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

OMB No. 0720-0008
OMB approval expires 20250930

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.tricare-west.com

Contractor for actions effective prior to January 1, 2025:	**Contractor for actions effective on/after January 1, 2025:**
Health Net Federal Services	TriWest Healthcare Alliance
Address: Health Net Federal Services PO Box 8458 Virginia Beach, VA 23450-8458	**Address**: TriWest Healthcare Alliance PO Box 43470 Phoenix, AZ 85080-3470
Toll-Free Number: 1-844-866-West (9378)	**Toll-Free Number:** 1-888-TRIWEST (874-9378)
Fax Number: 1-844-388-8282	**Fax Number:** 1-866-566-9915
Website: www.tricare-west.com	**Website:** www.tricare.mil/West

UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP):

Address: (1) USFHP at CHRISTUS Health, PO Box 169001, Irving TX 75016 (2) Pacific Medical Centers, 1200 12th Ave S, Seattle, WA 98144

Toll Free Number: 1-800-585-5883, Option 1

Fax Number: (1) 1-210-766-8854 (2) 1-206-326-2458

SPONSOR'S SSN/DBN:

TRICARE PRIME OPTION DESIRED:

☐ **TRICARE Prime:** Active duty service members have to enroll in TRICARE Prime. (Enrollment is not automatic.)

☐ **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 - 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)*	**5. SPONSOR'S E -MAIL ADDRESS**	**6. SPONSOR'S DATE OF BIRTH** *(YYYYMMDD)*
a. WORK: c. CELL: b. HOME:		

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

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

9. SPONSOR'S MILITARY ASSIGNMENT

a. UNIT	c. STATE, ZIP CODE AND COUNTRY OF WORK ADDRESS
b. UNIT IDENTIFICATION CODE (UIC) *(If known)*	

10. SPONSOR'S REQUESTED ACTION *(X one)*

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

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 Requested *(YYYYMMDD)*:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*

a. WORK: b. HOME: c. CELL:

f. E -MAIL ADDRESS

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.)*

(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 Requested *(YYYYMMDD)*:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*

a. WORK: b. HOME: c. CELL:

f. E -MAIL ADDRESS

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.)*

(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

14.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 Requested *(YYYYMMDD)*:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*

a. WORK: b. HOME: c. CELL:

f. E -MAIL ADDRESS

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.)*

(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

(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 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 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 OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*

ENROLLMENT NOTE: Your regional contractor will process your enrollment, disenrollment or change request to be effective on the date requested or the date of event (e.g., initial eligibility, marriage, birth) as appropriate. If your regional contractor receives your enrollment request within 90-days of loss of other TRICARE or healthcare coverage, your TRICARE Prime coverage can start on the day after the loss of your other coverage provided all enrollment fees are 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.

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 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 Transfer: EFT is for monthly or quarterly payments only. The initial payment cannot be made via EFT.

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

A - ALLOTMENT (where feasible, as mandated by law (NDAA for FY2020, Section 702))

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

NOTE: Only retired Uniformed Services members may establish an allotment from their retired pay. The Uniformed Service member must sign below. Your Regional Contractor will charge the correct fee amount each month based on your enrollment, individual or family. (The current rates are at www.tricare.mil/costs)

B - ELECTRONIC FUNDS TRANSFER

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

Name and Address of Financial Institution _____

Name on Account _____ Telephone Number of Financial Institution _____

Account Number _____ ABA Routing Number _____

NOTE: Your Regional Contractor will charge the correct fee amount based on your enrollment, individual or family. (The current rates are at www.tricare.mil/costs)

C - CREDIT/DEBIT CARD

☐ INITIAL 3-MONTH PAYMENT ☐ MONTHLY RECURRING PAYMENTS

Name of Cardholder _____

CREDIT/DEBIT CARD Number: _____ Exp. Date *(MM/YYYY)*: _____

Card Verification Code (CVC) *(3-digit number on reverse side of card* _____

NOTE: Your Regional Contractor will charge the correct fee amount based on your enrollment, individual or family. (The current rates are at www.tricare.mil/costs)

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, SPOUSE OR OTHER LEGAL GUARDIAN OF BENEFICIARY	**DATE** *(YYYYMMDD)*