



**STATE OF NEW YORK  
DIVISION OF MILITARY AND NAVAL AFFAIRS  
330 OLD NISKAYUNA ROAD  
LATHAM, NEW YORK 12110-3514**

**FOLLOW-UP CARE REQUEST FORM**

**Prior approval is required from State Human Resources Management (MNHS) before receiving follow-up care.**

**\*NOTE: Service Members who seek follow-up care treatment prior to receiving approval from MNHS may be liable for any/all incurred costs should their Line-of-Duty be “non-concurred”.**

**Please print / type all information.**

1. Service Member's Name: \_\_\_\_\_  
Last First Mi

2. LOD Number: \_\_\_\_\_

3. Date of Occurrence: \_\_\_\_\_

4. Service Member's Company/Unit: \_\_\_\_\_

5. Provide brief explanation of condition, illness or disease – as explained by Service Member:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor requesting follow-up care.

Service Member requesting follow-up care.

Reason why follow-up care is being requested:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date and Time of follow-up care: \_\_\_\_\_

MNHS approval (for MNHS use only): \_\_\_\_\_