



TRICARE LATIN AMERICA & CANADA (TLAC) PRIME ENROLLMENT APPLICATION (Puerto Rico (TPRC))

SPONSOR INFORMATION

CAN BE COMPLETED BY ANY ADULT BENEFICIARY. SEE REVERSE FOR DIRECTIONS. PLEASE PRINT CLEARLY.

1. Sponsor Name (last, first, middle initial)	2. Sponsor Social Security Number	3. Sex	4. Country Sponsor Residing in:	5. Date of Birth (dd/mmm/yyyy)	6. Rank	7. Telephone Numbers		
						Home: (787)		
						Duty: (787)		
8. Duty Address (Unit, Office Symbol, Station, APO/FPO)	9. DEORS/PRD (*required*)	10. Mailing Address in Puerto Rico			11. Sponsor Branch of Service (Must be Active Duty)			
-----		-----			Army	Air Force	Navy	
					Marines	USCG	NOAA/PHS	
12. E-Mail Address (if available) Please Print Clearly	13. Active Duty Primary Care Manager (PCM)/MTF Selection (Please check one)							
	<input type="checkbox"/> Rodriguez Army Health Clinic, Fort Buchanan (RAHC) Active duty only. <input type="checkbox"/> Ramey Clinic, Borinquen (RCB)			<input type="checkbox"/> San Juan Base, Sick Bay (Active Duty Only) (SJSB) <input type="checkbox"/> Civilian PCM from the HMHS Website (RemPR) <small>(www.humanamilitary.com/PuertoRico/Provider/NetProvDir.asp)</small>			Enter PCM Name for Active Duty Sponsor: <small>(Enter City for Remote Puerto Rico)</small>	

FAMILY MEMBER INFORMATION

LIST ALL FAMILY MEMBERS WHO ACCOMPANIED THE SPONSOR TO PUERTO RICO AND ARE APPLYING FOR ENROLLMENT. PLEASE PRINT CLEARLY

14. Family Member Name (last, first, middle initial)	15. Family Member's Social Security Number	16. Sex (M or F)	17. Relationship to Sponsor	18. Date of Birth (dd/mmm/yyyy) & Age	19. Residing in Puerto Rico?	20. Family Member PCM Selection (Civilian HMHS PCM from Web)
				Age:	Yes No	<i>(Enter Provider's Name)</i>
				Age:	Yes No	<i>(Enter Provider's Name)</i>
				Age:	Yes No	<i>(Enter Provider's Name)</i>
				Age:	Yes No	<i>(Enter Provider's Name)</i>
				Age:	Yes No	<i>(Enter Provider's Name)</i>
				Age:	Yes No	<i>(Enter Provider's Name)</i>

21. SIGNATURE: "I have read the instructions on the reverse side of this form and understand the Privacy Act Statement listed there. I further request enrollment for my listed family members in TRICARE Latin America & Canada Prime."

SIGNATURE _____ DATE _____

COPY OF ORDERS REQUIRED

INSTRUCTIONS

1. SPONSOR NAME. Last name, first name, middle initial.
2. SPONSOR SOCIAL SECURITY NUMBER. This is the SSN of the active duty member
3. SEX. M or F.
4. SPONSOR RESIDING IN: Country in which the sponsor is stationed.
5. DATE OF BIRTH. Enter DOB of sponsor. List by dd/mmm/yyyy (example: 11 Oct 1962).
6. RANK. List rank of sponsor (not pay grade). (example: Army 0-4 should be MAJ).
7. TELEPHONE NUMBER. Sponsor's work & home phone numbers.
8. DUTY ADDRESS. Please list Unit, Office Symbol, Installation, APO/FPO, Zip Code (Please include the actual country you work in, i.e. Cuba, Paraguay, Canada, etc.)
9. DEROS/PRD: Enter the sponsor's date of estimated return from overseas/projected rotation date.
10. MAILING ADDRESS. This is your mailing address in Puerto Rico where you currently reside. Include PSC, Box Number, APO and Zip Code.
11. **SPONSOR BRANCH OF SERVICE:** Circle the appropriate selection.
Note: **Currently, only Active Duty and their accompanying family members are authorized to enroll in TLAC Prime.**
12. E-MAIL ADDRESS: Please provide if one exists for work, home or both. (This will provide another avenue for important medical benefit information to be distributed)
13. PRIMARY CARE MANAGER (PCM) SELECTION.
If you have any questions please contact the nearest TRICARE Service Center. The HMHS civilian PCM roster is available at:
<http://www.humanamilitary.com/PuertoRico/Provider/NetProvDir.asp>.
14. FAMILY MEMBER NAME. List each family member (last name, first name, middle initial) who accompanied the sponsor to Puerto Rico, is listed on the sponsor's original orders, and/or who will reside within a Military Treatment Facility's catchment area in Puerto Rico. For more catchment area information contact the TSC.
15. FAMILY MEMBER SOCIAL SECURITY NUMBER. Please list the Social Security Numbers for each family member. If the family member has not yet been issued a SSN,

write that in this section. If you do not know the number, please write UNKNOWN in this block.

16. SEX. Please enter the Family Member's Sex (M for male or F for female)
17. RELATIONSHIP TO SPONSOR: Please enter the appropriate response using the samples below (For questions please contact the TLAC Support Office):
 - SPOUSE
 - DAUGHTER
 - SON

**** IF SPOUSE IS ALSO ON ACTIVE DUTY, PLEASE INDICATE IT IN THIS BLOCK****

18. DATE OF BIRTH. List the date of birth for each family member.
(dd/mmm/yyyy) i.e. 01 Jan 1960
19. CURRENTLY RESIDING IN PUERTO RICO. Circle appropriate response.
20. SELECT A PCM FOR EACH FAMILY MEMBER. If living remotely in Puerto Rico you may choose to enroll to a MTF PCM or use a remote network provider. Contact the nearest TSC for more information. **See Prime enrollee TLAC InfoPak for beneficiary cost information concerning use of network/non-network providers in Puerto Rico.**
21. SIGNATURE. Either adult beneficiary must sign and date the form. The signature of the sponsor or the sponsor's spouse is required.

Mail or deliver completed forms along with a copy of the **sponsor's orders** to the nearest TRICARE Service Center at Rodriguez Army Health Clinic, Fort Buchanan or Naval Hospital, Roosevelt Roads

Or mail to: TRICARE Area Office
LATLAC – B38802 (Enrollment)
Fort Gordon, GA 30905-5650

OR FAX to: (706) 787-3024 (DSN: 773)

OR E-mail completed form (as attached file) to **tricare15@amedd.army.mil**

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC, Sec. 1095 and 1099; EO 9397

PRINCIPAL PURPOSE(S): Information will be used to enroll the beneficiary(ies) in TRICARE Latin America & Canada Prime, and to assign Primary Care Managers (PCMs) to each enrollee. Information will also be used by military treatment facility (MTF) staff and TRICARE contractors to determine eligibility for care and payment of claims.

ROUTINE USE(S): The information on this form will be released to the MTF staff, TRICARE contractors, and providers of health care.

DISCLOSURE: Is voluntary, however, failure to provide the information requested may preclude your enrollment in TRICARE Latin America & Canada Prime.

