TRICARE PRIME ENROLLMENT / TRANSFER FORM

Make Checks Payable To: HMHS, Inc.

Thank you for choosing TRICARE Prime. Please print all information clearly in ink and sign the form. Your enrollment will be effective the first day of the following month if this form is received by the 20th of the current month, all information is complete, and appropriate payment has been received. If transferring, enrollment is effective on the date a complete form is received. Failure to fully complete any section and sign the form will result in a delay in your enrollment in TRICARE Prime. If you are unsure how to answer a question, please call our toll-free telephone number 1-800-444-5445. Our Beneficiary Service Representatives will be happy to assist you.

IMPORTANT: Carefully read the form completion instructions, and then print 2 copies of each form. Write information clearly and legibly in ink. Select payment methods, chose the appropriate address based on your military status, and transfer the address onto an envelope. Remember to add the required postage, sign your enrollment form, and enclose any applicable enrollment fee, then mail. Once received, a follow-up packet will be mailed to you. Enrollment is subject to eligibility, PCM assignment, and all other TRICARE regulations. Upon completion of the entire enrollment process, a Prime identification card will be mailed to you.

1. Check appropriate box - New Enrollment, Portability or Split Enrollment. Portability is a feature of TRICARE Prime that allows active duty and retiree military families the opportunity to transfer their healthcare coverage from one TRICARE contractor region to another. The split enrollment option allows members of the same family to enroll in separate TRICARE contractor regions, with a maximum of one family enrollment fee.
2. Sponsor's Name - Last Name, First Name, Middle Initial.
3. Sponsor's Social Security Number.
4. Sponsor's Address - Street / P.O. Box, Apt. Number, City, County, State, & Zip.
5. Sponsor's Birthdate - Month, Day, Year.
6. Is sponsor still on Active Duty? Check the appropriate box.
7. Active Duty Sponsor's Pay Grade - Check the appropriate box.
8. Is sponsor Deceased, Retired, Enrolling? Check the appropriate box. (Note: It is not necessary for Active Duty Service Members to complete form). Note: If sponsor and spouse are both retired from the military and plan to enroll additional family members in TRICARE Prime, you must visit the local personnel office to have a family medical record created under one social security number.
9. Phone Numbers - Sponsor (Home / Work), Spouse (Work).
10. Active Duty Unit of Assignment.
11. If sponsor is enrolling, list sponsor's first choice for a Primary Care Manager (PCM) from the directory. A Military Treatment Facility team \PCM or a civilian physician MUST be selected from your TRICARE provider directory. TRICARE Standard physicians are not necessarily contracted physicians. Note that some physician practices are full and will only accept existing patients.
12. List sponsor's second choice for a Primary Care Manager (PCM) from the directory. A Military Treatment Facility team \PCM or a civilian physician MUST be selected from your TRICARE provider directory.
13. Family Member Information - List information for all family members who are enrolling in the TRICARE Prime program. MUST select PMC to enroll. Please state two PCM choices for each Prime member. HMHS will assign a PCM if your first and second choice cannot be honored. If enrolling more than four (4) family members, please use a second enrollment form. Indicate sponsor's name at the top of the second form.
14. All beneficiaries who print, complete, and submit this website enrollment form will receive additional enrollment materials, I.e. CHOICES Handbook, Health Enrollment and Assessment Review Form (HEAR), etc.
15. Payment options. Retirees and their family members wishing to enroll in Prime must enclose a non refundable enrollment fee. Please state whether you would like to pay annually or quarterly - Check the appropriate box. Please indicate amount enclosed or to be charged. Please indicate the method of payment - Check the appropriate box. The enrollment fee must be paid at the time of initial enrollment for TRICARE Prime. If paying by credit card, a signature is required. Do not send post dated checks.

