Hours of Operation

TRICARE Service Center Naples
Location: USNH Naples, RM 2019
Monday-Friday: 0730-1600

US NAVAL HOSPITAL NAPLES
Location: Support Site
INFO 629-6155/081-811-6155

Primary Care Clinics

Mon/Wed/Thu/Fri	0730-1630
Tuesday	0730-1200

For Appointments:
COMM:081-811-6000 DSN: 629-6000

USNH Dental Clinic

Mon/Wed/Thu/Fri	0730-1600
Tuesday	0730-1145
Sick Call	0730-1100

For Appointments:
COMM: 081-811-6007/8 DSN: 629-6007/8

USNH Pharmacy
Monday—Wednesday & Friday 0800-1700
Thursday 0800-1400
Sat*/Sun*/Holidays* 1300-1600
***Refill pick up only**

BRANCH HEALTH CLINIC CAPODICHINO
Location: Capodichino, Bldg. 457

Primary Care Clinics

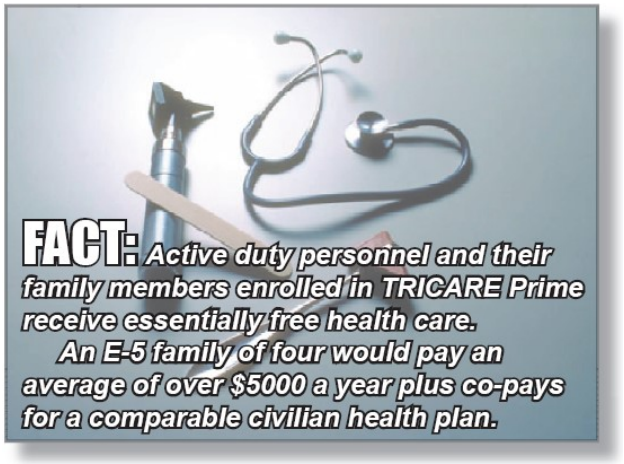
Mon/Wed/Thu/Fri	0730-1600
Tuesday	0730-1145

For Appointments:
COMM: 081-568-4786 DSN: 626-4786

Branch Dental Clinic

Mon/Wed/Thu/Fri	0730-1600
Tuesday	0730-1130

For Appointments:
COMM: 081-568-4644 DSN: 626-4644



TRICARE Service Center Naples
US Naval Hospital Naples
PSC 827 Box 16TA
FPO AE 09617

COMM phone: 081-811-6330
COMM Fax: (+39) 081-811-4128
DSN Fax: 629-4128
DSN: 629-6330
E-mail:
usn.naples.navhospnaplesit.list.tricare@mail.mil

Last Update: Dec 2018

TRICARE Service Center Naples

"The information you need, to get the health care you deserve."

US Naval Hospital Naples

TRICARE Service Center Naples
U.S. Naval Hospital Naples Italy

TRICARE / Managed Care Representatives

Beneficiary Service Representative
COMM: 081-811-6330
DSN: 629-6330

- Enrollments / disenrollments & PCM changes
- Verification of beneficiary coverage
- Assists with TRICARE-related PCS information
- TRICARE briefings

Health Benefits Advisors / Preferred Provider Network (PPN) / Claims

Gina Andreana
COMM: 081-811-4132
DSN: 629-4132

Raffaele Esposito
COMM: 081-811-4141
DSN: 629-4141

Marina Tavano
COMM: 081-811-6331
DSN: 629-6331

Pasquale De Rosa
COMM: 081-811-6212
DSN: 629-6212

Maurizio D'Aria
COMM:081-811-6636
DSN:629-6636

- Assist with all aspects of PPN referrals & visits
- Managed Care Relations Representative
- Claims Processing

Emergency Response Numbers

ON-BASE: 911

OFF-BASE: 118

Nurse Advice Line

Call Toll Free from anywhere in Europe*

00-800-4759-2330

Stateside Registered Nurse
available to provide healthcare advice

24 hours a day / 7 days a week

*except Greece & Turkey
See your local TRICARE Service Center
for these toll free access numbers

DEERS & TRICARE Eligibility

Remember to verify and update DEERS **ANNUALLY** or when you have a change in:

