INSTRUCTIONS FOR:

TRICARE® Other Health Insurance Questionnaire

Privacy Act Statement

This statement serves to inform you of the purpose for collecting your personal information through a *TRICARE Other Health Insurance Questionnaire* and how that information will be used.

Authority: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

Purpose: To collect information from you in order to process your TRICARE medical claims under your TRICARE insurance and coordinate payment activities with other health insurance that may be available to you or members of your family.

Routine uses: Your records may be disclosed to the federal and state agencies and to other health insurers in order to coordinate your benefits and payments for health care received.

Use and disclosure of your records outside of the Department of Defense (DoD) may also occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and health care operations.

Disclosure: Voluntary. If you choose not to provide this information, no penalty may be imposed, but failure to provide the requested information may result in the delay or denial of payments and claims.

Reporting Your Other Health Insurance

Return **completed** questionnaire to:

TRICARE West Region
Claims Department
P.O. Box 7064
Camden, SC 29021-7064

Fax: 855-708-4772

You can also update your other health insurance information (OHI) online through your secure www.uhcmilitarywest.com account. If you have any questions about this questionnaire, please call UnitedHealthcare Military & Veterans at 1-877-988-WEST (1-877-988-9378).

Visit www.tricare.mil/ohi for more information on OHI.

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TRICARE Other Health Insurance Questionnaire

UnitedHealthcare Military & Veterans offers TRICARE West Region beneficiaries access to a secure account to manage their health care online at any time. Visit www.uhcmilitarywest.com to set up your account. Already registered? Log in and update your information online. For more information regarding other health insurance (OHI), please visit www.tricare.mil/ohi.

Sponsor's name: _____

Sponsor's Social Security number (SSN) or
Department of Defense Benefits Number (DBN): _____ Sponsor's date of birth: _____

Sponsor's mailing address: _____

City: _____ State: _____ ZIP code: _____

Sponsor's home phone: _____ Sponsor's work phone: _____

Have you or any of your family members been covered by health insurance other than TRICARE within the past three years? ☐ Yes ☐ No

If you answered yes above, complete the remainder of this questionnaire. Regardless of your answer above, please read, sign on page 3, and return the questionnaire using one of the methods indicated on page 1.

TRICARE pays after commercially purchased health care plans and Medicare, but is the primary payer over state medical assistance plans (Medicaid) and policies specifically sold as TRICARE supplemental plans. You or your provider should submit health care claims to any primary payers **before** submitting claims to TRICARE with proof of what the primary insurance paid and your remaining liability.

Reference:

OHI INFORMATION					
Covered beneficiary 1: **EXAMPLE**	First name	Last name	Year of birth	SSN or DBN	
	Jane	***Doe***	***1964***	***001122334-01***	
Health insurance carrier name	Phone	Policy number	Coverage type*	Original start date of policy	Expiration date (if applicable)
1. ***Blue Cross***	***1-800-555-1234***	***Xhj123456789a***	***1***	***1/1/2009***	***N/A***
2. ***M.O.A.A.***	***1-800-555-1234***	***123456789A***	***2***	***1/1/2005***	***N/A***

*** Use the following coverage types when completing the questionnaire:**

1 = Employer-sponsored health plan	**2 = TRICARE supplement**	**3 = Private—not through employment**	**4 = Medicaid/state medical assistance plan**	**5 = Student plan**
6 = Medicare supplement	**R = Pharmacy**	**C = Medicare**	**H = Medicare HMO or Medicare Advantage Plan**	

OHI INFORMATION					
Covered beneficiary 1:	First name	Last name	Year of birth	SSN or DBN	
Health insurance carrier name	Phone	Policy number	Coverage type*	Original start date of policy	Expiration date (if applicable)
1.					
2.					
Covered beneficiary 2:	First name	Last name	Year of birth	SSN or DBN	
Health insurance carrier name	Phone	Policy number	Coverage type*	Original start date of policy	Expiration date (if applicable)
1.					
2.					
Covered beneficiary 3:	First name	Last name	Year of birth	SSN or DBN	
Health insurance carrier name	Phone	Policy number	Coverage type*	Original start date of policy	Expiration date (if applicable)
1.					
2.					
Covered beneficiary 4:	First name	Last name	Year of birth	SSN or DBN	
Health insurance carrier name	Phone	Policy number	Coverage type*	Original start date of policy	Expiration date (if applicable)
1.					
2.					

*** Use the following coverage types when completing the questionnaire:**

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6 = Medicare supplement	**R = Pharmacy**	**C = Medicare**	**H = Medicare HMO or Medicare Advantage Plan**	

If you have more covered beneficiaries, please use an additional sheet of paper.

Are any of these policies limited to a specific coverage such as cancer, nursing home, dental, vision, pharmacy, etc.?
☐ Yes ☐ No

If yes, please list the insurance name and specific coverage: _____

_____

Do any of these policies have exclusion(s)? ☐ Yes ☐ No

If yes, please list the name of the insurance and the exclusion(s): _____

_____

The statements made above are true and correct to the best of my knowledge. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting or making false, fictitious, or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from uniformed services legal offices, public libraries, and many Beneficiary Counseling and Assistance Coordinators.

Name: _____ **Relationship to sponsor:** _____
(please print)

Signature: _____ **Sponsor SSN or DBN:** _____ **Date:** _____

Please review "Important Definitions and Information" on page 4.

Important Definitions and Information

Sponsor
The uniformed service member—either active duty, retired, or deceased—whose relationship to you (spouse, parent, etc., as reflected in the Defense Enrollment Eligibility Reporting System) makes you eligible for TRICARE.

Beneficiary
Active duty service members, National Guard and Reserve members, retirees, family members, and survivors who are eligible for TRICARE benefits.

Employer-sponsored health plan
A policy purchased by an employer that is offered to eligible employees of the company as a benefit of working for that company.

TRICARE supplement
Coverage plans specifically designed to cover any copayment, cost-shares, or deductibles that are not covered by TRICARE. Unlike other health insurance plans, TRICARE supplemental plans are frequently available from military associations and other private organizations and firms.

Private—not through employment
Health insurance plans purchased by individuals directly from an insurer. Coverage of specific types of medical services can vary. Plan types may include hospital indemnity policies, which pay a fixed daily, weekly, or monthly benefit.

Medicaid
A public health care program, administered by states, for certain people and families with low income and resources.

Student plan
A school-sponsored individual policy covering students meeting eligibility requirements.

Medicare supplement
Medicare supplement insurance, also called a Medigap policy, is a health insurance policy sold by private insurance companies to cover expenses not covered by the original Medicare plans (Medicare Part A and Part B).

Pharmacy
A plan that covers the costs of prescription drugs purchased from a pharmacy.

Medicare
The national health program that pays certain medical and hospital expenses. The program is open to individuals over age 65 and individuals with permanent disabilities. Learn more about Medicare at www.medicare.gov. If you are eligible for Medicare Part A, you must purchase Part B to retain TRICARE eligibility unless your sponsor is active duty. When you are eligible for TRICARE and have Medicare Part A and Part B, you are using TRICARE For Life. Visit www.tricare.mil/tfl for more information.

Medicare HMO/Medicare Advantage Plan
A Medicare health plan choice you may have as part of Medicare. Medicare Advantage Plans, sometimes called Part C or MA Plans, are offered by private companies approved by Medicare.

Department of Defense Benefits Number (DBN)
An 11-digit number used to determine benefits eligibility. The first nine digits are common to the sponsor but is not their Social Security number; the last two digits identify the specific person, much like with a commercial benefit plan.