TRICARE Mid-Atlantic

Anthem Alliance

TRICARE Prime Enrollment Application

To Enroll in TRICARE Prime:

1. Review your DEERS information with Military personnel or call 1 (800) 538-9552. It is important that your family names, addresses, and other pertinent information is correct in the DEERS data bank.
2. On page 2, please initial and sign document, stating you understand your role in the TRICARE program.
3. On page 3 is your TRICARE Prime Enrollment Application. Section 1: Sponsor's Information. Complete this section and include your request for Primary Care Managers.
4. If you have Other Health Insurance, provide the name of company, address, city, state, and identification number. Also indicate the effective date.
5. If you are a retiree or family member of a retiree, and you wish to pay by check or credit card, so indicate in Section 3. A payment schedule is provided in this section for those who wish to pay quarterly. Please do not forget to put your credit card number, expiration date, name of card, and signature. Note: At the bottom of this page please read the paragraph for all enrollees and initial the box provided.
6. Turn to the fourth page. Section 4: Family Member Information. Please provide information about your family members you wish to enroll in TRICARE Prime. Notice again as you have in Section 1, all information must be filled out with the option to fill out race or ethnic background. Also, we ask that you initial the box below Section 4 if you are residing outside this service area. This will identify you as an enrollee having a Primary Care Manager within a 30 minute drive time. Please indicate your choices for a Primary Care Manager. If there are additional members to be enrolled, please include them on a separate sheet of paper with the required information.
7. Sign and date the application.
8. Keep a copy for your records and send the original to the address provided on your pre-addressed envelope. Anthem Alliance, 514 Butler Farm Road, Hampton, VA 23666.

Remember: If your enrollment application and any applicable enrollment fees are received by the 20th of the month, your enrollment will become effective on the first day of the month following the month in which the application was received. All applications received after the 20th of the month will become effective on the first day of the second month after it is received.(i.e. An application received on June 20 will become effective on July 1, but an enrollment application received on June 21 will become effective on August 1.)

PLEASE INITIAL EACH ITEM BELOW TO ACKNOWLEDGE YOUR AGREEMENT SIGN AND DATE ON THE SIGNATURE LINE BELOW

Beneficiary Expectations • Initial These Statements and Sign Below

_____I have read the information provided to me in the TRICARE Prime and Extra brochure and hereby apply for TRICARE Prime enrollment. I understand that the eligibility to TRICARE benefits will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS).

_____I understand that my family members and I must indicate a preference for or be assigned a Primary Care Manager (PCM): Military Treatment Facility (MTF), an Anthem Alliance TRICARE Network Provider, or a clinic site. I understand that an MTF Commander may designate my PCM regardless of my choice.

_____I understand that, except for emergencies, all TRICARE Prime services must be coordinated through my PCM. If care is obtained that has not been coordinated by my PCM and authorized by an Health Care Finder (HCF), I understand that I will be responsible for payment of charges in accordance with the provisions of the Point-of-Service Option. The Point-of-Service Option is described in the TRICARE Prime and Extra brochure, the TRICARE Prime Handbook, and the TRICARE Standard Handbook.

_____I understand that enrollment in TRICARE Prime is for 12 consecutive months, and that I and eligible family members may choose to disenroll after each 12-month enrollment period. If I disenroll after the 12-month period, I may re-enroll at any time. I may request to disenroll prior to completing the 12-month enrollment period by requesting early disenrollment from an MTF Commander or the Lead Agent. If I am disenrolled before the end of my 12-month enrollment period for any reason other than Permanent Change of Station or permanent move to another region, I may not re-enroll for a period of 12 months.

_____I further understand that I will be disenrolled for non-payment of a quarterly enrollment fee (if applicable) by the required date, and if disenrolled, I may not re-enroll for a period of 12 months.

_____I understand that if I move out of the TRICARE Mid-Atlantic Region, I have the option to disenroll from the TRICARE Mid-Atlantic Region Program, if TRICARE Prime is not available in the area to which I have transferred. If TRICARE Prime is available, I may elect to transfer enrollment as soon as I establish a residence.

_____If there is an enrollment transfer, I authorize the former TRICARE contractor to disenroll the members listed in Section 4.

