m. Some NATO/Coalition/HN forces/contractors cannot travel to certain MTFs based upon MEDROE and various nation specific visa requirements. Review MEDRO and consult higher patient movement entity/liaisons to ensure compliance.

n. Non-U.S. Military Patients

(1) See Appendix Q for movement of NATO/Coalition forces

(2) See Appendix R for movement of contractors (DoD and non-DoD)

(3) Foreign Nationals (FN)

(a) An exception to policy for movement may apply if injury was caused by DoD or coalition actions. Urgent movement (life, limb or eyesight) within the HN country.

(b) Movement beyond country of origin requires Secretarial Designee approval. This approval requires coordination with the local Embassy office and one of the Secretary of the Armed Forces Braches (Army, Air Force, Navy, Marines). See DoDI 6025.23.

(4) Ensure civilian companies coordinating civilian air ambulance movement possess Prior Permission Require form (PPR) processes. These must be completed prior to approval for landing a civilian aircraft on a foreign airfield.

o. Non-Medical Attendants (NMAs)

(1) It is the responsibility of the patient's unit to provide a NMA and ensure patient and NMA have a government travel card (GTC). Include NMA information on PMR. NMA must be same rank or higher and same gender. Verify NMA possesses required documentation i.e., orders, ID card and passport (foreign/civilian).

(2) All NMAs must possess appropriate travel orders (DD 1610) from the originating MTF authorizing the same category/method of movement as the patient. The MTF, in coordination with the unit of record, prepares the travel orders. The travel orders clearly state reimbursable items, costs and accounting codes as specified in the Defense Travel System (DTS). Return travel must be identified and annotated on the orders.

(3) Landstul Regional Medical Center (LRMC) Liaison (LNO) coordinates return travel to theater (major hubs only) for NMAs not accompanying a patient to CONUS. The NMA's unit coordinates return travel from CONUS to theater once NMA is released from NMA duties.

(4) At ANYTIME in the patient movement process, the Theatre Validating Flight Surgeon can release the NMA and their baggage. This happens mostly if the patient travels to CONUS. USTRANSCOM and medical personnel take into consideration the patient's needs at the time, assets available and the aircraft the patient will be traveling on for movement to definitive care.

p. Sexual Assault (SA) Cases

(1) Medical care provided to the sexual assault victim is the same regardless of the reporting option (restricted or unrestricted). PAD is the critical link between care, documentation and evacuation for higher role of care. Confidentiality must be maintained throughout the process.

(2) Role 3, limited Role 2E and HN MTFs have Sexual Assault Medical Forensics Examiners (SAMFEs) and the capabilities to perform a Sexual Assault Forensic Exam (SAFE). Sexual assaults are very sensitive and often require restrictive messaging in order to protect the victim.

(3) These patients are required to be moved as **urgent** patient in order to facilitate the timely requirement for evidence collection and to provide patient with appropriate victim support. For MEDEVAC/aeromedical evacuation, identify patient as an "urgent" with diagnosis of "physical examination required". Do not include any information or statements regarding sexual assault in the PMR.

q. Patient Safety Concerns

a. All patient safety concerns or incidences (i.e., near misses, etc.) are documented in the online Joint Patient Safety Report System at https://patientsafety.csd.disa.mil. Information for patient safety may be located at https://jts.amedd.army.mil/index.cfm/PI_CPGs/pi/patient_safety.

5. **Resources:** Below are documents to assist with the AE process i.e., creating PMRs, checklists for patients and NMAs, utilizing TPMRC/ISOS, etc.


ISOS Checklist continuity.docx


Creating a PMR TRAC2ES.docx


TPMRC-E TRIFOLD.pdf


Commonly Used CENTCOM ICAO Code


TPMRC-E Patient Prep Checklist - 10Aug


AE Stocked Meds as of Feb 2019.pdf


Command LOR for PMRs.docx


Example email sent to commands for rou


Prohibited Luggage Items on AE Missions.


TCCS Policy Memo CY19-02_Medical Atte


AE Patient Movement MFR - MEDPAX 9V.do


C12_Antihijacking Worksheet.pdf


Example Release from Theater Memo.p


Prohibited Luggage Items.pdf


RW and FW Flow Charts v20190306 cjtf

APPENDIX J: MOD 14

1. **Purpose**: Describe the procedures and responsibilities for processing MOD 14 disqualifications.

2. General: PPG-TAB A MOD 14, Amplification of the Minimal Standards of Fitness for Deployed to the USCENTCOM area of Responsibility outlines medical standards for personnel deployed in USCENTCOM. Those not meeting the requirements of MOD 14 will be processed for administrative release from theater.

3. **Responsibilities**:

a. Medical providers identify patients with medically disqualifying conditions per MOD 14 15.c.2.

b. PAD, Chief/Officer in Charge (OIC) ensures all patients found unfit by a physician with a MOD 14 disqualifying condition are processed accordingly to policies and procedures set forth by USCENTCOM.

c. PAD Clerk receives and processes documentation for MOD 14 cases.

4. **MOD 14 Waivers:**

a. If a service member arrives in the theater without the required waiver, the home station will be contacted to submit the medical waiver package and all supporting documentation for each diagnosis requiring a waiver.

b. The deployed location will complete a face-to-face assessment of the patient to determine the stability of the condition and provide a recommendation of the ability to remain in theater.

c. The adjudicating authority will provide the final disposition to the home station as well as to the deployed location.

(1) Service members with approved waivers may remain in the theater. Home station locations will be notified that future waivers MUST be approved prior to departure.

(2) Service members with disapproved waivers will depart the theater.

5. **MOD 14 Disqualifications:**

a. Receive all MOD 14 requests from the medical officer. Requests will be made using standard Memorandum for Record (MFR) detailing condition and reasoning upon disqualification.

b. Review all requests and complete Patient Administration memo that will accompany Provider's memo. Interview patients upon receipt of MOD 14 to insure all administrative information, to include Commander and 1SG information is correct.

c. Annotate the patient as a MOD 14 in the local MOD 14 tracking log/register/report.

d. Report all patients designated MOD 14 to the Chief, Patient Administration in accordance with appropriate local regulations. Command Interest patients (as established by local SOP) will be reported to Deputy Commander of Nursing and Deputy Commander of Clinical Services and S3.

e. Notify the patient's Commander and 1SG the patient has been identified as medically unfit by MOD 14 with disqualifying medical condition.

(1) Provide the patient's Commander with provider memorandum, PAD memorandum and flight information.

(2) Provide patient's Command with Patient Administration memorandum with flight information sheet. **Only Command authorized personnel receive patient's information containing PHI.** See Annex K Release of Information and HIPAA Compliance for specific information, authorized personnel to receive PHI and PHI which can be released to authorized personnel.

(3) Ensure unit understands MOD 14 routine flight non-MEDEVAC is the responsibility of the patients unit. Unit is responsible for contacting HRC in order to amend/curtail PCS orders (Active Duty). Reserve/National Guard (NG) units

(4) A patient who will be evacuated CONUS via Routine Air coordinated by Soldier's Unit (notification Memo). MOD 14 Non-PMR routine flight.

(5) MOD 14 Routine Flight – (MOD 14 disqualifying medical conditions that doesn't allow a Soldier to remain in country) these are non-PMR flights organized by the Soldier's unit to return them to the States. This is an administrative function.

(6) Send to Service Member's unit:

(a) MOD 14 Provider's Memo

(b) Routine Flight SATO information

(7) Patient's Unit is responsible for coordinating Soldier's movement from Theater. Active Component: The SM's S1 coordinates with HRC and Case Manager, Reserve Component: S1 Coordinates with MOB Station.

