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

OMB No. 0720-0008 OMB approval expires May 31, 2019

The public reporting burden for this collection of information, 0720-0008, 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 Services, at whs mo-alex esd mbx dd-dod-information-collections@mail.mil. Respleaths 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.

#### 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 <a href="http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx">http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx</a>. 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**

#### (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://www.dmdc.osd.mil/appj/bwe/.

#### (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: <a href="https://www.dmdc.osd.mil/milconnect/">https://www.dmdc.osd.mil/milconnect/</a> 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.tricare.mil or the Regional Contractor's website at:
REGIONAL CONTRACTOR: REGION, ADDRESS, TELEPHONE AND FAX NUMBERS:
Region:
Address:
Toll-Free Number:
Fax Number:
UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP):
Address:
Toll-Free Number:

Fax Number:

SPONSOR'S SSN/DBN:							
TRICARE PRIME OPTION	N DESIRED:						
TRICARE Prime: Active duty service members have to enroll in TRICARE Prime. (Enrollment is not automatic.)							
TRICARE Prime Re		you may be enro	olled in TR	ICARE Prime	Remote or TRI	ICARE Prim	ne Remote for
	lf eligible, you may						enrollment criteria of rees are not eligible for
	listed on Page 1.	For the service					nrollment Application to tions, please visit the
		SECTION I - S	PONSOF	RINFORMAT	TION		
1. SPONSOR'S NAME (L	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) (XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX						
3. SPONSOR IS: (X one)	Active Duty	Retired	De	ceased (Go to	Section II.)	Unrem	arried Former Spouse
<ul><li>4. SPONSOR'S TELEPH</li><li>a. WORK:</li><li>b. HOME:</li></ul>	ONE NUMBER (In c. CELL:	<i>,</i>	5. SPON	ISOR'S E-MA	IL ADDRESS		6. SPONSOR'S DATE OF BIRTH (YYYYMMDD)
8. SPONSOR'S MAILING	i ADDRESS (Provi	de APO or FPO if s	stationed ov	verseas)	Same as resi	idence	New New
9. SPONSOR'S MILITAR	Y ASSIGNMENT						
a. UNIT	TAGGIGINILIVI		C.	STATE, ZIP C	CODE AND CO	OUNTRY OF	WORK ADDRESS
b. UNIT IDENTIFICATION	CODE (UIC) (If k	nown)					
10. SPONSOR'S REQUE  None (go to Section II)  Effective Date Requested	) Enroll	· —	sfer Enroll	ment	PCM Change	e D	isenroll (Non-AD only)
11. SPONSOR'S PCM PR and your uniformed se member services (non	rvice guidelines. I	Review PCM opt	ions online		_	-	-
a. 1st CHOICE  MTF PRP (ADSM)  Civilian	FULL NAME or M	TF/CLINIC					
b. 2nd CHOICE  MTF  Civilian	FULL NAME or M	TF/CLINIC					
c. PCM SPECIALTY	No Preference	ce Family	//General I	Practice	Internal Medi	cine	Flight Medicine
d. PREFERRED PCM G	ENDER	No Preference	е	Male	Female		

