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

OMB No. 0720-0008 OMB approval expires 20250930

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, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dodinformationcollections@ mail.mil. 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.

#### 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 <a href="https://milconnect.dmdc.osd.mil">https://milconnect.dmdc.osd.mil</a>

## (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://milconnect.dmdc.osd.mil">https://milconnect.dmdc.osd.mil</a> to view specific information. For additional information on TRICARE, visit the TRICARE website at <a href="https://www.tricare.mil">www.tricare.mil</a> or the Regional Contractor's website at: <a href="https://www.tricare.mil">https://www.tricare.mil</a> or the Regional Contractor's website at: <a href="https://www.tricare.mil">www.tricare.mil</a> or the Regional Contractor's website at: <a href="https://www.tricare.mil">www.tricare.mil</a> or the Regional Contractor's website at: <a href="https://www.tricare.mil">www.

## **REGIONAL CONTRACTOR: REGION, ADDRESS, TELEPHONE AND FAX NUMBERS:**

#### **Region: EAST REGION**

Address: Humana Military, Attn: PNC Bank, PO Box 105838, Atlanta GA 30348-5838

Toll-Free Number: 1-800-444-5445

Fax Number: 1-866-836-9535

## UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP):

Address: (1) Martin's Point, PO Box 9746, Portland ME 04104 (2) Johns Hopkins, P.O. Box 8689, Elkridge, MD 21075, (3) Brighton Marine, PO Box 9195, Watertown MA 02471-9900, (4) St Vincent's NYC, 5 Penn Plaza, 9th Floor, New York NY 10001

Toll-Free Number: (1) 1-888-241-4566, (2) 1-800-801-9322, (3) 1-800-818-8589, (4) 1-800-241-4848

Fax Number: (1) 1-207-828-7822, (2) 1-410-424-4770, (3) 1-617-923-5898, (4) 1-212-356-4949

SPONSOR'S SSN/DBN:				
TRICARE PRIME OPTION DESIRED:				
TRICARE Prime: Active duty service members have to e	nroll in TRICAR	E Prime. (Enrollment i	s not automa	atic.)
TRICARE Prime Remote: If eligible, you may be enrolled Active Duty Family Members.	I in TRICARE F	Prime Remote or TRICA	ARE Prime F	Remote for
<ul> <li>TRICARE Overseas Program Prime: Family members must be command sponsored and meet specific enrollment criteria of</li> <li>the overseas area. If eligible, you may be enrolled in TRICARE Overseas Program Prime Remote. Retirees are not eligible for TRICARE Overseas Program Prime.</li> </ul>				
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 - S	PONSOR INF	ORMATION		
1. SPONSOR'S NAME (Last, First, Middle Initial) (Must match DE	EERS)	2. SPONSOR'S SOC (XXX-XX-XXXX) or Dol (XXXXXXXXXXXX)	IAL SECUR D BENEFITS	ITY NUMBER (SSN) S NUMBER (DBN)
3. SPONSOR IS: (X one) Active Duty Retired	Deceas	ed (Go to Section II.)		arried Former Spouse
4. SPONSOR'S TELEPHONE NUMBER (Include Area Code)	5. SPONSOR'	S E -MAIL ADDRESS		6. SPONSOR'S
a. WORK: c. CELL:				DATE OF BIRTH (YYYYMMDD)
b. HOME:				. ,
8. SPONSOR'S MAILING ADDRESS (Provide APO or FPO if s	tationed oversea	s) 🗌 Same as res	idence [	New
9. SPONSOR'S MILITARY ASSIGNMENT				
a. UNIT	c. STAT	E, ZIP CODE AND CO	UNTRY 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 FULL NAME or MTF/CLINIC				
Civilian (ADSM)				
b. 2nd CHOICE FULL NAME or MTF/CLINIC MTF				
Civilian				
c. PCM SPECIALTY No Preference Family	/General Practi	ce 🗌 Internal Med	dicine [	Flight Medicine
d. PREFERRED PCM GENDER ON Preference Male Female				
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PREVIOUS EDITION IS OBSOLETE.

CUI (when filled in)

CUI (when filled in)

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	Effective Date Requested (YYYYMMDD): Disenroll			
d. RESIDENCE AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if dif	ferent from Sponsor)			
Same as Sponsor New				
e. TELEPHONE NUMBER (Include Area Code)	f. E -MAIL ADDRESS			
a. WORK: b. HOME: c. CELL:				
g. PCM PREFERENCE (Please list your first and second choices below. PCM assignment depen Review PCM options online or call your Regional Contractor or USFHP customer services for available.				
(1) 1st CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CL				
(2) 2nd CHOICE MTF Civilian Same as Sponsor FULL NAME or MTF/CL	INIC			
h. PCM SPECIALTY No Preference Family/General Practice Internal	Medicine Pediatrics Flight Medicine			
i. PREFERRED PCM GENDER No Preference Male Fen	nale			
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	Effective Date Requested (YYYYMMDD): Disenroll			
d. RESIDENCE AND MAILING ADDRESS (Provide address, with ZIP Code and Country, if dif	ferent from Sponsor)			
Same as Sponsor New				
Same as Sponsor New e. TELEPHONE NUMBER (Include Area Code)	f. E -MAIL ADDRESS			
e. TELEPHONE NUMBER (Include Area Code)         a. WORK:       b. HOME:       c. CELL:				
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PREVIOUS EDITION IS OBSOLETE.

