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)*

CHAMPVA OTHER HEALTH INSURANCE (OHI) CERTIFICATION NOTES, DEFINITIONS, AND INSTRUCTIONS

INSTRUCTIONS

Failure to complete all applicable sections on the front can result in a delay or denial of benefits. Use this form to report any changes in your other health insurance.

- New beneficiaries - we need OHI information from the date your CHAMPVA eligibility became effective.
- Re-certification - update OHI information every time a change is made to your OHI coverage.
- To specify a Medicare supplement plan A, B, C, D, F, G, K, L, M, N, refer to your policy cover sheet or your insurance membership card.
- If there are additional policies use plain bond paper and either type or legibly print your name, SSN, and the information for each item. Attach to this form. If submitting this form electronically add an attachment to the submission.

ITEMS TO RETURN WITH THIS 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 (front and back).

DEFINITIONS

OHI: OHI refers to insurance or benefits you may have other than CHAMPVA called “Other Health Insurance.”

EOB: The abbreviation for an “explanation of benefits” form or letter that must accompany claims submitted to CHAMPVA. An EOB is a statement or “Remittance Advice” from an insurance carrier or benefit program that summarizes the action taken on a claim. Note: If you have OHI primary to CHAMPVA you must submit EOB's for each primary insurance along with health care claims. If your OHI does not issue EOB's i.e. some HMO's and PPO's, you must submit a copy of your active co-payment information shown on your insurance card or a document showing your co-payments with every health care claim so CHAMPVA can calculate benefit payments.

Carrier: Carrier is the insurance company that provides your medical benefits.

OHI primary to CHAMPVA: CHAMPVA by law is always supplemental or the secondary payer of health care benefits except for Medicaid, State Victims of Crimes Compensation Programs, and policies purchased exclusively to supplement CHAMPVA benefits.

Supplemental CHAMPVA policies: These are policies specifically purchased for the purpose of covering your cost share after CHAMPVA has completed adjudication of a claim.

Medicare supplemental policies: These are policies that are specifically for the purpose of covering your Medicare out of pocket expenses. These Medicare supplemental policies such as “Medigap” or Policies offered through employment are primary to CHAMPVA and must provide an EOB along with the Medicare EOB (**two EOBs**) for each claim submitted to CHAMPVA.

Indemnity: Plans that pay a flat fee or daily rate to supplement lost income while hospitalized are called Indemnity Plans.

Termination date: This is the date the policy ended or ceased to be active. The end date for a period shown on a card that will be reissued is not the termination date. Closing a policy will generate a true termination date.

PRIVACY ACT INFORMATION: Information on this form is collected in accordance with the System of Records Notice 54VA10NB3, Veterans and Beneficiaries Purchased Care Community Health Care Claims, Correspondence, Eligibility, Inquiry and Payment Files-VA (Published March 3, 2015, FR 80, number 41). **Category:** Records maintained in the system include program applications, eligibility information concerning the Veteran, family members, caregivers, other health insurance information to include information regarding eligibility or entitlement to other federal medical programs. **Authority:** 38 USC 501 and 1781. **Purpose:** Records may be used for purposes of establishing and monitoring eligibility to receive VA benefits, processing claims for medical care and services, and processing stipends. **Routine Use:** The Privacy Act permits VA to disclose information about individuals without their consent under the Privacy Act Routine Use Disclosure when the information will be used for a purpose that is compatible with the purpose for which VA collected the information. **Disclosure**: Voluntary. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, it may delay or result in denial of your request for CHAMPVA benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled.

VA BURDEN STATEMENT: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0219, and it expires 12/31/2027. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0219 in any correspondence. Do not send your completed VA Form 10-10d to this email address. If you have questions about your eligibility for CHAMPVA benefits or how to complete this form, you may call the CHAMPVA Help Line at 800-733-8387.