- Military Career Status (i.e., rank or retirement)
- Activation (Guard/Reserve)
- Change of Address
- Marriage or Divorce
- Birth or Adoption
- Full-time Student Age 21 – 23
- Death of dependent family member

Contact your local ID Card facility @
COMM: 081-568-5632
DSN: 626-5632

TRICARE Websites

TRICARE Overseas
http://www.tricare-overseas.com
- Managed by International SOS (ISOS)
- Beneficiary programs available in Europe
- TRICARE Overseas Fact Sheets
- Find Preferred Providers
- **ISOS Eurasia/Africa Service Center**
  (+44) 20-8762-8384 or Toll Free 800-915-994

TRICARE (CONUS)
http://www.tricare.mil
- Beneficiary Programs available by Region
- TRICARE Fact Sheets
- Find Providers
- Enrollment/Disenrollment Forms & Information
- Military Treatment Facility & TRICARE Service Center Contact Information
- Claims Processing Information

TRICARE Dental
http://www.tricare.mil/coveredservices/dental
- Eligibility & Benefits
- Find Dental Providers
- Online Enrollment/Disenrollment
- Claim Forms & Process
- **1-844-653-4060**

TRICARE Pharmacy Program
https://www.express-scripts.com/tricare
- Registration Forms
- Order Refill
- Check status of order

Mil Connect
https://www.dmdc.osd.mil/milconnect

USNH Naples
http://www.med.navy.mil/sites/napoli

TRICARE OVERSEAS PROGRAM (TOP) 2021 — MYCARE OVERSEAS™ BENEFICIARY APP AND PORTAL

MYCARE™ OVERSEAS

INTERNATIONAL SOS | TRICARE®

International SOS is honored to continue in our role as the TRICARE Overseas Program (TOP) contractor. We understand that many of our beneficiaries may be deployed or accompanying a sponsor overseas for the first time. As a result, you may be experiencing new languages, assimilating to new cultures, or even learning to navigate new street signs. All of this can be a daunting experience, especially when you first arrive to your Duty Station.

International SOS is committed to providing easy-to-access, high quality health care services, and putting your experience of care at the forefront of all that we do. To this end, International SOS is excited to introduce **MyCare Overseas™** — a secure and user-friendly Beneficiary Mobile App and web-based Portal that will enhance your health care experience.

MyCare Overseas™ is a self-service tool that offers easy access to our services, including checking your TRICARE Health Plan, verifying TRICARE covered services, and accessing other reliable sources of information.

FEATURES

Innovative Self-Service Features to Help Improve Your Patient Experience

24/7 Assistance
Quick access to the local Near Patient Team*, the Global First Call Desk, the Beneficiary Support Center, and Technical Support.

Chat
Access to a self-service ChatBot for immediate answers to FAQs and if needed, a direct link to chat with the Beneficiary Support Center.

My Appointments & Referrals
Keep track of your appointments and view provider contact details. Easy check of referral status and issued authorizations.

Healthcare Finder
Intuitive search tool which assists you in finding a TOP Network Provider.

Country Information
Useful country information such as emergency numbers, medical risk ratings and cultural tips.

My Medical Translations
Submit request for Medical Records Translations and download translated documents. **Note:** Applicable for TOP Prime and TOP Prime Remote ONLY.

Translation Help
Local language support via Microsoft Translate or easily connecting with real-time telephonic language assistance.

My Plan & Claims
Easy check of TRICARE Health Plan enrollment as well as useful links to TRICARE covered services and a direct link to the TOP Beneficiary Secure Claims Portal.

**International SOS' Near Patient Teams are available in Germany, Benelux (Belgium, Netherlands, Luxembourg), Italy, Spain, Greece, Poland, Bahrain, South Korea, and Japan.*

DOWNLOAD NOW

SPREAD THE WORD

Scan the QR code (to the right) or click on the App Store or Google Play buttons to download the new MyCare Overseas™ Beneficiary App!

Download on the App Store

GET IT ON Google Play

WORLDWIDE REACH.
HUMAN TOUCH.