# CUI (when filled in)

SPONSOR'S SSN/DBN:							
SECTION III - REASON FOR DISENROLLMENT OR PCM CHANGE (Complete if disenrolling or making a PCM change)							
Name of Family Member	:	Relocatio	on 🗌 Dissa	atisfied	PCS		Other:
Name of Family Member	:	Relocatio	n 🗌 Dissa	atisfied [	PCS		Other:
Name of Family Member	:	Relocatio	on 🗌 Dissa	atisfied [	PCS		Other:
Name of Family Member	Relocation Dissatisfied PCS Other:						
	SECTI	ON IV - OTH			ANCE		
PLEASE IDENTIFY IF AN	IYONE IS CURRENTLY CO	OVERED BY	OTHER HE		SURANCE.		
TRICARE Supplement	: (no other information is neede	ed)					
Medical Insurance:	Person(s) Covered:						
Policy Holder Name:			Car	rier Nam	e:		
Policy Number:	Policy Effective Date:						
Dental Insurance:	Person(s) Covered:						
Policy Holder Name:			Car	rier Nam	e:		
Policy Number:			Poli	icy Effect	ive Date:		
Vision Insurance:	Person(s) Covered:						
Policy Holder Name:			Car	rier Nam	e:		
Policy Number:			Poli	icy Effect	ive Date:		
Prescription Insurance	: Person(s) Covered:						
Policy Holder Name:	-		Car	rier Nam	e:		
Policy Number:			Poli	icy Effect	ive 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 SPON LEGAL GUARDIAN O	ISOR, SPOUSE, OR OTHE F BENEFICIARY	ĒR	2. RELATIC	ONSHIP T	o sponso	OR	3. DATE SIGNED (YYYYMMDD)
<b>ENROLLMENT NOTE</b> : 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).							
<b>DISENROLLMENT NOTE:</b> 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.							
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SPONSOR'S SSN/DBN:					
SECTION VI - PAYMENT OF TRICARE PRIME ENROLLMENT FEES					
NOTE: This section is only for	r 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				
<ul> <li>PAYMENT OPTIONS: See Sections A, B, and C below for payment options.</li> <li>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.</li> <li>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.)</li> </ul>					
	nent by check (money order, cashier's or personal) is limited to the initial three mont g payment will not be accepted.	h payment only.			
Note 4, Electronic Funds Tran	sfer: EFT is for monthly or quarterly payments only. The initial payment cannot be	made via EFT.			
PAYMENT FEE, PLAN AND METHOD OPTIONS (Some	MONTHLY Allotment From Retired Pay Electronic Funds Transfer				
options are location specific)	INITIAL 3-MONTH PAYMENT: Check Money Order	Credit/Debit Card (Section C below)			
	QUARTERLY Credit/Debit Card				
	ANNUAL Credit/Debit Card				
A - ALL	OTMENT (where feasible, as mandated by law (NDAA for FY2020, Se	ction 702))			
<b>NOTE:</b> 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 <u>www.tricare.mil/costs</u> )					
	B - ELECTRONIC FUNDS TRANSFER				
ELECTRONIC FUNDS TRA	NSFER FOR AUTOMATIC PAYMENTS Checking (attach v	voided check)			
Name and Address of Fina	ncial Institution				
Name on Account	Telephone Number of Financial Institution				
Account Number	ABA Routing Number				
<b>NOTE:</b> Your Regional Contractor will charge the correct fee amount based on your enrollment, individual or family. (The current rates are at <u>www.tricare.mil/costs</u> )					
C - CREDIT/DEBIT CARD					
INITIAL 3-MONTH PAYMEN	NT MONTHLY RECURRING PAYMENTS				
Name of Cardholder					
CREDIT/DEBIT CARD Nur	nber: Exp. Date (MM/YYYY):				
Card Verification Code (CVC) (3-digit number on reverse side of card					
<b>NOTE:</b> Your Regional Contractor will charge the correct fee amount based on your enrollment, individual or family. (The current rates are at <a href="http://www.tricare.mil/costs">www.tricare.mil/costs</a> )					
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	POUSE OR OTHER LEGAL GUARDIAN OF BENEFICIARY	DATE (YYYYMMDD)			
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