(8) Service Members who are PCS'd to theater will coordinate with their S1 who will reach out to the SM's assignment branch to reassign them so they can obtain continuity of care. (This will happen prior to redeployment so the PT can return to CONUS)

(9) The Patient will return to point of DMOB site or CRC to receive the care needed. The

patients need to reverse SRP and show the MOD 14 memo so the SRP site (CRC) can ensure the patient is provided appropriate care.

5. Resources: Templates for MOD 14 packets and example SOP. Highlighted portions may be updated for respective AO, facility, Passenger Travel Office, etc.


MOD 14 Provider's Memo Template.docx


CENTCOM MOD 14 Waiver Request Form.


Example MOD 14 SOP.doc.pdf


Commercial Flight Information Sheet.doc

APPENDIX K: Release of Medical Information (ROI) & HIPAA Compliance

1. Purpose: To outline the procedures associated with maintaining confidentiality of protected health information (PHI), the release of medical information (ROI), responding to HIPAA violations (i.e., breaches) and required training.

2. General: Confidentiality of medical information will be maintained for all patients to the maximum extent possible. All personnel have a professional and ethical obligation to keep medical information confidential.

a. **Privacy Rule:** The Health Information Portability and Accountability Act (HIPAA) Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. The Privacy Rule is located at 45 CFR Part 160 and Subparts A and E of Part 164.

b. Military Commanders are authorized access to limited PHI related to how a Service Member's (SM's) medical condition impacts readiness and unit mission requirements.

c. Unauthorized disclosure of PHI is grounds for administrative and/or disciplinary action.

3. Responsibilities:

a. All health care personnel in a covered entity abide required to comply with HIPAA privacy and security rules and report unauthorized disclosure of PHI.

b. PAD professionals manage/process official and unofficial ROI.

c. Facility commanders:

(1) Ensure all personnel are trained and proficient in HIPAA security and privacy rules

(2) Maintain an environment conducive to patient privacy

(3) Appoint a HIPAA Compliance Officer/NCO to manage complaints and reports of unauthorized disclosure of PHI.

d. HIPAA Compliance Officer/NCO respond to complaints/reports of unauthorized disclosure of PHI, ensure patients receive Notice of Privacy Practices (NoPP), advise staff of HIPAA compliance and best practices, and advise facility commanders of HIPAA compliance issues.

4. ROI Procedures:

a. Although medical information is confidential, it may be disclosed under certain conditions. All requests for medical information must be approved by the Chief of the Administration Division or his/her designated representative.

(1) Official requests will be made in writing, utilizing DD Form 2870 (Authorization for Disclosure of Medical or Dental Information) or service/entity specific form. The request needs to be specific on what information is required and the reason for the request. Those submitting the request will present their credentials/identification. Official requests include requests for a copy of an individual's medical information from:

(a) outside facilities/providers
(b) investigation/law enforcement entities
(c) unit commands

(2) Process official requests IAW service/facility specific regulations/procedures. When an request a copy of an individual's medical information, complete a DD 2870 or service specific form, state specifically what the requester is looking for in the medical record (positive lab results of a urinalysis, disqualifying medical condition, etc.). Only a printed copy specific to the request will be released to the agency or unit making the request, they will also be briefed on the policies and procedures in which they may use the information and also briefed on The Privacy Act of 1974. For more information please refer to OTSG/MEDCOM Policy Memo 16-087 (Release of Protected health Information to Unit Command Officials).

(3) Unofficial requests approved when authorized by the patient. Unofficial requests will be submitted using DD 2870**.** The request includes the period of hospitalization or treatment for the information which is being requested, the purpose for which the information is to be used, the name of the individual or organization to which the information is to be released and state specific medical/dental information to be released. Requests may be submitted by the patient and family members with a power of attorney (POA). A copy of the DD Form 2870 will be filed in the patient's medical record upon completion of the request.

(a) Grant requests from patients unless a medical provider determines it may adversely affect the patient's physical or mental health. When such a decision is made, inform the patient the information may be released to provider named by the patient. Annotate the ROI to patient denied and list provider information released to instead on DD Form 2870.

(b) Submit requests from the media through appropriate public affairs office (PAO) channels i.e. Army DA Form 4876, Requests and Release of Medical Information to Communications Media.

b. Limited information is authorized for release directly to designated personnel serving in leadership roles specifically the patient's Commander. Only location of SM (in the hospital accountability) and disposition i.e., duty limiting status may be released to Commander/ command representative without documentation that has been adjudicated through legal. Copies

of documentation must be officially requested through the PAD office. Service specific regulations apply. Service specific documentation for official investigations by law enforcement or judge advocate elements (i.e. forms utilized by law enforcement and investigative entities) do not require permission of or notification to the SM.

c. Facilities may have additional requirements or procedures related to release of medical information.

d. HIPAA Violations

(1) Federal law outlines the criteria for HIPAA violations including breach, loss of PHI and accidental disclosure of PHI. Each MTF must comply with applicable HIPAA security and privacy rules and report violations IAW USCENTCOM guidance.

(2) MTF Commanders appoint a HIPAA Compliance Officer IAW DoD 6025.18-R, AR 40-66, AFI 41-200 and service specific regulation to monitor and ensure HIPAA compliance.

(3) The following outlines procedures for reports of noncompliance.

(a) Report HIPAA violation to HIPAA Compliance Officer, PAD OIC and/or PAD NCOIC or MTF OIC.

(b) Report violation to higher command if disclosure meets command criteria for an incident report (i.e., breach, disclosure of DV information, etc.). Engage legal, information technology (IT) section and other entities as appropriate.

(c) Counsel SM(s) in writing as appropriate. SM(s) may be subject to additional administration or punitive actions.

(d) Conduct remedial HIPAA and Information Awareness (IA) training to ensure proper disclosure and prevention procedures are employed at MTF.

(e) Notify patient of disclosure if violation meets criteria as outlined in USCENTCOM guidance.

e. Special Considerations

(1) Casualty Affairs reports limited and specific medical information through personnel and command channels to account for deaths and significant injury/illness of personnel admitted/treated at MTFs related to battle injuries (BI) or non-disease/battle injuries (NDBI).

(2) Any person completing a release of medical information for consideration of receiving a Purple Heart may have records associated with the event, to include medical documentation, made public upon approval of the award.

5. **Training:** Prior to access to PHI, all personnel complete appropriate HIPAA training for their respective role(s) at the MTF. MTFs maintain copies of training certificates for facility personnel.

6. **Resources:**


ROI - The Military Command Exception a


DHA How to File a HIPAA Complaint Instr


HIPAA guide.docx

APPENDIX L: Line of Duty Procedures (LODs)

1. **Purpose:** To prescribe the procedures necessary for initiate an LOD, as required per AR 600-8-4, AFI 36-2910, BUMEDINST 6320.103, Section 3 for personnel treated at an MTF or civilian facility.

2. **General:** Line of Duty Investigations provide a means for continuity of care for patients becoming significantly ill or injured while performing duties on a qualifying duty status. An LOD does not determine or recommend disability rating or compensation for the injury or illness. It states whether or not continued medical care is reasonably expected. An LOD is not utilized to document an injury/illness; the SMs health records document the occurrence of an injury/illness. A SMs orders reflect whether or not the patient was on a qualifying Active Duty status at the time of injury/illness. LOD approval authority determines whether or not the injury/illness occurred "in the Line of Duty" and authorizes continued medical care.

3. **Responsibilities:**

a. Provider determines if injury/illness meets requirements for LOD.

b. PAD (or personnel designated to fill the role): initiates DA 2173 or DD 261 and provides copies of requested substantiating medical records.

c. Unit Command complete and process LOD investigation IAW service specific regulation.

4. **Procedures:**

a. Service Member's (SM) injury/illness meets requirements for LOD as outlined in service specific regulations AR 600-8-4, AFI 36-2910, BUMEDINST 6320.103, Section 3.

(1) Refer to service specific regulations when initiating/processing LODs for patients from various branches of service. Contact PAD counterparts in that branch of service for additional guidance/assistance.