ENROLLMENT FEES	ACTIVE DUTY FAMILY MEMBERS	RETIREES AND THEIR FAMILIES			
	None	Individual:	$230 annually or $57.50 per quarter	Family:	$460 annually or $115 per quarter

16. If you have other health insurance, you must also complete the attached OHI Form (other health insurance) for you and your family members. Your other health insurance may interfere with payment of claims.
17. Are you or any family members requesting enrollment, participating in the Program For Persons With Disabilities (PFPWD)?
18. How did you hear about TRICARE Prime? Check the appropriate box.
19. Specify the last time the sponsor or family member used TRICARE Standard, not including the Military Treatment Facility - Check the appropriate box.

*** Remember to select from one of the two addresses (based on your military status) when submitting your enrollment form and applicable enrollment fee.*

20. Read the acknowledgment. Sign and date form and indicate relationship to sponsor.

Your completed form will be processed, and a Prime identification card will be mailed to each eligible family member. The effective date of membership will be indicated on each card.

AGENCY DISCLOSURE STATEMENT: Public reporting of this collection of information is estimated to average 15 minutes per application, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data need, 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, to Washington Headquarters Services, Directorate of Information Operations and Reports, 1216 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4802; and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington DC 20508. PLEASE DO NOT RETURN THIS FORM TO EITHER OF THESE ADDRESSES, INSTEAD USE ONE OF THE ADDRESS SHOWNON THE FORM.

PRIVACY ACT STATEMENT: (1) 44 USC 8101; 10 USC 1079 AND 1086, 88 USC 4318; EO 9397. (2) Purpose: To evaluate for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (82 CFR, Part 199.17). (3) Uses: 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 the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); to the Department of Justice for representation of the Secretary of Defense in civil actions; and to congressional Offices in response to inquiries made in the request of the person to whom a record pertains. 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. (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.

Retrieve Data | Reset Radio Buttons | Reset Form

TRICARE Prime Enrollment / Transfer Form

Please refer to the TRICARE provider directory for guidance on Primary Care Manager (PCM) selection in your area.
Humana Military Healthcare Services, Inc. will assign a PCM if your first and second choice cannot be honored.

SPONSOR INFORMATION

1) Check appropriate box ☐ **New Enrollment** ☐ **Transfer:** **Portability** If you are currently enrolled in TRICARE Prime outside of regions 3 and 4. ☐ **Split Enrollment** Members of the same family enrolling in separate TRICARE contractor regions.

2) Sponsor's Name Last First MI | 3) Sponsor's Social Security Number

4) Street or P.O. Box Apt. No. City County State Zip Code

5) Birthdate Mo. Day Yr. | 6) Active Duty? ☐ Yes ☐ No | 7) Active Duty Sponsor's Pay Grade ☐ E1 - E4 ☐ E5 and above | 8) Is sponsor: Enrolling ☐ ☐ Deceased ____ Date ☐ Retiring ____ Date ☐ Retired ____ Date

9) Sponsor's Phone Home Work Spouse Work | 10) Active Duty Unit of Assignment **If sponsor is active duty or deceased, skip to #13**

11) Retired sponsor's 1st Choice - PCM (MTF Team \PCM or Civilian Physician) * **Must complete to enroll**
List PCM Name & Complete Address

12) Retired sponsor's 2nd Choice - PCM (MTF Team \PCM or Civilian Physician) * **Must complete to enroll**
List PCM Name & Complete Address

FAMILY MEMBER INFORMATION

13) Name Last First MI | Social Security Number | Sex M / F
Street or P.O. Box Apt. No. City County State Zip Code
Phone | Family Member Birthdate | Family Relationship to Sponsor
Family Member's 1st Choice - PCM (MTF Team \PCM or Civilian Physician)* **Must complete to enroll**
List PCM Name & Complete Address
Family Member's 2nd Choice - PCM (MTF Team \PCM or Civilian Physician)* **Must complete to enroll**
List PCM Name & Complete Address

13) Name Last First MI | Social Security Number | Sex M / F
Street or P.O. Box Apt. No. City County State Zip Code
Phone | Family Member Birthdate | Family Relationship to Sponsor
Family Member's 1st Choice - PCM (MTF Team \PCM or Civilian Physician)* **Must complete to enroll**
List PCM Name & Complete Address
Family Member's 2nd Choice - PCM (MTF Team \PCM or Civilian Physician)* **Must complete to enroll**
List PCM Name & Complete Address

