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

OMB No. 0720-0008 OMB approval expires 20250930

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dodinformationcollections@ mail.mil. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

#### PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 113, Secretary of Defense; 5 U.S.C. 552, Freedom of Information Act, as amended; 5 U.S.C. 552a, Privacy Act of 1974, as amended; 32 CFR part 286, DoD Freedom of Information Act (FOIA) Program; 32 CFR part 310, Protection of Privacy and Access and Amendment of Individual Records Under the Privacy Act of 1974; DoD Directive, 5400.07, DoD Freedom of Information Act (FOIA) Program; DoD Instruction 5400.11, DoD Privacy and Civil Liberties Programs; DoD Manual 5400.07, DoD Freedom of Information Act (FOIA) Program; DoD 5400.11-R, DoD Privacy Program; and Executive Order 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): In addition to those disclosures generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use to private physicians and federal agencies to include 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. DoD's Routine Use disclosures are limited to those explicitly stated in each SORN. For a full listing of the Routine Uses, refer to below applicable SORNs hyperlinked below. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

APPLICABLE SORN: Defense Manpower Data Center (DMDC) 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS) (May 31, 2022; 87 FR 32384. https://www.federalregister.gov/documents/2022/05/31/2022-11610/privacy-act-of-1974-system-of-records

DISCLOSURE: Voluntary. If you choose not to provide the requested information, there may be an administrative delay processing your request and the DoD may be unable to process it; however, no penalty will be imposed.

#### **APPLICATION OPTIONS**

#### (1) ONLINE:

You may request to enroll, disenroll or change your primary care manager (PCM) by logging into the Beneficiary Web Enrollment website at https://milconnect.dmdc.osd.mil

#### (2) TELEPHONE:

You may enroll, disenroll, or change your PCM by calling your Regional Contractor or US Family Health Plan (USFHP) at the toll-free numbers on this page.

#### (3) ENROLLMENT FORM:

You may also enroll, disenroll, or change your PCM by completing and submitting the form to your Regional Contractor or USFHP at the address or fax number below.

#### (4) NOTES:

You will be notified of your enrollment or PCM change via email or postcard. You can then log into milConnect at: https:// milconnect.dmdc.osd.mil to view specific information. For additional information on TRICARE, visit the TRICARE website at www.tricare.mil or the Regional Contractor's website at: www.humanamilitary.com

REGIONAL CONTRACTOR: REGION, ADDRESS, TELEPHONE AND FAX NUMBERS:

Region: EAST REGION

Address: Humana Military, Attn: PNC Bank, PO Box 105838, Atlanta GA 30348-5838

Toll-Free Number: 1-800-444-5445

Fax Number: 1-866-836-9535

#### **UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP):**

Address: (1) Martin's Point, PO Box 9746, Portland ME 04104 (2) Johns Hopkins, P.O. Box 8689, Elkridge, MD 21075, (3) Brighton Marine, PO Box 9195, Watertown MA 02471-9900, (4) St Vincent's NYC, 5 Penn Plaza, 9th Floor, New York NY 10001

CUI (when filled in)

Toll-Free Number: (1) 1-888-241-4566, (2) 1-800-801-9322, (3) 1-800-818-8589, (4) 1-800-241-4848

Fax Number: (1) 1-207-828-7822, (2) 1-410-424-4770, (3) 1-617-923-5898, (4) 1-212-356-4949

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Controlled by: DHA CUI Category: PRVCY, HLTH Page 1 of 5

