UnitedHealthcare | TRICARE

TRICARE Prime Reconsideration Request Form

Please type or print all entries.

TRICARE Prime Sponsor Information				
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:			

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 once enrollment fees have been paid current. If approved, claims for health care services received during your disenrollment would then be processed under TRICARE Prime.

☐Please **Reenroll** coverage. If a lockout waiver is approved, **you must purchase new coverage by submitting a new TRICARE enrollment form**. Any claims for health care services received during your disenrollment must be covered by the beneficiary or the existing coverage at time of service.

☐Please **Retroactively Enroll** coverage. For emergency cases that should be placed under immediate case management, exceptions may be made on a case-by-case basis for retroactive enrollment with an effective date not earlier than the first day of the month that the application is submitted.

Step 2: Please provide a DETAILED explanation & list each person to be reinstated/reenrolled/retroactively enrolled.

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

Beneficiaries to be reenrolled/reinstated: _____

_____

_____

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.*

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 *Signature must be of sponsor, spouse or other legal guardian of beneficiary.*

Signature_____ ***Date***_____

****Request will not be processed without a 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!

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Electronic Payment Authorization Form

Reconsideration Purpose Use Only

Please type or print all entries.

TRICARE Prime Electronic Payment Authorization Form

Sponsor Name: Last	First	M.I.	Sponsor 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:** _____

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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."