Exhibit 4.H.2. OVERSEAS SCREENING FOR ACTIVE DUTY DEPENDENTS PART I

Family Member Name:	Relationship to Sponsor/Ben Code:	SSN:	Date:

Service Member Name:	Grade/Rate:	SSN:	Current Duty Station:
Overseas Unit A/D member is being assigned:			Reporting Date:

Medical Screening: Is completed by the medical provider to identify any special needs, and determine if a family member is suitable to accompany the active duty member to an overseas unit. (Note: A physical may be required at medical provider's discretion).

YES	NO	ITEM *(list all "YES" answers in the remarks section).*
		1. Have all health records been reviewed by local Tricare Provider?
		2. Are all Immunizations up to date. Do they meet destination requirements?
		3. Are there any pending consults or tests that have a bearing on assignment suitability?
		4. For dependent wives. (List any abnormal results in the remarks section)
		a. Has a pap smear/pelvic and breast exam been performed within the past 12 months? Date of Exam: _____ Results: _____
		b. Mammogram current (based on age)? Date of test: _____ Results: _____
		c. Pregnancy Screening? (Verbal inquiry) Date of test: _____ Results: _____
		d. If pregnant, estimated date of delivery? _____
		e. Are there any foreseen complications of the pregnancy? ( )Yes ( )No If "yes" describe: _____
		5. Are there any conditions requiring ongoing care in the following area? (List under remarks section)
		a. Orthopedic conditions (e.g., chronic back, knee, joint pain or weakness)
		b. Cardiovascular conditions (e.g., chest pain/angina, arrhythmia, valve disease, infarction)
		c. Gynecologic conditions (e.g. chronic pelvic pain, abnormal PAP, breast mass)
		d. Neurological conditions (e.g. seizure, pinched nerve, migraine, neuropathy)
		e. Respiratory condition (e.g. asthma, RAD, chronic sinus, allergies)
		f. Mental health, or behavioral conditions (e.g. depression, adjustment/personality disorder, ADD/ADHD)
		g. Chronic or frequent medication use: (List all medications under remarks section)
		h. Alcohol abuse or dependence
		i. Developmental concerns (e.g., motor, cognitive, communication, social/emotional or adaptive development)
		j. Other conditions or concerns? (e.g. diabetes), explain: _____ _____
		6. For service family members with underlying medical conditions: (List under remarks section)
		a. Is there a requirement for special medical supplies, adaptive equipment, assistive technology devices, special accommodation, etc?
		b. If exposed to a physically or emotionally demanding environment, could the underlying condition become life threatening, pose a risk for dangerous or disruptive behavior, or result in a MEDEVAC situation?

Exhibit 4.H.2.b. OVERSEAS SCREENING FOR ACTIVE DUTY DEPENDENTS
PART I

YES	NO	ITEM *(list all "YES" answers in the remarks section).*
		c. Are there any chronic medical or mental health conditions requiring routine or continuing access to care or access to specialized medical care ?
		d. Other concern? (specify in remarks section)
		7. Have all dental records been reviewed by the Dental Provider?
		a. Are there any chronic dental conditions requiring routine or continuing access to care or access to specialized dental care? (e.g., TMJ, periodontal disease)
		b. Is family member under going active orthodontics treatment? Date started: _____Estimated completion date: _____
		c. Date of last Dental Exam? _____
		d. Other concern? (specify in remarks section)

Dental Provider Remarks: *(Explain all "YES" answers).*

Health Care Provider Remarks: *(Explain all "YES" answers).*

"THE INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY ONLY BE RELEASED IN ACCORDANCE WITH THE FREEDOM OF INFORMATION AND PRIVACY ACT"

Exhibit 4.H.2. OVERSEAS SCREENING FOR ACTIVE DUTY DEPENDENTS
PART II (Command Endorsements)

Family Member Name:	Relationship to Sponsor/Ben Code:	SSN:	Date:

Service Member Name:	Grade/Rate:	SSN:	Current Duty Station:
Overseas Unit A/D member is being assigned:			Reporting Date:

Medical Provider Comments:

Medical Provider Name: (print)	Medical Provider/Screener Signature:	Date:
MTF/PCM Name:	Address:	Phone Number:

Dental Provider Comments:

Dental Provider Name:	**Dental Provider/Screener Signature:**	**Date:**
MTF/PCM Name:	**Address:**	**Phone Number:**

Receiving Command:

1. Can the (MTF/PCM) provide current required medical/dental support? ( ) Yes ( ) No
   If "NO" list reason why: _____
2. Can the (MTF/PCM) provide required medical/dental support (diagnostic, therapeutic and medications) if the underlying condition is exacerbated? ( ) Yes ( ) No
   If "NO" list reason why: _____

Receiving Command Endorsement:

(A copy of this questionnaire must be returned to originating unit prior to orders being executed) Article 4-H-2-3.e.)