13) Name Last First MI | Social Security Number | Sex M / F
Street or P.O. Box Apt. No. City County State Zip Code
Phone | Family Member Birthdate | Family Relationship to Sponsor
Family Member's 1st Choice - PCM (MTF Team \PCM or Civilian Physician)* **Must complete to enroll**
List PCM Name & Complete Address
Family Member's 2nd Choice - PCM (MTF Team \PCM or Civilian Physician)* **Must complete to enroll**
List PCM Name & Complete Address

13) Name Last First MI | Social Security Number | Sex M / F
Street or P.O. Box Apt. No. City County State Zip Code
Phone | Family Member Birthdate | Family Relationship to Sponsor
Family Member's 1st Choice - PCM (MTF Team \PCM or Civilian Physician)* **Must complete to enroll**
List PCM Name & Complete Address
Family Member's 2nd Choice - PCM (MTF Team \PCM or Civilian Physician)* **Must complete to enroll**
List PCM Name & Complete Address

OTHER

14) All beneficiaries who print, complete, and submit this website enrollment form will receive additional enrollment materials, i.e. HEAR Form, CHOICES Handbook, etc.

15) Payment Option ☐ Annual ☐ Quarterly
Amount enclosed or to be charged $ (Not applicable for Active Duty Families)
Method of Payment Attached (Must pay fees at time of enrollment)
Type of card ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover
Check #
Money Order #
Credit card number ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐
Expiration date
Your signature authorizes the credit card company to charge the initial fee to the card number above.
Signature

16) Have you completed the other health insurance form for you and your family members? ☐ Yes ☐ No

17) Are you or any dependents requesting enrollment, participating in the Program For Persons With Disabilities (PFPWD)? ☐ Yes ☐ No
If yes, please list participants:

18) How did you hear about TRICARE Prime? ☐ Mailer ☐ Newspaper ☐ Radio ☐ At an MTF ☐ Word of mouth ☐ Other

19) When was the last time you or your family members used TRICARE Standard? ☐ Within past 12 months Newly eligible for TRICARE ☐ 1 - 5 years ☐ Over 5 years Use MTF only ☐ Never

PAYMENT

Please mail your completed enrollment and OHI form, along with the appropriate enrollment fee to one of the following addresses:

FOR ACTIVE DUTY DEPENDENTS:
Humana Military Healthcare Services
PO Box 740061
Louisville, KY 40201-7461

FOR NON-ACTIVE DUTY:
Humana Military Healthcare Services
Attn: PNC
PO Box 105838
Atlanta, GA 30348-9758

ACKNOWLEDGMENT

20) **I have read the information on benefits and restrictions of the TRICARE Prime program provided me.** I understand the restrictions as stated or explained to me and hereby apply for enrollment. I understand that I must choose a Primary Care Manager (PCM) participating in TRICARE Prime or select a military hospital, clinic or dispensary, when available, as my Primary Care Site to be covered by the Plan. **If I decide to obtain care which has not been coordinated by my PCM and authorized by the Health Care Finder, or seek services from a non-TRICARE Prime provider, I understand that TRICARE Prime coverage will not apply and I will be responsible for payment under the Point of Service option for all services received.** I understand that I must pay an initial or annual non refundable enrollment fee if the sponsor is retired/deceased. I understand that enrollment is subject to verification of funds. I understand I must remain enrolled in TRICARE Prime for 12 consecutive months. I understand that my entitlement to TRICARE benefits will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS). I authorize the Plan to examine, disclose and copy records of any physician, hospital or provider when necessary for proper payment of benefits for all enrollees listed on this document. I hereby certify that the information provided on this document is true and complete. I agree to abide by the provisions of membership. I must disenroll from TRICARE Prime when I am no longer eligible or move from areas where TRICARE Prime is offered. The Plan will not discriminate, or have the effect of discriminating, against any beneficiaries on the basis of health status, age, race, sex, family size, sponsor status or sponsor rank. I understand that there is a possibility that some medical specialty diagnosis or treatment may require travel to health care providers which exceed stated access standards. (PCM's will be available within a 30 minute drive from your home and specialists within a one hour drive).

