TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

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AGENCY DISCLOSURE NOTICE

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, Executive Services Directorate (0720-0008). 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.

PLEASE DO NOT RETURN YOUR APPLICATION TO THE ABOVE ORGANIZATION.
SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION INSTRUCTION SHEET.

PRIVACY ACT STATEMENT

AUTHORITY: 5 U.S.C. 552a, 10 U.S.C. 1079 and 1086, 58 FR 45318, 65 FR 30966, May15, 2000.

PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR 199.17).

ROUTINE USE(S): Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions. Appropriate disclosures may be made to other Federal, State, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.

DISCLOSURE: Voluntary; however, failure to provide information will result in the denial of enrollment.

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This form is for the following:

- Eligible beneficiaries who want to enroll in TRICARE Prime, TRICARE Prime Remote (TPR), or US Family Health Plan.
- Portability transfers to a new region for the TRICARE program listed above.
- Address changes within the same region for the TRICARE program listed above.
- Primary Care Manager (PCM) changes as follows: Within the same Military Treatment Facility (MTF)/Clinic, to an MTF/Clinic, or to a civilian PCM.

Review the eligible categories (1 through 5) below to determine the application sections you must complete.

ELIGIBLE CATEGORIES	SECTION I Sponsor Information	SECTION II Enrolling Family Members	SECTION III Other Health Insurance	SECTION IV Reason for PCM Change	SECTION V Signature	SECTION VI Enrollment Fee Payment
1. Active Duty Members, Reserve Component Members called or ordered to active duty for 30 days or more.	X			Complete if changing PCM		
2. Active Duty Family Members (ADFMs) and Survivors of Active Duty (first three years in survivor status).	X	X	X	Complete if changing PCM	X	
3. Active Duty Family Members of Reserve Component Members called or ordered to active duty for 31 days or more. Must be eligible in DEERS.	X	X	X	Complete if changing PCM	X	
4. Retirees, retiree family members, survivors, and eligible former spouses under 65 years of age who reside within the 50 United States or the District of Columbia. **This excludes beneficiaries over the age of 65 who are eligible for TRICARE Prime.**	X	X	X	Complete if changing PCM	X	X *(Must include required payment)*
5. ADFMs, Retirees, retired family members, survivors and eligible former spouses 65 years or older and entitled to Medicare Part A. **(Applicable only to US Family Health Plan.)**	X	X	X	Complete if changing PCM	X	X *(If not enrolled in Medicare Part B)*

GENERAL INSTRUCTIONS

1. **TRICARE Prime** - Active duty service members are required to enroll in Prime. Active duty family members, retirees and their family members are encouraged, but not required, to enroll in Prime.

2. **TRICARE Prime Remote (TPR)** is a program for active duty service members and their family members when the sponsor lives and works over 50 miles or one hour drive from a Military Treatment Facility (MTF) and the family member lives with the sponsor.

3. Families with more than three members need multiple copies of page 6.

4. Print all information in **ink**. Make sure the information is complete and accurate.

5. Ensure personal and family information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center (DMDC) Support Office at 1-800-538-9552 and refer to your name as printed on your military ID card.

If you are an unremarried former spouse, please remember to use your personal SSN as the sponsor number.

6. There are two address fields for the sponsor and each family member. The Residence address block should be completed if it is known. If you haven't established a residence at the time you are completing this form, insert "To be determined." in the Residence address block and complete the Mailing address block. The Mailing address block is only to be completed if mail is to be sent to an address other than the Residence address. If the Mailing address block is blank, all mail will be sent to the Residence address. The addresses and telephone numbers you include on this form will update DEERS.

It is very important that you update your personal information in DEERS whenever your residence address, mailing address, telephone number or Medicare status changes. Please see instruction 5 above.

7. Sign and date the application (Section VI).

8. Please keep a copy of the completed TRICARE Prime Application/PCM Change Form for your records.

Enrollment in TRICARE Prime requires that all services, except for emergencies, must be coordinated through the PCM. If not, the beneficiary will be responsible for payment of charges in accordance with the Point-of-Service (POS) option as described in the TRICARE Beneficiary Handbook.

GENERAL INSTRUCTIONS *(Continued)*

9. **US Family Health Plan** is a TRICARE Prime enrollment option for eligible individuals and families who live in seven specific parts of the country: Seattle, Washington; Cleveland, Ohio; Portland, Maine; Brighton, Massachusetts; Staten Island, New York; Baltimore, Maryland; and Houston, Texas. The primary difference between other TRICARE options and the US Family Health Plan is that US Family Health Plan may be used by uniformed service retirees and their eligible family members who are age 65 or older.

