

U.S. DEPARTMENT OF
HOMELAND SECURITY
U.S. COAST GUARD
CG-5534 (6-04)

NONFEDERAL HEALTH CARE CERTIFICATION FORM
Complete Sections A and B and Submit within 5 days
of Receipt of Invoice to Comply with Provisions of the
Federal Prompt Payment Act

(See Instructions and Privacy Act Statement on Page 2)

SUBMIT INVOICE TO: (referring unit's address)

A. PATIENT/SPONSOR INFORMATION AND ACKNOWLEDGMENT (To be completed by Patient or Command)

PATIENT'S LAST NAME		FIRST	MI	RELATIONSHIP TO SPONSOR (Check one)	
				<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> IN-LAW <input type="checkbox"/> OTHER	
SPONSOR'S LAST NAME		FIRST	MI	RATE/RANK	BRANCH OF SERVICE
SPONSOR'S SSN			DUTY STATUS (Check one)		
			<input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> RETIRED <input type="checkbox"/> CIVILIAN <input type="checkbox"/> RESERVE <input type="checkbox"/> DECEASED		
SPONSOR'S OPFAC	UNIT NAME AND ADDRESS				UNIT PHONE NO.

REASON FOR TREATMENT

I acknowledge receipt of the services or products indicated on the attached invoice on the date(s) indicated and authorize the U.S. Coast Guard or its representatives to view, be furnished copies, or be given details of all medical and/or information regarding my care.

DATE SIGNATURE (PATIENT * COMMAND)

* Signature of Command or representative is acceptable if the patient is not available for signature. Indicate why patient was not available for signature and how receipt of services was verified.

B. COMMAND CERTIFICATION (To be completed by Command)

PATIENT REFERRED BY (Check one)		PATIENT REFERRED TO (Check only one)	
<input type="checkbox"/> SELF <input type="checkbox"/> SPONSOR'S COMMAND <input type="checkbox"/> COAST GUARD CLINIC/SICKBAY <input type="checkbox"/> DOD MEDICAL TREATMENT FACILITY <input type="checkbox"/> UNIFORMED SERVICES TREATMENT FACILITY <input type="checkbox"/> DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER <input type="checkbox"/> NONFED CONTRACT PROVIDER <input type="checkbox"/> OTHER (Specify): _____		<input type="checkbox"/> NON-CONTRACT HEALTH CARE PROVIDER <input type="checkbox"/> CONTRACT HEALTH CARE PROVIDER USCG CONTRACT NO. (If not on invoice): _____ WAS THIS AN EMERGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO	

REQUIRED DOCUMENTATION (Check appropriate blocks)

Attached original invoices are complete and fully itemized. (See page 2 for instructions.)

Member is authorized reimbursement for personal expenses. SF-1034 and a paid receipt attached.

Possible Third Party Claim (i.e., injury caused by another person, or patient covered by other insurance). Copy of CG-4899 attached.

Reservists Only: Copy of Orders (CG-4436B or letter orders) or, if applicable, copy of CG-4671.

Supplemental Health Care (Dependents/Retirees/Survivors only). Copy of DD-2161 attached.

MLC PRE-AUTHORIZATION NUMBER, IF APPLICABLE	HEALTH CARE PROVIDER'S FEDERAL TAX IDENTIFICATION NUMBER (FTIN), (SSN if no FTIN)

IF PATIENT RECEIVED SERVICES/PRODUCTS FROM WITHIN 40 MILES OF A FEDERAL MEDICAL FACILITY, IDENTIFY THE FACILITY AND EXPLAIN WHY IT WAS NOT USED.

I CERTIFY that the above named patient is an eligible beneficiary and that Sections A and B are complete.

DATE	COMMAND SIGNATURE

C. MLC USE ONLY (optional)		OBJECT CLASS	AMOUNT PAID	DATE SENT TO FINCEN
			\$	
DATE(S) OF SERVICE	DIAGNOSIS CODES (ICD-9)		PROCEDURES CODE (CPT)	
NAME OF PROVIDER			PHONE (Area Code)	
			()	
ADDRESS	STATE	ZIP CODE		

GENERAL INFORMATION

1. This form will assist the patient, command, and the MLC to obtain information necessary to certify health care invoices for payment as required by Public Law. The proper completion of this form will reduce needless payment delays for the health care provider and duplicate payments by the Coast Guard. This form is *NOT TO BE MODIFIED*.

