

PLEASE REFER TO INSTRUCTIONS ON PAGE TWO BEFORE COMPLETING FORM

EBD: **Please Print Clearly**

SPONSOR INFORMATION	1) Sponsor's Name Last First MI				2) Sponsor's Social Security Number			
	3) Street or P.O. Box			Apt. No.	City		State	Zip Code
	4) Sex M/F	5) Birthdate Mo/Day/Yr	6) Email address		7) Service Branch USN US Army	USMC USAF	USPHS USCG	Other (Specify) NOAA
	8) Sponsor's Phone Home Work				9) Sponsor's Work ZIP Code		10) Active Duty? Yes No	
	11) Active Duty Sponsor's Pay Grade E1-E4 E5 and Above		12) Active Duty Unit of Assignment		13) Rank		14) Is sponsor an Active Duty Reservist? Yes No If yes, indicate separation date and attach copy of orders:	
	15) Is sponsor: Deceased Retired Enrolling				If sponsor is deceased, skip to #20			
	16) Sponsor's 1st Choice Primary Care Manager (Check one box) Military Treatment Facility name and DMIS ID#				Full name of Civilian Physician			
	17) List 1st Choice Primary Care Manager's Complete Address, if civilian provider							
	18) Sponsor's 2nd Choice Primary Care Manager (Check one box) Military Treatment Facility name and DMIS ID#				Full name of Civilian Physician			
19) List 2nd Choice Primary Care Manager's Complete Address, if civilian provider								

FAMILY MEMBER INFORMATION	20) Name Last First MI				Social Security Number			
	Street or P.O. Box			Apt. No.	City		State	Zip Code
	Phone Number	Sex M/F	Birthdate Mo/Day/Yr	Email address		Relationship to Sponsor	If spouse, are you retired from the military? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Family Member's 1st Choice Primary Care Manager (Check one box) <input type="checkbox"/> Military Treatment Facility name and DMIS ID#				<input type="checkbox"/> Full name of Civilian Physician			
	List 1st Choice Primary Care Manager's Complete Address, if civilian provider							
	Family Member's 2nd Choice Primary Care Manager (Check one box) <input type="checkbox"/> Military Treatment Facility name and DMIS ID#				<input type="checkbox"/> Full name of Civilian Physician			
	List 2nd Choice Primary Care Manager's Complete Address, if civilian provider							
	Name Last First MI				Social Security Number			
	Street or P.O. Box			Apt. No.	City		State	Zip Code
	Phone Number	Sex M/F	Birthdate Mo/Day/Yr	Email address		Relationship to Sponsor		
Family Member's 1st Choice Primary Care Manager (Check one box) <input type="checkbox"/> Military Treatment Facility name and DMIS ID#				<input type="checkbox"/> Full name of Civilian Physician				
List 1st Choice Primary Care Manager's Complete Address, if civilian provider								
Family Member's 2nd Choice Primary Care Manager (Check one box) <input type="checkbox"/> Military Treatment Facility name and DMIS ID#				<input type="checkbox"/> Full name of Civilian Physician				
List 2nd Choice Primary Care Manager's Complete Address, if civilian provider								

OTHER	21) Have all non-active duty beneficiaries age 17 or older completed a Health Enrollment Assessment Review (HEAR) form? <input type="checkbox"/> Yes <input type="checkbox"/> No				22) Fee Information (MUST PAY FEE AT TIME OF ENROLLMENT)							
	23) Other Health Insurance (OHI)				Failure to pay quarterly/annual fees when due will result in disenrollment.							
	Policy Number: _____				Payment Option		Annual Enrollment:		Quarterly Enrollment:		Amount Enclosed: \$ _____	
	Insurance Company Name: _____				<input type="checkbox"/> Active Duty None		<input type="checkbox"/> Individual \$230.00		<input type="checkbox"/> Active Duty None		<input type="checkbox"/> Individual \$57.50	
	Effective Dates: From _____ To _____ Type of Coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual				<input type="checkbox"/> Family \$460.00		<input type="checkbox"/> Family \$115.00					
	Policy Type: <input type="checkbox"/> TRICARE Supplemental <input type="checkbox"/> Commercial <input type="checkbox"/> Employer GRP				Method of Payment							
	Policy Holder Name: _____ (Last) (First) (Middle)				<input type="checkbox"/> Personal Check* No. _____		<input type="checkbox"/> Cashiers Check No. _____					
	Policy Holder SSN: _____				<input type="checkbox"/> Traveler's Check No. _____		<input type="checkbox"/> Money Order No. _____					
	Patient Name: _____ (Last) (First) (Middle)				Type of card <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Discover							
	Relationship to Insured: <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse <input type="checkbox"/> Child				Credit card number		Expiration Date					
Pharmacy Benefit: <input type="checkbox"/> Yes <input type="checkbox"/> No				Your signature authorizes the credit card company to charge the card number above.								
Do you currently have Medicare benefits? If so, please indicate the effective date of coverage and what coverage you have:				Signature _____								
Medicare Part A <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____				*There is a fee for returned checks.								
Medicare Part B <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____												

