WNG AGR/AD Orders Claims Processing Information Guide

You can submit a claim when you are within 6 months (180 days) of your final date on orders. As long as you complete the application submission within 364 after separating or retiring, you will get paid back to your first day off orders.

The goal is to accomplish the process (claim submission) in two visits:

1. Go over medical evidence to determine if it is enough to verify all conditions.
2. Complete and submit application online. It is imperative that the claim is in at least 91 days prior to your final date. If it is submitted in the 90 day window, VA will not start processing the claim until the day after your final date on orders or first day as a retiree.

First meeting:

1. The claim will need medical documentation for every issue. Please remember; never send any original medical paperwork ever to the VA. **Always send a copy, never the originals**. The main reason for a condition to not be approved is when there is not a clear diagnosis. All body parts need radiology to confirm. You can have three separate ratings for each part: bone/cartilage, nerve or muscle rating. The VA must know which category your condition falls under. Arthritis or "degenerative changes" is valid. You need to complain about every condition whether or not you want to file for it now.

   a. Medical documentation from:
      1. Military exit physical
      2. Active duty installations (CD from AD installation is better but paper copies will also work).
      3. Civilian medical records (if any)

      Note: Sleep Apnea can only be approved with an in-service sleep study. You do not need to complete the study prior to your final date, but it should be orders before leaving service. If you suspect Sleep Apnea, please get a sleep study immediately.

NOTE: It is preferred to have all records on a cd, but you can bring in paper copies of your medical/military files to the first meeting. Please convert all records to a digital format and place on a cd (no thumb/hard drives) prior to the second meeting.

Second meeting:

2. VA forms and personnel records completed. (Please bring back the worksheet we developed at our first meeting).

   a. Application: 21-526C-Application will be done online through the VA portal www.va.gov. Please start the process but stop at the section that lists disabilities to claim. We will do that together and upload all documents at that time.

   b. VA forms information is on page 3 of this binder.

   c. Will need all DD 214's and copy of RPAS statement showing all duty. We will also need any orders that did not produce a DD 214. A retirement order is also

needed to validate end date. DD 214 from this period of service will need to be sent in when you get it.

d. Need copy of any combat awards (CIB/CAB or Purple Heart, Combat Action Medal, etc.).

4. VA.gov: How To File A VA Disability Claim | Veterans Affairs

YOU CANNOT START THE CLAIM ONLINE UNTIL YOU HIT THE 180 DAY MARK PRIOR TO YOUR RETIREMENT DATE OR FINAL DATE IN MILITARY.

If you log into this site with your CAC, you will get immediate access. Once the claim is in, you can track its progress. Once you are in this site; be sure to create a manual login and password so you can get into the site after your CAC is turned off.

You can also create a manual password to use after CAC is no longer active. DOD site: "My Access Center".

https://www.dmdc.osd.mil/identitymanagement/authenticate.do?execution=e1s1

Note: You do not need to meet with me face-to-face to do this processing. We can do this via email and phone. While working remotely, you will need to upload all medical records and send to me via DOD SAFE. I will review records and report back what is needed so you get approval first time out. See info/link on next page.

If you have questions, please contact:
Annie DeAndrea, WNG Transition Assistance Specialist
Building 3, Camp Murray
Office Phone: 253-512-8722
Email: antionette.m.deandrea.civ@army.mil

To book an appointment, please call:
Mark DeAndrea, Military and Family Readiness Specialist
Office: 253-912-3143
Cell: 253-355-5936
mark.deandrea.civ@army.mil

Additional Meetings/contact:

As we input the claim, We will go over what to expect when you do exams with the VA. You are welcome to contact me a day or two before each exam to go over what you should do and say for a successful outcome.

When your claim has been decided, we should get together to go over the document to ensure you were rated correctly. When you get both (2) letters form the VA with their decision, you should call for an appointment. You will never lose services with the WNG Joint Services Support.

VA Forms needed for claim:

https://www.va.gov/find-forms/ This site will allow you to download all forms:

21-686C Dependency

When you get a 30% or higher rating, you will receive additional funds for having a spouse and/or children. You will need to complete this form to enable this benefit. You will only need marriage certificate. Children will be validated by their social. You do not need birth certificates unless the children were adopted out of the US. Note: there will be a lot of blank sections on this form. If it does not apply, ignore.

21-674 College enrollment Verification

If you have a child that has graduated high school and is enrolled in college, you can complete this form to still receive dependency allowance until they turn 24. Note: you will need to include a screenshot of their student portal showing enrolled and expected graduation dates.

Separation Health Assessment

https://www.va.gov/resources/separation-health-assessment-for-service-members/

If you are retiring, you no longer need a DoD retirement physical if you file a VA claim either before or shortly after retiring. Instead of a DoD physical, you are required to complete the Separation Health Assessment.