(a) Active Duty Army personnel: initiate all line of duty investigations within 5 days of SMs injury/illness meeting the criteria for an LOD.

(b) Army Reserve/National Guard: must submit line of duty investigations NLT 6 months after released from active duty (REFRAD).

(3) Line of Duty letters/determinations authorize patients for continued medical care as outlined in service specific regulations.

b. PAD initiates DA 2173 for informal investigations for Army personnel, completing Section I. AF Form 348 completed for Air Force personnel. For formal investigations, the investigating officer initiates a DD Form 261. PAD provides medical information required for DD Form 261, or other service specific documents, with appropriate release of information (ROI) documentation on file (DD 2870). See Appendix K for Release Of Information.

(1) Write diagnosis and treatment information in simple, yet complete terms capturing the most pertinent information related to injury/illness and circumstances.

(2) Patient or unit representative provides patient administrative data and unit point of contact information.

c. Patient completes release of information request for copies of documents related to injury/illness. Process DD 2870 as outlined in Appendix K Release of Information.

d. Forward LOD documents (i.e., DA 2173/DD 261) to patient's unit Commander/ investigating officer for processing. Request a copy of the completed and signed DA 2173/DD 261 from the unit command. Ensure SM has a copy of completed 2173. Upload completed DA 2173 into TMDS and include in inpatient records for retirement.

e. Army Reserve and Army National Guard SMs' LODs must be completed through their chain of command and uploaded into eMMPS on MEDCHART by their unit/Command POC for processing. LOD approval occurs through respective approval chain for all branches of service.

f. The Sexual Assault Response Coordinator (SARC) initiates a LOD for restricted or an unrestricted reports for sexual assault victims. Service specific rules apply to when LODs are initiated, how they are processed and the LOD approval channels. Contact the Command/Installation SARC for additional guidance.

APPENDIX M: Decedent Affairs

1. **Purpose:** To prescribe the procedures necessary for processing deaths occurring within the cache of an MTF.

2. **General:** The death of any active duty or base personnel can be a challenging task from an emotional, administrative and logistical perspective. There are additional requirements for providing decedent care/transfer that many medical personnel are unfamiliar with due to our location. The purpose of this SOP is to prescribe the procedures and responsibilities involved in administratively processing patients and the handling of remains in event that there is a death in this Area of Responsibility.

3. **Responsibilities:**

a. PAD personnel (or personnel designated to fill the role) ensures proper completion of documents in death packet, inventory and store personal effects of deceased until claimed by unit representative or turned over to mortuary affairs for processing of remains, initiates Line of Duty investigation for military personnel IAW regulation, uploads documents into TMDS and records death as CRO or disposition in TC2.

b. Medical provider completes death certificate and hospital report of death, as required by MTF.

c. Casualty affairs process report of death through personnel/command channels.

d. MTF coordinates with mortuary affairs (MA) for movement of remains to collection point.

e. Mortuary affairs (MA) processes remains, documents personal effects and coordinates movement to CONUS.

4. **Decedent Affairs Procedures:**

a. Military/DoD Personnel

(1) Prepare Death Packet consisting of the following forms:

(a) DD Form 2064 Overseas Death Certificate, April 2019 version ONLY
DO NOT USE April 1977 version

(b) DD 565 (Statement of Recognition of Deceased)

(c) DD 1075 Chain of Custody for Transportation of Remains

(d) DA Form 3894 Hospital Report of Death (for death occurring in an Army MTF)

(e) DA Form 2984 VSI/SI/SPECAT. (for deaths occurring in an Army facility)

(f) Other forms as directed by facility SOP.

Note: Required forms will depend on the status of the deceased/facility SOP. Not all forms will be used for each deceased. Each facility may have additional forms/reporting procedures

(2) As with MASCAL packets, store death packets in accessible area. Inform staff of location.

(3) Provide assistance to staff and physician supporting completion of all necessary forms. Train beforehand to ensure familiarity of forms and procedures and understanding of proper completion.

(4) Notify the Casualty Affairs and Mortuary Affairs of death. Protocols for transportation of remains to Mortuary Affairs varies by facility. Follow local procedures for coordinating transportation of remains to Mortuary Affairs collection point.

(5) Ensure DA Form 3894 (Hospital Report of Death), blocks 1-11 is completed and signed by the Medical Officer in attendance.

(6) Prepare DD Form 2064 [Certificate of Death (Overseas)] and ensure that form is completed and signed by the Medical Officer in attendance. Stamp or handwrite "Pending AFME Official Determination" under Medical Statement/Cause of Death section.

(7) Complete entire death packet for internal hospital records maintaining copy on file. Original death packet documents, including original medical documents, accompany remains and all personal effects to mortuary affairs. Complete packet as quickly as possible as to not delay movement of remains to mortuary affairs.

(8) Upload medical records of deceased into TMDS.

(9) Discharge deceased patient from hospital in TC2 for deaths occurring during inpatient care.

(10) In the event of patient death in the emergency department/operating room or any location prior to admission to facility, admit patient as Carded for Record Only (CRO) and subsequently discharge. See (d) Carded for Record Only below.

(11) Create an inpatient medical record utilizing record jacket (DA Form 3444). Place all completed forms and original medical documents with the exception of DD 565 (Statement of Recognition of Deceased), DD 1075 Chain of Custody for Transportation of Remains, and DD 2064 (Certificate of Death-Overseas) signed by attending physician. Mortuary Affairs requires completion of DD 2064 with signature before transferring the remains to mortuary affairs for processing.

(a) Original Death Certificate, Hospital Report of Death, and inpatient medical records accompanies the remains. (PAD KEEPS COPY TO UPLOAD INTO TMDS)

(b) Copies of DD Form 565, DD Form 1075, and DD 2064 are placed into the inpatient medical record.

(c) Mark retained inpatient medical record with the word "Deceased" and file with the other deceased inpatient medical records.

b. Local/Foreign National/Coalition Partner Service Member

(1) Complete DD Form 2064, Death Certificate Overseas, and DA 2985 Admission and Coding Sheet or TC2 equivalent. Create and register CRO as described in Appendix E if death occurred outside

(2) Turn over remains, body parts, and any personnel effects to Mortuary Affairs. Mortuary Affairs coordinates return of remains, etc. to local authorities or coalition partner.

c. Military Working Dogs

(1) Process death paperwork for Military Working Dogs (MWD) the same as a U.S. Service Member. See Policy Letter 106 Repatriation of Deceased Military Working Dogs 4 Jun 2019 for further details regarding handling for deceased MWDs.

d. Carded for Record Only (CRO)

(1) CRO cases account for deaths occurring outside MTF including, but not limited to, the following deaths:

(a) If a Service member or patient is dead on arrival (DOA) or expires in the emergency department of the MTF, it is reported as a CRO and an IRT is prepared.

(b) The role 3 with geographic control within the CENTCOM AOR is responsible for initiating the CRO for all Service members and is required to monitor and coordinate that geographic area mortuary affairs. Coordination must occur through the respective Role 3 and command surgeon's office as appropriate.

(c.) Death in another facility outside the role 3 requires CRO by preparing, DD Form 1380 (Tactical Combat Casualty Care Card). A register number will be assigned to each CRO case.

(2) Ensure completion of DD 2064, Overseas Death Certificate and DA 2985 Admission and Coding Sheet or TC2 equivalent.

