



Request for Retroactive Enrollment



Date of Request ____/____/____ (today's date)

Request for retroactive enrollment in TRICARE Prime for my (select one) family member/myself (print beneficiary name) _____ . My family member is/I am eligible for TRICARE and the person named above resides in TRICARE's South Region.

By signing below, I affirm that the person requesting expedited enrollment has a qualifying medical condition. (The service representative assisting you can provide you with a list of qualifying medical conditions.)

I will provide a written statement from a physician confirming this medical condition. I understand that I may include the documentation with this enrollment package or send it directly to the approval authority (the service representative will give you this information). The physician's name, address, and phone number must be included on the medical statement. This application can be processed faster if the medical statement is included.

If approved and the approval is appropriate, the effective date will bill no earlier than the first of the month that the enrollment application is submitted. Humana Military Healthcare Services (HMHS) will notify you of the decision.

(Signature of Sponsor or Dependent if over 18)

Please submit this request to your nearest TRICARE Service Center (TSC). The TSC will forward the request to the appropriate approval authority.

Sponsor's Name _____ Sponsor's SSN _____

Street Address _____

City/State/Zip Code _____

Relationship of Patient to Sponsor _____

Requested Enrollment Start Date _____

Enrollment effective date may not be earlier than the first day of the month.

Day and Evening Phone Numbers for Sponsor and/or Spouse or Patient (if patient is an adult)

Name _____

Day Phone Number _____ Evening Phone Number _____

MTF OR TRICARE REGIONAL OFFICE USE ONLY

Approval Authority _____

Approved/Disapproved Date _____

Enrollment Effective Date _____

Signature _____

Print/Type Name _____

Title _____