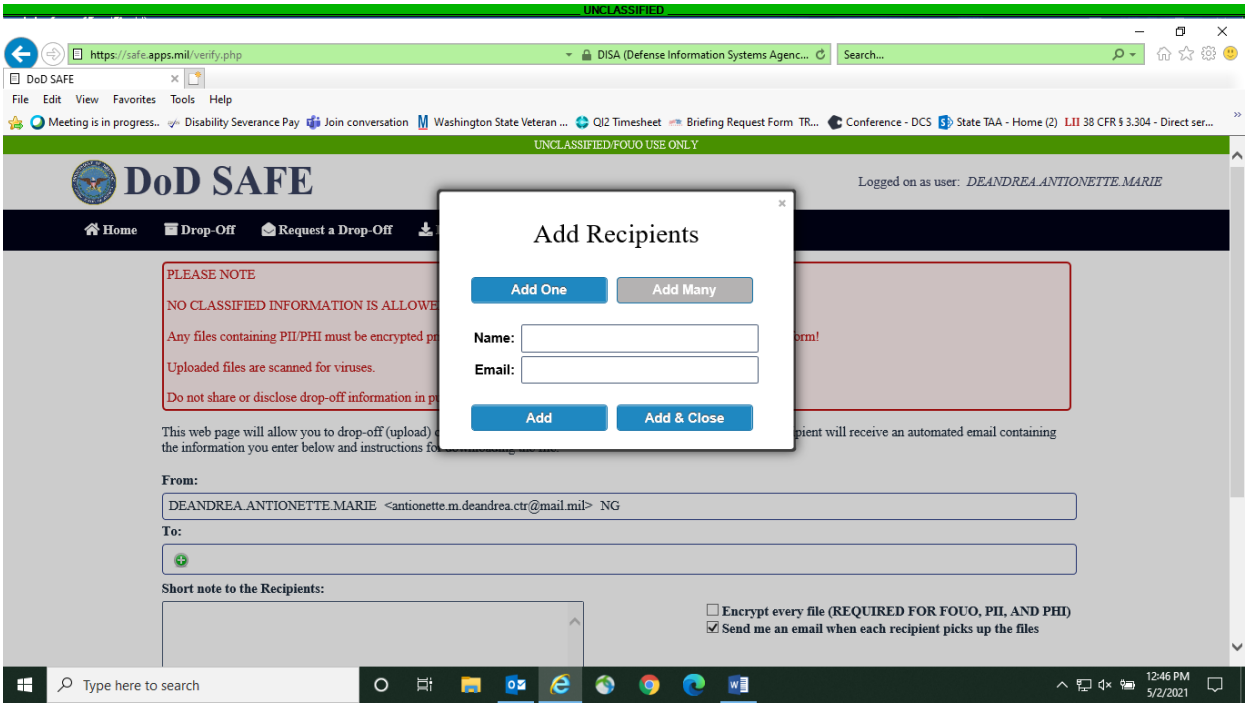
Tips:

1. Whether or not a condition is caused by your military service, all conditions need to be documented on this form. You should also annotate if you have an LOD for any of the conditions. By doing this form, you may be able to file a claim for that condition later. Note: for conditions that have no military link, you should still list. If congress changes policy for NG claims processing, you can file it later. This guarantees your right to file later if needed.
2. Driving to and from duty does count. If you have had a car accident driving to AT, you can claim any injuries. You must have taken the same route as you normally would do.
3. If you have a confirmed diagnosis, use the wording on your medical record to describe the condition.

DoD SAFE portal

https://safe.apps.mil/verify.php

After you CAC login, you will see:



Add my email as recipient: antionette.m.deandrea.civ@army.mil

It will require me to CAC login to get your documents. Please note: if you add an additional passphrase, please email the passphrase to me so I can get your documents.

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 authorizationto disclose alcohol or drug abuse patient information from medical records or for authorization to disclose informationfrom records of an alcohol or drug abuse treatment program. In addition, any use as an authorizationto use or disclose psychotherapy notes may not be combinedwith 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. DOD ID NUMBER OR SSN
4. PERIOD OF TREATMENT: FROM - TO *(YYYYMMDD)*	5. TYPE OF TREATMENT *(X one)* ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE *MADIGAN ARMY MEDICAL CENTER* TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PHYSICIAN, FACILITY, OR TRICARE HEALTH PLAN YOUR NAME:	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

Email address:_____

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		

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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 McChord Clinic **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)*
SELF	
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)* VA Benefits
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

All medical and behavioral health records

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.
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☐ AUTHORIZATION REVOKED		

17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:

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