OMB Number 2900-0219
Estimated burden: 10 minutes

Department of Veterans Affairs — CHAMPVA Other Health Insurance (OHI) Certification

VA Health Administration Center, PO BOX 469063, Denver, CO 80246-9063 1-800-733-8387 www.va.gov/hac FAX: 1-303-331-7808
Failure to provide the requested information will result in a delay or denial of reimbursement until OHI information is received.
This form is also used to report any changes in your other health insurance status. Updates can be sent by FAX or call by phone.
PLEASE READ INSTRUCTIONS AND INFORMATION ON THE REVERSE SIDE BEFORE COMPLETING THIS FORM

SECTION I: BENEFICIARY INFORMATION - PLEASE USE A SEPARATE FORM FOR EACH FAMILY MEMBER

LAST NAME	FIRST NAME	MI

ADDRESS (NUMBER, STREET, PO BOX, APT #)	SEX
	Male ☐ Female ☐

CITY	STATE	ZIP CODE

PHONE # (INCLUDE AREA CODE)	SOCIAL SECURITY NUMBER	CHECK IF NEW ADDRESS
		☐

SECTION II: MEDICARE BENEFICIARIES: ATTACH A COPY OF YOUR MEDICARE CARD

Part A: Yes ☐ No ☐	Part B: Yes ☐ No ☐	Part D: Yes ☐ No ☐
EFFECTIVE DATE (MMDDYYYY)	EFFECTIVE DATE (MMDDYYYY)	EFFECTIVE DATE (MMDDYYYY)
PART A CARRIER NAME	PART B CARRIER NAME	PART D CARRIER NAME

Does your Medicare provide Pharmacy benefits? Yes ☐ No ☐ | Did you choose a Medicare HMO for your Medicare coverage? Yes ☐ No ☐

Do you have health insurance other than MEDICARE? Yes ☐ No ☐ IF NO, go to Section IV

SECTION III:

Provide all periods of other health insurance coverage since the sponsors (permanent and total) eligibility
Required: Attach a copy of any active health insurance cards (front & back)

Name of insurance # 1

EFFECTIVE DATE (MMDDYYYY)	TERMINATION DATE (MMDDYYYY)	Only put in the termination date if the policy is inactive

Is this insurance through employment? Yes ☐ No ☐ | Does the insurance cover prescriptions? Yes ☐ No ☐

Does the insurance provide an explanation of benefits for prescriptions? Yes ☐ No ☐

What type of insurance? ☐ HMO ☐ PPO ☐ Medicaid/State Assistance ☐ Prescription Discount

☐ Medigap [if Medigap, specify ▼ (A-J)] ☐ Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)

Comments

Name of insurance # 2

EFFECTIVE DATE (MMDDYYYY)	TERMINATION DATE (MMDDYYYY)	Only put in the termination date if the policy is inactive

Is this insurance through employment? Yes ☐ No ☐ | Does the insurance cover prescriptions? Yes ☐ No ☐

Does the insurance provide an explanation of benefits for prescriptions? Yes ☐ No ☐

What type of insurance? ☐ HMO ☐ PPO ☐ Medicaid/State Assistance ☐ Prescription Discount

☐ Medigap [if Medigap, specify ▼ (A-J)] ☐ Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)

Comments

SECTION IV: CERTIFICATION BY BENEFICIARY, SPONSOR OR LEGAL GUARDIAN

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious or fraudulent statements of claims.
I certify that the above information is correct to the best of my knowledge and belief. If there is any change in insurance status for the above person, I agree to promptly notify VA's Health Administration Center. Sign, date below and return to the address at the top of the form.

SIGNATURE(type if electronic): DATE:

CHAMPVA OTHER HEALTH INSURANCE (OHI) CERTIFICATION

NOTES, DEFINITIONS, AND INSTRUCTIONS

INSTRUCTIONS

Failure to complete all aplicable sections on the front can result in a delay or denial of benefits. Use this form is to report any changes in your other health insurance.

-- New beneficiaries - we need OHI information from the date your CHAMPVA eligibility became effective.

-- Re-certification - update OHI information every time a change is made to your OHI coverage.

-- To specify a medicare supplement plan A - J, refer to your policy cover sheet or your insurance membership card.

-- If there are additional policies use plain bond paper and either type or legibly print your name, SSN, and the information for each item. Attach to this form. If submitting this form electronically add an attachment to the submission.

ITEMS TO RETURN WITH THIS COMPLETED OTHER HEALTH INSURANCE (OHI) CERTIFICATION

-- A **COPY** of your Medicare card (do NOT send the original).

-- A **COPY** of your other health insurance (OHI) member ID card (front and back).

-- If your OHI does not issue EOBs, then attach a copy (card or document) of your schedule of benefits that lists your co-payments.

DEFINITIONS

OHI: OHI refers to insurance or benefits you may have other than CHAMPVA called “Other Health Insurance”.

EOB: The abbreviation for an “explanation of benefits” form or letter that must accompany claims submitted to CHAMPVA. An EOB is a statement or “Remittance Advice” from an insurance carrier or benefit program that summarizes the action taken on a claim.

Note: If you have OHI primary to CHAMPVA you must submit EOB's for each primary insurance along with health care claims. If your OHI does not issue EOB's i.e. some HMO's and PPO's, you must submit a copy of your active co-payment information shown on your insurance card or a document showing your co-payments with every health care claim so CHAMPVA can calculate benefit payments.

Carrier: Carrier is the insurance company that provides your medical benefits.

OHI primary to CHAMPVA: CHAMPVA by law is always supplemental or the secondary payer of health care benefits except for Medicaid, State Victims of Crimes Compensation Programs, and policies purchased exclusively to supplement CHAMPVA benefits.

Supplemental CHAMPVA policies: These are policies specifically purchased for the purpose of covering your cost share after CHAMPVA has completed adjudication of a claim.

Medicare supplemental policies: These are policies that are specifically for the purpose of covering your Medicare out of pocket expenses. These Medicare supplemental policies such as “Medigap” or Policies offered through employment are primary to CHAMPVA and must provide an EOB along with the Medicare EOB (**two EOBs**) for each claim submitted to CHAMPVA.

Indemnity: Plans that pay a flat fee or daily rate to supplement lost income while hospitalized are called Indemnity Plans.

Termination date: This is the date the policy ended or ceased to be active. The end date for a period shown on a card that will be reissued is not the termination date. Closing a policy will generate a true termination date.

Privacy Act Information: The authority for collection of the requested information on this form is 38 USC 501 and 1781. The purpose of collecting this information is to determine payer status when other health insurance coverage exists. The information you provide may be verified by a computer matching program at any time. You are requested to provide your Social Security number as your VA record is filed and retrieved by this number. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, it may delay or result in denial of your request for CHAMPVA benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled. The responses you submit are considered confidential and may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records number 54VA16, titled "Health Administration Center Civilian Health and Medical Program Records -VA", as set forth in the Compilation of Privacy Act Issuances via online GPO access at **http://www.gpoaccess.gov/privacyact/index.html**. For example, information including your Social Security number may be disclosed to contractors, trading partners, health care providers and other suppliers of health care services to determine your eligibility for medical benefits and payment for services.

Paperwork Reduction Act: This information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing the burden, may be addressed by calling the CHAMPVA Help Line, 800-733-8387. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. This collection of information is to determine payer status when other health insurance coverage exists.