



Automatic Monthly TRICARE Payment Setup Request

A new regional contractor – TriWest Healthcare Alliance (TriWest) – will be administering TRICARE in your area effective January 1, 2025. This request is to obtain your preferred auto payment information for TRICARE premiums starting January 1, 2025. This form must be completed and returned for coverage to continue.

Sponsor Information

Last Name: _____ First Name: _____

Sponsor SSN (XXX-XX-XXXX): _____

or Sponsor DoD Benefits Number (DBN) (XXXXXXXXXX - XX): _____

TRICARE Young Adult (TYA) Name (if applicable):

TYA Last Name: _____ TYA First Name: _____

TYA SSN (XXX-XX-XXXX): _____

or TYA DoD Benefits Number (DBN) (XXXXXXXXXX - XX): _____

TRICARE Program Information

Identify your current TRICARE program.

- | | |
|--|---|
| <input type="radio"/> TRICARE Prime | <input type="radio"/> TRICARE Select |
| <input type="radio"/> TRICARE Reserve Select (TRS) | <input type="radio"/> TRICARE Retired Reserve (TRR) |
| <input type="radio"/> TRICARE Young Adult (TYA) Prime | <input type="radio"/> TRICARE Young Adult (TYA) Select |

Monthly Payment Fee Options

Please choose the payment option to process automatic monthly payments.

- VISA/Mastercard/Discover Recurring Credit Card Payment**

Cardholder Name: _____

Card Number: _____ Expiration (MM/YY): _____ Billing Zip _____

- EFT Checking or Transactional Savings Account**

Account Holder's Name: _____

Bank Name: _____ Checking: Savings:

Nine Digit Bank or ABA Routing Number: _____

Account Number: _____

Monthly fee information

Payments will be processed between the first and fifth of each month.



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Authorization and Signature

I authorize TriWest to automatically charge my monthly TRICARE premium to my credit/debit card or bank account beginning January 2025.

Signature (Required): _____

Day (DD)/Month (MM)/Year (YYYY): _____

Please return this form to:

TriWest Healthcare Alliance
PO Box 2605
Virginia Beach, VA 23450

For more information:

www.TRICARE.mil/West

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by TriWest Healthcare Alliance (TriWest) and how it will be used.

Authority: 10 U.S.C. 1079 and 1086; 38 U.S.C. Chapter 17; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

Purpose: This information will be used by TriWest Healthcare Alliance (TriWest) to start or change electronic payments for your monthly TRICARE enrollment fees from your credit card, checking or savings accounts.

Routine uses: 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 Department of Defense (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, these records may be specifically disclosed outside the DOD as a routine use under 5 U.S.C. 552a(b)(3) as per DOD Blanket Routine Uses as published at <http://dpclo.defense.gov/privacy/SORNs>.

Disclosure: This information will be used by TriWest Healthcare Alliance (TriWest) to start or change electronic payments for your monthly TRICARE enrollment fees from your credit card, checking or savings accounts.