Update Your Automatic Payments

TRICARE Prime | TRICARE Reserve Select
TRICARE Young Adult | TRICARE Retired Reserve

You can also login to manage your automatic payments through your secure **TriWest.com** account.

This form can only be used to make a change to **existing** automatic payments. Use the TRICARE Prime Allotment form at TriWest.com/Forms to request a change to an existing allotment.

Sponsor Name: ______________________________ Sponsor SSN or DoD Benefits Number: ________________

TRICARE Young Adult Only: Enrollee Name: ________________________________

TRICARE Prime Only: ☐ Please cancel my automatic payments.

☐ Make a Change to Electronic Funds Transfer (EFT)

Account Holder's Name: ______________________________

Bank Name: ______________________________ Bank Phone: (______)________________

Bank Address: ____
Street City State ZIP

ABA Routing Number (9 digits): ____________________ Account Type: ☐ Checking (attach voided check)

Bank Account Number: ____________________ ☐ Savings (attach deposit slip)

☐ Make a Change to Recurring Credit/Debit Card

Cardholder Name: ______________________________ Phone: (____)__________

Cardholder Billing Address: ____
Street City State ZIP

Card Number ______________________________ Exp Date __________

Cardholder Signature: ______________________________ Type: ☐ Visa® ☐ MasterCard® ☐ Discover®

☐ Adjust Automatic Payment Amount

I have changed my enrollment type. Please adjust my monthly payments accordingly. Costs are at TRICARE.mil/Costs.

☐ I have changed my enrollment from Individual/Member to Family.

☐ I have changed my enrollment from Family to Individual/Member.

I hereby authorize TriWest Healthcare Alliance on the 1st business day of each billing cycle to initiate a debit entry to my checking or savings account from the financial institution indicated above. I understand that in the event the original transaction is rejected due to insufficient funds, a $20.00 service charge will be directly billed to me, in addition to the enrollment fee owed for that billing cycle. I authorize TriWest Healthcare Alliance Corp. to adjust my monthly enrollment fee at a future date should my enrollment status or amount due change. *For TRICARE Prime only*: I authorize TriWest to bill me for any past due amounts should the credit/debit card be declined or the transaction be rejected due to insufficient funds.

This authorization is to remain in full force and effect as long as TriWest Healthcare Alliance remains the TRICARE West Region Managed Care Support Contractor or until TriWest receives written notification from me of its termination in such time and manner as to afford TriWest a reasonable opportunity to act on it. If I disenroll from the TRICARE West Region before March 31, 2013, it is my responsibility to notify TriWest to discontinue the automatic payment option.

____
Signature Date

Privacy Act Statement – This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only." Violations may be punishable by fines, imprisonment, or both.

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