TRICARE PRIME ENROLLMENT, DISENROLLMENT, AND PRIMARY CARE MANAGER (PCM) CHANGE FORM

OMB No. 0720-0008
OMB approval expires 20250930

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 113, Secretary of Defense; 5 U.S.C. 552, Freedom of Information Act, as amended; 5 U.S.C. 552a, Privacy Act of 1974, as amended; 32 CFR part 286, DoD Freedom of Information Act (FOIA) Program; 32 CFR part 310, Protection of Privacy and Access and Amendment of Individual Records Under the Privacy Act of 1974; DoD Directive, 5400.07, DoD Freedom of Information Act (FOIA) Program; DoD Instruction 5400.11, DoD Privacy and Civil Liberties Programs; DoD Manual 5400.07, DoD Freedom of Information Act (FOIA) Program; DoD 5400.11-R, DoD Privacy Program; and Executive Order 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain information necessary to permit individuals to enroll, disenroll, or change their provider in TRICARE Prime Overseas or TRICARE Prime Remote Overseas, as requested by the individual.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use to private physicians and federal agencies to include Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and other Federal, State, local, or foreign government agencies, private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation. DoD's Routine Use disclosures are limited to those explicitly stated in each SORN. For a full listing of the Routine Uses, refer to below applicable SORNs hyperlinked below. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

APPLICABLE SORN: Defense Manpower Data Center (DMDC) 02 DoD, Defense Enrollment Eligibility Reporting Systems (DEERS) (May 31, 2022; 87 FR 32384. **https://www.federalregister.gov/documents/2022/05/31/2022-11610/privacy-act-of-1974-system-of-records**

DISCLOSURE: Voluntary. If you choose not to provide the requested information, there may be an administrative delay processing your request and the DoD may be unable to process it; however, no penalty will be imposed.

APPLICATION OPTIONS

(1) ONLINE:
You may request to enroll, disenroll or change your primary care manager (PCM) by logging into the Beneficiary Web Enrollment website at https://milconnect.dmdc.osd.mil

(2) TELEPHONE:
You may enroll, disenroll, or change your PCM by calling your Regional Contractor at the toll-free numbers on this page.

(3) ENROLLMENT FORM:
You may also enroll, disenroll, or change your PCM by completing and submitting the form to your Regional Contractor at the address or fax number below.

(4) NOTES:
You will be notified of your enrollment or PCM change via email or postcard. You can then log into milConnect at: https://milconnect.dmdc.osd.mil to view specific information. For additional information on TRICARE, visit the TRICARE website at www.tricare.mil or the Regional Contractor's website at: www.tricare-overseas.com

REGIONAL CONTRACTOR: REGION, ADDRESS, TELEPHONE AND FAX NUMBERS:

Region: OVERSEAS REGION

Address: International SOS Government Services, LLC, PO Box 760217, San Antonio, TX 78245

Toll-Free Number: www.tricare-overseas.com/contact-us

Fax Number: 1-215-773-2740

SPONSOR'S SSN/DBN:

TRICARE PRIME OPTION DESIRED:

☐ **TRICARE Prime:** Overseas Family members must be command sponsored and meet specific enrollment criteria of the overseas area. Retirees are not eligible for TRICARE Prime Overseas.

☐ **TRICARE Prime Remote Overseas:** If eligible, you may be enrolled in TRICARE Prime Remote Overseas. Family members must be command sponsored and meet specific enrollment criteria of the overseas area.

SECTION I - SPONSOR INFORMATION

1. SPONSOR'S NAME *(Last, First, Middle Initial) (Must match DEERS)*	**2. SPONSOR'S SOCIAL SECURITY NUMBER (SSN)** *(XXX-XX-XXXX)* **or DoD BENEFITS NUMBER (DBN)** *(XXXXXXXXX-XX)*

3. SPONSOR IS: *(X one)* ☐ Active Duty ☐ Retired ☐ Deceased *(Go to Section II.)* ☐ Unremarried Former Spouse

4. SPONSOR'S TELEPHONE NUMBER *(Include Area Code)*	**5. SPONSOR'S E -MAIL ADDRESS**	**6. SPONSOR'S DATE OF BIRTH** *(YYYYMMDD)*
a. WORK: c. CELL: b. HOME:		

