Drive Time Waiver

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the Health Net Federal Services Information System and how it will be used.

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.

PURPOSE: To collect information from you in order to manage your TRICARE enrollment provide your benefits and/or pay for those services.

ROUTINE USES: Your records may be disclosed to investigate waste fraud abuse, security and privacy concerns. Use and disclosure of your records outside of DoD may also occur in accordance with the DoD Blanket Routine Uses published at **http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx** and as permitted by the Privacy Act of 1974 as amended (5 U.S.C. 552a(b)). 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. Permitted uses and disclosures of PHI include but are not limited to treatment payment and healthcare operations.

DISCLOSURE: Voluntary. If you choose not to provide your information no penalty may be imposed but absence of the requested information may result in administrative delays or the inability to process your request.

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HEALTH NET FEDERAL SERVICES | TRICARE

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Step 1: Complete Sponsor and Beneficiary Information:

Coverage: ☐ TRICARE Prime ☐ TRICARE Young Adult (TYA) PRIME	
Sponsor name:	**Sponsor SSN or DBN:**
Beneficiary name:	**TYA Beneficiary SSN or DBN:**
Home address for the beneficiary:	
Street address	
City **State** **ZIP**	

Step 2: Access to Care/Drive Time Waiver

I understand that by signing this statement, I acknowledge and accept my travel time for primary care may exceed 30 minutes from my home and my travel time for specialty care may exceed one hour from my home.

Please note: To complete the request to stay with your current PCM, HNFS must receive this form within 30 days of your PCM change request, either by U.S. mail or fax (see below). Otherwise, you may be assigned to a PCM within a 30-minute drive time of your residence.

Step 3: Sign Request Form ***Request will not be processed without signature.***

______________________________ Signature

______________ Date (mm/dd/yyyy)

______________________________ Relationship to Sponsor

Step 4: Please mail to the address below or fax.

Mail this form to:	Or, fax to:
Health Net Federal Services, LLC PO Box 8458 Virginia Beach, VA 23450-8458	1-844-388-8282

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