



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 list of qualifying medical conditions can be found on the next page.)

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 _____

Approval Authority _____
Approved/Disapproved Date _____
Enrollment Effective Date _____
Signature _____
Print/Type Name _____
Title _____

Qualifying Medical Conditions for Retro Enrollment

The following conditions call for referral to case management for evaluation.
These lists are not all inclusive and are effective April 1, 2009.

Medical

Transplant evaluation or procedure (solid organ or bone marrow/peripheral stem cell)
Ventilator dependent beneficiary
Acute inpatient rehabilitation (not skilled facility with therapy only)
Traumatic brain injury, spinal cord injury, stroke, blindness
New quadriplegia or paraplegia
Premature infant: ventilator-dependent more than 24 hours and/or weight less than 1500 grams
Planned long term acute care (LTAC) admission
Catastrophic illness or injury, amputation, multiple trauma
Pregnancy with significant identified risks
Hourly nursing more than 4 hours per day
Burn injury requiring a burn unit
Unplanned admissions to acute hospital 3 times or more within 90 days with the same diagnosis
Chronic condition resulting in high resource consumption (e.g. hemophilia, Gaucher's Disease)
ECHO Requests
Beneficiary transfer to a MTF or network facility

Behavioral Health/Substance Abuse

High utilization of services, including multiple providers without coordination of care
Congressional or high profile case
Repeated non-compliance with recommended treatment resulting in higher levels of care
Chronic suicidal, lethal, dangerous behaviors
Beneficiaries with support or resource needs who are unable to navigate system
Beneficiaries with insufficient supports causing significant impairment or stress
Newly diagnosed patients requiring assistance with education about their illness and resources
Medical and mental health co morbidity needing facilitation of communication between providers
Dual diagnosis clients with 2 or more relapses or hospitalizations in one year
History of discharge against medical advice with no discharge plan
Beneficiary failure to follow through with PCM recommendation for mental health treatment
Beneficiary transfer to a MTF or network facility
Referral to RTC has been denied
Eating disorder patient has exhausted her yearly benefit
Post-traumatic stress disorder in ADSM