2. When the referring unit receives a provider's itemized invoice, the command will ensure that Sections A and B of this form are completed correctly, and will: obtain the patient's signature, indicating that he/she received the services/products indicated on the invoice; attach the invoice to the CG-5534; and submit it to MLC(kma). A separate certification form (CG-5534) is required for each invoice.

Section A. PATIENT/SPONSOR INFORMATION AND ACKNOWLEDGMENT: The patient or the sponsor's command is responsible for the completion of all items in this Section. It can be either hand written or typed, but must be legible. The following applies:

Patient: Patient's Last Name, First Name and MI (Do not use nicknames.) (NOTE: Ensure that it is entered correctly. Failure to do so may result in a significant delay in payment.) Check the appropriate box to indicate the patient's relationship to the sponsor.

Sponsor: Sponsor's Last Name, First Name and MI (If the sponsor is the patient, leave blank.) Sponsor's rate/rank (LCDR, SN, BM3, etc.), *not paygrade* (E-1, O-3, etc.) Sponsor's Branch of Service (USCG, USAF, USN, USA, etc.) Sponsor's SSN, Duty Status: (Sponsor is active duty, retired, etc.) **Unit OPFAC:** OPFAC of sponsor's unit. Unit Name and Address: Mailing address of sponsor's unit. Unit Phone: Commercial or FTS phone number of sponsor's unit.

Reason For Treatment: Briefly explain why treatment was required.

Signature: Patient Acknowledgment: This Section must be completed, acknowledging that the services and/or products indicated on the itemized invoice were received. Without this acknowledgment the claim will be returned unpaid because the government has no way to determine if billed services/products were received. If the patient is unavailable for signature, the command must determine whether the services/products were received and sign for the patient. Indicate why patient was unable to sign and how verification was accomplished (beside visit/telephone conversation with patient, etc.).

SECTION B. COMMAND CERTIFICATION: This Section *must* be completed by the command. It serves as the government's certification that the receipt of care was a valid beneficiary, that the forms and invoice are complete and correct, and that all required documentation is attached. Check ALL applicable boxes. Additionally, the following applies:

Referral Information: Check appropriate blocks.

Emergency Determination: In your opinion, did treatment constitute emergency care, i.e., treatment was required before a preauthorization could be granted?

Required Documentation:

Itemized Invoice: Ensure that the provider's original invoice is correct and complete, including provider's name, address, phone no., Federal tax ID No. (or SSN); patient's name; date(s) of service, itemized listing of services and charges, total charges; and diagnosis or reason for visit.

Member Reimbursement: Attach SF-1034 and a paid receipt for reimbursement.

Third Party Claim: See COMDTINST 6010.16. Attach copy of CG-4899.

Reservists: Attach copy of orders (CG-4436B or letter orders) or copy of CG-4671.

Supplemental Care: See 11-A-6, COMDTINST M6000.1 (series), Medical Manual. Attach copy of DD-2161 (front and back).

Preauthorization: If care was preauthorized, indicate this by entering the MLC preauthorization number in the space provided. This will simplify the bill review process, reduce the amount of documentation that must be forwarded with the bill, and expedite payment.

FTIN: If the provider's invoice is complete and correct except for the Federal Tax Identification Number (or SSN if provider has no FTIN), call the provider's office, obtain the information, and enter it in the space provided.

Nearest Federal Facility: Federal facilities include USCG, DOD, USTF, and DVA facilities. Reasons why Federal facilities were not used could include emergency, weather conditions, operational requirements, etc.

Signature: The command (or a designated representative) dates and signs the certification form. This signature is the command's certification that the patient is a valid Coast Guard beneficiary eligible for the care that was rendered, the invoice is itemized, and the certification form is correct and complete.

SECTION C. MLC USE ONLY. Leave spaces blank for use.

Privacy Act Statement

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN) : Title 5, United States Code, Section 7901; Title 10, United States Code, Sections 505, 510, 1074, 1076, and 6148; Title 14, United States Code, Section 211; Federal Register, Volume 54; Number 188, Friday, September 29, 1989.

2. PRINCIPAL PURPOSES/ROUTINE USES OF THIS INFORMATION: The information provided will enable the USCG Finance Center to process accurately and efficiently nonfederal health care invoices for payment incurred by Coast Guard members or authorized beneficiaries. It will also certify that nonfederal health care was provided to Coast Guard members and authorized beneficiaries.

3. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL FOR NOT PROVIDING INFORMATION: In the case of military personnel, the requested information is mandatory. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, nonfederal health care invoices will not be processed for payment by the Coast Guard. The individual not providing the information may be responsible for payment of all services and/or products provided by the nonfederal health care provider.