I UNDERSTAND ENROLLMENT FEES ARE NOT REFUNDABLE. SIGNATURE IS REQUIRED TO COMPLETE ENROLLMENT FORM.
Please review the Agency Disclosure and The Privacy Act before signing.

Signature | **Relationship to Sponsor** | **Today's Date**

AUTHORITY: 10 U.S.C Chapter 55, CHAMPUS PRINCIPAL PURPOSES: Enrollment in the TRICARE Prime program. ROUTINE USES: Verify eligibility and produce identification cards. DISCLOSURE IS VOLUNTARY. Failure to provide the information could result in denial of reimbursement under the CHAMPUS program.

Please print and complete 2 copies. Return 1 completed copy, retaining the other for your records.

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TRICARE OTHER HEALTH INSURANCE (OHI) COVERAGE QUESTIONNAIRE

Do you or one of your family members currently have Other Health Insurance (OHI) coverage? YES ☐ NO ☐

Have you or one of your family members had OHI during the past 12 months and recently cancelled or changed that coverage? YES ☐ NO ☐
If you answered YES to either of the above questions, proceed to question #1.

IF YOU ANSWERED NO TO BOTH OF THE QUESTIONS LISTED ABOVE, DO NOT COMPLETE OR SUBMIT THIS FORM.

1. TRICARE Sponsor's Name: _____ **TRICARE Sponsor's SSN:** _____

2. CURRENT STATUS - Complete only if you or one or more of your family members currently have OHI.

Current OHI Status - I, or one of my family members, currently have other health insurance.

General Information

Does this coverage include pharmacy benefits? YES ☐ NO ☐
Does this coverage provide any other benefits? YES ☐ NO ☐
Does this coverage provide specific coverage exclusions? YES ☐ NO ☐
(If yes, attach a copy of the exclusion page).

TYPE OF CURRENT OHI COVERAGE

Group ☐ Individual ☐ Supplemental ☐ Student plan ☐ Medicare ☐ Medicaid ☐ Other_____

Note: Complete one TRICARE OHI Coverage Questionnaire for each type of current OHI coverage.

3. PRIOR OHI STATUS - Complete only if you have had OHI within the last 12 months, but do not have the coverage now.

Prior OHI Status - I, or one of my family members, have had OHI during the past 12 months and have recently cancelled that coverage.

TYPE OF PRIOR OHI COVERAGE

Group ☐ Individual ☐ Supplemental ☐ Student plan ☐ Medicare ☐ Medicaid ☐ Other_____

Note: Complete one TRICARE OHI Coverage Questionnaire for each type of prior OHI coverage.

IF YOU HAVE COMPLETED SECTION 2 OR 3 ABOVE, please complete the following information, sign and submit with your enrollment and HEAR forms.

	Name of Covered Member	Sex	Date of Birth	Carrier Name and Address	Policy/Group Plan #	Effective Date	Expiration Date (Applies for only Section 3)
Policyholder or Subscriber							
Other Family Members							

The statements made above are true and correct to the best of my knowledge. I understand that federal laws [8 U.S.C. and 100] provide for criminal penalties for submitting or making false, fictitious or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from Uniformed Services legal offices, public libraries and many Health Benefit Advisors.

_____ Your Signature

_____ Relationship to TRICARE Sponsor

_____ Today's Date

If Mailing OHI with Prime Enrollment Form:
SEE enrollment form for address instructions

Please Note: Incomplete forms may result in a claims payment delay.

If Mailing OHI Form Separately:
Humana Military Healthcare Servies
P.O. Box 740061, Louisville, KY 40201-7461

Save Data Print Email Form