24) Are you or any family member requesting enrollment participating in the Program For Persons With Disabilities (PPPWD)? Yes No
If yes, please list participants:

25) I have read the information on benefits and restrictions of the TRICARE Prime program provided me. I understand the restrictions as stated or explained to me and hereby apply for enrollment. I understand that I must choose a Primary Care Manager (PCM) participating in TRICARE Prime or select a military hospital, clinic or dispensary, when available, as my Primary Care Site to be covered by the Plan. If I decide to obtain care which has not been coordinated by my PCM and authorized by the Health Care Finder, or seek services from a non-TRICARE Prime provider, I understand that TRICARE Prime coverage will not apply and I will be responsible for payment under the Point of Service option for all services received. I understand that I must pay an initial and annual non-refundable enrollment fee if the sponsor is retired/deceased. I understand that enrollment is subject to verification of funds. I understand I must remain enrolled in TRICARE Prime for 12 consecutive months. I understand that my entitlement to TRICARE benefits will be confirmed through the Defense Enrollment Eligibility Reporting System (DEERS). I authorize the Plan to obtain examine, disclose and copy records of any physician, hospital or provider when necessary for proper payment of benefits for all enrollees listed on this document; this form serves as Medical Records Release. A photographic copy of this authorization shall be valid as the original document. I here by certify that the information provided on this document is true and complete. I agree to abide by the provisions of membership. I must disenroll from TRICARE Prime when I am no longer eligible or move from the TRICARE Prime regions. The Plan will not discriminate, or have the effect of discriminating, against any beneficiaries on the basis of health status, age, race, sex, family size, sponsor status or sponsor rank. I understand that I may be asked to waive travel access standards to seek medical treatment.

I UNDERSTAND ENROLLMENT FEES ARE NOT REFUNDABLE.
Please review the Agency Disclosure and the Privacy Act on the reverse side of this application before using.

Signature _____ Relationship to Sponsor _____ Date _____

AUTHORITY: 10 U.S.C. Chapter 55 CHAMPUS PRINCIPAL PURPOSES: Enrollment in the TRICARE Prime program. ROUTINE USES: Verify eligibility and produce enrollment cards.
DISCLOSURE IS VOLUNTARY. Failure to provide the information could result in denial of reimbursement under the CHAMPUS program.

TRICARE PRIME ENROLLMENT FORM INSTRUCTIONS

ATTENTION: DO NOT use this form if you want to:

- Change your TRICARE Prime enrollment (Portability) from another TRICARE region to the Northeast Region (Region 1)
- Add a family member or newborn to TRICARE Prime
- Change your Primary Care Manager (PCM)
- Change your address (Also call DEERS at 1-800-538-9552)
- Change your status from Active Duty to Retired Military
- Change your other health insurance information
- Disenroll from TRICARE Prime.

FOR FASTER PROCESSING, please use a **Change Form** for the items listed above, **NOT** an Enrollment Form.
Only use an Enrollment Form when first joining TRICARE Prime when no other family members are enrolled.

Thank you for choosing TRICARE Prime. **Please print all information in pen and fill out the form accurately and completely.** Your application will be delayed if your family information is incomplete or does not match the DEERS file. If you are unsure how to answer a question, please call our toll-free telephone number 1-888-999-5195. Our Beneficiary Services Representatives will be happy to assist you.

