



### CHAMPVA-Other Health Insurance (OHI) Certification

VA Health Administration Center PO BOX 65023 Denver, CO 80206-9023 1-800-733-8387 www.va.gov/hac Fax (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.

#### Section I: Beneficiary information (not veteran)

ONE FORM PER FAMILY MEMBER

Name and Address:

Last name										First name										MI	
Social Security #										Phone #											
Street Address																					
City										State					Zip						

Check if address is new

#### Section II: About your Other Health Insurance

Do you have or have you had other health insurance (other than CHAMPVA)?

No If no, please sign and date form and return to the address at the top of form.

Yes If yes, please send us a copy of your member card or the schedule of benefits for us to determine what type of policy this is and the effective period.

Do you have Medicare?

If you do have Medicare, Please attach a copy of your Medicare card.

Part A:  Yes  No Effective date (mm/dd/yyyy) \_\_\_\_\_

Part B:  Yes  No \_\_\_\_\_

Other than Medicare and CHAMPVA, starting with the most current, list any other health insurance below.

Be sure to attach a copy of your member ID Card.

Is this insurance through employment?

Yes  No

If not, does this insurance pay before CHAMPVA?

Yes  No  Don't Know

Name of policy \_\_\_\_\_

Effective date (mm/dd/yyyy)	Start	_____	Policy #	_____
	End	_____		Phone#

(Only put the end date if you no longer have this policy)

Is this policy a Medicare supplemental?

Yes  No

Does this policy cover prescription drugs?

Yes  No

If yes please specify which plan (A-J).

Name of policy \_\_\_\_\_

Effective date (mm/dd/yyyy)	Start	_____	Policy #	_____
	End	_____		Phone#

(Only put the end date if you no longer have this policy)

Is this policy a Medicare supplemental?

Yes  No

Does this policy cover prescription drugs?

Yes  No

If yes please specify which plan (A-J).

#### Section III: Certification to be completed by the 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 will promptly notify VA's Health Administration Center. Sign, date below and return to the address at the top of the form.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

X \_\_\_\_\_