OMB Control Number: 2900-0219
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Department of Veterans Affairs

CHAMPVA Claim Form

Chief Business Office Purchased Care, CHAMPVA, PO Box 469064, Denver CO 80246-9064 | Customer Service Center: 1-800-733-8387

ATTENTION: Refer to the following information for instructions and assistance completing this form in its entirety (print or type only). Return the form and any additional, requested information to the address shown above.

Claim form usage: This form is to be completed by the patient, sponsor or guardian and is mandatory for all beneficiary claims. This claim form is **NOT** to be used for provider submitted claims.

Other Health Insurance (OHI): By law, other coverage must be reported. Except for CHAMPVA supplemental policies, CHAMPVA is always the secondary payer. If OHI exists, attach an Explanation of Benefits (EOB) from the other health insurance to the provider's itemized billing statement(s). Dates of service and provider charges on the EOB must match billing statements.

Timely filing requirement: Claims must be received no later than one year after the date of service or, in the case of inpatient care, within one year of the discharge date.

Itemized billing statements: An itemized statement must be attached and contain:
- patient name, date of birth, and CHAMPVA Identification Card Member Number (same as patient's Social Security number);
- provider name, degree, tax identification number (TIN), address and telephone number; and
- service dates, itemized charges and appropriate procedure/diagnosis codes for each service (i.e., CPT-4, HCPCS, and ICD-9-CM codes), including narrative descriptions.

Pharmacy claims must include name, quantity, strength, and National Drug Code (NDC) of each drug.

SECTION I – PATIENT INFORMATION

Last Name *(required field)*	First Name *(required field)*	MI	CHAMPVA Member Number *(required field)*

Street Address	☐ Check if new address	Date of Birth *(mm/dd/yyyy)*

City	State	ZIP Code	Phone Number *(include area code)*

SECTION II – OTHER HEALTH INSURANCE (OHI) INFORMATION

If more space is needed, please continue in the same format on a separate sheet.

Was treatment for a work-related injury/condition? ☐ Yes ☐ No | Was treatment for an injury or accident outside of work? ☐ Yes ☐ No

Is patient covered by OHI, to include coverage through a family member? *(Supplemental or secondary insurance excluded)*

☐ Yes (check type and provide coverage information below) ☐ No (proceed to Section III)

◯ employer sponsored (group) ◯ private (non group) ◯ Medicare (Part A or B) ◯ other: (specify) _____

Name of Other Health Insurance (OHI)	Name of Other Health Insurance (OHI)
Policy Number	Policy Number
Phone Number *(include area code)*	Phone Number *(include area code)*

SECTION III – SPONSOR INFORMATION

Last Name	First Name	MI

SECTION III – CLAIMANT CERTIFICATION

I certify that the information on this form and any attachments are correct and represent actual services, dates, and fees charged. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to Title 18, United States Code, Sections 287 and 1001. *(Sign and date below.)*

If certification is signed by a person other than the patient, complete the following:	Signature _____	Date

Last Name	First Name	MI	Relationship to Patient

Street Address	City	State	Zip Code	Phone Number *(with area code)*