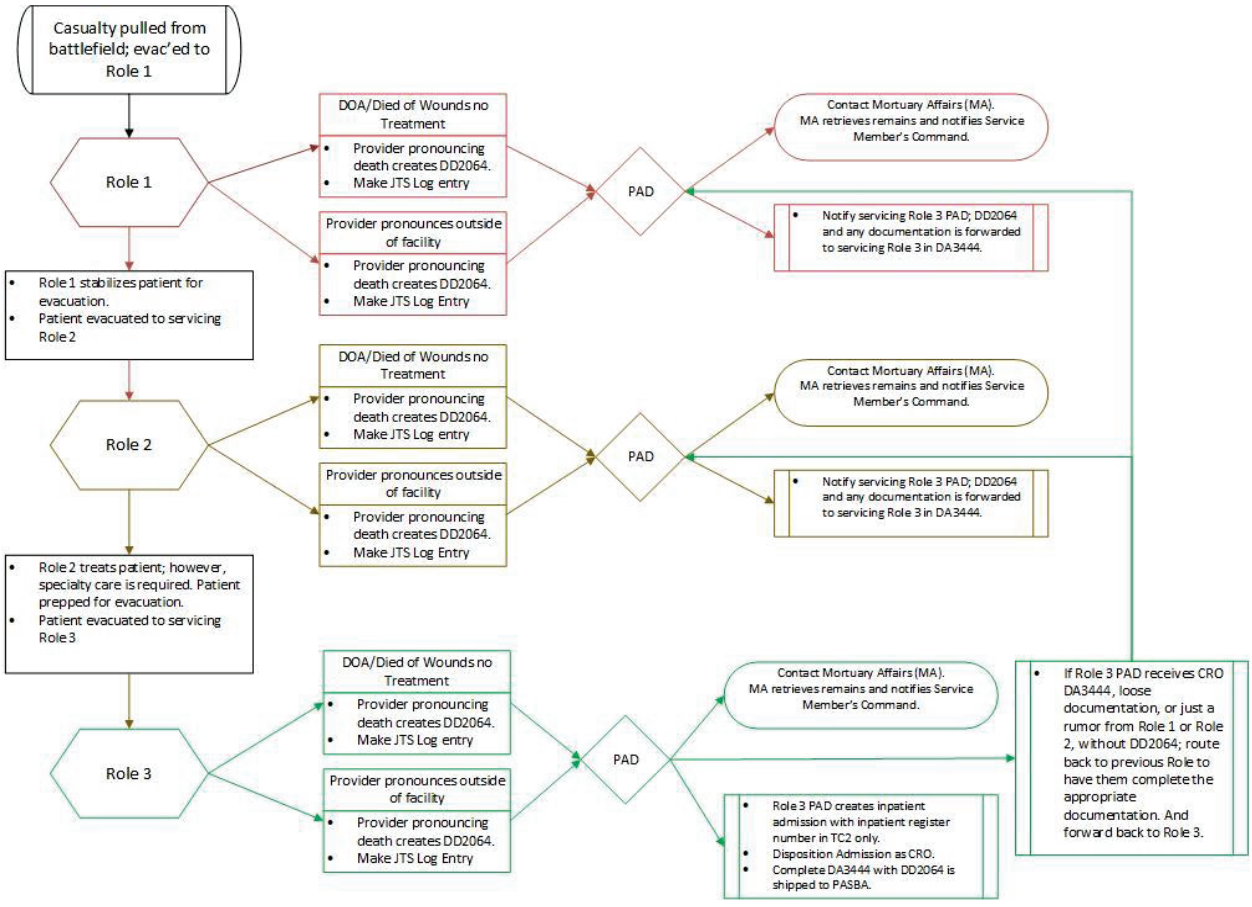
(3) Register in TC2 as CRO (Role 3 or Role 2 with inpatient care capabilities). Role 1 or 2 facilities forward documents to Role 3 for patient registration in TC2.

(4) Enter on trauma log (for JTS) with register number from TC2.

(5) Scan all medical documents into TMDS.

(6) Create and retire record following same procedures as inpatient records.

5. **Resources: CRO flow chart, DD 2064, Death Packet Checklist Example and MWD Repatriation policy**



DD 2064 Certificate of Death Overseas Ap

Policy Letter 106 Repatriation of Decea

Carded for Record (CRO) SOP & Step by

AF2519 Death Package Checklist Jun

APPENDIX N: MASCAL/ Trauma Procedures

1. Purpose: To outline patient administration procedures associated with MASCAL incidents at various roles of care.

2. General: Specific actions and protocols for responding to a MASCAL varies by MTF and AOR; not all procedures will apply to all sites.

3. Responsibilities: PAD's primary function is accountability of patients during a MASCAL incident. Secondary responsibilities include securing and storing personal effects and coordinating movement to a higher role of care ICW other patient movement entities (i.e., PMC, MRO, PECC, ERPSS).

4. **PAD MASCAL Procedures**:

a. Initiate recall of personnel upon notification of MASCAL.

b. Designate roles and locations to personnel per local SOP. Roles and locations may include: accountability at triage, admission clerk in PAD office, runners, patient reporting at emergency operations center (EOC), coordinate MEDEVAC with PMC/PECC/MRO, etc.

c, Stage PAD clerk with trauma packets by triage. PAD places trauma packet with patient, wristband, and annotate initial destination of patient (delayed, minimal, expectant, deceased, and immediate). Documentation for MASCAL is paper chart unless electronic is more feasible and accessible.

(1) Trauma Packet Contents vary by MTF and may include the following:
- (a) Record jacket
- (b) Wristband
- (c) Forms may include:
  - (1) DD 1380 TCCC
  - (2) DD 3019 Resuscitative Nursing Form,
  - (3) SF 600 Chronological Care,
  - (4) Request for Blood/Blood Products
  - (5) SF 518 Lab Order request form
  - (6) SBAR form (internally generated form)
  - (7) SF 519 Radiology Request;
  - (8) AF 3899 PMR
- (d) Preprinted labels with pseudo SSN (PSSN) and patient trauma name (PTN)

***Packets are customized contingent on the needs/capabilities of the facility and staff**

d. Gather, label and secure personal effects in large bag. Biohazard in separate bag (this will not follow patient). Secure in storage area for inventory.

e. Track patients and maintain accountability throughout MASCAL. Facility protocols may include:

(1) Runners maintain accountability of patients and report location of patients to OIC/NCOIC at specified time intervals.

(2) OIC/NCOIC records information on facility tracker in a centralized area and reports information to clinical/facility leadership.

(3) Communicate with staff via handheld radios

(4) Utilize additional staff members outside of section to augment PAD during MASCAL

f. Coordinate with MRO/flight surgeon/PMC/ERPSS for movement if patient requires evacuation for higher role of care. Provide 9 Line requests or submit PMRs as required to MRO/PECC/PMC.

g. Conduct a warm hand-off directly with gaining facility (Role 1 to Role 2; Role 2 to Role 3), via SIPR if possible. Provide patient registration information. This will prevent duplicate patients. Ensure documentation and personal protective equipment (PPE) accompanies patient.

h. After MASCAL, register patients and upload hand-written documents in AHLTA-T/TMDS as with other patients. Inventory and log patient effects. See Annex T Personal Effects, Patient Belongings and Patient Trust Fund.

i. MASCAL Best Practices:

(1) Pre-enroll MASCAL patients in AHLTA-T

(2) Red allergy wristband on patient when lab completes cross-match, annotate blood type bracelet

(3) Standardized placement of patient wristband (i.e., placed only on left wrist).

j. PAD not conducting 24 hour operations remain on call in the event of emergencies and after-hours admissions. MTF or base emergency operations centers (EOCs) notify PAD staff of a recall after duty hours. Upon recall notification, PAD ensures patients are registered and/or admitted into TC2, if applicable. PAD will maintain adequate stock of pre-positioned trauma/MASCAL packets in a centralized location. Inform MTF personnel of MASCAL packets location and availability.

APPENDIX O: TRICARE Overseas Program (TOP) and Non-U.S. Medical Treatment Facilities (Host Nation/NATO)

1. Purpose: To outline patient administration procedures associated treatment of U.S. military personnel in a non-U.S. medical treatment facility (MTF) including Host Nation (HN), NATO, Coalition or Department of State (DoS) facilities.

