

## TRICARE PLUS ENROLLMENT APPLICATION

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

OMB No. 0720-0028  
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### AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information is estimated to average 8 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, 1155 Defense Pentagon, Washington, DC 20301-1155 (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. 1074, 1076, 1079, 1086, 1095; and E.O. 9397.

**PRINCIPAL PURPOSE(S):** To identify those individuals who have elected to use the Military Health System TRICARE Plus benefit.

**ROUTINE USE(S):** Information from application forms and related documents may be disclosed to the Department of Health and Human Services, and/or Department of Veterans Affairs consistent with their statutory administrative responsibilities under TRICARE and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); CHAMPVA; the Department of Justice and the United States attorneys where the United States is an interested party; and to Congressional Offices in response to inquiries made in the request of the person to whom a record pertains. Based on a valid "need to know" and with strict compliance with applicable routine use, appropriate disclosure may be made to Federal, state, local, and foreign government agencies, private business entities, 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 and criminal litigation related to the operation of the TRICARE program.

**DISCLOSURE:** Voluntary; however, failure to provide required information may result in denial of application for enrollment 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](http://www.tricare.osd.mil).

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

<b>1. Sponsor Social Security Number (SSN)</b>	<b>2. Sponsor Name (Last, First, Middle Initial)</b>	<b>3. Date of Birth (YYYYMMDD)</b>
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## SECTION II - INDIVIDUAL ENROLLMENTS

<b>4. Sponsor Requesting Enrollment</b>		
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. Requested Military Treatment Facility (MTF) and Provider's Name (If known)		
(1) First Choice	(2) Second Choice	
<input type="checkbox"/> X if under the care of this provider or MTF	<input type="checkbox"/> X if under the care of this provider or MTF	

**For Government Use Only**

<b>5. Enrolling Family Members</b>		
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)
<input type="checkbox"/> X if same as sponsor		<input type="checkbox"/> 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	
<input type="checkbox"/> X if under the care of this provider or MTF	<input type="checkbox"/> X if under the care of this provider or MTF	

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## SECTION III - SIGNATURE

<b>6. I understand that TRICARE Plus:</b> (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.**