



myTRICARE.com USER ACCESS REQUEST FORM
(Authorized Government Users Only)

Please complete all sections except those in gray and return to PGBA, LLC in one of the following ways:
 8733 Highway 17 Bypass MB-79J
 Surfside Beach, South Carolina 29575
 Fax: 843-650-0071
 e-mail: FHF.FILES@PGBA.COM and HEFHF.FILES@PGBA.COM

Type of Request: <input type="checkbox"/> Initial <input type="checkbox"/> Modification <input type="checkbox"/> Deletion	Date:
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Name: <i>(Last, First, MI)</i>	PGBA RACF ID: <i>(Modifications/Deletions Only)</i>
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Organization:	Title and Grade/Rank:
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Office E-mail Address:

Office Mailing Address:

Office Phone Number:	Office Fax Number:
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User Role: (select only one) <input type="checkbox"/> BCAC (su01) <input type="checkbox"/> DCAO (su08) <input type="checkbox"/> BCAC and DCAO (su11) <input type="checkbox"/> JAG (su07) <input type="checkbox"/> TRICARE Advocate or HBA (su02) <input type="checkbox"/> TRO (su05) <input type="checkbox"/> TMA (su04) <input type="checkbox"/> Other _____ <p align="center"><small>(please specify)</small></p>

Please provide a detailed explanation as to why access is required to perform job duties if you are not a BCAC or HBA:
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User Agreement: I accept the responsibility for the information to which I am granted access and will not exceed my authorized level of system access. I will not further disclose beneficiary information except as needed for treatment, payment or healthcare operations. When required by the HIPAA Privacy Rule, the Privacy Act of 1974, DoD Privacy Program (DoD 5400.11-R) or the TRICARE Operations Manual, I will obtain the beneficiary's authorization prior to retrieving beneficiary information. I will use professional judgment when accessing beneficiary information. I understand that my access may be revoked or terminated for non-compliance with privacy or security policies. I accept responsibility to safeguard the information from unauthorized or inadvertent modification, disclosure, destruction, and use. I understand and accept that my use of the data will be monitored as part of managing the system, protecting against unauthorized access and verifying security problems.
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User Signature:	Date:
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Expiration Date:	I agree to notify PGBA, LLC when access is no longer required by calling 1-877-698-7422 or by faxing this form with "Deletion" selected under the Type of Request section. Otherwise, this authorization will expire upon termination or expiration of the North Region Contract.
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Supervisor Signature: _____ (Signature certifies that this user requires access as requested, is cleared to view protected health information, or personally identifiable information, including sensitive diagnosis, and has received appropriate privacy and security training.)	Date:
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PGBA, LLC Only	
Approver Name: <i>(First, MI, Last Name)</i>	Title:
Signature:	Date:

Date Received:	Date Completed:	Date Notified:
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PGBA RACF ID:	VPN ID:
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Completed By:
