TRICARE PRIME ENROLLMENT, DISENROLLMENT, AND PRIMARY CARE MANAGER (PCM) CHANGE FORM

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PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE ADDRESS BELOW.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079 and 1086, 38 U.S.C. Chapter 17; 32 CFR 199.17; and E.O. 9397 (SSN), as amended.
PRINCIPAL PURPOSE(S): To obtain information necessary to permit individuals to enroll, disenroll, or change their provider in TRICARE Prime, TRICARE Prime Remote, or the Uniformed Services Family Health Plan, as requested by the individual.
ROUTINE USE(S): Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by DoD 6025.18-R, the DoD Health Information Privacy Regulation. In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, the DoD "Blanket Routine Uses" under 5 U.S.C. 552a(b)(3) apply to this collection. A complete listing of the routine uses permitted under 5 U.S.C. 552a(b)(3) is published at http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html. Collected information may be shared with the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and other Federal, State, local, or foreign government agencies, private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.
DISCLOSURE: Voluntary; however, your failure to provide all the requested information may result in the denial of the request to enroll in, transfer, or terminate your TRICARE Prime health plan coverage.

APPLICATION OPTIONS

ONLINE:
You may electronically complete, submit and print a copy of your enrollment, disenrollment or change online by logging into the Beneficiary Web Enrollment (BWE) website at https://www.tricare.mil/bwe/. The BWE website is not available to beneficiaries in overseas areas.

MAILING THE FORM:
For manual enrollment, disenrollment, or Primary Care Manager (PCM) changes in TRICARE Prime, TRICARE Prime Remote or US Family Health Plan, complete and submit the form to the address below.

1. Forms may be mailed to the contractor identified below or, with the exception of USFHP applications, taken to a TRICARE Service Center (TSC). Call your Contractor to determine when your new or transferred enrollment will begin.
2. For enrollment assistance, please call *USFHP at Christus Health* *1-800-678-7347*
3. For additional information on TRICARE, visit the TRICARE website at www.tricare.mil, the Contractor's website at *www.christus.usfhp.com* or your local TRICARE Service Center (TSC).

(TMA BE&S/Contractors will add servicing contractor information. Include name, mailing address and web address of contractor, and enrollment fees.)

Uniformed Services Family Health Plan (USFHP)

SOUTH REGION

US Family Health Plan
at Christus Health

PO Box 169001
Irving, TX 75016

1-800-678-7347

SPONSOR'S SSN/DBN:

TRICARE PRIME OPTION DESIRED:

☐ **TRICARE Prime:** Active duty service members (ADSM) are required to enroll in TRICARE Prime. Please note that enrollment is not automatic.

☐ **TRICARE Prime Remote:** If eligible, you may be enrolled in TRICARE Prime Remote (TPR) or TRICARE Prime Remote for Active Duty Family Members (TPRADFM).

☐ **TRICARE Overseas Program Prime:** Dependents must be command sponsored and meet specific enrollment criteria of the overseas area. If eligible, you may be enrolled in TRICARE Overseas Program Prime Remote. Retirees are not eligible for TRICARE Overseas Program Prime.

☐ **Uniformed Services Family Health Plan (USFHP):** Available in six locations. Submit the completed Enrollment Application to the USFHP address listed on Page 1. For the service area descriptions and telephone numbers for questions, please visit the TRICARE website at www.tricare.mil/.

SECTION I - SPONSOR INFORMATION

1. SPONSOR'S NAME *(Last, First, Middle Initial) (Must match DEERS)*

2. SPONSOR'S SOCIAL SECURITY NUMBER (SSN) *(XXX-XX-XXXX)* **or DoD BENEFITS NUMBER (DBN)** *(XXXXXXXXX-XX)*

3. SPONSOR IS: *(X one)* ☐ Active Duty ☐ Retired ☐ Deceased *(Go to Section II.)* ☐ Unremarried Former Spouse

4. SPONSOR'S TELEPHONE NUMBER *(Include Area Code)*

a. WORK:

b. RESIDENTIAL:

5. SPONSOR'S E-MAIL ADDRESS

☐ *(X box to receive TRICARE e-mails)*

6. SPONSOR'S RESIDENCE ADDRESS *(Street, Apartment No., City, State, ZIP Code, Country)* ☐ New

7. SPONSOR'S MAILING ADDRESS *(Provide APO or FPO if stationed overseas)* ☐ Same as residence ☐ New

8. SPONSOR'S MILITARY ASSIGNMENT

a. UNIT

b. UNIT IDENTIFICATION CODE (UIC) *(If known)*

c. STATE, ZIP CODE AND COUNTRY OF WORK ADDRESS

9. REQUESTED ACTION *(X one)*

☐ None *(go to Section II)* ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll

Effective Date: _____

10. SPONSOR'S PRIMARY CARE PCM PREFERENCE *(Please list your first and second choices below. Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF, or US Family Health Plan Member Services (non-active duty only) for availability of PCMs.)*

a. 1st CHOICE ☐ MTF ☐ Civilian	FULL NAME or MTF/CLINIC
b. 2nd CHOICE ☐ MTF ☐ Civilian	FULL NAME or MTF/CLINIC

c. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Flight Medicine

d. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

SPONSOR'S SSN/DBN:

SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE *(Use additional copies of this page as necessary)*

11.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date: _____

d. RESIDENCE/MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)* ☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK:
(2) RESIDENTIAL:

f. E-MAIL ADDRESS ☐ *(X box to receive TRICARE e-mails)*

g. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Please list your first and second choices below. Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

12.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date: _____

d. RESIDENCE/MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)* ☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK:
(2) RESIDENTIAL:

f. E-MAIL ADDRESS ☐ *(X box to receive TRICARE e-mails)*

g. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Please list your first and second choices below. Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

13.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date: _____

d. RESIDENCE/MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)* ☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK:
(2) RESIDENTIAL:

f. E-MAIL ADDRESS ☐ *(X box to receive TRICARE e-mails)*

g. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Please list your first and second choices below. Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

SPONSOR'S SSN/DBN:

SECTION III - REASON FOR DISENROLLMENT OR PCM CHANGE

Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other: _____
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other: _____
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other: _____
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other: _____

SECTION IV - OTHER HEALTH INSURANCE

PLEASE IDENTIFY IF ANYONE IS CURRENTLY COVERED BY OTHER HEALTH INSURANCE.

