TRICARE PRIME ENROLLMENT APPLICATION AND PCM/PCP CHANGE FORM

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

X one:		Prime Enrollment		Prime Remote Enrollment		US Family Health Plan Enrollment		PCM/PCP Change

SECTION I – SPONSOR INFORMATION

1. SPONSOR SOCIAL SECURITY NUMBER (SSN)

2. SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*

3. SPONSOR DATE OF BIRTH *(YYYYMMDD)*

4. SPONSOR IS: *(X one)*		Active Duty		Retired
		Deceased *(Go to Section II.)*		Former Spouse

5. RESIDENCE ADDRESS *(Street/P.O. Box, Apartment No., City, State, ZIP Code)*

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

7. SPONSOR TELEPHONE NUMBERS *(Include Area Code)*	a. HOME	b. WORK

8. CITY AND COUNTRY OF MILITARY ASSIGNMENT *(OCONUS only)*

9. MEMBER'S UNIT AND UNIT IDENTIFICATION CODE (UIC) *(If known)*

10. ZIP CODE OF WORK ADDRESS

11. E-MAIL ADDRESS

12. SPONSOR'S ACTION *(X one)*		New Enrollment		PCM Change		None

13. SPONSOR PRIMARY CARE MANAGER (PCM)/PHYSICIAN (PCP) 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/PCPs.) (Complete all that apply.)*

a. PCM/PCP NAME MTF/CLINIC *(If known)*	1st CHOICE
	2nd CHOICE

b. PCM/PCP SPECIALTY		No Preference		Flight Medicine
		Family/General Practice		Internal Medicine

c. PREFERRED PCM/PCP GENDER		No Preference		Male		Female

SPONSOR SOCIAL SECURITY NUMBER

SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*

SECTION II – ENROLLING FAMILY MEMBER INFORMATION
(Use additional copies of this page to continue as necessary)

a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. RESIDENCE ADDRESS *(Street/P.O. Box, Apartment No., City, State, ZIP Code)*

☐ Same as Sponsor

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

☐ Same as Sponsor

e. RELATIONSHIP TO SPONSOR	☐ Spouse	☐ Former Spouse	☐ Child
f. TELEPHONE NUMBERS *(Include Area Code)*	(1) HOME	(2) WORK	

g. PRIMARY CARE MANAGER (PCM)/PHYSICIAN (PCP) 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/PCP NAME MTF/CLINIC *(If known)*	1st CHOICE ☐ Same as Sponsor					
	2nd CHOICE ☐ Same as Sponsor					
(2) PCM/PCP SPECIALTY	☐	No Preference	☐	Flight Medicine	☐	Pediatrics
	☐	Family/General Practice	☐	Internal Medicine		
(3) PREFERRED PCM/PCP GENDER	☐	No Preference	☐	Male	☐	Female

a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. RESIDENCE ADDRESS *(Street/P.O. Box, Apartment No., City, State, ZIP Code)*

☐ Same as Sponsor

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

☐ Same as Sponsor

e. RELATIONSHIP TO SPONSOR	☐ Spouse	☐ Former Spouse	☐ Child
f. TELEPHONE NUMBERS *(Include Area Code)*	(1) HOME	(2) WORK	

g. PRIMARY CARE MANAGER (PCM)/PHYSICIAN (PCP) 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/PCPs.) (Complete all that apply.)*

(1) PCM/PCP NAME MTF/CLINIC *(If known)*	1st CHOICE ☐ Same as Sponsor					
	2nd CHOICE ☐ Same as Sponsor					
(2) PCM/PCP SPECIALTY	☐	No Preference	☐	Flight Medicine	☐	Pediatrics
	☐	Family/General Practice	☐	Internal Medicine		
(3) PREFERRED PCM/PCP GENDER	☐	No Preference	☐	Male	☐	Female

SPONSOR SOCIAL SECURITY NUMBER

SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*

SECTION III

1. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE? ☐ Yes ☐ No

If Yes, provide a copy of the Medicare card for each family member that is under the age of 65 and entitled to Medicare.

2. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE *(not a TRICARE Supplement)?* ☐ Yes ☐ No

If Yes, provide the name of the other health insurance and the insurance identification number:

SECTION IV REASON FOR PCM/PCP CHANGE

REASON FOR CHANGE *(X one per affected family member)*

Name
☐ Move ☐ Other *(Explain)*

Name
☐ Move ☐ Other *(Explain)*

Name
☐ Move ☐ Other *(Explain)*

Name
☐ Move ☐ Other *(Explain)*

SECTION V ACCESS WAIVER

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

Your enrollment application indicates that your current address is outside the service area. You may travel to a location where there is a provider network and enroll at that location. However, since you live outside the service area, by signing below, you indicate 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 caremay exceed one hour.

SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	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.

SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	DATE SIGNED *(YYYYMMDD)*