TRICARE PRIME ENROLLMENT APPLICATION AND PRIMARY CARE MANAGER (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, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 1155 Defense Pentagon, Washington, DC 20301-1155 (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: 10 U.S.C. 1079 and 1086, 32 U.S.C. Chapter 17; 32 CFR 199.17; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.
PRINCIPAL PURPOSE(S): To obtain information necessary to permit individuals to enroll in the 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 Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and to other Federal, State, local, or foreign government agencies, and to 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.
DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of enrollment.

This form is for the following:

- To allow eligible beneficiaries to apply for enrollment in TRICARE Prime, TRICARE Prime Remote (TPR), or US Family Health Plan.
- Enrollees to change to a new region for the TRICARE programs listed above.
- Enrollees to update their personal contact information to include addresses, phone numbers, and email within the same region for the TRICARE programs listed above.

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 Access to Care Waiver	SECTION VI Signature	SECTION VII Enrollment Fee Payment
1. Active Duty Members, Guard and Reserve Component Members called or ordered to active duty for more than 30 consecutive days.	X			Complete if changing PCM*	Complete if you live more than 30 minutes from selected PCM	X	
2. Active Duty Family Members (ADFMs) and Survivors of Active Duty (in transitional survivor status).	X	X	X	Complete if changing PCM*	Complete if you live more than 30 minutes from selected PCM	X	
3. Family Members of Guard and Reserve called or ordered to active duty for more than 30 consecutive days may be eligible in DEERS.	X	X	X	Complete if changing PCM*	Complete if you live more than 30 minutes from selected PCM	X	
4. Eligible retirees, their 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 includes beneficiaries 65 years and over who are NOT eligible for Medicare Part A on their record or their spouse's record.**	X	X	X	Complete if changing PCM*	Complete if you live more than 30 minutes from selected PCM	X	X *(Must include required payment)*
5. ADFMs, retirees, retired family members, survivors and eligible former spouses who are entitled to Medicare Part A.	X	X	X	Complete if changing PCM*	Complete if you live more than 30 minutes from selected PCM	X	X *(If not enrolled in Medicare Part B)*

* Complete Section V (Access to Care Waiver) if you live more than 30 minutes from desired PCM.

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. Please note that enrollment is not automatic.

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. Note: If residing in a Prime Service area, family members wishing to enroll must choose Prime and not TPR ADFM.

3. **US Family Health Plan** is a TRICARE Prime enrollment option for eligible individuals and families who live in six specific parts of the country: Seattle, Washington; Portland, Maine; Boston, 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.

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:

US Family Health Plan
at St. Vincent's NYC

450 W 33rd Street, Mezzanine

New York, NY 10001

1-800-241-4848

4. If enrolling more than three family members, fill out additional copies of Page 5.

5. Print in blue or black **ink**; make sure all available information is complete, accurate and legible.

6. Make sure all personal information matches that in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Support Office at 1-800-538-9552 or log on to http://www.dmdc.osd.mil/mydodbenefits/ and refer to your name as printed on your military ID card.

7. If you are an unremarried former spouse, make sure you show in DEERS under your own Social Security Number and use your own SSN as the "Sponsor Social Security Number" on the enrollment form (block 1).

8. If you become Medicare-eligible, for any reason, make sure your Medicare Part A and B status is correctly reflected in DEERS (Part B is required for all TRICARE beneficiaries, other than active duty family members. Though Part B is not required for US Family Health Plan enrollees, the Department of Defense highly encourages enrollment in Part B when first eligible to avoid potential Medicare Part B surcharges for enrollment.)

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

10. 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.

MAILING INSTRUCTIONS

1. For enrollment or PCM changes in TRICARE Prime/TRICARE Prime Remote, 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 3 above.)

US Family Health Plan at St. Vincent NYC
450 W 33rd Street – Mezzanine
New York, NY 10001

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.

2. For additional information on TRICARE, contact the local TRICARE Service Center (TSC) or visit the TMA website at www.tricare.mil.

3. For enrollment assistance, please call *St. Vincent Catholic Medical Centers US Family Health Plan* at *1-800-241-4848*

PAY INSTRUCTIONS

1. If you have elected monthly allotment from retired pay as the payment method for your TRICARE Prime enrollment fees, you must also complete and submit the allotment authorization letter with your application. If you select this type of payment, you must make the first quarterly payment by check, credit card or money order 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 VII, Part B of the enrollment application form. If you select this type of payment, you must make the first quarterly payment by check, credit card or money order at the time of application.