_____I authorize Anthem Alliance, its subcontractor(s), and/or its network providers for all enrollees listed on this application to examine, disclose, and copy records of any physician, hospital, or provider to the appropriate government organization when necessary for proper payment, and if authorization is not given, that payment may not be made. Further, it is understood that medical information will be provided by Anthem Alliance, its subcontractors, and/or its network providers to the PCM for continuity of care and overall treatment purposes.

_____I understand that Anthem Alliance reserves the right to require me to prepay for prescription drug costs if I have other health insurance that covers prescription drugs. Following payment by the other health insurance, I must submit a claim to Anthem Alliance for secondary payment.

_____I agree to waive the drive time if my preferred PCM or specialty care is more than a 30-minute drive from my residence.

_____I understand that if I am referred by an HCF to a non-network provider, I will not be responsible for balance-billing charges above my usual copayment.

_____I hereby certify the information provided on this document is true and complete. I agree to abide by the provisions of enrollment in TRICARE Prime.

_____I understand that if my enrollment application and any applicable enrollment fees are received by the 20th of the month, my enrollment will become effective on the first day of the month following the month in which the application was received. All applications received after the 20th of the month will become effective on the first day of the second month after it is received.(i.e. An application received on June 20 will become effective on July 1, but an enrollment application received on June 21 will become effective on August 1.)

_____I understand that TRICARE Prime enrollment fees are non-refundable.

Signature _____ Date _____

Public reporting burden for 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, to Washington Headquarters Services, Directorate of Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4302: and the Office of Management and Budget Paperwork Reduction Project 0720-0008, Washington, DC 20508. PLEASE DO NOT RETURN YOUR APPLICATION TO EITHER OF THESE ADDRESSES. SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION INSTRUCTION SHEET.

(1) Authority: 5 USC 522a, 10 uSC 1079 and 1086, 58 FR 45318. (2) Purpose: To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 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 TRICARE; to the department of Justice for representation of the Secretary of Defense in civil actions and to Congressional Offices in response to inquiries made on eh request of the other 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 Program. (4) Disclosure: Voluntary; however, failure to provide information will result in denial of enrollment.

Participation by TRICARE-eligible beneficiaries in the TRICARE Prime Program will not be denied or restricted based on age, race, gender, religion, family size, health status, prior medical condition, sponsor status or sponsor rank. The TRICARE Program is a nondiscriminatory program for TRICARE eligibles offered without regard to beneficiary age, race, religion, gender, rank, sponsor status, family size, or personal income. TRICARE is Your Military Health Plan administered in the TRICARE Mid-Atlantic Region by Anthem Alliance Health Insurance Company. MFO0128M-399

IMPORTANT - Check all that apply:
- ☐ Transferring from Another Region (Portability)
- ☐ Initial Enrollment
- ☐ Sponsor is Enrolling
- ☐ Sponsor is not Enrolling

TRICARE Prime Enrollment Application

Please use ink when completing this application and print all information.
Please fill out all sections completely. Incomplete information may delay the enrollment process.
If you have any questions about completing this application, please call your TRICARE Service Center at 1-800-931-9501.

Before completing this application, verify that your and your family's information is correct in DEERS. If the information is incorrect, your enrollment will be delayed.

SECTION 1: Sponsor Information

Sponsor's Last Name	First	Middle	Social Security Number	Gender ☐ Male ☐ Female
Street	City	State	ZIP	
Date of Birth (Mo/Day/Year)	Phone Number home (_____) _____ work (_____) _____			

(List 1st, 2nd, and 3rd choices for a Primary Care Manager. If your choice is unavailable, you'll be enrolled with your next choice. **This section must be completed to enroll.**)

1st Choice	2nd Choice	3rd Choice
☐ New	☐ New	☐ New
☐ Current	☐ Current	☐ Current

Branch of Service: ☐ USAF ☐ USPHS ☐ NOAA ☐ US ARMY ☐ USN ☐ USMC ☐ USCG ☐ _____	Pay Grade (current or at time of retirement):	Status: ☐ Active Duty ☐ Retired ☐ Deceased ☐ Active Guard/Reserve

Does Active Duty Sponsor live more than fifty miles from a military hospital or clinic? ☐ Yes ☐ No	Station Unit/UIC:

Race: (optional) ☐ White ☐ Black ☐ Asian-Pacific Islander ☐ Other Western Hemisphere Indians ☐ Other: _____	Ethnic Background: (optional) ☐ Filipino ☐ Hispanic ☐ Asian-Pacific Islander ☐ Unknown ☐ SE Asian ☐ Other: _____