10. For enrollment or PCM changes in the **US Family Health Plan**, submit the completed Application/PCM Change Form to the US Family Health Plan address listed below. For questions regarding enrollment/PCM changes in the US Family Health Plan, contact the US Family Health Plan member services at:

MAILING INSTRUCTIONS

1. Submit the completed Application/PCM Change Form to the address below. For enrollment or PCM changes in the US Family Health Plan please see instruction 10 above.

Applications can be mailed to the contractor identified above or dropped off at a TRICARE Service Center (TSC). Contact the local TSC in person or call the telephone number listed below in instruction 3 to determine when your new or transferred enrollment will begin.

3. For enrollment assistance, please call at

PAY INSTRUCTIONS

1. If you have elected monthly allotment from retired pay as the payment method for your TRICARE Prime enrollment fees, you must complete an allotment authorization letter provided. If you select this type of payment, you must make the first quarterly payment by check at the time of application.

2. If you elected electronic funds transfer (EFT) as the payment method for your TRICARE Prime enrollment fees, ensure you provide your banking information in Section VI, Part B of the enrollment application form. If you select this type of payment, you must make the first quarterly payment by check at the time of application.

3. If you elected credit card as the method for your TRICARE Prime enrollment, ensure you provide your credit card information in Section VI, Part C of the enrollment application form. If you select this type of payment, these payments are made either quarterly or annually.

TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

X one:		Prime Enrollment		Prime Remote Enrollment		US Family Health Plan Enrollment		PCM Change

1. SPONSOR SOCIAL SECURITY NUMBER (SSN)				
2. SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*				
3. SPONSOR DATE OF BIRTH *(YYYYMMDD)*				
4. SPONSOR IS: *(X one)*		Active Duty		Retired
		Deceased *(Go to Section II.)*		Former Spouse
5. RESIDENCE ADDRESS *(Street/P.O. Box, Apartment No., City, State, ZIP Code)*				
6. MAILING ADDRESS *(If different from residence address)*				
7. SPONSOR TELEPHONE NUMBERS *(Include Area Code)*	a. HOME		b. WORK	
8. CITY AND COUNTRY OF MILITARY ASSIGNMENT *(OCONUS only)*				
9. MEMBER'S UNIT AND UNIT IDENTIFICATION CODE (UIC) *(If known)*				
10. ZIP CODE OF WORK ADDRESS				
11. E-MAIL ADDRESS				

12. SPONSOR'S ACTION *(X one)*		New Enrollment		PCM Change		None	

13. SPONSOR PRIMARY CARE MANAGER (PCM) PREFERENCE *(Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF, or US Family Health Plan Member Services for availability of PCMs.) (Complete all that apply.)*

a. PCM NAME MTF/CLINIC *(If known)*	1st CHOICE					
	2nd CHOICE					
b. PCM SPECIALTY		No Preference		Flight Medicine		
		Family/General Practice		Internal Medicine		
c. PREFERRED PCM GENDER		No Preference		Male		Female

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CARBON COPY: RETAIN FOR YOUR RECORDS.

SPONSOR SOCIAL SECURITY NUMBER							
SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*							
	a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*						
	b. DATE OF BIRTH *(YYYYMMDD)*						
	c. RESIDENCE ADDRESS *(Street/P.O. Box, Apartment No., City, State, ZIP Code)*						
	☐ Same as Sponsor						
	d. MAILING ADDRESS *(If different from residence address)*						
	☐ Same as Sponsor						
	e. RELATIONSHIP TO SPONSOR	☐	Spouse	☐	Former Spouse	☐	Child
	f. TELEPHONE NUMBERS *(Include Area Code)*	(1) HOME			(2) WORK		
	g. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)*						
	(1) PCM NAME MTF/CLINIC *(If known)*	1st CHOICE ☐ Same as Sponsor					
		2nd CHOICE ☐ Same as Sponsor					
	(2) PCM SPECIALTY	☐	No Preference	☐	Flight Medicine	☐	Pediatrics
		☐	Family/General Practice	☐	Internal Medicine		
	(3) PREFERRED PCM GENDER	☐	No Preference	☐	Male	☐	Female
	a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*						
	b. DATE OF BIRTH *(YYYYMMDD)*						
	c. RESIDENCE ADDRESS *(Street/P.O. Box, Apartment No., City, State, ZIP Code)*						
	☐ Same as Sponsor						
	d. MAILING ADDRESS *(If different from residence address)*						
	☐ Same as Sponsor						
	e. RELATIONSHIP TO SPONSOR	☐	Spouse	☐	Former Spouse	☐	Child
	f. TELEPHONE NUMBERS *(Include Area Code)*	(1) HOME			(2) WORK		
	g. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)*						
	(1) PCM NAME MTF/CLINIC *(If known)*	1st CHOICE ☐ Same as Sponsor					
		2nd CHOICE ☐ Same as Sponsor					
	(2) PCM SPECIALTY	☐	No Preference	☐	Flight Medicine	☐	Pediatrics
		☐	Family/General Practice	☐	Internal Medicine		
	(3) PREFERRED PCM GENDER	☐	No Preference	☐	Male	☐	Female

