FACSIMILE TRANSMITTAL SHEET **America's Express Urgent Care**

TO:
90th Medical Group/MDSS/SGST
ATTN: TOPA STAFF

FROM:
America's Express Urgent Care
7124 Commons Drive, Suite C
CHEYENNE, WY 82009

FAX NUMBER:
(866) 639-0354

DATE:

COMPANY:

TOTAL NUMBER OF PAGES INCLUDING COVER:

PHONE NUMBER:

SENDER'S REFERENCE NUMBER:
COM: 426-4060 FAX: 426-4061

RE:
URGENT CARE VISITS

YOUR REFERENCE NUMBER

TRICARE PRIME AMERICA'S EXPRESS URGENT CARE REPORT
90th Medical Group
ALL QUESTIONS MUST BE COMPLETED FOR THE REFERRAL TO BE APPROVED

Date: _____ Time Checked in: _____AM/PM (Circle one) Patient's Date of Birth: _____

Patient's Name: _____ Sponsor SSN: _____

PRP (circle one): Yes No Unit: _____ DP: _____ PCM: _____

Reason for Patient's Visit: (symptoms) _____

_____ STATUS: AD/ OTHER: (circle one)

NOTE: If you are PRP certified (including PRP suspension) you must notify your unit PRP monitor and the 90th Medical Group PRP office (x3580) regarding this visit. Please include diagnosis, treatment, and medications received.

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THE FOLLOWING INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 AND IS INTENDED "FOR OFFICIAL USE ONLY"

PATIENT/PARENT/SPONSOR SIGNATURE: _____ **DATE:** _____

90 MDG ACTION ONLY: APPROVE DISAPPROVE **MDG AUTHORIZING SIGNAURE:**
_____

DATE: _____ REF: Y N T-Con Y N TSC: _____ REF# _____

REFERRING PROVIDER: _____ TIME: _____