2. General: U.S. service members are eligible for care, as necessary, when services required are not available at DoD medical facilities. DoD civilians may be eligible for referral to HN facilities. Contractors are not eligible for HN referrals unless specifically noted on their Letter of Authorization (LOA). This includes treatment at HN, NATO, Coalition Forces, and/or DoS medical facilities. Procedures outlined in this section do not apply to all locations. Each MTF establishes local SOPs outlining specific procedures for non-DoD medical/dental treatment for their respective AO. Not all procedures listed in this section apply to all MTF locations.

ISOS is the contact agency for the TRICARE Overseas Program (TOP) facilitating care at HN facilities.

3. Responsibilities:

a. Host Nation Liaison (HNL/LNO)/TRICARE Office serves as the primary liaison between providers, MTFs, unit representative, patients and HN facilities. Civilian staff, PAD or other medical personnel may serve as an HNL/LNO. HNL/LNO facilitates:

(1) Referrals for urgent, emergent, inpatient, specialty and routine care not available at MTFs
(2) Transportation to HN facilities
(3) Securing documentation for upload into electronic health records
(4) Billing through TRICARE/ISOS or regional contracting officer
(5) Coordinate follow-up care and/or patient movement to U.S. MTF for definitive care

b. PAD personnel, or those performing PAD functions, ensure:

(1) Proper accountability SMs admitted for inpatient care at HN MTF
(2) Scan documentation from non-U.S. MTF(s) into TMDS
(3) Coordinate movement to higher role of care through respective PMC/PECC/MRO/ERPSS per MTF protocols

c. In the absence of a HNL, PAD personnel may be required to complete those duties.

4. **Utilization of Non-U.S. Facility Procedures**:

a. Referrals to HN

(1) Non-emergent Care

(a) Provider completes an SF 513 consult form requesting referral for services

including a brief, yet detailed, reason for the consult. Patient may need to complete additional forms i.e., statement of understanding, release of medical information, etc.

(b) HNL/LNO submits the consult to processing authority i.e., International SOS (ISOS), Referral Management Office (RMO). RMO or LNO coordinates the appointment date and time and notifies the patient.

(c) HNL/LNO/designated medical staff transports patient, as needed, and patient's battle buddy/wingman. Local SOP may require patient's unit to provide transportation to appointments. Personnel traveling to HN facilities should wear civilian attire, unless event is a medical emergency.

(2) Emergent Care to HN

(a) HNL/LNO coordinates patient transfer to appropriate HN facility with ER/medical staff and ISOS. HNL will escort patient to the designated facility with ambulance crew if time permits. If not, the HNL will diligently change into civilian attire, obtain Off Post Memorandum (OPM)/trip ticket and other necessary travel documents and report to the HN facility where patient was transferred. Upon arrival, HNL will facilitate patient admission process ensuring patient is admitted to appropriate department, receive plan of care from provider, and ensure patient is settled prior to leaving.

(b) Some locations may perform an ambulance exchange at the gate from military ambulance crews to HN ambulance services.

(3) Host Nation Admissions

(a) All patients admitted to HN facilities will be pre-approved. In cases of emergencies, HNL will contact appropriate personnel at each facility to coordinate the admission process.

(b) HNL ensures patient has a Battle Buddy and a contact phone number to remain with patient throughout their hospital stay. All patients and companions are required to be in civilian attire while at the HN facilities. Battle Buddies are not allowed to leave the facilities once the patient is admitted. They are welcome to utilize the cafeteria and coffee shops in the facilities.

(c) HNL contacts patient's unit and inform the leaders of the patient's location, and room number. The HNL will notify Clinic about admissions and update leaders as necessary.

(4) Host Nation Discharges

(a) All HN discharges will be coordinated with the HN provider and the accepting provider. HNL/LNO will ensure both providers communicate a plan of care for the patient prior to discharge. Once a time is established, HNL will obtain the OPM and proceed to the facility to discharge the patient.

(b) Upon discharge, the billing representative from the facility will present the HNL with the necessary discharge documents for signatures. The HNL will sign and bring copies of the patient's record for billing with TRICARE and additional to patient's electronic health record.

(c) PAD uploads documents from HN facility into TMDS.

(5) Documentation and Billing

(a) For TRICARE approved/ISOS facilities, SMs should not pay for any pre-approved services out of pocket up front. HNL/LNO will assist securing copies of documentation from HN facilities and translating services, if needed. HNL/LNO submits documentation as required to RMO/ISOS/TRICARE Overseas Program for appropriate billing. Provide copies to PAD/medical staff to upload into TMDS.

b. NATO/Coalition/Department of State (DoS)

(1) U.S. Service Members (SMs) are eligible to receive medical/dental care at NATO, Coalition, and DoS facilities across the CJOA.

(2) PAD personnel/medical staff coordinate required care between facilities i.e., **provider to provider hand-off**.

(3) MEDEVAC procedures for care required from MTFs at different bases apply for urgent/priority patients. Units utilize space available (Space A/Space R) travel for routine care obtained at another base.

(4) PAD/medical personnel ensures any prior care documentation for related care accompanies patient receiving treatment at the other MTF. PAD/medical personnel uploads documents into TMDS.

(5) Patient/PAD requests copies of medical documents from the non-DoD MTF and for addition to their EHR.

c. SMs not under the cache of a DoD or non-DoD facility (Embassy, SOF, etc.) may be authorized to coordinate care directly with HN through ISOS or a SOFA.

5. Resources: Example HNL SOP

USMH-K HOST
NATION LAIASON STA

APPENDIX P: Military Working Dogs (MWD) and Non-DoD/Contract Working Dogs (CWD)

1. **Purpose:** Patient Administration procedures when an MTF receives an injured Military Working Dog (MWD) that needs treatment or medical evacuation out of Theater.

2. **Applicability:** This regulation applies to all facilities within the USCENTCOM AOR.

3. **Background:** At any given time, there are at least 100 Military Working Dogs in the USCENTCOM area. When they are injured, they receive the same level of care as a Service Member or Contractor at all military facilities.

a. Military working dog (MWD). MWDs are required by the using DOD component for a specific purpose, mission, or combat capability. MWDs are trained to perform the following functions: patrol, patrol and narcotic/contraband, and patrol and explosive/contraband detector, mine detection, specialized search dogs and any other DOD recognized capability that is used to save lives.

b. Military Working Dog Team is a team (both dog and handler) trained by DOD/Executive Agent and has an appropriately qualified, assigned handler.

4. **MWD/CWD Procedures:**

a. Registration, Emergency and Routine Medical Care

(1) Register MWD utilizing same procedures as a U.S. Service Member; use their ID number in place of an SSN/DoD ID.

(2) Medical treatment is recorded in Remote Online Veterinary Record (ROVR). If ROVR access is unavailable, then encounters will be recorded on a SF600 and placed in the MWD deployment record to travel with dog and handler. Canine Tactical Combat Casualty Card (DD Form 3073) and Canine Treatment and resuscitation Record (DD Form 3074) will be used accordingly to document MWD care for all trauma and DNBI.

No encounters are annotated in AHLTA-T or TC2. Registration in AHLTA-T and TC2 allows use of ancillary services for care at Role 1-3 facilities.

(3) Naming convention for registration in AHLTA-T is as follows:

(a) Last name: MWDOG (DoD) or K9 (Dept. of State)
(b) First name: actual first name and tattoo number (i.e., PennyV023)
(c) SSN: last 9 digits of microchip number
(d) DOB and Gender
(e) FMP: 20 (Sponsor)

(f) PATCAT reflects branch of service or Dept. of State: A11, F11, M11, N11, K51 (state department overseas)

(e) Rank: Always one rank above handler; no rank for Dept. of State working dogs.

b. Medical Evacuation

(1) Submit a Patient Movement Request (PMR) in TRAC2ES, following the same procedures as a Service Member.