In case of emergency, contact:
Name Address Day Phone ( )

SECTION 2: Other Health Insurance

Do you or your family members (requesting enrollment in TRICARE Prime) have other health insurance coverage? ☐ Yes ☐ No

Type of Coverage (Check all that apply) ☐ Employment (Group) ☐ Private (Non-Group) ☐ Medicare ☐ Student Plan ☐ Medicare Supplemental Insurance ☐ Other (Please Specify) _____

Name of Insurance Company	Address	City	State	ZIP

Insurance Identification Number	Insurance Effective Date (Month/Day/Year)

SECTION 3: Payment Method - please check appropriate boxes

Annual Payment: Active-Duty Family Members: No Enrollment Fee
Retiree/Retiree Family Member(s): ☐ $230 Individual ☐ $460 Family (Two or More)

Quarterly Payment:
1. You may pay your enrollment fee in quarterly or yearly installments.
2. When you select a payment option, the amount enclosed must match that of the option selected, or your application will be delayed.
3. When paying enrollment fees on a quarterly basis, you will receive an invoice 30 days prior to your next payment due date.
4. A 30-day grace period is in effect starting from the due date for payments of the quarterly fees. If payment is not received at the end of the 30-day grace period, you will be responsible for the deductible and cost shares for any health care received after expiration of the grace period applicable under TRICARE Standard and TRICARE Extra.
5. You will be disenrolled for non-payment of your quarterly enrollment fees. Disenrollment will be effective retroactive to the beginning of the 30-day grace period. If this occurs, you may not re-enroll in TRICARE Prime for a period of 12 months. You may use TRICARE Standard or TRICARE Extra during the lockout period.

☐ **Option #1** 1st quarterly payment only (amount submitted must reflect this choice)
Retiree/Retiree Family Member(s) Individual: $57.50 x 1 = $57.50 Retiree/Retiree Family Member(s) Two or more: $115.00 x 1 = $115.00

☐ **Option #2** 1st and 2nd quarterly payment only (amount must reflect this choice)
Retiree/Retiree Family Member(s) Individual: $57.50 x 2 = $115.00 Retiree/Retiree Family Member(s) Two or more: $115.00 x 2 = $230.00

☐ **Option #3** 1st, 2nd and 3rd quarterly payment only (amount submitted must reflect this choice)
Retiree/Retiree Family Member(s) Individual: $57.50 x 3 = $172.50 Retiree/Retiree Family Member(s) Two or more: $115.00 x 3 = $345.00

Method of Payment: ☐ Check # ☐ Cashiers Check ☐ Money Order *Make Check or Money Order payable to Anthem Alliance - TRICARE.*
☐ VISA ☐ MasterCard

If paying by credit card, please complete the following:

Card Number: _____ Expiration Date: _____

Print name on card: _____ Signature: _____

All Enrollees: Please read and initial the following statement

_____I have read and understand the information presented on this TRICARE Prime Enrollment Form as well as any TRICARE materials presented to me. I understand the restrictions and guidelines I must follow by enrolling in TRICARE Prime. I understand that I must keep my information updated in the Defense Enrollment Eligibility Reporting System (DEERS), choose a Primary Care Manager for each TRICARE Prime enrollee, and pay any applicable enrollment fees to ensure that my enrollment is not delayed. I understand that that I must choose my Primary Care Manager from a Military Treatment Facility, based on the Military Treatment Facility Commander guidelines, or from the Anthem Alliance TRICARE Network of providers. I understand that I must receive all non-emergency and non-urgent care from my Primary Care Manager or be subject to Point-of-Service charges. I understand that I will need to pay applicable enrollment fees on a yearly or quarterly basis if my sponsor is retired or deceased. I understand that TRICARE Prime enrollment is for 12 month, and if I request early disenrollment, my applicable enrollment fees are non-refundable and I will be subject to the 12-month lock-out period. I understand that I must disenroll from TRICARE Prime if I am no longer eligible. I hereby certify that the information I have provided in this document is true and complete.

