(Updated 20241122)

REPORT OF TREATMENT FURNISHED PAY PATIENTS OUTPATIENT TREATMENT FURNISHED (PART B)

1. INSTALLATION PROVIDING TREATMENT *(Name and address)*	2. MONTH AND YEAR COVERED BY THIS REPORT
3. CATEGORY OF PATIENTS	4. AUTHORITY FOR ADMISSION

NAME *(Last, first, middle initial)* AND SSN 5	MILITARY GRADE 6	ORGANIZATION 7	DIAGNOSIS 8	TREATMENT	
				DATES 9	NUMBER 10

11. DATE	12. AUTHENTICATION *(Signature, military grade, organization of Commanding Officer)*	13. TOTAL

Controlled by: DHA
CUI Category: PRVCY
Distribution/Dissemination Control: FEDCON
POC: dha.ncr.bus-ops.mbx.dha-formsmanagement@health.mil

Reset