PHARMACY SERVICES

TRICARE Claim Worksheet

PROVIDER'S Name: _____

PROVIDER'S Address: _____

Patient's Name: _____

Sponsor's SSN (or DBN): _____

Date(s) of Service: _____

Diagnosis or Description of Symptoms. (*List all pertinent diagnoses.*)

1	
2	
3	
4	
5	

List each Medication issued:

Medication	**Strength or Dosage**	**Quantity (# pills, ML, etc.)**	**Charges***
(**Charges are assumed to be in Thai Baht unless otherwise indicated.)*		***Total Paid:***	

Note: A properly completed and signed DD Form 2642 claim form, and copies of the associated medical certificate or medical report, and all itemized receipts with proof of payment for these services are required documentation when filing a TRICARE Overseas claims. This worksheet is an optional supplement that may be included with your claim. (1 January 2018)

Privacy Act of 1974 (amended) and HIPAA applies.