Section 4: Family Member Information

Name (Last, First, MI) | Date of Birth: | Relationship to Sponsor:

Other Health Insurance: ☐ Yes ☐ No (If yes, complete Section 2) | SSN: | Is this family member participating in Program for Persons with Disabilities? ☐ Yes ☐ No

(Please name your 1st, 2nd, and 3rd choices for a Primary Care Manager. If your choice is unavailable, you will be enrolled with your next choice.)

1st Choice ☐ Current ☐ New ☐ See section 1 | 2nd Choice ☐ Current ☐ New ☐ See section 1 | 3rd Choice ☐ Current ☐ New ☐ See section 1

Complete only if different from sponsor's address

Street | City | State | ZIP

Race: (optional) ☐ White ☐ Black ☐ Asian-Pacific Islander ☐ Other Western Hemisphere Indians ☐ Other: _____

Ethnic Background: (optional) ☐ Filipino ☐ Hispanic ☐ Asian-Pacific Islander ☐ Unknown ☐ SE Asian ☐ Other: _____

In case of emergency, contact:

Name | Address | Day Phone ( )

Name (Last, First, MI) | Date of Birth: | Relationship to Sponsor:

Other Health Insurance: ☐ Yes ☐ No (If yes, complete Section 2) | SSN: | Is this family member participating in Program for Persons with Disabilities? ☐ Yes ☐ No

(Please name your 1st, 2nd, and 3rd choices for a Primary Care Manager. If your choice is unavailable, you will be enrolled with your next choice.)

1st Choice ☐ Current ☐ New ☐ See section 1 | 2nd Choice ☐ Current ☐ New ☐ See section 1 | 3rd Choice ☐ Current ☐ New ☐ See section 1

Complete only if different from sponsor's address

Street | City | State | ZIP

Race: (optional) ☐ White ☐ Black ☐ Asian-Pacific Islander ☐ Other Western Hemisphere Indians ☐ Other: _____

Ethnic Background: (optional) ☐ Filipino ☐ Hispanic ☐ Asian-Pacific Islander ☐ Unknown ☐ SE Asian ☐ Other: _____

In case of emergency, contact:

Name | Address | Day Phone ( )

Name (Last, First, MI) | Date of Birth: | Relationship to Sponsor:

Other Health Insurance: ☐ Yes ☐ No (If yes, complete Section 2) | SSN: | Is this family member participating in Program for Persons with Disabilities? ☐ Yes ☐ No

(Please name your 1st, 2nd, and 3rd choices for a Primary Care Manager. If your choice is unavailable, you will be enrolled with your next choice.)

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In case of emergency, contact:

Name | Address | Day Phone ( )

Name (Last, First, MI) | Date of Birth: | Relationship to Sponsor:

Other Health Insurance: ☐ Yes ☐ No (If yes, complete Section 2) | SSN: | Is this family member participating in Program for Persons with Disabilities? ☐ Yes ☐ No

(Please name your 1st, 2nd, and 3rd choices for a Primary Care Manager. If your choice is unavailable, you will be enrolled with your next choice.)

1st Choice ☐ Current ☐ New | 2nd Choice ☐ Current ☐ New | 3rd Choice ☐ Current ☐ New

Complete only if different from sponsor's address

Street | City | State | ZIP

Race: (optional) ☐ White ☐ Black ☐ Asian-Pacific Islander ☐ Other Western Hemisphere Indians ☐ Other: _____

Ethnic Background: (optional) ☐ Filipino ☐ Hispanic ☐ Asian-Pacific Islander ☐ Unknown ☐ SE Asian ☐ Other: _____

In case of emergency, contact:

Name | Address | Day Phone ( )

Prime Member/Sponsor Signature _____ Date _____

Relationship to Sponsor _____

All Eligible Beneficiaries Residing Outside a TRICARE Prime Service Area Must Initial the Following Statement to Enroll in TRICARE Prime:

_____ I understand that because my place of residence is outside the TRICARE Prime Service area, I may not have access to primary care delivery sites within 30 minutes travel time from my home, and specialty care delivery sites may not be available within one hour travel time from my home. (Call 1-800-931-9501 to help determine whether you reside outside the TRICARE Prime Service Area.)

If you are retroactively enrolling, please complete the following:

Retroactive Enrollment Rationale: (requires MTF Commander and Lead Agent approval) ☐ Approved ☐ Disapproved

_____

_____

MTF Commander _____ Date _____

Lead Agent _____ Date _____

Please make a copy and keep for your records