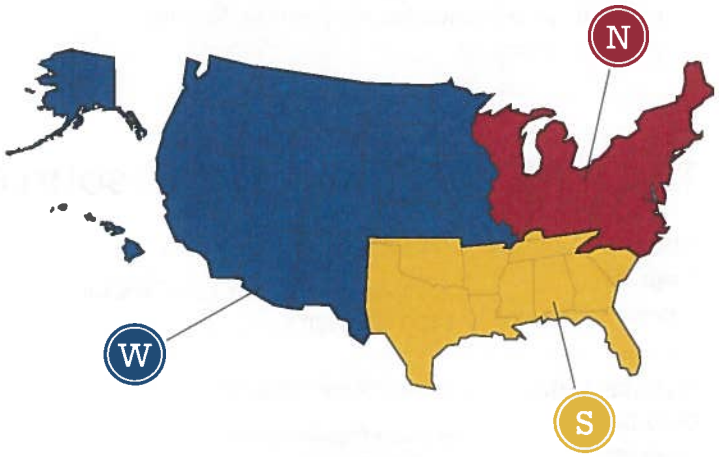
TRICARE® Resources for Service

This overview provides a snapshot of TRICARE service and support resources offered through a variety of convenient Internet options and toll-free call centers.

Visit the "I want to … " section at www.tricare.mil to:

- Enroll in or Purchase a Plan
- File or Check a Claim
- View Referrals and Prior Authorizations
- Find a Doctor
- Go Paperless
- Change Your Primary Care Manager
- See What's Covered
- Compare Plans
- Manage Prescriptions

… and more



TRICARE Regional Contractors

Regional contractors work with the Department of Defense to administer the TRICARE medical benefit.

STATESIDE

North Region
Health Net Federal Services, LLC
1-877-TRICARE (1-877-874-2273)
www.hnfs.com

South Region
Humana Military, a division of Humana Government Business
1-800-444-5445
Humana-Military.com

West Region
UnitedHealthcare Military & Veterans
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

OVERSEAS

TRICARE Overseas Program (TOP)
International SOS Government Services, Inc.
www.tricare-overseas.com

TOP Regional Call Centers

Eurasia-Africa
+44-20-8762-8384 (*overseas*)
1-877-678-1207 (*stateside*)

Latin America and Canada
+1-215-942-8393 (*overseas*)
1-877-451-8659 (*stateside*)

Pacific (*Singapore*)
+65-6339-2676 (*overseas*)
1-877-678-1208 (*stateside*)

Pacific (*Sydney*)
+61-2-9273-2710 (*overseas*)
1-877-678-1209 (*stateside*)

*This overview is **not** all-inclusive. For additional information, please visit www.tricare.mil.*

November 2014

SIGN UP FOR eCORRESPONDENCE
Visit http://milconnect.dmdc.mil to provide your e-mail address and receive eCorrespondence for important information about your TRICARE benefit.

KEEP YOUR DEERS INFORMATION UP TO DATE!
The key to receiving timely TRICARE benefits is keeping your information in the Defense Enrollment Eligibility Reporting System (DEERS) up to date.

www.tricare.mil/deers

You have several convenient options for updating DEERS:

- milConnect: http://milconnect.dmdc.mil
- 1-800-538-9552 or 1-866-363-2883 (*TDD/TTY*)
- 1-831-655-8317 (*fax*)

Find a local identification card-issuing facility: www.dmdc.mil/rsl

TRICARE PROGRAM COSTS
Health care costs vary depending on your TRICARE program option. Get the latest TRICARE cost information including dental and pharmacy costs.

www.tricare.mil/costs

TRICARE COVERED SERVICES
Get details about TRICARE coverage, limitations, and exclusions.