☐ TRICARE Supplement *(no other information is needed)*

☐ Medical Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ Dental Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ Vision Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ Prescription Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

SECTION V - ACCESS WAIVER AND SIGNATURE (REQUIRED)

☐ *(X if waiving drive time)* If my selected or assigned Primary Care Manager (PCM) is greater than a 30 minute drive-time from my residence, or if I reside outside the Prime Service Area, I understand that: (1) I must also waive the specialty care access standard of one hour drive-time from my residence, and (2) this application constitutes my agreement to waive both the primary care and specialty care access standard as applicable.

I understand that if I selected a PCM by name, team, or location (MTF or civilian), the TRICARE Program will enroll me with that PCM if capacity exists. I understand that it is my responsibility to comply with all TRICARE Prime, TRICARE Prime Remote, TRICARE Overseas Program Prime, and/or USFHP policies and procedures. By signing this form, I certify the information provided is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments, or concealment of a material fact may be subject to fine and/or imprisonment under applicable Federal law.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*

ENROLLMENT NOTE: Initial enrollment effective dates are based primarily on the 20th of the month rule (applications received by the 20th of the month are effective the first day of the next month). You should confirm enrollment and PCM assignment before obtaining routine medical care by calling your contractor. (Note: This section does not apply to TRICARE Overseas.)

DISENROLLMENT NOTE: For retirees and their family members, you may incur a 12 month lock-out from TRICARE Prime for failure to pay enrollment fees. You may not be allowed to re-enroll in TRICARE Prime for 12 months from the date of the disenrollment.

PAYMENT OPTIONS: See Section VI on next page.

SPONSOR'S SSN/DBN:

SECTION VI - PAYMENT OF TRICARE PRIME ENROLLMENT FEES

NOTE: This section is only for retirees, retiree family members, survivors and eligible former spouses.
Retired beneficiaries and retiree family members under age 65 who are entitled to Medicare Part A must be enrolled in Medicare Part B to be eligible for enrollment in TRICARE prime. TRICARE Prime enrollment fees are waived for individuals enrolled in Medicare Part A and Part B, as reflected in DEERS.

PAYMENT OPTIONS: See Sections A, B, and C below for elective payment options. Your initial enrollment application must include payment for at least the first three (3) months of coverage. You may pay this amount either by credit card, money order or personal check. Checks should be made payable to:

USFHP at Christus Health

Note 1, Monthly Allotment: If you select the monthly payment plan, you must make an initial three month payment by check, credit card or money order at the time of application. Monthly bills will not be sent.

Note 2, Quarterly and Annual: Bills will be sent on a quarterly and annual basis for credit card payment. The payments can be recurring as established by the enrolling contractor.

Note 3, Personal Check: Payment by check is limited to the initial three month payment for beneficiaries who elect allotment or EFT.

Note 4, Electronic Funds Transfer: EFT is for monthly payments only. The initial payment cannot be made electronically.

PAYMENT FEE, PLAN AND METHOD OPTIONS *(Some options are location specific)*	**MONTHLY** ☐ Allotment From Retired Pay ☐ Electronic Funds Transfer ☐ VISA or MasterCard INITIAL 3-MONTH PAYMENT: ☐ Check ☐ Money Order ☐ Credit Card (Section C below)
	QUARTERLY ☐ VISA or MasterCard
	ANNUAL ☐ VISA or MasterCard

A - MONTHLY ALLOTMENT

I choose to have my enrollment fees paid by monthly allotment from my Uniformed Services retired pay.

☐ Individual $ _____ ☐ Family $ _____ (The current rates are at www.tricare.mil/costs)

Signature _____

NOTES: Only retired Uniformed Services members may establish an allotment from their retired pay. An Allotment form is required and must be submitted with the application. See Note 1 above.

B - ELECTRONIC FUNDS TRANSFER

☐ ELECTRONIC FUNDS TRANSFER FOR AUTOMATIC MONTHLY PAYMENTS ☐ Checking *(attach voided check)* ☐ Savings

☐ Individual $ _____ ☐ Family $ _____ (The current rates are at www.tricare.mil/costs)

Name and Address of Financial Institution _____

Name on Account _____ Telephone Number of Financial Institution _____

Account Number _____ ABA Routing Number _____

Signature _____

C - CREDIT CARD

☐ INITIAL 3-MONTH PAYMENT

☐ VISA/MASTERCARD MONTHLY RECURRING PAYMENTS:

☐ Individual $ _____ ☐ Family $ _____ (The current rates are at www.tricare.mil/costs)

VISA/MASTERCARD: Number _____ Exp. Date *(MM/YYYY)* _____

Security Code *(3-digit number on reverse side of card)* _____

Name of Cardholder _____

Cardholder Signature _____