

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

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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 <https://milconnect.dmdc.osd.mil>

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

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

CUI (when filled in)

SPONSOR'S SSN/DBN:	
SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE <i>(Use additional copies of this page as necessary)</i>	
12.a. FAMILY MEMBER NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>	b. DATE OF BIRTH (YYYYMMDD)
c. REQUESTED ACTION : <input type="checkbox"/> Enroll <input type="checkbox"/> Transfer Enrollment <input type="checkbox"/> PCM Change <input type="checkbox"/> Disenroll Effective Date Requested (YYYYMMDD):	
d. RESIDENCE AND MAILING ADDRESS <i>(Provide address, with ZIP Code and Country, if different from Sponsor)</i>	
<input type="checkbox"/> Same as Sponsor <input type="checkbox"/> New	
e. TELEPHONE NUMBER <i>(Include Area Code)</i>	
a. WORK:	b. HOME:
c. CELL:	
f. E -MAIL ADDRESS	
g. PCM PREFERENCE <i>(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)</i>	
(1) 1st CHOICE <input type="checkbox"/> MTF <input type="checkbox"/> Civilian <input type="checkbox"/> Same as Sponsor	FULL NAME or MTF/CLINIC
(2) 2nd CHOICE <input type="checkbox"/> MTF <input type="checkbox"/> Civilian <input type="checkbox"/> Same as Sponsor	FULL NAME or MTF/CLINIC
h. PCM SPECIALTY <input type="checkbox"/> No Preference <input type="checkbox"/> Family/General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Flight Medicine	
i. PREFERRED PCM GENDER <input type="checkbox"/> No Preference <input type="checkbox"/> Male <input type="checkbox"/> Female	
13.a. FAMILY MEMBER NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>	b. DATE OF BIRTH (YYYYMMDD)
c. REQUESTED ACTION : <input type="checkbox"/> Enroll <input type="checkbox"/> Transfer Enrollment <input type="checkbox"/> PCM Change <input type="checkbox"/> Disenroll Effective Date Requested (YYYYMMDD):	
d. RESIDENCE AND MAILING ADDRESS <i>(Provide address, with ZIP Code and Country, if different from Sponsor)</i>	
<input type="checkbox"/> Same as Sponsor <input type="checkbox"/> New	
e. TELEPHONE NUMBER <i>(Include Area Code)</i>	
a. WORK:	b. HOME:
c. CELL:	
f. E -MAIL ADDRESS	
g. PCM PREFERENCE <i>(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)</i>	
(1) 1st CHOICE <input type="checkbox"/> MTF <input type="checkbox"/> Civilian <input type="checkbox"/> Same as Sponsor	FULL NAME or MTF/CLINIC
(2) 2nd CHOICE <input type="checkbox"/> MTF <input type="checkbox"/> Civilian <input type="checkbox"/> Same as Sponsor	FULL NAME or MTF/CLINIC
h. PCM SPECIALTY <input type="checkbox"/> No Preference <input type="checkbox"/> Family/General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Flight Medicine	
i. PREFERRED PCM GENDER <input type="checkbox"/> No Preference <input type="checkbox"/> Male <input type="checkbox"/> Female	
14.a. FAMILY MEMBER NAME <i>(Last, First, Middle Initial) (Must match DEERS)</i>	b. DATE OF BIRTH (YYYYMMDD)
c. REQUESTED ACTION : <input type="checkbox"/> Enroll <input type="checkbox"/> Transfer Enrollment <input type="checkbox"/> PCM Change <input type="checkbox"/> Disenroll Effective Date Requested (YYYYMMDD):	
d. RESIDENCE AND MAILING ADDRESS <i>(Provide address, with ZIP Code and Country, if different from Sponsor)</i>	
<input type="checkbox"/> Same as Sponsor <input type="checkbox"/> New	
e. TELEPHONE NUMBER <i>(Include Area Code)</i>	
a. WORK:	b. HOME:
c. CELL:	
f. E -MAIL ADDRESS	
g. PCM PREFERENCE <i>(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)</i>	
(1) 1st CHOICE <input type="checkbox"/> MTF <input type="checkbox"/> Civilian <input type="checkbox"/> Same as Sponsor	FULL NAME or MTF/CLINIC
(2) 2nd CHOICE <input type="checkbox"/> MTF <input type="checkbox"/> Civilian <input type="checkbox"/> Same as Sponsor	FULL NAME or MTF/CLINIC
h. PCM SPECIALTY <input type="checkbox"/> No Preference <input type="checkbox"/> Family/General Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Pediatrics <input type="checkbox"/> Flight Medicine	
i. PREFERRED PCM GENDER <input type="checkbox"/> No Preference <input type="checkbox"/> Male <input type="checkbox"/> Female	

SPONSOR'S SSN/DBN: _____

SECTION VI - PAYMENT OF TRICARE PRIME ENROLLMENT FEES

NOTE: This section is only for 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 DEERS.

PAYMENT OPTIONS: See Sections A, B, and C below for payment options.

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.

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.)

Note 3, Personal Check: Payment by check (money order, cashier's or personal) is limited to the initial three month payment only.
Checks received for ongoing payment will not be accepted.

Note 4, Electronic Funds Transfer: EFT is for monthly or quarterly payments only. The initial payment cannot be made via EFT.

PAYMENT FEE, PLAN AND METHOD OPTIONS <i>(Some options are location specific)</i>	MONTHLY <input type="checkbox"/> Allotment From Retired Pay <input type="checkbox"/> Electronic Funds Transfer <input type="checkbox"/> Credit/Debit Card
	INITIAL 3-MONTH PAYMENT: <input type="checkbox"/> Check <input type="checkbox"/> Money Order <input type="checkbox"/> Credit/Debit Card (Section C below)
	QUARTERLY <input type="checkbox"/> Credit/Debit Card _____
	ANNUAL <input type="checkbox"/> Credit/Debit Card _____

A - ALLOTMENT (where feasible, as mandated by law (NDAA for FY2020, Section 702))

I choose to have my enrollment fees paid by monthly allotment from my Uniformed Services retired pay.

NOTE: 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 www.tricare.mil/costs)

B - ELECTRONIC FUNDS TRANSFER

ELECTRONIC FUNDS TRANSFER FOR AUTOMATIC PAYMENTS Checking (*attach voided check*) Savings

Name and Address of Financial Institution _____

Name on Account _____ Telephone Number of Financial Institution _____

Account Number _____ ABA Routing Number _____

NOTE: Your Regional Contractor will charge the correct fee amount based on your enrollment, individual or family.
(The current rates are at www.tricare.mil/costs)

C - CREDIT/DEBIT CARD

INITIAL 3-MONTH PAYMENT MONTHLY RECURRING PAYMENTS

Name of Cardholder _____

CREDIT/DEBIT CARD Number: _____ Exp. Date (MM/YYYY): _____

Card Verification Code (CVC) (*3-digit number on reverse side of card*) _____

NOTE: Your Regional Contractor will charge the correct fee amount based on your enrollment, individual or family. (The current rates are at www.tricare.mil/costs)

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, SPOUSE OR OTHER LEGAL GUARDIAN OF BENEFICIARY

DATE (YYYYMMDD)