SPONSOR'S SSN/DBN:					
TRICARE PRIME OPTION DESIRED:					
TRICARE Prime: Active duty service members have to e	enroll in TRICAR	RE Prime. (Enrollment	is not automa	atic.)	
TRICARE Prime Remote: If eligible, you may be enrolled Active Duty Family Members.	TRICARE Prime Remote: If eligible, you may be enrolled in TRICARE Prime Remote or TRICARE Prime Remote for Active Duty Family Members.				
TRICARE Overseas Program Prime: Family members 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/usfhp.					
SECTION I - S	SPONSOR INF	ORMATION			
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) (XXXXXXXXXX-XX)			
3. SPONSOR IS: (X one) Active Duty Retired	Deceas	sed (Go to Section II.)	Unrema	rried Former Spouse	
4. SPONSOR'S TELEPHONE NUMBER (Include Area Code)  a. WORK:  b. HOME:	5. SPONSOR'S E -MAIL ADDRESS		•	6. SPONSOR'S DATE OF BIRTH (YYYYMMDD)	
7. SPONSOR'S RESIDENCE ADDRESS (Street, Apartment No. 1971)  8. SPONSOR'S MAILING ADDRESS (Provide APO or FPO if Street)	·		sidence [	New	
9. SPONSOR'S MILITARY ASSIGNMENT a. UNIT	c STAT	E, ZIP CODE AND C		MODK ADDDESS	
a. ONIT	C. STAT	E, ZIP CODE AND C	OUNTRY OF	WORK ADDRESS	
b. UNIT IDENTIFICATION CODE (UIC) (If known)					
10. SPONSOR'S REQUESTED ACTION (X one)					
	Enrollment	PCM Change	Disenro	II (Non-AD only)	
Effective Date Requested (YYYYMMDD):  11. SPONSOR'S PCM PREFERENCE (Please list your first and second choices below. PCM assignment depends upon availability and your uniformed service guidelines. Review PCM options online or call your Regional Contractor, preferred MTF, or USFHP member services (non-active duty only) for availability of PCMs.)					
a. 1st CHOICE MTF FULL NAME or MTF/CLINIC  MTF PRP  Civilian (ADSM)					
b. 2nd CHOICE FULL NAME or MTF/CLINIC  MTF  Civilian					
c. PCM SPECIALTY No Preference Family/General Practice Internal Medicine Flight Medicine					
d. PREFERRED PCM GENDER					

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SPONSOR'S SSN/DBN:						
SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE (Use additional copies of this page as necessary)						
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 D	Effective Date Requested (YYYYMMDD):					
d. RESIDENCE AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if diffe	rent from Sponsor)					
Same as Sponsor New						
,	F. E -MAIL ADDRESS					
a. WORK: b. HOME: c. CELL:	s upon availability and uniformed service guidelines					
g. PCM PREFERENCE (Please list your first and second choices below. PCM assignment depends Review PCM options online or call your Regional Contractor or USFHP customer services for available.						
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN	IIC					
(2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN	IIC					
h. PCM SPECIALTY No Preference Family/General Practice Internal N						
i. PREFERRED PCM GENDER No Preference Male Fema	le					
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 D	Effective Date Requested (YYYYMMDD):					
d. RESIDENCE AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if different	rent from Sponsor)					
Same as Sponsor New						
	E -MAIL ADDRESS					
a. WORK: b. HOME: c. CELL:						
g. PCM PREFERENCE (Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)						
g. PCM PREFERENCE (Please list your first and second choices below. PCM assignment depends Review PCM options online or call your Regional Contractor or USFHP customer services for available.	s upon availability and uniformed service guidelines. ability of PCMs.)					
g. PCM PREFERENCE (Please list your first and second choices below. PCM assignment depends. Review PCM options online or call your Regional Contractor or USFHP customer services for availated (1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN						
FULL NAME or MTF/CLIN	IIC					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN	IIC					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN	IIC  Idedicine Pediatrics Flight Medicine					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal M	IIC  Idedicine Pediatrics Flight Medicine					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal No PREFERRED PCM GENDER No Preference Male Femal  14.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)	IIC  Idedicine Pediatrics Flight Medicine  Idedicine Pediatrics Flight Medicine					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal No PREFERRED PCM GENDER No Preference Male Femal  14.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)	IIC  Idedicine Pediatrics Flight Medicine  Idea b. DATE OF BIRTH (YYYYMMDD)  Effective Date Requested (YYYYMMDD):					
(1) 1st CHOICE	IIC  Idedicine Pediatrics Flight Medicine  Idea b. DATE OF BIRTH (YYYYMMDD)  Effective Date Requested (YYYYMMDD):					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal No Preference Male Femal  14.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)  c. REQUESTED ACTION: Enroll Transfer Enrollment PCM Change Cande Country, if difference And Mailing Address (Provide address, with ZIP Code and Country, if difference Same as Sponsor New	IIC  Idedicine Pediatrics Flight Medicine  Idea b. DATE OF BIRTH (YYYYMMDD)  Effective Date Requested (YYYYMMDD):					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal M.  i. PREFERRED PCM GENDER No Preference Male Femal  14.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)  c. REQUESTED ACTION: Enroll Transfer Enrollment PCM Change C. RESIDENCE AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if difference Same as Sponsor New  e. TELEPHONE NUMBER (Include Area Code)  a. WORK: b. HOME: C. CELL:	IIC  Idedicine Pediatrics Flight Medicine  Idea b. DATE OF BIRTH (YYYYMMDD)  Effective Date Requested (YYYYMMDD):  Internet from Sponsor)  F. E -MAIL ADDRESS					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal M.  i. PREFERRED PCM GENDER No Preference Male Femal  14.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)  c. REQUESTED ACTION: Enroll Transfer Enrollment PCM Change C. RESIDENCE AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if difference Same as Sponsor New  e. TELEPHONE NUMBER (Include Area Code)	IIC  Idedicine Pediatrics Flight Medicine  Idea b. DATE OF BIRTH (YYYYMMDD)  Effective Date Requested (YYYYMMDD):  Internet from Sponsor)  F. E -MAIL ADDRESS					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal M.  i. PREFERRED PCM GENDER No Preference Male Femal  14.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)  c. REQUESTED ACTION: Enroll Transfer Enrollment PCM Change C. RESIDENCE AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if difference Same as Sponsor New  e. TELEPHONE NUMBER (Include Area Code)  a. WORK: b. HOME: C. CELL:	IIC  Idedicine Pediatrics Flight Medicine  Idea b. DATE OF BIRTH (YYYYMMDD)  Effective Date Requested (YYYYMMDD):  Insert from Sponsor)  F. E -MAIL ADDRESS  Supon availability and uniformed service guidelines.  Substitute of PCMs.)					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal No Preference Male Femal  14.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)  c. REQUESTED ACTION: Enroll Transfer Enrollment PCM Change Code and Residence AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if difference Same as Sponsor New  e. TELEPHONE NUMBER (Include Area Code) a. WORK: b. HOME: c. CELL:  g. PCM PREFERENCE (Please list your first and second choices below. PCM assignment dependence Review PCM options online or call your Regional Contractor or USFHP customer services for available FULL NAME or MTF/CLIN	IIC  Idedicine Pediatrics Flight Medicine  Ide  Ide  Ide  Ide  Ide  Ide  Ide  I					
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  (2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CLIN  h. PCM SPECIALTY No Preference Family/General Practice Internal M.  i. PREFERRED PCM GENDER No Preference Male Femal  14.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)  c. REQUESTED ACTION: Enroll Transfer Enrollment PCM Change C.  d. RESIDENCE AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if difference at WORK:  b. HOME: c. CELL:  g. PCM PREFERENCE (Please list your first and second choices below. PCM assignment dependence Review PCM options online or call your Regional Contractor or USFHP customer services for availation.  FULL NAME or MTF/CLIN  FULL NAME or MTF/CLIN	IIC  Idedicine Pediatrics Flight Medicine  Ide  Ide  Ide  Ide  Ide  Ide  Ide  I					