1-14. Mandatory: Sponsor information must be filled out in order to process Enrollment. Failure to complete this section will result in delays.

15. Is Sponsor Deceased, Retired, Enrolling - Check appropriate box. Even if sponsor is deceased, you must complete sections 1-15. *Note: If sponsor and spouse are both retired from the military and plan to enroll additional family members in TRICARE Prime, you must visit the local personnel office to have a family medical record created under one Social Security Number.*
16. Choose a Primary Care Manager. If sponsor lives 30 minutes or 20 miles from a Military Treatment Facility (MTF), list the MTF name and DMIS ID#. The MTF DMIS ID# can be found by calling your MTF or on www.sierramilitary.com in the Provider Directory when searching for a Primary Care Manager. If the sponsor does not live near an MTF, choose a civilian provider from the Provider Directory. If enrolling to a civilian provider, call the provider to make sure the practice is accepting new patients.
17. List first choice Primary Care Manager's Address, City, State, Zip Code (if civilian provider).
18. List Sponsor's second choice for a Primary Care Manager (Military Treatment Facility or civilian physician) from the Directory.
19. List second choice Primary Care Manager's Address, City, State, Zip Code (if civilian provider).
20. Family member information - List information for all family members who are enrolling in the TRICARE Prime program. You **MUST** select a Primary Care Manager to enroll. Please choose two (2) Primary Care Managers for each Prime member. If enrolling more than two (2) family members, use a Supplemental Enrollment Form for additional family members.
21. Have all beneficiaries age 17 and older completed a Health Enrollment Assessment Review (HEAR) form? Check the appropriate box.
22. Billing options. Retirees and their family members wishing to enroll in Prime must pay an annual enrollment fee. Please state whether you would like to pay annually or quarterly - Check the appropriate box. Indicate the amount enclosed or to be charged.

Important:

Return one copy to SMHS Enrollment, P.O. Box 828450, Philadelphia, PA 19182. Keep a copy for your records. Enrollment is subject to eligibility, Primary Care Manager assignment and all other TRICARE regulations. Upon completion of the enrollment process, a Prime identification card will be mailed to you. In the meantime, please use your copy.

ENROLLMENT FEES		
ACTIVE DUTY FAMILY MEMBERS None	RETIREES AND THEIR FAMILIES Individual: \$230 annually or \$57.50 per quarter	Family: \$460 annually or \$115 per quarter

Method of payment - Check the appropriate box. Enrollment fees must be paid at the time of initial enrollment into TRICARE Prime. If paying by credit card, a signature is required. List the credit card number and expiration date in the spaces provided. Make Checks Payable To: SMHS, Inc. There is a fee for returned checks. Please refer to the TRICARE Provider Directory for guidance on Primary Care Manager selection in your area. Mail your application and appropriate enrollment fee to the following address: SMHS Enrollment, P.O. Box 828450, Philadelphia, PA 19182-8450. **Failure to pay quarterly/annual fees when due will result in disenrollment.**

23. Does the Sponsor or eligible family member have other health insurance coverage, including Medicare?
24. Are you or any family members requesting enrollment participating in the Program For Persons With Disabilities (PFPWD)?
25. Read the acknowledgement. Sign and date application form and indicate relationship to sponsor.

SMHS must receive your paperwork by the 20th of the month for your enrollment to be effective the first of the next month.

Your completed application form will be processed, and a Prime enrollment card will be mailed to each eligible family member. The effective date of membership will be indicated on each card.

AGENCY DISCLOSURE STATEMENT: Public reporting of 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, 1216 Jefferson Davis Highway, Suite 1204, Arlington, VA 92202-4802; and the Office of Management and Budget, Paperwork Reduction Project 0720-0008, Washington DC 20508. **PLEASE DO NOT RETURN YOUR ENROLLMENT APPLICATION TO EITHER OF THESE ADDRESSES. SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION SHEET.**

PRIVACY ACT STATEMENT: (1) 44 USC 8101; 10 USC 1079 and 1086, 38 USC 613; EO 9397. (2) Purpose: To evaluate for medical care provided by civilian sources to Military Health System beneficiaries applying for coverage under the TRICARE Program (82 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 the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made in the request of the 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 the denial of enrollment.