**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 | ☐ Family/General Practice | ☐ Flight Medicine | ☐ Internal Medicine | | | |
| c. PREFERRED PCM GENDER | ☐ No Preference | ☐ Male | ☐ Female | | | | |

| SPONSOR SOCIAL SECURITY NUMBER<br>– – | 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 |
|---|---|---|---|
| | (1) HOME | (2) WORK | |
| ☐ Spouse ☐ Child | ( ) | ( ) | |

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<br>☐ Same as Sponsor<br>☐ MTF<br>☐ Other |
| | 2nd CHOICE<br>☐ Same as Sponsor<br>☐ MTF<br>☐ 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 |
|---|---|---|---|
| | (1) HOME | (2) WORK | |
| ☐ Spouse ☐ Child | ( ) | ( ) | |

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<br>☐ Same as Sponsor<br>☐ MTF<br>☐ Other |
| | 2nd CHOICE<br>☐ Same as Sponsor<br>☐ MTF<br>☐ 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)* |
|---|---|
| _ _ | |

## 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)* |
|---|---|
| _ _ | |

## 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.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **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 | $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)** | | | 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 (Single - $57.50/family - $115.00) 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 *Health Net Federal Services*
**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)* | (4) ACCOUNT NUMBER | (5) BANK OR ABA ROUTING NO. |
| ☐ Savings ☐ Checking *(Attach voided check)* | | |
| (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 reoccurring 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)* |
|---|---|---|
| | | |