3. If you elected credit card as the method for your initial TRICARE Prime enrollment, ensure you provide your credit card information in Section VII, Part C of the enrollment application form. These payments are made either quarterly or annually.

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

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

SECTION I - SPONSOR INFORMATION

X one:

☐	**Prime Enrollment**	☐	**Prime Remote Enrollment**	☐	**US Family Health Plan Enrollment**	☐	**PCM Change**	☐	**Transfer Enrollment**	☐	**Split Enrollment**

1. SPONSOR IS: *(X one)*

☐ Active Duty ☐ Retired ☐ Deceased *(Go to Section II.)* ☐ Former Spouse

2. SPONSOR SOCIAL SECURITY NUMBER (SSN)	**3. SPONSOR NAME** *(Last, First, Middle Initial) (Must match DEERS)*	**4. SPONSOR DATE OF BIRTH** *(YYYYMMDD)*
__ __ __ – __ __ – __ __ __ __		

5. RESIDENCE ADDRESS

a. STREET	b. APARTMENT/ SUITE NO.	c. CITY	d. STATE	e. ZIP CODE

6. MAILING ADDRESS *(If different from residence address)*

a. STREET	b. APARTMENT/ SUITE NO.	c. CITY	d. STATE	e. ZIP CODE

7. SPONSOR TELEPHONE NUMBERS *(Include Area Code)*		**8. CITY AND COUNTRY OF MILITARY ASSIGNMENT** *(OCONUS only)*
a. HOME ( )	b. WORK ( )	

9. MEMBER'S UNIT	**10. UNIT IDENTIFICATION CODE (UIC)** *(If known)*	**11. ZIP CODE OF WORK ADDRESS**	**12. E-MAIL ADDRESS**

13. SPONSOR PRIMARY CARE 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 FULL NAME, MTF/CLINIC ADDRESS *(If known)*	1st CHOICE	☐ MTF ☐ Other
	2nd CHOICE	☐ MTF ☐ Other
b. PCM SPECIALTY	☐ No Preference	☐ Flight Medicine
	☐ Family/General Practice	☐ Internal Medicine
c. PREFERRED PCM GENDER	☐ No Preference	☐ Male ☐ Female

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

SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE

(Use additional copies of this page to continue as necessary)

1.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*	b. DATE OF BIRTH *(YYYYMMDD)*

c. RESIDENCE ADDRESS ☐ Same as Sponsor				
(1) STREET	(2) APARTMENT/ SUITE NO.	(3) CITY	(4) STATE	(5) ZIP CODE

d. MAILING ADDRESS *(If different from residence address)* ☐ Same as Sponsor				
(1) STREET	(2) APARTMENT/ SUITE NO.	(3) CITY	(4) STATE	(5) ZIP CODE

e. RELATIONSHIP TO SPONSOR	f. TELEPHONE NUMBERS *(Include Area Code) (If different from sponsor)*		g. E-MAIL ADDRESS
☐ Spouse ☐ Child	(1) HOME ( )	(2) WORK ( )	

h. 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 FULL NAME MTF/CLINIC ADDRESS *(If known)*	1st CHOICE ☐ Same as Sponsor ☐ MTF ☐ Other	
	2nd CHOICE ☐ Same as Sponsor ☐ MTF ☐ Other	

(2) PCM SPECIALTY	☐ No Preference	☐ Flight Medicine	☐ Pediatrics	☐ Family/General Practice	☐ Internal Medicine
(3) PREFERRED PCM GENDER	☐ No Preference	☐ Male	☐ Female		

2.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*	b. DATE OF BIRTH *(YYYYMMDD)*

c. RESIDENCE ADDRESS ☐ Same as Sponsor				
(1) STREET	(2) APARTMENT/ SUITE NO.	(3) CITY	(4) STATE	(5) ZIP CODE

d. MAILING ADDRESS *(If different from residence address)* ☐ Same as Sponsor				
(1) STREET	(2) APARTMENT/ SUITE NO.	(3) CITY	(4) STATE	(5) ZIP CODE

e. RELATIONSHIP TO SPONSOR	f. TELEPHONE NUMBERS *(Include Area Code) (If different from*		g. E-MAIL ADDRESS
☐ Spouse ☐ Child	(1) HOME ( )	(2) WORK ( )	

h. 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 FULL NAME MTF/CLINIC ADDRESS *(If known)*	1st CHOICE ☐ Same as Sponsor ☐ MTF ☐ Other	
	2nd CHOICE ☐ Same as Sponsor ☐ MTF ☐ Other	

