INSTRUCTIONS FOR:

TRICARE® Other Health Insurance Questionnaire

East Region

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.

Submit Questionnaire						
Note: An incomplete questionnaire may result in a claims payment delay. Questions? Call 1-800-444-5445	Mail questionnaire to: TRICARE East Region P.O. Box 8923 Madison, WI 53708-8923	Fax questionnaire to: 1-608-221-7536				

OHI Questionnaire Form Instructions

1, General Information

TRICARE Sponsor Name: Fill in the TRICARE Sponsor name

Sponsor's Social Security Number or Department of Defense Benefits Number: Fill in either the Sponsor number (9 digits) OR the DoD Benefits Number (11 digits). The DoD Benefits number can be found on the back of the newer Military IDs.

Do you or any of your family members currently have Other Health Insurance (OHI) coverage? Select 'Yes' if you or any of your family members currently have OHI coverage

Have you or any of your family members had OHI coverage in the past 12 months? Select 'Yes' if you or any of your family members have had OHI coverage in the last 12 months

2: Primary OHI Status (Do NOT include TRICARE).

Policy Holder Name: Name of your insurance company

Policy number: Enter the policy number of the plan. This can usually be found on your insurance card.

Group/Plan number: Enter the Group/Plan number of the plan. This can usually be found on your insurance card.

Carrier Address and Phone #: Enter the address and phone number of your insurance company. This is usually given somewhere on your insurance card. For Medicare, this is only needed if you have a Medicare Advantage/Replacement plan.

Type of plan: Select the type of insurance plan (explanation of plans below)

- HDHP/HMO/PPO (Non-Medicare Plan) Includes High Deductible Health Plan (HDHP), Health Maintenance Organization (HMO) or a Preferred Provider Plan (PPO) that is **not** a Medicare plan. This includes Medicare supplemental plans, which are plans purchased to pay additional benefits after traditional Medicare pays.
- Medicare Includes standard Medicare Part A and/or Medicare Part B coverage.
- Medicare Advantage/Replacement Plan Includes all forms of Medicare Advantage/Replacement plans, including Medicare HMOs, Medicare PPOs, and Medicare Cost Plans, that are approved by Medicare to administer Medicare benefits. They replace standard Medicare coverage. (Do NOT use for Medicare supplement plans.)
- TRICARE Supplemental Plan that pays after TRICARE
- Medicaid/MediCal State Medicaid plan
- Student Health Plan Health plan that is provided while you are enrolled in college or through a school.
- Other If your plan is not listed above, please provide the type of plan.

Does this coverage include pharmacy benefits? Does this plan cover prescription medications?

<u>Does this coverage have benefit exclusions or limitations?</u> Does your policy limit the types of services provided? Some examples would be cancer coverage only, or no heart disease coverage, etc. If you check 'YES', indicate what services are excluded or limited.

Name of Covered Member: Enter the first and last name of the person(s) covered by this plan.

Member ID: Enter the member ID of the person(s) covered by this plan.

Date of Birth: Enter the date of birth of the person(s) covered by this plan.

Gender: Enter the gender of the person(s) covered by this plan.

Effective Date: Enter the date the policy became effective for this person(s). This will be the original effective date of the policy. For Medicare this is usually the first of the month of your birthday month.

Expiration Date: If you no longer have this coverage enter the date the policy expired. If the coverage is still in effect, write "current".

3: Additional OHI Status (Do NOT include TRICARE).

If you have more than one OHI Policy, enter the information in this section. You would follow the same instructions as given in 2. If you have more than two OHI, include an additional sheet with the additional insurance information and attach to this form. Provide the same information as given in 2.

4 - Prior OHI Status (Do NOT include TRICARE).

Complete only if you or any of your family members have had OHI within the last 12 months that is no longer effective. You would follow the same instructions as given in 2.

Read the consent information and if you agree fill in the following information.

Your Signature: Sign your name.

Relationship to Sponsor: Fill in your relationship to the sponsor. The sponsor is the person who served in the Military.

Date: Fill in the date you signed the form.



TRICARE Other Health Insurance Questionnaire



1 - General Information							
TRICARE Sponsor Name:							
Sponsor's Social Security Nu	imber or Department of Def	ense Benefits Numbe	r:				
Do you or any of your family members currently have Other Health Insurance (OHI) coverage? □ Yes □ No							
Have you or any of your family members had OHI coverage in the past 12 months?			□ Yes	□ No			
If you answered yes to either quest please read and sign the questionr	tion above, please complete the r naire at the bottom and submit th	remainder of the questionhe questionnaire to the	nnaire (duplic address or fax	ate the questionnai number provided o	re for multiple policie on page 1.	es). Regardless of your answers above,	
2 – Primary OHI Status - 0	Complete only if you or any	of your family men	nbers curren	tly have OHI.			
Policyholder name:		Policy number:			Group/Plan number:		
Name of carrier:						te:	
Carrier address and phone nun							
Type of Plan: ☐ HDHP/HM	O/PPO (Non-Medicare Plan)	□ Medicare □ Med	licare Advant	age/Replacement	Plan □ TRICARI	E Supplemental	
□ Medicaid/MediCal □ Student Health Plan □ Other							
Coverage is through: □ Empl	loyer Spouse Private	e □ School □ Gov	vernment				
Does this coverage include pha							
Does this coverage have benef	fit exclusions or limitations?	$P \square Yes \square No If Y$	es, please in	dicate which one(s	s):		
Name of covered member:	Member ID:	Date of birth:	Gender:	Effective	date:(if different)	Expiration date:(if different)	
3 – Additional OHI Status	- Complete only if you or a	any of your family m	embers curr	ently have any a	dditional OHI.		
Policyholder name:		Policy number:			Group/Plan number:		
Name of carrier:		Effective date:			Expiration date:		
Carrier address and phone nun	<u> </u>						
Type of Plan: ☐ HDHP/HMC				ige/Replacement l	Plan □ TRICARE	E Supplemental	
	iCal □ Student Health Plan						
Coverage is through: □ Empl			ernment				
Does this coverage include pha							
Does this coverage have benef	fit exclusions or limitations?	$P \square \text{ Yes } \square \text{ No } \text{ If }$	Yes, please i	ndicate which one	(s):		
Name of covered member:	Member ID:	Date of birth:	Gender:	Effective date	e:(if different)	Expiration date:(if different)	
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TRICARE Other Health Insurance Questionnaire



4 - Prior OHI Status - Con	aplete only if you or any of	your family member	rs have had (OHI within the last 12 months.		
Policyholder name:		Policy number:		Group/Plan		
Name of carrier:					Expiration date:	
Carrier address and phone nun						
Type of Plan: ☐ HDHP/HMC	O/PPO (Non-Medicare Plan)	□ Medicare □ Medi	icare Advanta	ge/Replacement Plan ☐ TRICAR	E Supplemental	
☐ Medicaid/Medi	iCal □ Student Health Plan	□ Other				
Coverage is through: □ Emp	loyer □ Spouse □ Private	e □ School □ Gov	rernment			
Does this coverage include pha	armacy benefits? Yes	l No				
Does this coverage have benef	it exclusions or limitations?	Yes □ No If	Yes, please i	ndicate which one(s):		
Name of covered member:	Member ID:	Date of birth:	Gender:	Effective date:(if different)	Expiration date:(if different)	
	claims in any matter within jurisd	iction of any department of	or agency of the		inal penalties for submitting or making falso copies of the laws cited may be obtained from	
Your signature			Relatio	nship to TRICARE Sponsor	Date	