www.tricare.mil/coveredservices

GETTING CARE
Find a doctor: www.tricare.mil/findaprovider

Military hospital and clinic appointments online: www.tricareonline.com

Military hospital and clinic locator: www.tricare.mil/mtf

TRICARE Programs and Resources

TRICARE Pharmacy Program Express Scripts, Inc.	www.tricare.mil/pharmacy www.express-scripts.com/TRICARE 1-877-363-1303
TRICARE Active Duty Dental Program United Concordia Companies, Inc.	www.tricare.mil/addp www.addp-ucci.com 1-866-984-2337
TRICARE Dental Program MetLife	www.tricare.mil/tdp www.metlife.com/tricare 1-855-638-8371 (*stateside*) +1-855-638-8372 (*overseas*)
TRICARE Retiree Dental Program Delta Dental of California	www.tricare.mil/trdp www.trdp.org 1-888-838-8737
TRICARE For Life Wisconsin Physicians Service	www.tricare.mil/tfl www.TRICARE4u.com 1-866-773-0404
Continued Health Care Benefit Program Humana Military	www.tricare.mil/chcbp Humana-Military.com 1-800-444-5445
US Family Health Plan	www.tricare.mil/usfhp www.usfhp.com 1-800-748-7347

Tobacco-Cessation Resources
North Region Tobacco Quitline: 1-866-459-8766
South Region Tobacco Quitline: 1-877-414-9949
West Region Tobacco Quitline: 1-888-713-4597

TRICARE Web site: www.tricare.mil/tobaccocessation
UCanQuit2 Web site: www.ucanquit2.org

New to TRICARE
Learn more about TRICARE—watch an overview video and take the free public TRICARE Fundamentals course online: www.tricare.mil/new

ADDITIONAL RESOURCES

TRICARE Contacts: www.tricare.mil/contactus

TRICARE SMART Site (*view/download TRICARE materials*): www.tricare.mil/smart

Claims: www.tricare.mil/claims

Enrollment: www.tricare.mil/enroll

Forms: www.tricare.mil/forms

Frequently Asked Questions: www.tricare.mil/faqs

Mental Health Care: www.tricare.mil/mentalhealth

Defense Health Agency—Great Lakes: 1-888-647-6676

Customer Service Community Directory: www.tricare.mil/bcacdcao

TRICARE Nurse Advice Line: 1-800-TRICARE (1-800-874-2273)

National Suicide Prevention Lifeline: 1-800-273-8255, Press 1

Military OneSource: www.militaryonesource.mil

Report Fraud and Abuse: www.tricare.mil/fraud

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CHCS REGISTRATION

This form is to register/update you and your dependents into the Composite Health Care System (CHCS).

SPONSOR INFORMATION REQUIRED

PLEASE PRINT ALL INFORMATION CLEARLY

NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH (DD/MMM/YY)	SSN	DoD ID

	BRANCH OF SERVICE	SPONSOR	PAY GRADE/RANK	MARITAL STATUS (As in DEERS)
	☐ USAF ☐ USMC ☐ USA ☐ USCG ☐ USN	☐ Active Duty ☐ Retired ☐ Deceased ☐ Other		

LOCAL RESIDENCE ADDRESS (Include street, city, state, and 9 digit zip code) (Do not use TLF, general delivery, or hotels)	SEX ☐ MALE ☐ FEMALE	

STATION/UNIT	OFFICE SYMBOL	HOME PHONE NUMBER CELL PHONE NUMBER	WORK PHONE NUMBER

RECORD LOCATION	PERSONNEL RELIABILITY PROGRAM (PRP)	ON FLYING STATUS
☐ Dyess Outpatient Records ☐ Dyess Flight Medicine ☐ Located at Another MTF ☐ Other_____	☐ YES ☐ NO	☐ YES ☐ NO

ORGAN DONOR	DRUG ALLERGIES (Such as Penicillin, Sulfa, Codeine, or Aspirin)
☐ YES ☐ NO ☐ UNDECIDED	

PCM (Primary Care Manager)

Please review "Your Rights Regarding Your Health Information" on the back of this form.
Military Health System, Notice of Privacy Practices
Effective October 1, 2013

