



Refund Request Form

This form is to be used by a TRICARE beneficiary to request a refund of TRICARE Prime enrollment fees or TRICARE Reserve Select premiums.

TRICARE Prime

TRICARE Reserve Select

Please read the following and provide the requested information.

A refund request does not guarantee that a refund will be issued. All requests will be reviewed by the Enrollment department to determine if a refund is due. The processing time for all refund requests is approximately eight weeks from the date the written request is received by TriWest.

Section A: Individual Submitting Refund Request

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (_____) _____

Sponsor's SSN: _____

Section B: Refund Information

Please specify the reason for and the requested amount of the refund and include any necessary documentation (for example, a copy of the active duty orders).

Amount: _____

Reason: _____

Section C: Signature Block

Signature

Date

This form and any other required documentation should be submitted to:

TriWest Healthcare Alliance
Attention: Enrollment Refunds
P.O. Box 41520
Phoenix, AZ 85080-1520

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services.

Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as "for official use only."

Violations of this may be punishable by fines, imprisonment, or both.