( ) Family member is approved to accompany active duty member to this unit.

( ) Family member is not approved to accompany active duty member to this unit.
List reason why: _____

Medical Officer/Health Care Provider Name:	**Signature:**	**Date:**
Receiving Command Name:	**Address:**	Phone:

"THE INFORMATION CONTAINED IN THIS QUESTIONNAIRE MAY ONLY BE RELEASED IN ACCORDANCE WITH THE FREEDOM OF INFORMATION AND PRIVACY ACT"

Exhibit 4.H.2. INSTRUCTION FOR COMPLETION OF OVERSEAS SCREENING FOR ACTIVE DUTY DEPENDENTS

Purpose: The information contained in this is gathered for the purpose of determining the dependent's suitability for overseas assignment and to ascertain whether competent medical care is reasonably available at the overseas location for any preexisting conditions.

Instructions for Releasing Command:

This screening form is comprised of two parts:

PART ONE - Overseas Screening for Active Duty Dependents. This form will be completed by the dependent's Primary Health Care provider. Dependents who are enrolled in TRICARE should contact their provider in order to complete the screening as soon as possible. The following procedure will be followed in order to ascertain the dependents' suitability for overseas transfer and to protect patient health information.

1. **Upon notification of pending transfer to an OCONUS duty station, dependents of active duty military members will schedule an appointment with their Primary Health Care provider. The unit will provide the member/dependent with a copy of the "Overseas Screening for Active Duty Dependents: form and 2 copies of the DD Form 2870 "Authorization for Disclosure of Medical or Dental Information to take to the provider.**

2. **If the provider is not a military treatment facility, the provider will complete the screening in accordance with the Route Physical Examinations procedures of the TRICARE Policy Manual 6010.54-M, August 1, 2002. Upon completion of the screening, the provider will either fax or mail the entire package to the medical representatives listed in Blocks 6a and 6b of DD Form 2870.**

PART TWO – Command Endorsement:

1. **Upon receipt of the completed screening form, the designated medical representative will review the form for completeness and coordinate delivery of the form to the receiving command's medical representative. In the event amplifying information is needed regarding the dependents' medical status, these will addressed solely and directly between medical facilities.**

2. **The receiving command's medical representative will review the screening form and make a determination whether the dependent is considered qualified to accompany the member overseas. Part Two will be returned to the releasing command to serve as notification of dependent's status in regard to eligibility to accompany the member overseas.**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH *(YYYYMMDD)*	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN	b. ADDRESS *(Street, City, State and ZIP Code)*
c. TELEPHONE *(Include Area Code)*	d. FAX *(Include Area Code)*

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION *(X as applicable)*

☐ PERSONAL USE	☐ CONTINUED MEDICAL CARE	☐ SCHOOL	☐ OTHER *(Specify)*
☐ INSURANCE	☐ RETIREMENT/SEPARATION	☐ LEGAL	

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE *(YYYYMMDD)*	10. AUTHORIZATION EXPIRATION ☐ DATE *(YYYYMMDD)* ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT *(If applicable)*	13. DATE *(YYYYMMDD)*

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE *(YYYYMMDD)*
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	

DD FORM 2870, DEC 2003

GUIDANCE FOR COMPLETION OF DD Form 2870

Two copies of this document will be completed. Both documents will contain the same information with the exception of Blocks 6a and 6b.

Copy 1: Blocks 6a and 6b will include the name of the current Coast Guard Healthcare Representative (i.e. CG Clinic).

Copy 2: Blocks 6a and 6b will include the name of the receiving command Coast Guard Healthcare Representative. (e.g. for CGC NAUSHON, the receiving clinic would be Ketchikan).

Section I Patient Data

Block 1. Self explanatory
2. Self explanatory
3. Self explanatory
4. Enter date of physical and any follow up care dates (inclusive).
5. Treatment type: Outpatient

Section II Disclosure

Block 6. Enter the name of the facility where the physical is being conducted
6a. Complete as described above.
6b. Complete as described above.
6c. Unit telephone number.
6d. Unit fax number.
7. Reason for request: OTHER: Physical Assessment/Overseas Screening.
8. Information to be release: All medical/dental information required to ensure dependent meets physical requirements for overseas assignment.
9. Start date: Date of appointment.
10. Expiration date should be the reporting date on the member's orders.

Section III Release Authorization

Block 11. Patient signature or guardian if dependent is a minor.
12. Self explanatory.
13. Self explanatory.

Section IV For Medical Staff Use Only.