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SPONSOR'S SSN/DBN:						
SECTION III - REASON FOR DISENROLLMENT OR PCM CHANGE (Complete if disenrolling or making a 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 need	eded)					
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 Number:		Policy Effective Date:			
Prescription Insurance: Person(s) Covered:						
Policy Holder Name:	Policy Holder Name:		Carrier Name:			
Policy Number:	Policy Number: Policy Effective Date:					
SECTION V - ACCESS WAIVER AND SIGNATURE (REQUIRED)						
(X if waiving drive time) If my selected or assignment residence, or if I reside outside the Prime Servione hour for specialty care						
I understand if I selected a PCM by name, team, or availability and uniformed services policy. I understance, Remote, TRICARE Overseas Program Prime, and/oprovided is true, accurate and complete. Federal fur concealment of a material fact may be subject to fire	and that it is my or USFHP polici nds are involved	responsibility to comply with all TF es and procedures. By signing this I in this program and any false clai	RICARE Prime, TRICARE Prime form, I certify the information ms, statements, comments, or			
1. SIGNATURE OF SPONSOR, SPOUSE, OR OTI LEGAL GUARDIAN OF BENEFICIARY	HER	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED (YYYYMMDD)			
<b>ENROLLMENT NOTE</b> : Your regional contractor will proced date of event (e.g., initial eligibility, marriage, birth) as app TRICARE or healthcare coverage, your TRICARE Prime of	ropriate. If your re	egional contractor receives your enrollm	nent request within 90-days of loss of other			

paid up. You should confirm the enrollment or change before obtaining care by calling your Regional Contractor or by viewing your enrollment on milConnect (www.tricare.mil/milconnect).