SPONSOR'S SSN/DBN:							
SECTION II - ENROLLING FAMII	LY MEMBE	R INFORMATION	OR PCM CH	HANGE (U	se addition	al copies of th	is page as necessary)
12.a. FAMILY MEMBER NAME (Last, First, Middle Initial) (Must match DEERS)  b. DATE OF BIRTH (YYYYMMDD)						F BIRTH (YYYYMMDD)	
c. REQUESTED ACTION: En	ıroll	Transfer Enrollmen	nt PCN	/I Change	Dise		ive Date ested:
d. RESIDENCE AND MAILING ADDRESS  (Provide address, with ZIP Code and Country, if different from Sponsor)							
e. TELEPHONE NUMBER (Include A	Same as Sponsor New  e. TELEPHONE NUMBER (Include Area Code)  f. E-MAIL ADDRESS						
(1) WORK: (2) HON	•	(3) CE	ELL:		=		
g. PCM PREFERENCE (Please list you Review PCM options online or call you	our first and s ur Regional	second choices below Contractor or USFHP	r. PCM assign customer sen	ment depen vices for ava	ds upon ava ilability of P0	nilability and unit CMs.)	formed service guidelines.
(1) 1st CHOICE MTF Civ	vilian	Same as Sponsor	FULL NAME	E or MTF/C	CLINIC		
(2) 2nd CHOICE MTF Civ	/ilian	Same as Sponsor	FULL NAME	E or MTF/C	CLINIC		
h. PCM SPECIALTY No Pre	eference	Family/General I	Practice	Internal M	edicine	Pediatrics	Flight Medicine
i. PREFERRED PCM GENDER		No Preference	Male	Fema	ale		
13.a. FAMILY MEMBER NAME (Las	t, First, Midd	lle Initial) (Must match	DEERS)			b. DATE O	F BIRTH (YYYYMMDD)
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d. RESIDENCE AND MAILING ADDRESS  (Provide address, with ZIP Code and Country, if different from Sponsor)							
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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 CO							
TRICARE Supplement (no other information is need	ded)						
Medical Insurance: Person(s) Covered:							
Policy Holder Name:		Carrier Name:					
Policy Number:		Policy Effective [					
Dental Insurance: Person(s) Covered:							
Policy Holder Name:		Carrier Name:					
Policy Number:		_ Policy Effective [					
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 - AC	CESS WAIVER	R AND SIGNATUR	E (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 hereby waive the drive time standards of thirty minutes for primary care and one hour for specialty care  I understand if I selected a PCM by name, team, or location (MTF or civilian), TRICARE will enroll me with that PCM subject to PCM availability and uniformed services policy. 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 OTHE LEGAL GUARDIAN OF BENEFICIARY	RELATIONSHIP 1	TO SPONSOR	3. DATE SIGNED (YYYYMMDD)				
<b>ENROLLMENT NOTE</b> : Prime enrollment start dates are based primarily on the 20th of the month rule (applications received on/before the 20th of the month are effective the first calendar day of the next month). You should confirm enrollment and PCM assignment before obtaining routine medical care. (Note: This does not apply to TRICARE Overseas Prime or to active duty service members.)							
<b>DISENROLLMENT NOTE:</b> In some cases, you may not be able to re-enroll in TRICARE Prime for a 12-month period from the date of the disenrollment. This one year period does not apply to any family member whose sponsor is in grade E-1 to E-4.							
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 fo	r payment optio	ns.		
Note 1, Monthly Payment: monthly payment plan, you i money order at the time of a	must make an	initial three mon	th payment by o			
Note 2, Quarterly and Ann (Your Contractor may offer r				ly or annual basis fo	r credit card	payments.
Note 3, Personal Check: F Checks received for ongoing				ersonal) is limited to	the initial thi	ree month payment only.
Note 4, Electronic Funds	Гransfer: EFT	is for monthly o	or quarterly payr	nents only. The initia	al payment c	annot be made via EFT.
PAYMENT FEE, PLAN AND METHOD OPTIONS (Some	MONTHLY INITIAL 3-MON	Allotment Fro	om Retired Pay	Electronic Funds Money Order		VISA or MasterCard
options are location specific)	QUARTERLY	VISA or M	lasterCard			· · · · · · · · · · · · · · · · · · ·
	ANNUAL	VISA or M	lasterCard			
I choose to have my e	nrollment fees	paid by monthly	allotment from	my Uniformed Service	ces retired pa	ay.
<b>NOTE:</b> Only retired Uniformed below. Your Regional Contract (The current rates are at <a costs"="" href="https://www.news.news.news.news.news.news.news.n&lt;/td&gt;&lt;td&gt;ctor will charge th&lt;/td&gt;&lt;td&gt;ne correct fee amo&lt;/td&gt;&lt;td&gt;&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;&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;td&gt;B - ELECT&lt;/td&gt;&lt;td&gt;RONIC FUNDS&lt;/td&gt;&lt;td&gt;TRANSFER&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;td&gt;&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td&gt;ELECTRONIC FUNDS T&lt;/td&gt;&lt;td&gt;RANSFER FOR&lt;/td&gt;&lt;td&gt;AUTOMATIC PA&lt;/td&gt;&lt;td&gt;YMENTS&lt;/td&gt;&lt;td&gt;Checking&lt;/td&gt;&lt;td&gt;(attach voide&lt;/td&gt;&lt;td&gt;d check) Savings&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td colspan=7&gt;Name and Address of Financial Institution&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td colspan=6&gt;Name on Account Telephone Number of Financial Institution&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td colspan=6&gt;Account Number ABA Routing Number&lt;/td&gt;&lt;/tr&gt;&lt;tr&gt;&lt;td colspan=6&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> )						
C - CREDIT/DEBIT CARD						
INITIAL 3-MONTH PAYN	MENT VI	SA/MASTERCARI	D MONTHLY REC	CURRING PAYMENTS:	:	
Number Exp. Date (MM/YYYY)						
Security Code (3-digit numbe NOTE: Your Regional Contra (The current rates are at www	actor will charge	the correct fee am				
SIGNATURE						
My signature authorizes the Regional Contractor to START, CHANGE, or STOP my automated payments as indicated above. Fee amounts, as determined by TRICARE and subject to change each fiscal year, will be withdrawn between the first and the fifth business day based on the payment option selected. This authorization will remain in force unless cancelled by me, my Regional Contractor or my financial institution. I understand a \$20.00 administrative fee may be assessed for any payments returned due to insufficient or unavailable funds.						
SIGNATURE OF SPONSOR, S						ATE