Start, Change, or Stop Allotments
for TRICARE Fees/Premiums

TriWest Healthcare Alliance (TriWest) will process your request to start, change, or stop an allotment from your military retirement pay when a change is authorized. TriWest will notify you of any issue processing your requested allotment or payment change. Allotments are only authorized from the military retirement received from DFAS, Coast Guard or Public Health. Allotments are not permitted from VA benefits, survivor benefits or any other related compensation.

Personal Information

Last Name: First Name: M.I.:

Sponsor SSN (XXX-XX-XXXX): or DoD Benefits Number (DBN) (XXXXXXXXX - XX):

Home Address: Street Apt No.:

City: State: ZIP:

Start A Monthly Allotment

To start a monthly allotment from your retirement pay, you must provide either a checking/savings account or credit card for a one-time payment to establish payments.

◎ Please start a monthly allotment from my retirement pay for my TRICARE enrollment fees.

I authorize a one-time payment of up to three months fees processed by TriWest if needed prior to the allotment begin date. I understand this payment is waived when transferring between regions and an allotment is already in place.

Option 1: Checking or Savings

Account Holder's Name:

Bank Name:

Checking: ◎ Savings: ◎

Nine Digit Bank or ABA Routing Number:

Account Number:

Option 2: Credit Card

Cardholder Name:

Card Number:

Expiration (MM/YY):

Change A Monthly Allotment

◎ Please change my existing monthly allotment to TriWest Healthcare Alliance from:

◎ Individual to Family ◎ Family to Individual

Stop A Monthly Allotment

◎ Please stop my existing monthly allotment to TriWest Healthcare Alliance effective:

Month (MM) /Day (DD)/ Year (YYYY):

Signature required – see page 2.

Start, Change, or Stop Allotments
for TRICARE Fees/Premiums

Authorization and Signature

I hereby authorize TriWest Healthcare Alliance to perform the above requested action from my military retirement pay beginning January 2025. I understand any authorization will continue until I request that it be changed or stopped. I authorize TriWest Healthcare Alliance to stop this allotment if my policy becomes disenrolled from the TRICARE West Region for any reason including transferring to another region. I understand that any returned payment will need to be replaced to prevent disenrollment and a possible 12-month lockout period.

Signature (Required):

Month (MM) /Day (DD)/ Year (YYYY):

Please return this form to:

TriWest Healthcare Alliance
P.O. Box 8550
Virginia Beach, VA 23450-8550

Fax: 866-566-9915

For more information:

www.TRICARE.mil/west

1-888-TRIWEST (874-9378)

Privacy Act Statement

Authority: 10 U.S.C. 1079 and 1086; 38 U.S.C. Chapter 17; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

Purpose: This information will be used by TriWest Healthcare Alliance (TriWest) to start or change electronic payments for your monthly TRICARE enrollment fees from your credit card, checking or savings accounts.

Routine Use: Information collected may be used and disclosed generally as permitted under 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules, as implemented by DOD 6025.18-R, the Department of Defense (DOD) Health Information Privacy Regulation. In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may be specifically disclosed outside the DOD as a routine use under 5 U.S.C. 552a(b)(3) as per DOD Blanket Routine Uses as published at http://dpclo.defense.gov/privacy/SORNs.

Disclosure: This information will be used by TriWest Healthcare Alliance (TriWest) to start or change electronic payments for your monthly TRICARE enrollment fees from your credit card, checking or savings accounts.