International SOS administers the TRICARE Overseas Program (TOP) benefit.
www.TRICARE-overseas.com
www.TRICARE.mil

MYCARE™ OVERSEAS

INTERNATIONAL SOS | TRICARE®

SUPPORTING THE PATIENT JOURNEY

The **MyCare Overseas™** Beneficiary App and Portal was developed based on actual feedback from TRICARE beneficiaries to address pain points, personal needs, and frustrations that may occur when trying to access health care overseas. This results in quicker access to clinical and non-clinical professionals who are dedicated to helping beneficiaries navigate their overseas health care experience.

ACCESSING MYCARE OVERSEAS™ BENEFICIARY APP AND PORTAL

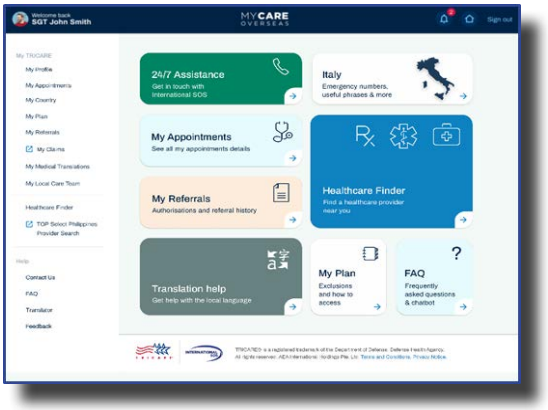
To access the **MyCare Overseas™** Beneficiary App and Portal, simply download the app onto your mobile device and register. This provides secure access to all relevant information and timely notifications, for the best experience of care.

The **MyCare Overseas™** Beneficiary App and Portal is the entry point for all TRICARE Overseas health care services and streamlines access to a convenient, easy-to-use application. This means TOP beneficiaries are empowered to get the information they need when they need it. Beneficiaries can fill out an important Episode of Care feedback form, set up reminders about upcoming medical appointments, access and download International SOS authorizations, locate health care facilities on a map, access translation assistance, or obtain help with follow-on care or other medical instructions.

Scan the QR code below or click on the App Store or Google Play buttons to download the new MyCare Overseas™ Beneficiary App!

Download on the App Store

GET IT ON Google Play



Alternatively, to access the new MyCare Overseas™ web-based Portal using your personal computer or laptop, visit https://top.internationalsos.com/beneficiary!

Revised September 2021

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM

THIS FORM IS FOR INTERNAL USE BY THE INTERNATIONAL SOS GROUP OF COMPANIES

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 1079 and 1086, 32 U.S.C. Chapter 17; 32 CFR 199.17; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain information necessary for the processing of requirements and benefits related to the TRICARE Overseas Program (TOP), including but not limited to medical management, your medical related claims, and proper updates of your medical record.

ROUTINE USE(S): 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 specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services, Homeland Security, and Veterans Affairs, and to other Federal, State, local, or foreign government agencies, and to private business entities, including entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.

DISCLOSURE: Voluntary; however, failure to provide consent may result in the inability of International SOS to provide the full range of services and benefits under the TOP.

BENEFICIARY DETAILS:

Beneficiary First Name:	**Beneficiary Last Name:**
Beneficiary Date of Birth:	**DoD Benefits Number (DBN):**
Beneficiary Phone Number:	**Beneficiary Email Address:**

Section is to be signed by TRICARE Beneficiaries ONLY

RELEASE OF MEDICAL INFORMATION

International SOS Government Services, Inc. and its affiliated entities (International SOS) is a data processor on behalf of the Defense Health Agency (DHA) of your personal data. You may contact International SOS at any of its locations or methods as identified on http://www.tricare-overseas.com or in the footer below. Your personal data will be used for the following purposes:

1. *Collection of medical record to load into the United States (U.S.) Government system of record for TRICARE beneficiaries.*
2. *Translation of medical records to support your continued health care and maintenance of your medical record in the U.S. system of record.*
3. *Case Management, utilization management, and other medical management activities required under the TRICARE benefit.*
4. *Claims inquiries and processing in accordance with the TRICARE benefit.*

The categories of personal data you are being asked to consent to International SOS' collection and use are your name, address, email address, telephone number, DoD Benefits Number (DBN), Social Security Number, and Personal Health Information. International SOS will share this information on an as needed and required basis with the DHA, the cognizant Military Treatment Facility, third-party medical translation vendors and/or Wisconsin Physician Services Insurance Corporation.

