UnitedHealthcare | TRICARE

TYA Reconsideration Request Form

Please type or print all entries.

TYA (Young Adult) **Sponsor and Beneficiary Information**				Select Coverage Type: ☐**Prime** ☐**Standard**
Sponsor Name: Last	First		M.I.	Sponsor SSN or DBN
Home Address: Street	Apt. No.	City	State	ZIP Code
Mailing Address: Street *If different then above*	Apt. No.	City	State	ZIP Code
Sponsor E-Mail Address:				
Day Time Phone Number:		Evening Phone Number:		
TYA Beneficiary Name: Last	First		M.I.	TYA Beneficiary SSN or DBN
TYA Home Address: Street	Apt. No.	City	State	ZIP Code
TYA Mailing Address: Street *If different then above*	Apt. No.	City	State	ZIP Code
TYA Beneficiary E-Mail Address:				

Step 1: Please specify the action you are requesting.

☐Please **Reinstate** coverage. If approved, your coverage will be continuous from your last paid through date when enrollment fees have been paid current as required by your plan. Any claims for health care services received during your disenrollment would then be covered by TRICARE if approved.

Step 2: Please provide a DETAILED explanation why requesting to be reinstated.

Detailed reason for reconsideration is required. If more space is needed, please attach an additional page.

Please note: *If you have been disenrolled for failure to pay your TRICARE enrollment fees, TRICARE policy states that you will be unable to enroll for 12 months. You may be eligible for reinstatement or to retroactively enroll in certain circumstances. The enrollment department and or DHA will review your request as submitting this form does not guarantee approval.*

Step 3: Please provide supporting documentation as applicable.

Proof of payment, fax confirmation, written documentation and/or print outs etc.

Step 4: Sign Request Form *TYA Signature is Required and CANNOT be processed if not provided*

TYA Signature_____ ***Date***_____

****Request will not be processed without this signature****

Step 5: Please mail or fax to the address below.

Mail this form to:

UnitedHealthcare Military & Veterans
TRICARE West Region Enrollment Department
P.O. Box 105492
Atlanta, GA 30348-5492

or Fax this form to:

1-877-890-7297

THANK YOU FOR YOUR SERVICE!

**** Please note: All three pages must be completed and submitted in order for request to be processed. ****

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Electronic Payment Authorization Form

Reconsideration Purpose Use Only

Please type or print all entries.

TYA (Young Adult) Electronic Payment Authorization Form

Sponsor Name: Last	First		M.I.	Sponsor SSN or DBN	
Home Address: Street	Apt. No.	City		State	ZIP Code
TYA Beneficiary Name: Last	First		M.I.	TYA Beneficiary SSN or DBN	
Home Address: Street	Apt. No.	City		State	ZIP Code

Step 1: Please select the method of payment option you wish to start below.

☐ **Electronic Funds Transfer (EFT)** Please begin automatic payments of my monthly premiums payable to UnitedHealthcare Military & Veterans by means of Electronic Funds Transfer from my financial institution.

Please check one: ☐ Checking ☐ Savings (Note: Please attach voided check)

_____ _____ _____

Name of Financial Institution | 9 Digit Bank or ABA Routing Number | Account Number

☐ **Recurring Credit Card (RCC)** Please begin automatic payments of my monthly premiums payable to UnitedHealthcare Military & Veterans by means of Recurring Credit Card from my financial institution.

Please check one: ☐ Visa ☐ MasterCard ☐ Discover

__ __ __ __-__ __ __ __-__ __ __ __-__ __ __ __ __ __/__ __ (MM/YY)

16 Digit Credit Card Number | Expiration Date

Step 2: Authorize this request with your signature and mail to the address below.

My signature authorizes UnitedHealthcare Military & Veterans to start automatic monthly payments using the method selected in Step 1 above to deduct my premiums due as determined by TRICARE. This agreement will remain in full force unless cancelled by me in writing or by my financial institution or UnitedHealthcare. I understand that a $20.00 administrative fee will be assessed for any payments returned due to insufficient or unavailable funds.

Authorized Signature (*Required*): _____ **Date:** _____

Mail this form to:

UnitedHealthcare Military & Veterans
TRICARE West Region Enrollment Department
P.O. Box 105492
Atlanta, GA 30348-5492

or Fax this form to:

1-877-890-7297

THANK YOU FOR YOUR SERVICE!

Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as "official use only."

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the UnitedHealthcare Military & Veterans Information System and how it will be used.

AUTHORITY:	10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.
PURPOSE:	To collect information from you in order to manage your TRICARE enrollment, provide your benefits, and/or pay for those services.
ROUTINE USES:	Your records may be disclosed to investigate waste, fraud, abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may also occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.
DISCLOSURE:	Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process your request.