DISENROLLMENT NOTE: If you voluntarily disenroll or do not pay your enrollment fee, you will only have space available care at a military hospital or clinic. You may re-enroll during the next open enrollment period or within 90-days of a qualifying life event (see www.tricare.mil/LifeEvents for details). If you don't have an appropriate waiver on file and your address is confirmed ineligible for TRICARE Prime, you will be disenrolled from Prime and automatically enrolled in TRICARE Select.

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.					
	e family members under age 65 who are e ne. TRICARE Prime enrollment fees are w				
PAYMENT OPTIONS: See Sections A, B, and C below for payment options.  Note 1, Monthly Payment: Monthly payments must be recurring payments, via allotment whenever feasible. You will not receive a monthly bill. If you select the monthly payment plan, you must make an initial three month payment by check (cashier's or personal check), credit/debit card, or money order at the time of application. Make checks payable to your regional contractor or your USFHP Designated Provider, as listed on page 1 of this form.  Note 2, Quarterly and Annual Payments: You will be billed on a quarterly or annual basis for credit card payments.					
(Your Contractor may offer recurring quarterly and/or annual payments.)  Note 3, Personal Check: Payment by check (money order, cashier's or personal) is limited to the initial three month payment only.  Checks received for ongoing payment will not be accepted.					
Note 4, Electronic Funds Tran	nsfer: EFT is for monthly or quarterly payr	ments only. The initial payment cannot	be made via EFT.		
PAYMENT FEE, PLAN AND	MONTHLY Allotment From Ref	tired Pay Electronic Funds Tran	sfer Credit/Debit Card		
METHOD OPTIONS (Some options are location specific)	INITIAL 3-MONTH PAYMENT:	Check Money Order	Credit/Debit Card (Section C below)		
, ,	QUARTERLY Credit/Debit Card				
	ANNUAL Credit/Debit Card				
A - ALL	LOTMENT (where feasible, as mand	dated by law (NDAA for FY2020,	Section 702))		
NOTE: Only retired Uniformed S	ollment fees paid by monthly allotmer Services members may establish an allotr or will charge the correct fee amount each ricare.mil/costs)	nent from their retired pay. The Uniforn	ned Service member must sign		
	B - ELECTRONIC	C FUNDS TRANSFER			
ELECTRONIC FUNDS TRA	ANSFER FOR AUTOMATIC PAYMENTS	Checking (attack)	ch voided check) Savings		
Name and Address of Fina	ncial Institution				
Name on Account		Telephone Number of Financial Inst	titution		
Account Number		ABA Routing Number			
<b>NOTE:</b> Your Regional Contractor (The current rates are at <a costs"="" href="https://www.trustractor.com/www.com/www.co&lt;/td&gt;&lt;td&gt;or will charge the correct fee amount base ricare.mil/costs)&lt;/td&gt;&lt;td&gt;ed on your enrollment, individual or fam&lt;/td&gt;&lt;td&gt;ily.&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td&gt;&lt;/td&gt;&lt;td&gt;C - CREDI&lt;/td&gt;&lt;td&gt;T/DEBIT CARD&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td&gt;☐ INITIAL 3-MONTH PAYMEN&lt;/td&gt;&lt;td&gt;NT MONTHLY RECURRING PA&lt;/td&gt;&lt;td&gt;AYMENTS&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td&gt;Name of Cardholder&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td&gt;CREDIT/DEBIT CARD Nur&lt;/td&gt;&lt;td colspan=5&gt;CREDIT/DEBIT CARD Number: Exp. Date (MM/YYYY):&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td&gt;Card Verification Code (CV&lt;/td&gt;&lt;td&gt;/C) (3-digit number on reverse side of care&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td colspan=5&gt;&lt;b&gt;NOTE:&lt;/b&gt; Your Regional Contractor will charge the correct fee amount based on your enrollment, individual or family. (The current rates are at &lt;a href=" https:="" www.tricare.mil="">www.tricare.mil/costs</a> )					
	SIGI	NATURE			
determined by TRICARE and su option selected. This authorizati	gional Contractor to START, CHANGE, or ubject to change each fiscal year, will be v ion will remain in force unless cancelled b be assessed for any payments returned du	withdrawn between the first and the fifth y me, my Regional Contractor or my fir	business day based on the payment		
SIGNATURE OF SPONSOR, S	POUSE OR OTHER LEGAL GUARDIAN	OF BENEFICIARY	DATE (YYYYMMDD)		

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