UnitedHealthcare | TRICARE

Refund Request Form
Beneficiary Enrollment Fees

Form Not Applicable for Claim Related Refunds

Please type or print all entries.

Coverage: ☐ **Prime** ☐ **TRS** (TRICARE Reserve Select) ☐ **TRR** (TRICARE Retired Reserve) ☐ **TYA** (TRICARE Young Adult)

Sponsor Name: Last	First	M.I.	Sponsor SSN or DBN
TYA Beneficiary Name: Last	First	M.I.	TYA Beneficiary SSN or ID

Home Address: Street	Apt. No.	City	State	ZIP Code

Step 1: Please specify the Dollar Amount of the refund you are requesting.

Refund Amount Requested: $_____

Step 2: Please specify the Reason that a refund is being requested.

I request a refund because: _____

_____

_____

_____

_____

Step 3: Please provide supporting documentation as applicable.

Please include any necessary documentation to support your request such as a copy of active duty orders, etc. If requesting a refund for a deceased beneficiary, a copy of the death certificate must be submitted to DEERS prior to submitting your refund request. Call the DEERS Support Office, toll-free, at 1-800-538-9552 for assistance with notification of a deceased beneficiary.

Step 4: Please authorize this request with your signature.

I hereby authorize UnitedHealthcare Military & Veterans to process my refund request in accordance with applicable TRICARE policy and acknowledge that a refund request does not guarantee a refund will be issued.

Sponsor Signature (*Required*): _____ **Date:** _____

Step 5: Please mail to the address below.

Mail this form to:

UnitedHealthcare Military & Veterans
TRICARE West Region Enrollment Department
P.O. Box 105492
Atlanta, GA 30348-5492

You can also Fax this form to:

1-877-890-7297

THANK YOU FOR YOUR SERVICE!

All requests will be reviewed by the Enrollment Department to determine if a refund is due. The processing time for all refund requests is approximately 4 to 6 weeks from the date the written request is received.

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the UnitedHealthcare Military & Veterans Information System and how it will be used.

AUTHORITY:	10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.
PURPOSE:	To collect information from you in order to manage your TRICARE enrollment, provide your benefits, and/or pay for those services.
ROUTINE USES:	Your records may be disclosed to investigate waste, fraud, abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may also occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNS/blanket_routine_uses.html and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.
DISCLOSURE:	Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process your request.