(2) PCM SPECIALTY	☐ No Preference	☐ Flight Medicine	☐ Pediatrics	☐ Family/General Practice	☐ Internal Medicine
(3) PREFERRED PCM GENDER	☐ No Preference	☐ Male	☐ Female		

SPONSOR SOCIAL SECURITY NUMBER	SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*
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SECTION III - OTHER HEALTH INSURANCE

1. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE *(not a TRICARE Supplement)***?** If Yes, provide the name of the family member and other health insurance, policy number, effective dates, and a copy of the other health insurance policy and their insurance card.	☐	Yes
	☐	No
2. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS UNDER AGE 65 AND ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE? If Yes, provide a copy of the Medicare card for each family member that is under the age of 65 and entitled to Medicare.	☐	Yes
	☐	No

SECTION IV - REASON FOR PCM CHANGE

1. NAME OF AFFECTED FAMILY MEMBER(S)	2. REASON FOR CHANGE *(X as applicable. If more than one family member and reason, specify.)*
	☐ Dissatisfied ☐ Permanent Change of Station (PCS) ☐ Relocation
	☐ Other *(Use Section II to specify change of PCM specialty/ gender preference for more than one family member.)*

SECTION V - ACCESS WAIVER

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

By signing this application, you indicate your understanding and acceptance 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.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*

SECTION VI - SIGNATURE

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.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*

SPONSOR SOCIAL SECURITY NUMBER	SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*
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SECTION VII - PAYMENT OF TRICARE PRIME ENROLLMENT FEES

NOTE: This section is only for retirees, retiree family members, survivors and eligible former spouses.
Retired beneficiaries under age 65 and retiree family members entitled to Medicare Part A must be enrolled in Medicare Part B to be eligible for enrollment in TRICARE prime. TRICARE enrollment fees are waived for individuals entitled to Medicare Part B, as reflected in DEERS. See www.tricare.mil/costs for current enrollment fees.

1. PAYMENT FEE OPTIONS	**MONTHLY** *(See Notes 1 and 3 below)*	**QUARTERLY** *(See Note 2 below)*	**ANNUAL** *(See Note 2 below)*
2. PLAN SELECTION *(X one)*	Single $22.44	Single $67.32	Single $269.28
	Family $44.88	Family $134.64	Family $538.56
3. PAYMENT METHOD *(X one)*	a. Allotment From Retired Pay **(Complete A below)**	VISA or Master Card **(Complete C below)**	VISA or Master Card **(Complete C below)**
	b. Electronic Funds Transfer *(See Note 4)* **(Complete B below)**		

Note 1: If you have elected a **monthly** payment option (Allotment or Electronic Funds Transfer) please see Pay Instructions on Page 3 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 2: Quarterly and **annual** bills will be sent on a quarterly and annual basis, respectively. Monthly bills will not be sent.
Note 3: Payment by check is limited to the first quarterly installment for beneficiaries who elect allotment or EFT for the monthly payment option. Make **check** payable to:
[Contractor's Name]
Note 4: Electronic Funds Transfer is for monthly payments only. Arrangement for electronic payments will be the responsibility of the enrollee. The initial payment cannot be made electronically.

A - MONTHLY ALLOTMENT

I, _____ choose to have my enrollment fees paid by monthly allotment from my Uniformed Services retired pay.
(Signature of sponsor)

NOTE: Only retired Uniformed Services members may establish an allotment from their retired pay. The additional Allotment Authorization Letter must be submitted with the application. Follow instructions on Premium Allotment Authorization letter and submit as directed.

B - ELECTRONIC FUNDS TRANSFER

I, _____ choose to have my enrollment fees paid by electronic funds transfer.
(Signature of account holder)

(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 NO.
(6) NAME ON ACCOUNT		

C - CREDIT CARD

I, _____ choose to have my initial enrollment fees billed to my credit card.
(Signature of card holder) *(Annual and Quarterly initial payments only)*

NOTE: This is not a recurring payment. You are responsible for all subsequent fees when paying with a credit card.

(1) NAME ON CREDIT CARD	(2) CREDIT CARD NUMBER	(3) EXPIRATION DATE *(MMYY)*