(2) The MWD will always be one rank above its handler.

(3) If the MWD is alert and oriented, he/she is required to travel in their kennel.

(4) If unable to utilize the kennel, he/she is leashed at all times.

(5) The MWD handler must accompany the MWD at all times.

(6) A Veterinarian or Animal Care Specialists (68T) may accompany the MWD as a Medical attendant.

(7) Non-DoD working dog are treated same as contractors. Contact TPMRC for additional guidance as needed non-DoD working dog evacuations.

(a) Contract working dogs are under the same medical care and evacuation restrictions as the contractor LOA. LOA must state care is authorized or contractor must provide billing information.

c. MWD Handler

(1) Another handler(s) or Animal Care Specialist (68T) must assume responsibility of the MWD when the handler is unable to maintain positive control of the MWD while receiving care as a patient.

d. Contractor animals:

(1) Animals provided by contractor or concessioner are not normally eligible for military veterinary services. The exception to this pertains to contractor animals supporting a contingency in a theater of operations where military veterinary assets are already available.

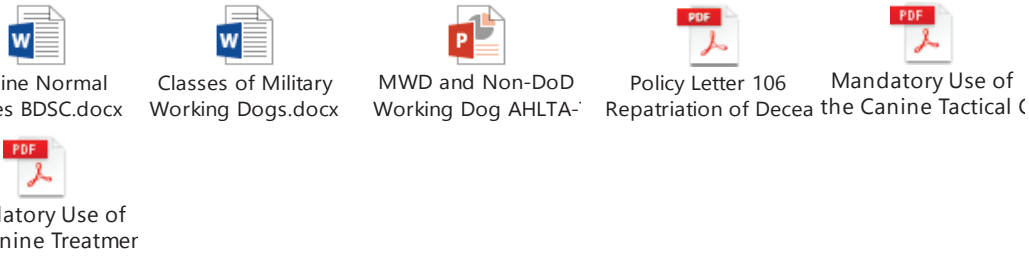
(2) If applicable, and included in the provisions of the contract, non-emergency veterinary services may be provided to contractor animals in the theater of operations, on a reimbursable and space available basis, within the capabilities of the deployed veterinary unit.

(3) Payment for civilian veterinary medical care (emergency and non-emergency) of contractor animals in the theater of operations remains the responsibility of the contractor.

e. MWD Deaths

(1) IAW AR 40-905/SECNAINST 6401.1B/ AFI 48-131 (29 August 2006)
Necropsy will be completed IAW TBMED 283 (24 May 2001) and recorded on DD Form 1626, which is reported with final pathology submissions and recorded in the MWD veterinary medical records via ROVR and/or in the MWD deployment record.
The VCO will prepare, sign, and submit to the responsible officer I the owning unit a Death Certificate of Military Working Dog (DD Form 1743) and file a copy in the MWD medical record via ROVR and/or in the MWD deployment record. Final medical encounters and all supporting documentation, including the death certificate, necropsy report, radiology reports and images, laboratory findings, and cremation records, will be recorded in the veterinary medical record via ROVR and/or in the MWD Deployment Record. All records will be returned to the owning unit for final medical record disposition. Repatriation process will be completed the same as a U.S. Service Member. See Appendix M Decedent Affairs and Policy Letter 106 Repatriation of Deceased Military Working Dogs 4 Jun 2019 (below in Resources) for further details regarding handling for deceased MWDs.

5. **Resources:**



APPENDIX Q: Coalition Forces

1. Purpose: To outline patient administration procedures associated treatment of coalition forces and financial arrangements in place for treatment of coalition personnel at a U.S. medical treatment facility (MTF).

2. General: Per USCENTCOM and operation MEDROE, coalition personnel are authorized to receive emergency and routine care at a U.S. MTF including rotary and fixed wing patient movement where required. The cost associated with these services is reimbursable to the US DOD by the coalition nation.

3. Responsibilities:

a. PAD ensures all patients are properly registered with correct patient category (PATCAT).

b. ACSA Program reviews and processes medical ASCA orders to national ACSA.

c. Each component processes invoices related to medical services provided to coalition personnel.

4. Procedures related to Coalition Forces:

a. Registration, Documentation and Medical Evacuation

(1) Register all coalition personnel receiving medical services at U.S. facilities with correct PATCAT K72 (Appendix B, Patient Registration). This ensures patients are tracked and services are billed appropriately.

(2) Conduct periodic audits of patients to ensure correct PATCATs utilized for coalition forces.

(3) Coordinate patient care and movement IAW established MEDROE.

(4) Medical Records

(a) At the end of the coalition partner's deployment cycle, a representative of the coalition nation or the individual member requests a copy of all medical documents from the servicing MTF.

(b) PAD processes a release of information, DD Form 2870, and provides a copy of inpatient records or the original of paper-based outpatient records to the nation's representative or individual member.

(c) Retire inpatient medical records IAW instruction in Appendix F Deployed Medical Records Process.

(d) In the event, a coalition SM does not request their records prior to departure from theater, mail the original outpatient documents and a copy of inpatient documents to the

POCs listed in the NATO Basic Medical Record policy, see Appendix E Medical Records.

(e) Add address of unlisted coalition/partner nation to list of POCs to mail documents at the end of their deployment cycle.

(5) Follow-Up Care

(a) Follow-up care required after deployment or as a result of medical evacuation out of theater will be coordinated and completed by coalition partner nation assets.

(b) Ensure patients have their PSSN, as well as any pseudo name they were registered under, available for follow-up care.

(6) Medical Evacuation/Patient Movement

(a) The patient's home country/military POC is responsible for coordinating movement to MTFs for care. This includes initial, higher role and follow-up care. DoD assets may be utilized for patient movement for follow-on care when coordinated through and with patient's home country/military POC and DoD. In order to use DoD assets for movement, the patient's home country/military POC must formally request in writing assistance/authorization to move (letter of authorization), provide an address for billing, and provide courses on actions of how patient will be moved from U.S. MTF to home nation for definitive care.

b. CJTF-OIR Reimbursement Process – This process applies specifically to CJTF-OIR facilities. Reimbursement procedures for services to Coalition/NATO forces provides in other operational areas (i.e., USFOR-A, etc.) may vary.

(1) One or before 5th of each month, ACSA Program Manager, Camp Arifjan, Kuwait, receives a roll-up of all medical outpatient and inpatient visits for coalition forces during the previous month from Chief CLINOPS. This includes date from clinics and hospitals.

(2) Quantity and type of visit are matched with the cost, including the cost for all medical services in the BLS/Services ACSA order for mutual logistics support to all nations receiving services in the previous month.

(3) ASCA orders sent to the national ACSA signer for verification and signature.

(4) USARCENT G8 processes invoices for medical services.

5. Resources:


Coalition Medical Visit Template.xlsx


Medical Billing Rates for Care Provided to (

APPENDIX R: Contractors

1. Purpose: To outline procedures related to medical treatment and patient movement of contractors (DoD and non-DoD) in the CJOA.

2. General: Contractor's medical care and patient movement in theater poses specific challenges to PAD personnel. Per DoDI 3020.41, enclosure 3 section 1.d. states, " Unless otherwise stated in the contract, all pre-, during-, and post-deployment medical evaluations and treatment are the responsibility of the contractor." The Letter of Authorization (LOA) determines the type of care and movement platforms available to contractors. Contracting companies are responsible for covering medical expenses through private health insurance or providing medical care directly. This is a cyclical question/issue that arises every now and again.

3. Responsibilities: PAD verifies eligibility, registers patients, coordinates release of medical information and assists contract companies with patient movement.

4. **Procedures related to Contractors**:

a. Patient Care

1. Contractors must possess a letter of authorization (LOA) with the primary care box checked to receive routine medical care at the MTF.

