OMB Control Number: 2900-0219
Estimated Burden: 10 minutes
Expiration Date: 12/31/2027

Department of Veterans Affairs

CHAMPVA OTHER HEALTH INSURANCE (OHI) CERTIFICATION

VHA Office of Integrated Veteran Care CHAMPVA Eligibility PO Box 137 Spring City, PA 19475
Customer Service Center: 1-800-733-8387 | FAX: 303-331-7808

ATTENTION: Please read the instructions on the reverse side before completing this form. Failure to provide the requested information will result in a delay or denial of reimbursement until OHI information is received. Return the form and any requested information to the address shown above. This form is also used to report any changes in your OHI status. Updates can be sent by FAX or call by phone.

SECTION I: BENEFICIARY INFORMATION – Please use a separate form for each family member

Last Name	First Name	MI	Social Security Number *(999-99-9999)*

Street Address *(Number, Street name/PO Box, Apt #)*	City	State	Zip Code *(99999-9999)*

Country Code	Email Address

Phone Number *(with area code)* *((999) 999-9999)*	☐ **Check if this is a new address**	Sex ☐ Male ☐ Female

SECTION II: MEDICARE BENEFICIARIES – Attach a copy of your Medicare card

Part A: ☐ Yes ☐ No	Part B: ☐ Yes ☐ No	Part C: ☐ Yes ☐ No	Part D: ☐ Yes ☐ No
Effective Date *(MM/DD/YYYY)*	Effective Date *(MM/DD/YYYY)*	Medicare Advantage/ Replacement Plan Carrier Name	MBI
			Effective Date *(MM/DD/YYYY)*
Do you have health insurance other than MEDICARE? ☐ Yes ☐ No		Effective Date *(MM/DD/YYYY)*	Termination Date *(MM/DD/YYYY)*
If NO, go to Section IV.			

SECTION III: OTHER HEALTH INSURANCE

Provide all periods of OHI coverage since becoming CHAMPVA eligible and attach a copy of any *active* health insurance cards (front and back).

Name of insurance #1		**Only input the termination date if the policy is inactive.**
Effective Date *(MM/DD/YYYY)*	Termination Date *(MM/DD/YYYY)*	
Is this insurance through employment? ☐ Yes ☐ No	Does the insurance cover prescriptions? ☐ Yes ☐ No	

What type of insurance is it?
☐ HMO ☐ PPO ☐ Medicaid / State Assistance ☐ Medigap *(if Medigap, specify A, B, C, D, F, G, K, L, M, N)*: ____
☐ Other *(specialty, limited coverage, or exclusively CHAMPVA supplemental)*

Comments

Name of insurance #2		**Only input the termination date if the policy is inactive.**
Effective Date *(MM/DD/YYYY)*	Termination Date *(MM/DD/YYYY)*	
Is this insurance through employment? ☐ Yes ☐ No	Does the insurance cover prescriptions? ☐ Yes ☐ No	

What type of insurance is it?
☐ HMO ☐ PPO ☐ Medicaid / State Assistance ☐ Medigap *(if Medigap, specify A, B, C, D, F, G, K, L, M, N)*: ____
☐ Other *(specialty, limited coverage, or exclusively CHAMPVA supplemental)*

Comments

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 the Chief Business Office Purchased Care.

SIGNATURE *(type if electronic)*	DATE *(MM/DD/YYYY)*