TRICARE PLUS ENROLLMENT APPLICATION

(Read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing form.)

OMB No. 0720-0028
OMB approval expires Feb 28, 2017

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 7 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, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (0720-0028). 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.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION. Return completed form to the Military Treatment Facility where you are requesting treatment.

PRIVACY ACT STATEMENT

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.

PRINCIPAL PURPOSE(S): This form collects the information necessary to process your request to enroll in TRICARE Plus.

ROUTINE USE(S): Your records may be disclosed to Federal agencies, and state, local and territorial governments, in order to collect debts and overpayments, to determine whether beneficiaries are eligible for, or enrolled in, other government or private health insurance plans, and to stop fraud, waste and abuse. Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html.
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 by DoD 6025.18-R. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide the requested information may result in the denial of your request to enroll in TRICARE Plus.

INSTRUCTIONS

This form is for eligible beneficiaries who want to enroll in TRICARE Plus. TRICARE Plus is an enrollment option for TRICARE beneficiaries who want an affiliation with a primary care provider at a Military Treatment Facility (MTF) and are either ineligible for TRICARE Prime or prefer a more limited relationship (primary care only). Enrollment in TRICARE Plus does not guarantee access to services at the MTF, however, if you are accepted for enrollment you will be assigned to a primary care provider at the MTF. The MTF will make every effort to provide complete and comprehensive primary care services within access standards. Beneficiaries enrolled into TRICARE Plus agree to rely on their MTF primary care provider for all their non-emergency primary care.

GENERAL INSTRUCTIONS:

1. Print all information in ink. Make sure the information is complete and accurate.
2. Ensure personal information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center Support Office at 1-800-538-9552 or refer to your name as printed on your ID card. The mailing address and telephone numbers you include on this form will update DEERS.
3. Sign and date the application (Section III).
4. Please keep a copy of the completed application for your records.
5. Submit completed application to the MTF where you are requesting enrollment. Each MTF has local policies for processing your application. For more information regarding enrollment to a specific MTF, contact the MTF directly.
6. For information on TRICARE Plus, contact any MTF or visit the TMA Website at www.tricare.osd.mil.

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SECTION I - SPONSOR INFORMATION *(Must be completed on all applications)*

1. Sponsor Social Security Number (SSN) or DoD Benefits Number (DBN)	2. Sponsor Name *(Last, First, Middle Initial)*	3. Date of Birth *(YYYYMMDD)*

SECTION II - INDIVIDUAL ENROLLMENTS

4. Sponsor Requesting Enrollment

a. Mailing Address *(Street/P.O. Box, Apartment Number, City, State, ZIP Code)*	b. Residence Address *(If different from mailing address)*

c. Telephone Number *(Include area code)*:	(1) Home:	(2) Work:

d. Sponsor's E-mail Address: ☐ X to receive TRICARE e-mails

e. Requested Military Treatment Facility (MTF) and Provider's Name *(If known)*

(1) First Choice	(2) Second Choice
☐ X if under the care of this provider or MTF	☐ X if under the care of this provider or MTF

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5. Enrolling Family Members

a. Name *(Last, First, Middle Initial)*	b. Date of Birth *(YYYYMMDD)*

c. Mailing Address *(Street/P.O. Box, Apartment Number, City, State, ZIP Code)*	d. Residence Address *(If different from mailing address)*
☐ X if same as sponsor	☐ X if same as sponsor

e. Telephone Number *(Include area code)*:	(1) Home:	(2) Work:

f. Requested Military Treatment Facility (MTF) and Provider's Name *(If known)*

(1) First Choice	(2) Second Choice
☐ X if under the care of this provider or MTF	☐ X if under the care of this provider or MTF

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SECTION III - SIGNATURE

6. I understand that TRICARE Plus:

(1) is a military treatment facility primary care enrollment program, not a comprehensive health plan; (2) does not guarantee access to specialty care at the military treatment facility where the beneficiary is enrolled; (3) enrollees may have out-of-pocket expenses for civilian health care; (4) enrollment at this military treatment facility is not transferable to another military treatment facility; and (5) by enrolling in TRICARE Plus I will be disenrolled from any other TRICARE enrollment program.

By signing this form, I certify that the information on this form is true, accurate and complete.

a. Signature	b. Date Signed *(YYYYMMDD)*

Return ORIGINAL completed form to the Military Treatment Facility where you are requesting treatment.
Keep a copy for your records.