

TRICARE PRIME CHANGE FORM INSTRUCTIONS

Thank you for choosing TRICARE Prime. Please print all information in ink and fill out the form accurately and completely. Your application will be delayed if your family information is incomplete or does not match the DEERS file. If you are unsure of how to answer a question, please call our toll-free telephone number 1-888-999-5195. Our Beneficiary Services Representatives will be happy to assist you.

1-12. Self-explanatory

13. Is Sponsor Deceased, Retired, Enrolling - Check appropriate box. Even if sponsor is deceased, you must complete sections 1-12.

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.

14. If sponsor lives within 30 minutes or 20 miles of a Military Treatment Facility (MTF), list the Team Name for the Primary Care Manager; if the sponsor does not live near an MTF, choose a civilian provider from the Provider Directory and list for the Primary Care Manager. Note that some physicians' practices are full and they will only accept patients that they have seen before. If unclear, call 1-888-999-5195 and speak with Enrollment.

15. List Military Treatment Facility team address or Primary Care Manager's Address, City, State, Zip Code.

16. Indicate whether the physician you have chosen is your current physician - Check the appropriate box.

17. List Sponsor's second choice for a Primary Care Manager (Military Treatment Facility team or civilian Primary Care Manager) from the Directory. A Military Treatment Facility team or a civilian physician MUST be selected from your TRICARE Provider Directory.

18. List second choice of Military Treatment Facility team address or Primary Care Manager's Address, City, State, Zip Code.

19. Indicate whether the physician you have chosen is your current physician - Check the appropriate box.

20. Family Member information - List information for all family members who are enrolling in the TRICARE Prime program. MUST select Primary Care Manager to enroll. Please state two (2) Primary Care Manager choices for each Prime member. SMHS will assign a Primary Care Manager if your first and second choice cannot be honored. If enrolling more than two (2) family members, use another form.

21. Does the Sponsor or eligible Family Members have other health insurance coverage, including Medicare?

22. Billing options. Retirees and their family members wishing to enroll in Prime must pay an annual 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.

Important:

Return White copy in enclosed envelope. The Yellow copy should be retained as proof of intent to change. Change is subject to eligibility, Primary Care Manager assignment and all other TRICARE regulations.

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

Method of payment - Check the appropriate box. All enrollment fees must be paid at the time of initial enrollment into TRICARE Prime. If paying by credit card, signature required. Make Checks Payable To: SMHS, Inc. There is a returned check fee. Please refer to the TRICARE Provider Directory for guidance on Primary Care Manager selection in your planning area. Sierra Military Health Services, Inc. will assign a Primary Care Manager if your first and second choice cannot be honored. Please mail your application and appropriate enrollment fee to the following address: SMHS Enrollment, P.O. Box 828450 Philadelphia, PA. 19101-9415.

23. Read the acknowledgement. Sign and date application form and indicate relationship to sponsor.

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 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, 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.

PRIVACY ACT STATEMENT: (1) 44 USC 8101; 10 USC 1079 and 1086, 38 USC 613; EO 9397. (2) Purpose: To evaluate for medical care provided by civilian sources to Military Health System beneficiaries applying for coverage under the TRICARE Prime 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 Prime Program. (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.

TRICARE Prime Change Form

Please mail your change form to: Sierra Military Health Services, Inc., P.O. Box 828450 Philadelphia, PA 19101-9415

Please check reason for submitting Change Form

Portability

List the region where you are currently enrolled _____ (Region)

Disenrollment

- Sponsor
- Family Member
- Transfer to another TRICARE Region

Change Primary Care Manager

- Sponsor
- Family Member

Change of Address

- Sponsor
- Family Member

Change Other Health Insurance

- Sponsor
- Family Member

Replacement of TRICARE Primary ID Card

- Sponsor
- Family Member

Adding a Family Member

Change from Active Duty Service Member to Retired Status
Date of Retirement _____

