Enrollment Fee Allotment Authorization Letter

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 Health Net 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 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.

☐ **TRICARE Prime** ☐ **TRICARE Select**

Please type or print all entries.

Name: Last	First	M.I.	Sponsor SSN - -
Home Address: Street	Apt. No.	City	State ZIP Code

Indicate below the action you wish to take for the allotment process.

Please mark one of the three boxes and complete the requested information.

☐ Please **start** a monthly allotment to HNFS from my retirement pay for TRICARE enrollment fees for the TRICARE West Region.

I authorize a card payment for up to three-months of TRICARE enrollment fees payable to HNFS, if required before the allotment begins.
I understand this payment is waived when transferring from another region and an allotment has already been set up in that region.
I understand HNFS will assess a $20 administrative fee for any payments returned due to insufficient or unavailable funds.

CARDHOLDER NAME (Please Print) _____

CARD NUMBER _____ EXP DATE (MM/YYYY) ____/____

CARDHOLDER SIGNATURE _____

☐ Please **change** my existing monthly allotment to HNFS from:
☐ Individual to Family ☐ Family to Individual

☐ Please **stop** my existing monthly allotment to HNFS effective (MM/YY) ___/____.

I hereby authorize the above action (start, change or stop) be taken by HNFS from my military retirement pay. I understand this authorization will remain in effect until I request it be changed or stopped; however, as a courtesy to me, I also hereby authorize HNFS to automatically stop this allotment at a future date if I become disenrolled from the TRICARE West Region for any reason, including transferring my enrollment to a different TRICARE region.

Sponsor Signature (Required): _____ **Date:** ____/____/____

HNFS will attempt to start the allotment from your military retirement pay by the next payment due date. You will be notified by HNFS to make alternative payment arrangements if the allotment from your retirement pay could not be started by this date. Allotments are only authorized from military retirement pay received from either DFAS, Coast Guard or Public Health. Other payments received such as VA benefits, survivor benefits or combat related compensation are not eligible.

Please complete, sign, and mail this form and payment to:

HEALTH NET FEDERAL SERVICES, LLC
PO BOX 8608, Virginia Beach, VA 23450-8608
FAX: 1-844-785-2604