Privacy Act of 1974

DEPENDENT INFORMATION

FAMILY MEMBER PREFIX (FMP)_____ Example: 1st Spouse = 30 2nd Spouse = 31 ect	FAMILY MEMBER SSN
SPOUSE'S NAME (Last, First, Middle Initial) (DO NOT COMPLETE ANY OF THE SPOUSE INFORMATION IF SPOUSE IS ACTIVE DUTY)	
SPOUSE'S ADDRESS (Include street, city, state and 9 digit zip code)	

DATE OF BIRTH (DD/MM/YY)	HOME PHONE NUMBER	WORK PHONE NUMBER

DRUG ALLERGIES (Such as Penicillin, Sulfa, Codeine, or Aspirin)

CHILDREN

NAME (Last, First, Middle Initial)	FMP 01=1ST BORN	DOB/AGE	GENDER	DRUG ALLERGIES	FAMILY MEMBER SSN

SIGNATURE OF MEMBER	DATE

PRIVACY ACT STATEMENT

AUTHORITY: Sections 133,1071-87, 3012, 5031, and 8012, title 10, United States Code and Executive Order 9397

PURPOSES: This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health records.

ROUTINE USES: The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to : Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state, and local agencies; compile statistical data; conduct research, teach; determine suitability of persons for service or assignment; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certifications and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

Medical In/Out-Processing Worksheet

Prior to submitting this form, make a copy of this Worksheet and Disclosure Form (if applicable) to give to your gaining base at Medical Right Start.

Date	☐ IN Processing		☐ OUT Processing		
Branch of Service	☐ USA	☐ USN	☐ USAF	☐ USMC	☐ USCG
Check All that Apply	☐ AD	☐ Reserve	☐ Retired	☐ PCS	☐ TDY
☐ Joint Base Move	☐ Separating/Retiring	☐ Dependent			

Losing Base	Departure Date of Losing Base	Gaining Base	Arrival Date at Gaining Base

Name (Rank, Last, First MI)	Complete DoD ID Number or Last 4 SSN	DOB (mm-dd-yyyy)

Are you and your dependents enrolled in MiCare Secure Messaging? If **NO**, please list names and emails of all dependents 18 years or older who are not enrolled. ☐ YES ☐ NO

Name & E-mail	Name & E-mail	Name & E-mail

Are you transferring to or coming from overseas, including Hawaii or Alaska? ☐ YES ☐ NO

1) Will your dependents be accompanying you at your gaining base?

☐ Yes ☐ Immediately ☐ 1-3 mos later ☐ 4-6 mos later ☐ NA - No Dependents

☐ NO - My dependents will physically reside at the following location: _____

2) Do you or your dependents have Asthma, Attention deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), or any other chronic medical condition that is treated by a Specialist (Cardiology, Neurology, Psychiatry, etc.)? **If Yes, please list name of family member and condition.**	☐ YES ☐ NO
3) Are you or your dependents enrolled with a case manager? **If Yes, please list family member and case manager's information.**	☐ YES ☐ NO
4) Have you completed or are you in the process of completing a Family Member Relocation Clearance (FMRC) for your dependents enrolled in Exceptional Family Member Program (EFMP) or Educational and Developmental Interventional Services (EDIS)?	☐ YES ☐ NO ☐ NA
5) Are your dependents enrolled in the Exceptional Family Member Program (EFMP), Educational and Developmental Interventional Services (EDIS), or have any dependents been provided an Individual Family Service Plan (IFSP), or the Individualized Education Plan (IEP)? **If Yes, please list each person enrolled and which program.**	☐ YES ☐ NO ☐ NA
6) Have you or your dependents been seen by a medical or behavioral health provider for mental health concerns in the last 5 years? **If Yes, please list the name of family member.**	☐ YES ☐ NO
7) Do you or your dependents have any outstanding or pending referrals, lab, radiology, or medical test results? **If Yes, please list name of family member and outstanding/pending test or result.**	☐ YES ☐ NO
8) Would you like to speak with someone about a sensitive issue? **If Yes, please indicate which agency.** ☐ Medical Professional ☐ Mental Health Clinic ☐ Chaplain ☐ Family Advocacy ☐ Other _____	☐ Yes ☐ NO ☐ NA

Type AUTHORITY: 10 U.S.C. 55. 10 U.S.C 8013 and E.O. 9397 (SSN) as amended. PURPOSE(S): Used to document, plan, and coordinate the health care of Active Duty and family members during relocation; determine eligibility and suitability for benefits for various programs; and compile statistical data. ROUTINE USE: Used to accumulate information for determining Active Duty and family member's medical in/out processing needs. DISCLOSURE: Voluntary; however, failure to provide SSN or other requested information may delay screening of Active Duty and family member's care when transitioning to new locations.

