



**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.

**PLEASE READ INSTRUCTIONS AND INFORMATION ON THE REVERSE SIDE BEFORE COMPLETING THIS FORM**

**SECTION I: BENEFICIARY INFORMATION**

**USE A SEPARATE FORM FOR EACH FAMILY MEMBER**

LAST NAME

FIRST NAME

MI

[Grid for last name]

[Grid for first name]

[Grid for MI]

ADDRESS (NUMBER, STREET, PO BOX, APT #)

[Grid for address]

SEX  M  
 F

CITY

STATE

ZIP CODE

[Grid for city]

[Grid for state]

[Grid for zip code]

PHONE # (INCLUDE AREA CODE)

SOCIAL SECURITY #

CHECK IF NEW ADDRESS

[Grid for phone number]

[Grid for social security number]

**SECTION II: THE BENEFICIARY'S OTHER HEALTH INSURANCE (OHI)**

A. DO YOU HAVE MEDICARE? (IF YES, ATTACH A COPY OF YOUR MEDICARE CARD.)

PART A:  YES  NO

PART B:  YES  NO

EFFECTIVE DATE (MMDDYYYY)

[Grid for Medicare Part A effective date]

EFFECTIVE DATE (MMDDYYYY)

[Grid for Medicare Part B effective date]

B. OTHER THAN CHAMPVA OR MEDICARE, DO YOU HAVE OR HAVE YOU HAD OHI SINCE BECOMING CHAMPVA ELIGIBLE? \*

- YES IF YES, COMPLETE SECTION III. SEND A COPY OF YOUR MEMBER IDENTIFICATION CARD(S) OR A COPY OF THE POLICY'S SCHEDULE OF BENEFITS. THEN COMPLETE SECTION IV. \*SEE REVERSE SIDE.
- NO IF NO, CONTINUE ON TO SECTION IV. READ THE CERTIFICATION, THEN SIGN AND DATE.

**SECTION III: OTHER HEALTH INSURANCE - OTHER THAN CHAMPVA OR MEDICARE**

INSURANCE PROVIDER

[Grid for insurance provider name]

POLICY #

CUSTOMER SERVICE PHONE #

[Grid for policy number]

[Grid for customer service phone number]

EFFECTIVE DATE: (MMDDYYYY)

TERMINATION DATE: (MMDDYYYY)

[ONLY PUT THE TERMINATION DATE IF POLICY IS NO LONGER ACTIVE]

[Grid for effective date]

[Grid for termination date]

IS THIS INSURANCE THROUGH EMPLOYMENT?  YES  NO

DOES THIS INSURANCE SUPPLEMENT CHAMPVA?  YES  NO

DOES THIS INSURANCE SUPPLEMENT MEDICARE?  YES  NO

DOES THIS INSURANCE COVER PRESCRIPTION DRUGS?  YES  NO

IF MEDIGAP, SPECIFY PLAN (A-J) [ ]  
(SEE DEFINITIONS ON REVERSE)

INSURANCE PROVIDER

[Grid for insurance provider name]

POLICY #

CUSTOMER SERVICE PHONE #

[Grid for policy number]

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EFFECTIVE DATE: (MMDDYYYY)

TERMINATION DATE: (MMDDYYYY)

[ONLY PUT THE TERMINATION DATE IF POLICY IS NO LONGER ACTIVE]

[Grid for effective date]

[Grid for termination date]

IS THIS INSURANCE THROUGH EMPLOYMENT?  YES  NO

DOES THIS INSURANCE SUPPLEMENT CHAMPVA?  YES  NO

DOES THIS INSURANCE SUPPLEMENT MEDICARE?  YES  NO

DOES THIS INSURANCE COVER PRESCRIPTION DRUGS?  YES  NO

IF MEDIGAP, SPECIFY PLAN (A-J) [ ]  
(SEE DEFINITIONS ON REVERSE)

**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:

DATE:

X \_\_\_\_\_

\_\_\_\_\_

## CHAMPVA OTHER HEALTH INSURANCE (OHI) CERTIFICATION

### NOTES, DEFINITIONS, AND INSTRUCTIONS

#### WHY IS THE OHI CERTIFICATION REQUIRED?

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 health care benefits. As part of our efforts to coordinate benefits among all involved insurance/benefit plans, **all beneficiaries are required to complete and return this OHI Certification.**

#### ITEMS TO RETURN WITH YOUR 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, this will help us identify your type of coverage.
- If, for any reason, your OHI does not issue EOBs, then attach a copy of your schedule of benefits that lists your co-payment information.
- If your policy is an Indemnity plan, send us a copy of your policy.

#### DEFINITIONS

**EOB:** The abbreviation for an "explanation of benefits" form or letter. An EOB is a statement from an insurance carrier or 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. There are supplemental policies available for Medicare and CHAMPVA. The primary insurance pays first.

**TERMINATION DATE:** If you no longer have the policy, this is the date the policy ended or ceased to be active. Some policies will renew every year and issue new member ID cards with new dates. These dates are policy periods and the end date is not the termination date. Closing a policy will generate a true termination date.

#### INSTRUCTIONS

**FAILURE TO COMPLETE SECTIONS II AND III ON THE FRONT CAN RESULT IN A DELAY OR DENIAL OF PAYMENT FOR COVERED SERVICES. THIS FORM IS ALSO USED TO REPORT ANY CHANGES IN YOUR OTHER HEALTH INSURANCE.**

MOST ITEMS ARE SELF-EXPLANATORY. ITEMS WHICH NEED CLARIFICATION ARE IDENTIFIED BELOW.

##### SECTION II.B.

- NEW BENEFICIARIES – WE NEED OHI INFORMATION SINCE THE LATEST OF THE FOLLOWING DATES:
  1. THE DATE OF THE VETERAN'S PERMANENT AND TOTAL (P&T) SERVICE-CONNECTED DISABILITY RATING,
  2. THE DATE OF DEATH WHICH QUALIFIES THE VETERAN AS AN ELIGIBLE CHAMPVA SPONSOR, OR
  3. THE DATE OF DEPENDENCY (THE DATE OF MARRIAGE, DATE OF BIRTH CERTIFICATE, THE DATE THAT THE SPOUSE'S REMARRIAGE TERMINATED, OR DATE OF ADOPTION).
- RE-CERTIFICATION – UPDATE OHI INFORMATION TO INCLUDE ANY CHANGES SINCE THE LAST CERTIFICATION.

##### SECTION III.

- TO SPECIFY A MEDICARE SUPPLEMENT PLAN A – J, REFER TO YOUR POLICY COVER SHEET OR YOUR INSURANCE MEMBERSHIP CARD.
- IF THERE ARE ADDITIONAL POLICIES FOR SECTION III, USE PLAIN BOND PAPER AND EITHER TYPE OR LEGIBLY PRINT YOUR NAME, SSN, AND THE INFORMATION FOR EACH ITEM. ATTACH TO THIS FORM.

**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 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. 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.