PHARMACY REDESIGN PILOT PROGRAM ENROLLMENT

(Read Privacy Act Statement and Payment Instructions on back before completing this form.)

Form Approved
OMB No. 0720-0023
Expires Jul 31, 2003

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO THE APPROPRIATE ADDRESS ON BACK.

1. SPONSOR INFORMATION

a. NAME *(Last, First, Middle)*	b. SOCIAL SECURITY NUMBER	c. DATE OF BIRTH *(YYYYMMDD)*	d. SEX *(X one)* ☐ MALE ☐ FEMALE

e. DECEASED *(X one)*	f. SPONSOR ENROLLING *(X one)*
☐ YES ☐ NO	☐ YES ☐ NO

g. ADDRESS

(1) STREET *(Include apartment number)*	(2) CITY	(3) STATE	(4) ZIP CODE

h. TELEPHONE NUMBERS *(Include area code)*		i. OTHER HEALTH INSURANCE *(X one)*
(1) HOME	(2) WORK	☐ YES *(If Yes, complete Item 3.)* ☐ NO

j. IN CASE OF EMERGENCY, CONTACT: (1) NAME *(Last, First, Middle Initial)*	(2) ADDRESS *(Street, City, State, ZIP Code)*	(3) TELEPHONE NUMBER *(Include area code)*

2. FAMILY MEMBER ENROLLMENT *(List all family members requesting enrollment. All family members must be registered in DEERS.) (Use additional pages if necessary.)*

a.

(1) NAME *(Last, First, Middle)*	(2) SOCIAL SECURITY NUMBER	(3) DATE OF BIRTH *(YYYYMMDD)*	(4) RELATIONSHIP TO SPONSOR

(5) ADDRESS *(f different from sponsor) (Street, City, State, ZIP Code)*	(6) TELEPHONE NUMBERS *(If different from sponsor) (Include area code)*		(7) OTHER HEALTH INSURANCE *(X one)*
	(a) HOME	(b) WORK	☐ YES *(If Yes, complete* ☐ NO *Item 3.)*

(8) IN CASE OF EMERGENCY, CONTACT: (a) NAME *(Last, First, Middle Initial)*	(b) ADDRESS *(Street, City, State, ZIP Code)*	(c) TELEPHONE NUMBER *(Include area code)*

b.

(1) NAME *(Last, First, Middle)*	(2) SOCIAL SECURITY NUMBER	(3) DATE OF BIRTH *(YYYYMMDD)*	(4) RELATIONSHIP TO SPONSOR

(5) ADDRESS *(f different from sponsor) (Street, City, State, ZIP Code)*	(6) TELEPHONE NUMBERS *(If different from sponsor) (Include area code)*		(7) OTHER HEALTH INSURANCE *(X one)*
	(a) HOME	(b) WORK	☐ YES *(If Yes, complete* ☐ NO *Item 3.)*

(8) IN CASE OF EMERGENCY, CONTACT: (a) NAME *(Last, First, Middle Initial)*	(b) ADDRESS *(Street, City, State, ZIP Code)*	(c) TELEPHONE NUMBER *(Include area code)*

3. OTHER HEALTH INSURANCE *(Complete only if you have other HEALTH insurance.)*

a. INSURANCE COMPANY NAME	b. TYPE OF COVERAGE *(X one)* ☐ FULL ☐ SUPPLEMENTAL	c. POLICY NUMBER	d. EXPIRATION DATE *(YYYYMMDD)*

e. ADDRESS *(Street, City, State, ZIP Code)*	f. TELEPHONE NUMBER *(Include area code)*	g. DOES YOUR POLICY HAVE PRESCRIPTION DRUG COVERAGE? *(X one)* ☐ YES ☐ NO

4. SPONSOR OR ENROLLEE SIGNATURE	5. DATE SIGNED *(YYYYMMDD)*

DD FORM 2814, NOV 2000 PREVIOUS EDITION IS OBSOLETE.

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PRIVACY ACT STATEMENT

AUTHORITY: 44 USC Sec. 101; 10 USC 1079 and 1088; 38 USC Sec. 13; EO Sec. 387.

PRINCIPAL PURPOSE(S): To evaluate for medical care provided by civilian sources to Military Health Services beneficiaries applying for coverage under the TRICARE Program (32 CFR, Part 198.17).

ROUTINE USE(S): Information from application forms and related documents may be given to the Department of Defense, Health and Human Services, and/or Transportation consistent with their statutory administrative responsibilities under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); to the Department of Justice for representation of the Secretary of Defense in civil actions; and to Congressional Offices in response to inquiries made in the request of the person to whom a record pertains. Appropriate disclosure may be made to other Federal, state, local, and foreign government agencies, private business entities, and individual providers of care, on matters relating to fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.

DISCLOSURE: Voluntary; however, failure to provide information will result in denial of enrollment.

PAYMENT INSTRUCTIONS

Mail all TRICARE Pharmacy Redesign Pilot Program enrollment forms to:

Region 3 (Okeechobee, FL area)

Humana Military Healthcare Services
Attn: Pharmacy Pilot Program Enrollment
500 West Main Street
515 Building, 3rd Floor
P.O. Box 740072
Louisville, KY 40201-7472

Region 5 (Fleming, KY area)

Anthem Alliance Health Insurance
Attn: Pharmacy Redesign Pilot Program Enrollment
333 W. First Street, Suite 210
Dayton, OH 45402

Complete credit card information below or attach a check or money order payable to **Anthem Alliance Health Insurance** or **Humana Military Healthcare Services** and include it with your enrollment form.

Credit Card: Type ☐ Visa ☐ Master Card ☐ Other _____
Credit Card Number _____
Expiration Date *(MMYY)* _____
Cardholder's Name _____

Cardholder's Signature _____

Payment Methods: Indicate the payment method you have chosen, the number of persons enrolling (i.e. Retiree/Sponsor 1, Retiree Family Member(s) 1), and the total payment you are enclosing.

☐ (1) **Annual Payment Method:**
$200.00 per person per year.

Retiree/Sponsor _____
Retiree Family Member(s) _____
Total Payment $ _____

☐ (2) **Semi-annual Payment Method:**
$100.00 per person at the time of enrollment, and $100.00 per person 6 months after each beneficiary is enrolled into the program.

Retiree/Sponsor _____
Retiree Family Member(s) _____
Total Payment $ _____

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