VA FORM JAN 2002 (T)

10-7959c

Department of Veterans Affairs

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: C H A M P V A
First name: M a r y
MI: M

Social Security #: 1 1 1 - 1 1 - 1 1 1 1
Phone #: ( ) -

Street Address: 1 2 3 S A s c o t t S t r e e t

City: D e n v e r
State: C O
Zip: 8 0 2 2 2 - 0 0 0 0

☐ 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): 0 4 0 1 2 0 0 0

Part B: ☒ Yes ☐ No — 0 4 0 1 2 0 0 0

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' Know

Name of policy: U S H e a l t h c a r e

Effective date (mm/dd/yyyy) Start: 0 1 0 1 1 9 9 9 — Policy #: A Z 6 4 5 1

End: 0 3 3 1 2 0 0 0 — Phone#: (8 0 0) 5 5 5 - 4 4 4 4

(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: B l u e S e l e c t

Effective date (mm/dd/yyyy) Start: 0 4 0 1 2 0 0 0 — Policy #: X Y Z 8 7 6 5 3 2 1 0

End: — Phone#: (8 0 0) 5 5 5 - 4 4 4 4

(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) C

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 and return to the address at the top of the form.

Signature: X Melissa Chamova

Date: Oct 3, 2001

SAMPLE

CHAMPVA other health insurance OHI certification important notes and definitions.

Why the OHI Certification?

Except for Medicaid, State Victims Compensation Programs, and policies purchased exclusively for the purpose of supplementing CHAMPVA benefits (see supplemental policy definition), CHAMPVA by law is always the secondary payer of healthcare benefits. As part of our efforts to coordinate benefits among all involved insurance/benefit plans, completion and return of this OHI Certification is required.

Things to return with your completed Other Health Insurance Certification

A **COPY** of your Medicare card

A **COPY** of your other health insurance member ID card, this will help us identify what type of coverage this is

If your other health insurance does not issue *EOB's for any reason, then a copy of your schedule of benefits that will list your co-payment information should be attached.

****EOB:*** Defined below.

If your policy is an Indemnity, send us a copy of your policy.

Definitions:

EOB : the abbreviation for an explanation of benefits form. An EOB is a statement from an insurance carrier/benefit program that summarizes the action taken on claim.

Indemnity: includes those plans that pay a flat fee or daily rate while hospitalized.

Supplemental policies: These are policies, such as American Association of Retired People (AARP), that are designed to pay only after primary health insurance.

End date: Some policies will renew every year and issue new member ID cards This is not a true end date. Only complete this field if you no longer have the policy.

OHI: Abbreviation for Other Health Insurance.

Privacy Act: All information collected is subject to the provisions of the Privacy Act under 5 USC 552a. The information collected will be entered into System No. 54VA17, titled "Health Administration Center Civilian Health and Medical Program Records - VA", published in the Federal Register, Vol. 65, Number 248, pages 81572 - 81575, December 26, 2000, or as updated and republished. Information from this system of records may be given to health care providers and suppliers of services directly for administration of CHAMPVA , 38 USC 1713. Additional disclosures may be found in the Federal Register notice cited above. Public Law 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches. Pursuant to 5 USC 552a, the Privacy Act of 1974, as amended, and the Office of Management and Budget Guidelines on the Conduct of Matching Programs, notice is hereby given of the VA's intent to conduct computer matches with Centers for Medicare and Medicaid Services (CMS). Data from the proposed matches will be utilized to verify Medicare entitlement for applicants and recipients for CHAMPVA benefits, whose eligibility for CHAMPVA is based upon entitlement for Medicare. **Authority:** This information is solicited under 38 USC 501 and 1713. **Disclosure:** Disclosure is voluntary, but failure to provide the information may result in delay or denial of CHAMPVA eligibility. Failure to furnish this information will have no adverse impact on any other VA benefits to which you may be entitled.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collected is in accordance with the clearance requirements of section 3507 of this Act. The public reporting burden for this collection of information is estimated to average 5 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. No person will be penalized for failing to furnish this information if it does not display a currently valid OMB control number. This collection of information is to determine what secondary insurance is carried by the beneficiary.