Your personal data will be transferred out of the European Union or other locality you are in and sent to the entities referenced above which are in the U.S. or on U.S. soil. Your personal data will be processed and stored in accordance with U.S., EU, and other applicable laws and record retention requirements applicable to International SOS.

Under our processes and these laws, you have the right to request access to, rectify, erase and restrict the processing of your personal data. You also have the right to revoke this consent to use your personal data. If you feel International SOS has violated your rights under a cognizant privacy regulation, you have the right to file a complaint with the appropriate supervisory authority.

I consent to International SOS using my personal data for the purposes described in this notice and understand that I can withdraw my consent at any time. This consent authorization shall be in force and effect until two (2) years from the date of execution at which time this authorization expires.

☐ I consent ☐ I do **not** consent

Signature of Beneficiary or Legally Authorized Representative _____ **Date** _____

Name and Relationship of Legally Authorized Representative to Patient _____

Address of the Beneficiary or Legally Authorized Representative_____

***Note**: If the beneficiary is considered a minor, their legal or authorized representative [the parent/s entitled to custody or guardian, and for adults the person in charge or designee] must sign on behalf of the beneficiary.*

TRICARE Latin America & Canada
Tel: +1-215-942-8393 | **Fax:** +1-215-773-2701
Email: tricarephl@internationalsos.com

TRICARE Eurasia-Africa
Tel: +44-20-8762-8384 | **Fax:** +44-20-8762-8255
Email: tricaretln.top@internationalsos.com

TRICARE Pacific
Tel: +65-6339-2676 | **Fax:** +65-6336-0921
Email: sin.tricare@internationalsos.com

Please provide copy of orders to be included with completed forms for enrollment

SPONSOR'S SSN/DBN:

TRICARE PRIME OPTION DESIRED:

☐ **TRICARE Prime:** Active duty service members have to enroll in TRICARE Prime. (Enrollment is not automatic.)

☐ **TRICARE Prime Remote:** If eligible, you may be enrolled in TRICARE Prime Remote or TRICARE Prime Remote for Active Duty Family Members.

☐ **TRICARE Overseas Program Prime:** Family members must be command sponsored and meet specific enrollment criteria of the overseas area. If eligible, you may be enrolled in TRICARE Overseas Program Prime Remote. Retirees are not eligible for TRICARE Overseas Program Prime.

☐ **Uniformed Services Family Health Plan (USFHP):** Available in six locations. Submit the completed Enrollment Application to the USFHP address listed on Page 1. For the service area descriptions and telephone numbers for questions, please visit the TRICARE website at www.tricare.mil/usfhp.

SECTION I - SPONSOR INFORMATION

1. SPONSOR'S NAME *(Last, First, Middle Initial) (Must match DEERS)*

2. SPONSOR'S SOCIAL SECURITY NUMBER (SSN) *(XXX-XX-XXXX)* **or DoD BENEFITS NUMBER (DBN)** *(XXXXXXXXX-XX)*

3. SPONSOR IS: *(X one)* ☐ Active Duty ☐ Retired ☐ Deceased *(Go to Section II.)* ☐ Unremarried Former Spouse

4. SPONSOR'S TELEPHONE NUMBER *(Include Area Code)*

a. WORK: c. CELL:

b. HOME:

5. SPONSOR'S E-MAIL ADDRESS

6. SPONSOR'S DATE OF BIRTH *(YYYYMMDD)*

7. SPONSOR'S RESIDENCE ADDRESS *(Street, Apartment No., City, State, ZIP Code, Country)* ☐ New

8. SPONSOR'S MAILING ADDRESS *(Provide APO or FPO if stationed overseas)* ☐ Same as residence ☐ New

9. SPONSOR'S MILITARY ASSIGNMENT

a. UNIT

c. PLEASE ENTER: Capodichino or Support Site or JFC

b. UNIT IDENTIFICATION CODE (UIC) *(If known)*

10. SPONSOR'S REQUESTED ACTION *(X one)*

☐ None *(go to Section II)* ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☒ Disenroll (Non-AD only)

