Enrollment Reconsideration Request

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (Health Net) on behalf of the TRICARE® program, and how it will be used.
AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.
PURPOSE: To collect information from you in order to assess reinstatement or waiver, and manage your TRICARE enrollment if applicable.
ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs 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 as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care 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 an individual's request.

Step 1: Please specify the plan you are requesting

☐ **TRICARE Select** ☐ **TRICARE Prime** ☐ **TRICARE Prime Remote** ☐ **TRICARE Reserve Select** ☐ **TRICARE Retired Reserve**

☐ **TRICARE Young Adult (TYA) Prime** or ☐ **TYA Select**

Requested Effective Date _____/_____/_____

Sponsor/TYA Enrollee Information

Sponsor/TYA Enrollee Name: _____ Sponsor/TYA Enrollee SSN: _____
Last Name *First Name* *M.I.*

Address: _____
Street Address *Apartment/Unit #* *City* *State* *ZIP Code*

Email: _____

Step 2: Please provide a *detailed* explanation and attach supporting documentation (if applicable) for your enrollment reconsideration request.

_____

_____

Step 3: For those who pay enrollment fees or premiums ONLY: Complete the Enrollment Fee Authorization attached.

Step 4: Please check the box below if you would like to include all eligible family members in the Defense Enrollment Eligibility Reporting System (DEERS) in your request. If not, please specify which family members you want to include:

☐ All eligible family members

_____

Step 5: Sign the request form.

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

Signature: _____ Date: _____

Step 6: Please mail or fax to the address below.

Health Net Federal Services, LLC
TRICARE West Region Enrollment Department
PO BOX 8458
Virginia Beach, VA 23450-8458
FAX: 1-844-388-8282

Important Information: Submission of this form does not guarantee an approved reconsideration to policy. Please allow 10 business days for review and processing. The determination of your request will be sent via mail or email.

STOP: Please ONLY complete this page if you pay enrollment fees or premiums.

TRICARE® West Region
Enrollment Fee Authorization

HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (HNFS) on behalf of the TRICARE program, and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: This information will be used by HNFS to electronically debit or stop payment of your monthly enrollment fees from your monthly retirement pay, checking or savings account, or credit card.

ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at dpcld.defense.gov 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 as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care 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 an individual's request.

To reinstate enrollment, you must pay past due fees AND set up automatic payments. Requests are processed within ten business days and notification will be sent via email.

Sponsor Information

Name Last: _____ First: _____ M.I.: ____ Sponsor SSN/DBN: _____

Step 1: One-Time Payment (Required)

☐ **Credit Card Payment**

Cardholder Name: _____

Credit/Debit Card Number: _____

Expiration Date: _____

Cardholder Signature: _____

☐ **Electronic Funds Transfer**

Account Holder Name: _____

Financial Institution name: _____

Nine-Digit Bank or ABA Routing Number: _____

Account number: _____

☐ Checking ☐ Savings

I authorize payment for up to 12 months of enrollment fees to HNFS (up to $150.00 for individual plans and $300.00 for family plans). HNFS will charge the minimum amount necessary to reinstate enrollment back to Jan. 1, 2021.

Step 2: Ongoing Payment Set Up (Required)

Ongoing payments must be made by allotment, when feasible. If you are unable to pay by allotment, you must set up automatic payments via a bank account (electronic funds transfer) or a recurring credit/debit card payment.

Select the preferred automated payment method and fill out the required fields.

☐ **ALLOTMENT –** HNFS will attempt to start the allotment from your military retirement pay by the next payment due date.

☐ **ELECTRONIC FUNDS TRANSFER (EFT)**

Account Holder Name: _____

Financial Institution Name: _____

Nine-Digit Bank or ABA Routing Number: _____

Account number: _____

☐ Checking ☐ Savings

☐ **VISA/MASTERCARD RECURRING CREDIT CARD PAYMENT (RCC)**

Cardholder Name: _____

Card Number: _____

Expiration Date: _____

Cardholder Signature: _____

Signature _____ *Date:* _____

This signature authorizes HNFS to reinstate TRICARE Select enrollment and start a monthly automated payment option using the method selected above. HNFS is also authorized to charge the One-Time Payment account indicated above the fees required to start my allotment, EFT or RCC. I understand HNFS will assess a $20 administrative fee for any payments returned due to insufficient or unavailable funds.

Please complete, sign and mail or fax this form to:

HEALTH NET FEDERAL SERVICES, LLC, PO BOX 8458, Virginia Beach, VA 23450-8458 | FAX: 1-844-388-8282