9) Have you deployed in the last 6 to 24 months? **If Yes, where and what time period were you deployed?**		☐ YES ☐ NO
10) Do you or your dependents need to have your medications refilled until you reach your new duty station? **If Yes, please list family member and medication needed.**		☐ YES ☐ NO
11) Have you had a Medical Evaluation Board (MEB)/RILO completed in the past or is one in the process now? **If Yes, what is the expiration date of the MEB?**		☐ YES ☐ NO
12) Have you been, or are you currently carrying a diagnosis of PTSD or TBI?		☐ YES ☐ NO
13) Have you been, or are you currently enrolled in the Air Force Wounded, Ill, and Injured (AFWII) program?		☐ YES ☐ NO
14) Are you on Profile or have an Assignment Limitation Code? **If Yes, please explain:**		☐ YES ☐ NO
15) **For Active Duty** - Are you on Student Status?		☐ YES ☐ NO
16) **For Active Duty** - If stationed overseas, did you receive a Blood Transfusion? (AFI 44-102)	☐ NA	☐ YES ☐ NO
17) Are you or your dependents pregnant? **If Yes, schedule a Follow Up OB appointment upon arrival at your gaining base.**	☐ Unsure ☐ NA	☐ YES ☐ NO
18) If you answered **Yes to #17**, is the pregnancy high risk?	☐ Unsure ☐ NA	☐ YES ☐ NO
19) Do you have any children less than 23 months old?	☐ NA	☐ YES ☐ NO
20) Do you know if their Well Baby Visits and Immunizations are up-to-date?	☐ Unsure ☐ NA	☐ YES ☐ NO

21) Are you on any of the following: (Check all that apply)

☐ PRP ☐ PSP ☐ Flying Status or 1042 Holder ☐ NA

If you checked PRP, PSP, Flying Status or 1042 Holder, Go to Flight Medicine Clinic to complete Medical I/O Processing

22) Are you **Retiring?** ☐ YES ☐ NO **If YES,** will you remain in the local area and continue care at the MTF? ☐ YES ☐ NO

If OUT-PROCESSING or RETIRING: It is your responsibility to obtain copies of medical records, results and/or refills of medications from off base Primary Care providers or Specialists. If you or your dependent had a Mammogram or Radiology Study, please obtain copy of films from the Radiology Department.

23) List the name and DOB of each dependent that are physically here with Sponsor:

Name	DOB mm-dd-yyyy	Name	DOB mm-dd-yyyy

Because email is not a HIPAA complaint method of sending personal health information, it is **NOT** recommended to send this form via email to the Medical Treatment Facility. The recommended method of submitting this form is to hand carry to the Medical Group.

Below items are for clinical personnel only:

Sponsor's PCM or PCMH Team: _____

Is ASIMS/IMR Up-to-Date? ☐ Yes ☐ No

X _____
Personnel Reviewing Form

X _____
Transcribed Above Info Into E-Medical Record

Clinical Representatives: Once transcribed into the electronic health record, this form must be returned to the HCI or designee for review. If Questions 21 checked, send form to Flight Medicine for review.

Type AUTHORITY: 10 U.S.C. 55; 10 U.S.C 8013 and E.O. 9397 (SSN) as amended. PURPOSE(S): Used to document, plan, and coordinate the health care of Active Duty and family members during relocation, determine eligibility and suitability for benefits for various programs; and compile statistical data. ROUTINE USE: Used to accumulate information for determining Active Duty and family member's medical in/out processing needs. DISCLOSURE: Voluntary; however, failure to provide SSN or other requested information may delay screening of Active Duty and family member's care when transitioning to new locations.