Effective Date Requested: _____ Date of arrival in Italy

11. SPONSOR'S PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and your uniformed service guidelines. Review PCM options online or call your Regional Contractor, preferred MTF, or USFHP member services (non-active duty only) for availability of PCMs.)*

a. 1st CHOICE
☐ MTF ☐ PRP (ADSM)
☐ Civilian

FULL NAME or MTF/CLINIC

Date of Entry into Italy: _____

b. 2nd CHOICE
☐ MTF
☐ Civilian

FULL NAME or MTF/CLINIC

c. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Flight Medicine

d. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

Only complete if dependents are on orders and in the country

SPONSOR'S SSN/DBN:

SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE *(Use additional copies of this page as necessary)*

12.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* | **b. DATE OF BIRTH** *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date Requested: _____

d. RESIDENCE AND MAILING ADDRESS
(Provide address, with ZIP Code and Country, if different from Sponsor)

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

13.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* | **b. DATE OF BIRTH** *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date Requested: _____

d. RESIDENCE AND MAILING ADDRESS
(Provide address, with ZIP Code and Country, if different from Sponsor)

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

14.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)* | **b. DATE OF BIRTH** *(YYYYMMDD)*

c. REQUESTED ACTION: ☐ Enroll ☐ Transfer Enrollment ☐ PCM Change ☐ Disenroll Effective Date Requested: _____

d. RESIDENCE AND MAILING ADDRESS
(Provide address, with ZIP Code and Country, if different from Sponsor)

☐ Same as Sponsor ☐ New

e. TELEPHONE NUMBER *(Include Area Code)*
(1) WORK: (2) HOME: (3) CELL:

f. E-MAIL ADDRESS

g. PCM PREFERENCE *(Please list your first and second choices below. PCM assignment depends upon availability and uniformed service guidelines. Review PCM options online or call your Regional Contractor or USFHP customer services for availability of PCMs.)*

(1) 1st CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

(2) 2nd CHOICE ☐ MTF ☐ Civilian ☐ Same as Sponsor — FULL NAME or MTF/CLINIC

h. PCM SPECIALTY ☐ No Preference ☐ Family/General Practice ☐ Internal Medicine ☐ Pediatrics ☐ Flight Medicine

i. PREFERRED PCM GENDER ☐ No Preference ☐ Male ☐ Female

SPONSOR'S SSN/DBN:

SECTION III - REASON FOR DISENROLLMENT OR PCM CHANGE

(Complete if disenrolling or making a PCM change)

Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:
Name of Family Member:	☐ Relocation ☐ Dissatisfied ☐ PCS ☐ Other:

SECTION IV - OTHER HEALTH INSURANCE

PLEASE IDENTIFY IF ANYONE IS CURRENTLY COVERED BY OTHER HEALTH INSURANCE.

☐ TRICARE Supplement *(no other information is needed)*

☐ Medical Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ Dental Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

☐ Vision Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: Policy Effective Date: _____

☐ Prescription Insurance: Person(s) Covered: _____

Policy Holder Name: _____ Carrier Name: _____

Policy Number: _____ Policy Effective Date: _____

SECTION V - ACCESS WAIVER AND SIGNATURE (REQUIRED)

☐ ***(X if waiving drive time)*** If my selected or assigned Primary Care Manager (PCM) is greater than a 30 minute drive-time from my residence, or if I reside outside the Prime Service Area, I hereby waive the drive time standards of thirty minutes for primary care and one hour for specialty care

I understand if I selected a PCM by name, team, or location (MTF or civilian), TRICARE will enroll me with that PCM subject to PCM availability and uniformed services policy. I understand that it is my responsibility to comply with all TRICARE Prime, TRICARE Prime Remote, TRICARE Overseas Program Prime, and/or USFHP policies and procedures. By signing this form, I certify the information provided is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments, or concealment of a material fact may be subject to fine and/or imprisonment under applicable Federal law.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*

ENROLLMENT NOTE: Prime enrollment start dates are based primarily on the 20th of the month rule (applications received on/before the 20th of the month are effective the first calendar day of the next month). You should confirm enrollment and PCM assignment before obtaining routine medical care. (Note: This does not apply to TRICARE Overseas Prime or to active duty service members.)

DISENROLLMENT NOTE: In some cases, you may not be able to re-enroll in TRICARE Prime for a 12-month period from the date of the disenrollment. This one year period does not apply to any family member whose sponsor is in grade E-1 to E-4.

PAYMENT OPTIONS: See Section VI on next page.