TRICARE POP OFF REQUEST

Please use this form to request TriWest outreach to network primary care providers once a Deputy Assistant Director, Healthcare Operations (DAD-HCO) has approved a MTF Director's/Commander's request for a Pop Off support. Request for network assessments of primary and specialty capability and capacity should be requested separately. Once all fields are complete, email the form to T5WestAdHocRFIRequests@triwest.com, the THP Business Operations Specialist (BOS) and TriWest Regional Director.

Requester Information

Last Name:	First Name:
Email:	DMIS ID(s):
THP BOS:	THP BOS Email:
DHN POC:	DHN POC Email:
MTF Name:	
Request Date (MM/DD/YYYY):	Due Date (MM/DD/YYYY):

Pop Off Objective: *(Situation, background, assessment, request)*

Pop Off Details: *(Provide the following information related to the Pop Off request.)*

Which primary care services are being assessed for a Pop Off? *(select all that apply)*

☐ Internal Medicine ☐ Family Practice ☐ Pediatric PCMs

How many MTF providers are projected to be temporarily reduced?	
How many potential beneficiaries could be sent to the community?	
What number and type of appointments will be needed per week? *(e.g. Pediatric 3 per day/15 per week, Family practice 10 per day/50 per week)*	
How long will Pop Off/community support be needed?	
Proposed Pop Off start date (MM/DD/YYYY):	
Proposed end date (MM/DD/YYYY):	

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Does the MTF staff have experience with previous Pop Offs? ☐ Yes ☐ No

If so, what network primary care practices were used? *(List the practice name, NPI, Tax ID and/or a POC from the clinic)*

Are certain locations more desirable based on where MTF enrollees live within the PSA? If so, please identify the ZIP codes associated with the desired locations.

Special considerations: (*e.g. a focus on pediatric or geriatric PCMs)*

Does this request require current patient access to care data? ☐ Yes ☐ No
(appointment wait time, drive time/geographic accessibility)

Has a Pop Off request been submitted to the DHN? ☐ Yes ☐ No

If so, what date was it approved?

Has a Referral Waiver request been submitted to the DHN? ☐ Yes ☐ No

If so, what date was it approved?

Please attach the DHA Primary Care Manager Pop Off and Referral Waiver Request that has been approved by the DHN Director or designee as an addendum to this form.