MICARE REGISTRATION FORM

MICARE FACTS AND REGISTRATION

MiCare Facts

What is MiCare?

MiCare is a user-friendly, confidential online healthcare messaging system that allows patients to communicate with their healthcare team, get test results, request prescription refills & maintain their own personal health record. In the future, information from your electronic health record will be available to transfer directly into your personal health record.

Who can use MiCare?

MiCare is scheduled for implementation Air Force wide. That means that once patients have registered, they will remain in the system. When PCS-ing, your account will travel with you so you are able to connect with your new clinic at your new duty station.

Is my privacy protected?

When using MiCare, a secure connection is established with the browser to validate that your personal information is encrypted and coded for transmission and storage. This ensures that your information and messages are only accessible by you and your healthcare team. Additionally, MiCare is in compliance with the Health Information Portability and Accountability Act of 1996.

How do I register?

Fill out the registration form below and return it to your Medical Treatment Facility (MTF). An MTF staff member will verify your identity using your military ID card. Following the in-person submission of your registration, you will receive an email asking you to complete the registration process online.

MiCare Registration Form

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Home Zip Code: _____

DoD ID #: _____ Gender (circle one): Male Female

Personal E-Mail Address: _____

Provider/Primary Care Manager: _____

This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a)

CLINIC USE ONLY

Patient ID Verified: **Date:** _____ **Staff Initials:** _____

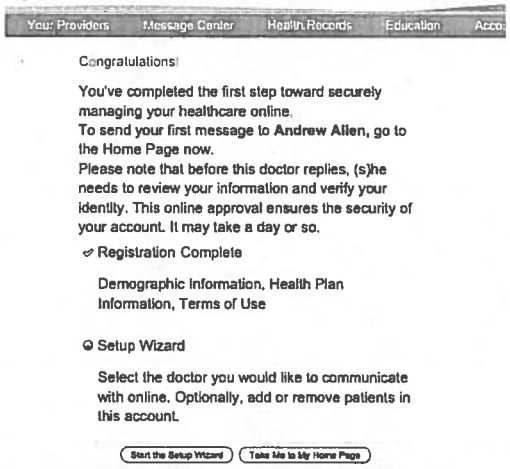
E-mail Invitation Sent: **Date:** _____ **Staff Initials:** _____

MiCare

Are you Really Registered for MiCare?

Steps to Complete MiCare Registration:

1. Once you leave the 7th Medical Group you will be **sent an email invitation to complete the last step of the registration process; the verification stage.** This email will be sent on behalf of your Primary Care Manager (PCM). Please ensure that you are checking your spam and junk mail for this invitation.
2. Open invitation and go to first hyperlink located in the email. The email subject should be "Your Dyess AFB Provider." The email will give you basic information about RelayHealth and provide you with a hyperlink to **complete the verification stage in your registration process.** Please note that this link is about halfway down the page.
3. You will be taken to a website and asked to do the following:
    a. **Verify Your Information:** Please enter your Date of Birth so that your doctor can verify your identity. Type in your DOB and click next.
    b. **Required Information:** Your personal information will automatically generate but you must input your zip code.
    c. **Sign in Information:** MiCare will give you a User ID; you must **erase the automatically generated User ID** and set it to your email address that the invitation has been sent to. You will also be asked to create a password.
    d. **Security Questions:** MiCare will ask you to provide three security questions. Please select the questions you wish to answer and provide the information.
    e. **Benefits Information:** Please skip this step and proceed to the accepting the terms.
    f. **Accept the Terms:** Please select the "I agree to Terms of Use" box and click " Next."
    g. **Congratulations! Click "Take Me to My Home Page"**



IF YOU DO NOT SEE THIS SCREEN YOU ARE NOT REGISTERED FOR MICARE

****Do not go to the Air Force Portal! You must come to the 7th MDG to register in person. The Air Force Portal Says: "You must FIRST sign up with your local clinic IN PERSON before you will have access due to security reasons."****

Any questions please contact Lt Megan Stanton at 325-696-6620