2. All contractors are covered for emergency care i.e., life, limb, and/or eyesight. Any additional care, to include medical evacuation requires additional authorization and billing information from the contract company.

3. Coordinate patient care and movement IAW established MEDROE per the patient's respective AO and operation. Contractors in support of Resolute Support (RS) in Afghanistan may be eligible for routine care and not just emergency care.

b. Medical Evacuation/Patient Movement

(1) The contacting company may elect to move the employee through private insurance. This may include complete a "fit to fly" form or medical release to travel via commercial air. PAD may be required to coordinate directly with the private insurance company to ensure patient is regulated to appropriate level of care upon release from the MTF.

(2) Contracting company must submit the following documents if the company elects DoD patient movement platform:

(a) Contractors (non-DoD)

(1) Patient's ID card (front and back)

(2) Passport (physical and a copy)

(3) Letter of authorization (stating charges are billable to the company's insurance, if applicable)

(4) Health insurance card (private)

(5) Letter from company: requesting military to move patient, stating company will cover costs associate with movement and signed by a designated company representative.

(b) Contractors (DoD)

(1) DoD ID card (front and back)

(2) Passport (physical and copy)

(3) Orders

(4) Health insurance card

c. Dual Status Retiree/Prior Service Member in Theater as a Contractor

(1) Contractors who are also retirees are subject to the restraints of their LOA in regards to routine medical care. Other MTFs refer contractors to the local economy based on their contract status.

(2) Based on MEDROE, contractors who are also retirees may receive patient movement on a Space Available (Space A) basis. **Contact TPMRC for additional guidance, as needed.**

(3) Unless it is specifically stated within the contract, routine medical care is not provided to contractors. Emergency care (life, limb or eyesight) however, is provided. See Resources below for excerpt from DoDI 3020.41 regarding authorized medical care for contractors accompanying forces.

(4) Retirees (or prior service members) are in the AOR as a contractor and operated under said contract. They are not in the AOR on their "retiree" status and must adhere to the guidance/contract that got them to our AOR.

d. Billing

(1) Billing in theater is based on the PATCAT and collected by DFAS.

5. Resources:


Contractor LOA Example.pdf


DODI 3020_41 Contractor Authorizec


Medical Billing Rates for Care Provided to (

APPENDIX S: PAD Reports

1. Purpose: To outline routine reports produced and submitted by PAD personnel or other clinical/administrative personnel at Role 2 and Role 3 medical treatment facilities.

2. General: Various reports capture hospitalization, surgical, outpatient, casualty and movement of patients while receiving medical treatment at all roles of care.

3. Responsibilities: PAD prepares and submits reports as required by local medical commands and CONUS entities.

4. **Procedures**:

a. MED SITREP including Bed Status – prepare and submit on Medical Situation Awareness Tool (MSAT) daily. Operations, Clinical Operations (CLINOPS) or another staff member may prepare this report. PAD ensures bed status data is accurate at the time of the report.

b. JTS Theater Trauma Log (Role 2) – submit weekly to Joint Trauma System (JTS).

c. Hospitalization Report (Role 3) – prepare and submit IAW local medical command policy.

d. Admission by Diagnosis Report (Role 3) – submit to JTS and Deployed Medical Records Processing Center (DMRPC/PASBA) weekly.

e. Daily Operational SITREP as required by higher command.

f. Daily/Weekly DNBI and Daily Special Surveillance Reports in MSAT (Public Health/Preventive Medicine may prepare these reports, not necessarily PAD). PAD must be cognizant of the type of care and services provided to patients in the MTF.

g. Open Encounters on a daily or weekly basis depending on the operational tempo (OPTEMPO) of the role 1 or 2 outpatient clinic. This information provides clinical staff with a list of encounters in need of signature by the provider in order to properly close out the encounter.

h. Any additional reports as required by facility or higher command: open encounters report, surgical procedures, etc.

5. Resources:


JTS TRAUMA LOG Template v2.xlsx


Steps to manually check for open encou

APPENDIX T: Patient Personal Effects and Patient Trust Fund (PTF)

1. **Purpose:** To specify the procedures for accounting and safeguarding of patient belonging, funds and valuables.

2. **General:** Provide all patients admitted to the hospital the opportunity to store personal belongings and deposit funds and valuables for safekeeping while they are an inpatient at an MTF. Upon admission, brief patients will be briefed on the services available and will be encouraged to deposit their funds and valuables.

a. Funds include legal tender in the Theater of Operations, either U.S. Currency or military Payment Certificate (MPC). If MPC is the authorized tender, U.S. currency will be treated as a valuable.

b. Valuables, include all negotiable and nonnegotiable instruments not considered as a fund. This includes valuable papers, jewelry, watches, rings, billfolds, foreign coins and currency and expensive items such as cameras, portable music devices and binoculars.

c. Effects/belongings include uniforms, boots, shoes, clothing, bags, backpacks, other issued clothing items and non-issued items.

d. Other items include organizational equipment i.e., IBA, ACH, protective equipment, weapons, and ammunition.

3. **Responsibilities:**

a. Custodian: The Commander appoints the custodian (Chief, Patient Administration). The custodian ensures proper receipt, safekeeping, disbursement and accounting of patient belongings/effects, funds and valuables deposited in the PTF. The NCOIC of Patient Administration office serves as assistant custodian. Restrict access to storage area to only one individual at a time and transfer duty at shift change.

b. PAD Personnel: Patient Administration office personnel are designated as responsible individuals with the delegated authority to inventory and collect patient funds and valuables when patients are unable to deposit directly with the custodian.

4. **Personal Effects and Patient Trust Fund (PTF) General Rules:**

a. Facilities determine which items are accepted and unaccepted for safe keeping in the Patient Administration personal effects/PTF storage area/vault.

b. Only patients may utilize the Patient Trust Fund or patient storage area.

c. Patient's unit is responsible for securing personal protective equipment (PPE), i.e., IBA, ACH, and assigned weapon.

d. No investments, loans, donations or check cashing will be done using PTF funds.

e. Funds and valuables will be placed in a safe or room with double locks which provides adequate protection from theft. Shelving, weapons racks, cabinets and wall lockers facilitate an organized storage area.

f. When a shortage in the fund or a loss of a valuable is discovered, the facility Commander will appoint an Investigating Officer, who is not associated with the PTF, to investigate the loss in accordance with service specific regulations.

5. **Personal Effects and PTF Procedures:**

a. Upon admission, advise the patient the facility assumes no liability or responsibility for the loss of personal belongings, funds or valuables which are kept in the patient's possession. Provide the patient the opportunity to deposit any funds or valuables into the PTF.

b. Patients who do not desire to make a deposit will sign DA Form 3696, Patient Deposit Record, AF Form 1122 Personal Property Inventory or other facility specific form, indicating they do not wish to make a deposit. If the patient is unable to sign, the form will be signed by a witness (non-PAD personnel). Ensure two signatures are on the form (Patient Administration staff and patient/witness). Forward the completed documentation to the custodian.

c. Refer patients desiring to make a deposit the patient to the custodian or designated representative.

d. Complete documents manually or electronically. Electronic versions of deposit documentation is authorized. Ensure patient receives a copy of the completed deposit/inventory documents. A copy of the completed documents stay with the collected valuables.

e. Collect all patient valuables and complete an inventory. The custodian, or designated representative, will account for each item being deposited on DA Form 3696, Patient Deposit Record. Complete form in duplicate. Annotate personal belongs on a DA Form 4160, Patient Effects and Clothing Record, AF Form 1122 Personal Property Inventory or other facility inventory sheet.

(1) Place any uniform items (OCPs, belts, boots, etc.) with blood or other body fluid inside a red biohazard bag and tape shut. Soiled patient clothing may be disposed of for infection control purposes. Follow local facility procedures for biohazard disposal.

