TRICARE® PRIME/SELECT ELECTRONIC FUNDS TRANSFER (EFT)/RECURRING CREDIT CARD (RCC) REQUEST FORM

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 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.

Instructions: *Please select the preferred automated payment method and fill out the required fields. Your account must be current to start an automated payment. If payment is due within the next 30 days, a one-time payment will be deducted using the preferred method of payment indicated below. In the event the monthly transaction is rejected, HNFS will stop the automated payment option and bill for any amount due.*

SPONSOR INFORMATION

Name_____ **Sponsor SSN**_____-_____-_____

Action Requested:

☐ Please **START** a monthly payment option ☐ Please **CHANGE** my existing authorization ☐ Please **STOP** my existing authorization

Please note: If you voluntarily disenroll from TRICARE Prime/Select, your recurring monthly payment will automatically stop.

☐ ELECTRONIC FUNDS TRANSFER (EFT)

Account Holder's Name (Please Print) _____

Financial Institution Name _____

Nine Digit Bank or ABA Routing Number _____

Account Number_____ ☐ Checking ☐ Savings

☐ VISA/Mastercard Recurring Credit Card Payment (RCC)

Cardholder Name (Please Print) _____

Card Number_____ Exp Date (MM/YYYY)____/_____

Signature _____

This signature authorizes HNFS to start a monthly automated payment option using the method selected above. Health Net Federal Services is also authorized to charge the account indicated the fees needed to start my 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 this form and payment to:

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