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SPONSOR SOCIAL SECURITY NUMBER	
SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*	

1. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE?	☐	Yes
	☐	No

If Yes, provide a copy of the Medicare card for each family member that is under the age of 65 and entitled to Medicare.

2. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE *(not a TRICARE Supplement)?*	☐	Yes
	☐	No

If Yes, provide the name of the other health insurance and the insurance identification number:

REASON FOR CHANGE *(X one per affected family member)*

Name
☐ Move ☐ Other *(Explain)*

Name
☐ Move ☐ Other *(Explain)*

Name
☐ Move ☐ Other *(Explain)*

Name
☐ Move ☐ Other *(Explain)*

Please read and sign only if you are outside the service area.

Your enrollment application indicates that your current address is outside the service area. You may travel to a location where there is a provider network and enroll at that location. However, since you live outside the service area, by signing below, you indicate that your travel time to the network of primary care delivery sites may exceed 30 minutes from your home to the delivery site and your travel time for specialty care may exceed one hour.

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

I understand that it is my responsibility to comply with all TRICARE Prime procedures. By signing the form, I certify that the information on this form 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 imprisonment under applicable Federal law.

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

SPONSOR SOCIAL SECURITY NUMBER
SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*

SECTION VII - PAYMENT OF TRICARE PRIME ENROLLMENT FEES

NOTE: This section is only for retirees, retiree family members, survivors and eligible former spouses.

1. Retired beneficiaries and retiree family members entitled to Medicare Part A and Medicare Part B must be enrolled in Medicare Part B to be eligible for enrollment in TRICARE prime. TRICARE enrollment fees are waived for these retirees and retiree family members if they provide a copy of their Medicare card as proof of entitlement to Medicare Part A and B and DEERS reflects their entitlement to Medicare Part A and B.
2. Explain all split enrollments (retiree family enrollment in more than one TRICARE Region) on a separate sheet of paper.

1. PAYMENT FEE OPTIONS		**MONTHLY**		**QUARTERLY**		**ANNUAL**
2. PLAN SELECTION *(X one)*		Single $19.17		Single $57.50		Single $230.00
		Family $38.34		Family $115.00		Family $460.00
3. PAYMENT METHOD *(X one)*		a. Allotment From Retired Pay **(Complete A below)**		a. Check/Cashiers Check/Money Order*		a. Check/Cashiers Check/Money Order*
		b. Electronic Funds Transfer **(Complete B below)**		b. VISA or Master Card **(Complete C below)**		b. VISA or Master Card **(Complete C below)**

If you have elected a monthly payment option (Allotment or Electronic Funds Transfer) please see Pay Instructions on Page 4 for further details regarding establishing monthly payments.
If you have elected Monthly Allotment or Electronic Funds Transfer, the first quarterly payment is due at the time of application.

NOTE: **Quarterly** and **annual** bills will be sent on a quarterly and annual basis, respectively. **Monthly** bills will not be sent.

*Make check payable to the

	I, _____ *(Signature of sponsor)* 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. Follow instructions on Premium Allotment Authorization letter and submit as directed.
	I, _____ *(Signature of account holder)* choose to have my enrollment fees paid by electronic funds transfer.
	(1) NAME AND ADDRESS OF FINANCIAL INSTITUTION
	(2) TELEPHONE NUMBER OF FINANCIAL INSTITUTION *(Include Area Code)*
	(3) ACCOUNT INFORMATION *(X)* ☐ Savings ☐ Checking *(Attach voided check)*
	(4) ACCOUNT NUMBER
	(5) BANK OR ABA ROUTING NUMBER
	(6) NAME ON ACCOUNT
	I, _____ *(Signature of card holder)* choose to have my initial enrollment fees billed to my credit card. *(Annual and Quarterly initial payments only)*
	(1) NAME ON CREDIT CARD
	(2) CREDIT CARD NUMBER AND EXPIRATION DATE *(MMYY)*
	(3) TYPE OF CARD *(X)* ☐ VISA ☐ Master Card