If you are requesting disenrollment, please list reason: _____

SPONSOR INFORMATION

1) Sponsor's Name			Last			First			MI			2) Sponsor's Social Security Number								
3) Street or P.O. Box						Apt. No.			City			State		Zip Code						
4) Sex M/F		5) Birthdate		Mo		Day		Yr		6) Service Branch		<input type="checkbox"/> USN		<input type="checkbox"/> USMC		<input type="checkbox"/> USPHS		<input type="checkbox"/> Other (Specify)		
										<input type="checkbox"/> US Army		<input type="checkbox"/> USAF		<input type="checkbox"/> USCG		<input type="checkbox"/> NOAA				
7) Sponsor's Phone						8) Active Duty?						<input type="checkbox"/> Yes		<input type="checkbox"/> No						
Home ()						Work ()						Sponsor's Work Zip Code								
9) Active Duty Sponsor's Pay Grade			10) Active Duty Unit of Assignment			11) Rank			12) Is sponsor an Active Duty Reservist?			If yes, indicate separation date								
<input type="checkbox"/> E1-E4			<input type="checkbox"/> E5 and Above						<input type="checkbox"/> Yes			<input type="checkbox"/> No								
13) Is sponsor:												If sponsor is deceased, skip to #20								
Deceased <input type="checkbox"/> Yes <input type="checkbox"/> No												Retired <input type="checkbox"/> Yes <input type="checkbox"/> No				Enrolling <input type="checkbox"/> Yes <input type="checkbox"/> No				
14) Sponsor's 1st Choice - Primary Care Manager												<input type="checkbox"/> Team Name at Military Treatment Facility				<input type="checkbox"/> Civilian Physician (if residence is not near an MTF)				
15) List 1st Choice Primary Care Manager's Complete Address												16) Is this your current physician?				<input type="checkbox"/> Yes <input type="checkbox"/> No				
17) Sponsor's 2nd Choice - Primary Care Manager												<input type="checkbox"/> Team Name at Military Treatment Facility				<input type="checkbox"/> Civilian Physician (if residence is not near an MTF)				
18) List 2nd Choice Primary Care Manager's Complete Address												19) Is this your current physician?				<input type="checkbox"/> Yes <input type="checkbox"/> No				

FAMILY MEMBER INFORMATION

20) Name			Last			First			MI			Relationship to Sponsor											
If spouse, are you retired from the military?						Social Security Number						Birthdate		Mo		Day		Yr		Sex		<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Yes <input type="checkbox"/> No																							
Street or P.O. Box						Apt. No.			City			State		Zip Code		Phone ()							
Family Member's 1st Choice - Primary Care Manager												<input type="checkbox"/> Team Name at Military Treatment Facility				<input type="checkbox"/> Civilian Physician (if residence is not near an MTF)							
List 1st Choice Primary Care Manager's Complete Address												Is this your current physician?				<input type="checkbox"/> Yes <input type="checkbox"/> No							
Family Member's 2nd Choice - Primary Care Manager												<input type="checkbox"/> Team Name at Military Treatment Facility				<input type="checkbox"/> Civilian Physician (if residence is not near an MTF)							
List 2nd Choice Primary Care Manager's Complete Address												Is this your current physician?				<input type="checkbox"/> Yes <input type="checkbox"/> No							

OTHER

21) Other Health Insurance (OHI)				22) Fee Information (MUST PAY FEE AT TIME OF ENROLLING)							
Policy Number: _____				Payment Option		Annual Enrollment:		Quarterly Enrollment:		Amount Enclosed: \$ _____	
Insurance Company Name: _____						<input type="checkbox"/> Active Duty None		<input type="checkbox"/> Active Duty None			
Effective Dates: From _____ To _____ Type of Coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual						<input type="checkbox"/> Individual \$230.00		<input type="checkbox"/> Individual \$57.50			
Policy Type: <input type="checkbox"/> Champus Supplemental <input type="checkbox"/> Commercial <input type="checkbox"/> Employer GRP						<input type="checkbox"/> Family \$460.00		<input type="checkbox"/> Family \$115.00			
Policy Holder Name: _____ (Last) (First) (Middle)				Method of Payment		<input type="checkbox"/> Personal Check* No. _____		<input type="checkbox"/> Cashiers Check No. _____			
Policy Holder SSN: _____						<input type="checkbox"/> Traveler's Check No. _____		<input type="checkbox"/> Money Order No. _____			
Patient Name: _____ (Last) (First) (Middle)				Type of card		<input type="checkbox"/> Visa		<input type="checkbox"/> MasterCard		<input type="checkbox"/> American Express <input type="checkbox"/> Discover	
Relationship to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse <input type="checkbox"/> Child				Credit card number		[][][][] - [][][][] - [][][][][]		Expiration Date		[][][] / [][][]	
Pharmacy Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No				Your signature authorizes the credit card company to charge the card number above.							
Do you currently have Medicare benefits? If so, please indicate the effective date of coverage and what coverage you have:				Signature _____							
Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____											
Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____											

ACKNOWLEDGMENT

23) 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 and 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 obtain 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; this form serves as Medical Records Release. A photographic copy of this authorization shall be valid as the original document. I here by 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 the TRICARE Prime regions. 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 I may be asked to waive travel access standards to seek medical treatment.

I UNDERSTAND ENROLLMENT FEES ARE NOT REFUNDABLE.
Please review the Agency Disclosure and the Privacy Act on the reverse side of this application before using.

Signature _____ Relationship to Sponsor _____ Date _____

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