(2) Place any explosives in the facility’s designated bunker/area for explosives. Notify Provost Marshall Office (PMO) or EOD to pick up any explosives. Contact PMO for weapons and ammunition storage, if facility does not accept weapons. Document all items turned over to PMO or EOD.

(3) Enter an appropriate description of each item to assist in the identification of the item. The entry accurately describes the item without attempting to indicate monetary value, for example; "Ring, yellow in color with clear stone" rather than "gold ring with diamond". Annotate identifiable brand names and clearly visible serial numbers. If additional space is needed, utilize additional forms clearly annotating number of pages; for example “Page 2 of 2”.

(4) Store items in the PAD vault/storage area in a suitable container, paper or plastic bag, envelope etc. Label each bag, weapon, and magazine, etc. with the patient's name, SSN, register number and ward utilizing labels, tags or TC2 patient labels. Recommend removing all batteries and SIM cards from host nation patients’ phones and placing items in a small clear biohazard bag labeled with the patient’s name.

(5) File the deposit records and inventory sheets IAW facility procedures.

(6) If able, the patient signs the block on the deposit record indicating the desire to make a deposit. The custodian also signs verifying funds, valuable, personal belongs received and recorded.

(7) All items belonging to expired United States Service Member accompany their body to Mortuary Affairs for processing.

f. Patients clear PTF and receive all personal belongings prior to disposition. Patients withdrawing funds in full present their copy of the deposit record to the custodian. The patient will sign the custodians copy in the block headed "Funds and Valuables Received in Full” which concludes the transaction. For personal effects/belongings, the patient and custodian sign the bottom of the personal effects/inventory sheet acknowledging the patient received all annotated items. The custodian who will destroy the patient copy after completing the transaction. The custodian retains the signed custodian copy and files IAW facility procedures.

g. In the event of patient movement to higher role of care, contact the patient’s unit Commander to retrieve patient belongings/valuables that were not able to accompany patient.

h. Patients may request a copy of their records by completing a DD Form 2870, Authorization for Disclosure of Medical or Dental Information. See Appendix U Release of Medical Information and HIPAA Compliance.

APPENDIX U: Miscellaneous Administrative Instructions

1. Purpose: To outline and describe miscellaneous administrative functions associated with patient administration at various roles of care.

2. General: Several miscellaneous administrative actions must be completed in order to complete patient administrative functions to include ordering supplies, forms, etc.

3. Responsibilities: Deployed PAD personnel are often responsible for duties/functions that enable them to perform their duties.

4. **Procedures**:

a. Dynamics for operating on a non-DoD base vary.

(1) Facility SOPs must address: badging, flight line access, aircraft and landing procedures i.e., frequency, request forms, and slot request (parking), landing fee, etc. Host nations control access to their respective air space. Adverse actions may be taken if proper procedures to airfield access are not followed.

b. Ordering/obtaining forms

(1) Most forms are available in electronic format. However, order forms such as DA 3444. NAVMED 6760 or AF 788A, Record Jackets and DD 600 Patient Baggage Tags through regular publication channels. This may be the S1/personnel office or S4/unit supply. PAD personnel may have their own publications account through their respective service branch.

c. Orders unique supplies

(1) Labels for wristbands – ordered through local medical logistics using DCAM. The exact product changes, but the description remains consistent. Label makers may vary by site and determine which labels are compatible with the label maker. Examples of label maker models which compliment an MC4 system include Dyno Label Writer 400 Turbo,

(2) Boxes for record retirement process – order records boxes through S4/supply/logistics channels. Contact sister MTFs or PASBA for emergency resupply of records retirement boxes if unable to obtain through normal ordering channels.

d. Scanners and other IT related items i.e., telehealth cameras, label makers, etc.

(1) Contact USCENTCOM HISO for assistance with ordering scanners, printers, label makers for MC4 systems, telehealth cameras and other IT items.

(2) Supply/Information Tech Systems (S6) personnel may also assist with ordering non-MC4 system items.

e. DoD Secure Access File Exchange (SAFE)

(1) DOD SAFE is a secure method of transferring large files that would normally be too large to send via email. This is the only approved method for transmitting large files of PHI and PII. DOD SAFE, a replacement for the Aviation and Missile Research Development and Engineering Center (AMRDEC) which will be sunset on Aug 2019. SAFE, is available for use by common access card (CAC) users.

(2) The file exchange will support transfer of files up to 8GB, an increase from current limit of 2GB limit formerly offered by AMRDEC, on the Non-classified Internet Protocol Router (NIPR) Network. The service can be used to transfer unclassified data to include For Official Use Only (FOUO), Personally Identifiable Information (PII) and Protected Health Information (PHI). https://safe.apps.mil

5. Resources:

DOD-SAFE-Fact-Sheet
_v2.pdf

Appendix V: PAD Roles, Responsibilities & Relationships between Facilities (Roles 2/3)

1. Purpose: To outline patient administration roles and responsibilities at various roles of care as well as describe the relationship and responsibilities between MTFs of different roles of care.

2. General: Personnel, capabilities and resources vary from MTF, AOR and named operation.

3. Responsibilities: All roles of care provide registration, documentation and evacuation to higher roles of care. Higher roles of care have a responsibility to provide support and resources to lower roles of care without degrading their mission capabilities. Command elements and CONUS entities enable all roles of care to perform respective duties by providing policy, guidance, expertise and allocating resources.

a. Role 1 Responsibilities

(1) Responsibilities may be completed by military or civilian PAD personnel or military or civilian medical staff (med tech/medic/corpsman, nurse, etc.)

(a) Register all patients receiving care at the MTF utilizing procedures as outlined in this SOP.

(b) Scan handwritten/paper based medical documentation into electronic system of record (i.e., AHLTA-T, TMDS).

(c) Coordinate medical evacuation to higher echelon of care.

(d) Coordinate host nation medical care if available in AO.

(e) Complete death certificate and other documents for mortuary affairs.

(f) Complete MSAT reports.

b. Role 2 PAD Responsibilities

(1) These responsibilities may be completed by military or civilian PAD personnel or military or civilian medical staff (med tech/medic/corpsman, nurse, etc.)

(a) Perform all responsibilities as Role 1 facilities.

(b) Provide administration and technical support to Role 1 MTFs including scanning, policy guidance, patient registration, etc.

(c) Notify Role 3 facility when death occurs at Role 2 MTF. Provide information necessary for CRO registration/discharge. If MTF provides in-patient care and has TC2 system, complete CRO in TC2 and upload documents in TMDS.

(d) Coordinate host nation medical care if available in AO.

(e) Complete death certificate and other documents for mortuary affairs.

(f) Submit trauma log to JTS.

(g) If provide in-patient care, retire in-patient records quarterly.

(h) If provide in-patient care, submit admission by diagnosis report monthly.

c. Role 3 PAD Responsibilities

(1) All responsibilities of Role 1 and 2 facilities.

(2) Provide trauma names and pseudo SSNs (PSSNs) to Role 2 facilities within their respective geographical cache.

(3) Provide additional administration and technical support to Role 1 and Role 2 MTFs including scanning, policy guidance, patient registration, patient movement, etc.

(4) Register CROs for deaths occurring at Role 1 MTFs and Role 2 MTFs without in-patient facilities.

(5) Admit, discharge and track inpatient care.

(6) Educate Role 2 facilities on death procedures documentation.

Appendix W: Directory, Forms List and Internet Links

1. Purpose: Provide additional information, guidance and resources to enable PAD professionals at all roles of care to execute mission and connect to a broader community for support and expertise.

2. General: Leadership, support entities and PAD professionals in CONUS and throughout the AOR form a community with a various levels of expertise, background, and resources. Every member of this community has an opportunity to assist others in executing the PAD mission.

3. **Resources**:


PAD Directory.xlsx


INTERNET LINKS.DOCX


Patient Administration Forms


PAD Policy References.docx


Useful Links for PAD.docx