7. SPONSOR'S RESIDENCE ADDRESS *(Street, Apartment No., City, State, ZIP Code, Country)* ☐ New

8. SPONSOR'S MAILING ADDRESS *(Provide APO or FPO if stationed overseas)* ☐ Same as residence ☐ New

9. SPONSOR'S MILITARY ASSIGNMENT

a. UNIT	c. STATE, ZIP CODE AND COUNTRY OF WORK ADDRESS
b. UNIT IDENTIFICATION CODE (UIC) *(If known)*	

10. SPONSOR'S REQUESTED ACTION *(X one)*

☐ None *(Go to Section II.)* ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll *(Non-AD only)*

Effective Date Requested *(YYYYMMDD)*:

11. SPONSOR'S PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and your uniformed service guidelines. Review PCM options online or call your Regional Contractor or preferred MTF (non-active duty only) for availability of PCMs.)*

a. 1st CHOICE MTF ☐ MTF ☐ PRP (ADSM)	FULL NAME or MTF/CLINIC
b. 2nd CHOICE ☐ MTF	FULL NAME or MTF/CLINIC

c. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Flight Medicine

d. PREFERRED PCM SEX ☐ No Preference ☐ Male ☐ Female

SPONSOR'S SSN/DBN:

SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE *(Use additional copies of this page as necessary)*

12.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION : ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll

Effective Date Requested *(YYYYMMDD)*:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*

a. WORK: b. HOME: c. CELL:

f. E -MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM SEX ☐ No Preference ☐ Male ☐ Female

13.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION : ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll

Effective Date Requested *(YYYYMMDD)*:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*

a. WORK: b. HOME: c. CELL:

f. E -MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM SEX ☐ No Preference ☐ Male ☐ Female

14.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*

b. DATE OF BIRTH *(YYYYMMDD)*

c. REQUESTED ACTION : ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll

Effective Date Requested *(YYYYMMDD)*:

d. RESIDENCE AND MAILING ADDRESS *(Provide address, with ZIP Code and Country, if different from Sponsor)*

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*

a. WORK: b. HOME: c. CELL:

f. E -MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM SEX ☐ No Preference ☐ Male ☐ Female

SPONSOR'S SSN/DBN:

SECTION III - REASON FOR DISENROLLMENT OR PCM CHANGE

(Complete if disenrolling or making a PCM change)

Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:

SECTION IV - OTHER HEALTH INSURANCE

PLEASE IDENTIFY IF ANYONE IS CURRENTLY COVERED BY OTHER HEALTH INSURANCE.

☐ TRICARE Supplement *(no other information is needed)*

☐ Medical Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ Dental Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ Vision Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ Prescription Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

SECTION V - SIGNATURE (REQUIRED)

I understand if I selected a PCM by name, team, or location (MTF or civilian), TRICARE will enroll me with that PCM subject to PCM availability and uniformed services policy. I understand that it is my responsibility to comply with all TRICARE Prime Overseas, and/or TRICARE Prime Remote Overseas policies and procedures. By signing this form, I certify the information provided is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments, or concealment of a material fact may be subject to fine and/or imprisonment under applicable Federal law.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*

ENROLLMENT NOTE: Your regional contractor will process your enrollment, disenrollment or change request to be effective on the date requested or the date of event (e.g., initial eligibility, marriage, birth) as appropriate. If your regional contractor receives your enrollment request within 90-days of loss of other TRICARE or healthcare coverage, your TRICARE Prime coverage can start on the day after the loss of your other coverage. You should confirm the enrollment or change before obtaining care by calling your Regional Contractor or by viewing your enrollment on milConnect (www.tricare.mil/milconnect).

DISENROLLMENT NOTE: If you voluntarily disenroll, you will only have space available care at a military hospital or clinic. You may re-enroll during the next open enrollment period or within 90-days of a qualifying life event (see www.tricare.mil/LifeEvents for details).