OMB Number 2900-0219
Estimated burden: 10 minutes

Department of Veterans Affairs — CHAMPVA Other Health Insurance (OHI) Certification

VA Health Administration Center, PO BOX 469063, Denver, CO 80246-9063 1-800-733-8387 www.va.gov/hac FAX: 1-303-331-7808
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. Updates can be sent by FAX or call by phone.
PLEASE READ INSTRUCTIONS AND INFORMATION ON THE REVERSE SIDE BEFORE COMPLETING THIS FORM

SECTION I: BENEFICIARY INFORMATION - PLEASE USE A SEPARATE FORM FOR EACH FAMILY MEMBER

LAST NAME	FIRST NAME	MI

ADDRESS (NUMBER, STREET, PO BOX, APT #)	SEX
	Male ☐ Female ☐

CITY	STATE	ZIP CODE

PHONE # (INCLUDE AREA CODE)	SOCIAL SECURITY NUMBER	
		☐ CHECK IF NEW ADDRESS

SECTION II: MEDICARE BENEFICIARIES: ATTACH A COPY OF YOUR MEDICARE CARD

Part A: Yes ☐ No ☐	Part B: Yes ☐ No ☐	Part D: Yes ☐ No ☐
EFFECTIVE DATE (MMDDYYYY)	EFFECTIVE DATE (MMDDYYYY)	EFFECTIVE DATE (MMDDYYYY)
PART A CARRIER NAME	PART B CARRIER NAME	PART D CARRIER NAME

Does your Medicare provide Pharmacy benefits? Yes ☐ NO ☐	Did you choose a Medicare Advantage Plan for your Medicare coverage? Yes ☐ No ☐

Do you have health insurance other than MEDICARE? Yes ☐ No ☐ IF NO, go to Section IV

SECTION III:

Provide all periods of other health insurance coverage since you became CHAMPVA eligible.
Required: Attach a copy of any active health insurance cards (front & back).

Name of insurance # 1

EFFECTIVE DATE (MMDDYYYY)	TERMINATION DATE (MMDDYYYY)	Only put in the termination date if the policy is inactive.

Is this insurance through employment? Yes ☐ No ☐ Does the insurance cover prescriptions? Yes ☐ No ☐

Does the insurance provide an explanation of benefits for prescriptions? Yes ☐ No ☐

What type of insurance? ☐ HMO ☐ PPO ☐ Medicaid/State Assistance ☐ Prescription Discount

☐ Medigap [if Medigap, specify ____ (A-J)] ☐ Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)

Comments

Name of insurance # 2

EFFECTIVE DATE (MMDDYYYY)	TERMINATION DATE (MMDDYYYY)	Only put in the termination date if the policy is inactive.

Is this insurance through employment? Yes ☐ No ☐ Does the insurance cover prescriptions? Yes ☐ No ☐

Does the insurance provide an explanation of benefits for prescriptions? Yes ☐ No ☐

What type of insurance? ☐ HMO ☐ PPO ☐ Medicaid/State Assistance ☐ Prescription Discount

☐ Medigap [if Medigap, specify ____ (A-J)] ☐ 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 VA's Health Administration Center. Sign, date below and return to the address at the top of the form.

SIGNATURE (type if electronic): DATE

VA FORM 10-7959c
FEB 2017

OMB Approval Number 2900-0648
Estimated Burden Avg: 4 minutes
Expiration Date: 03/31/2019

Department of Veterans Affairs — Foreign Medical Program (FMP) Registration Form

Veterans can use this form to register in the VA Foreign Medical Program. The information provided on this form will be used by VA to determine your eligibility for reimbursement for medical services outside the United States. Please complete and submit to the FMP office at the address listed below or FAX to 1-303-331-7803. All items must be completed (if not applicable, please write or type *None* or *N/A).*

Foreign Medical Program
PO Box 469061, Denver, CO 80246-9061 USA
Telephone number: 1-303-331-7590 | Fax number: 1-303-331-7803 | Email: hac.fmp@va.gov
Website: http://www.va.gov/purchasedcare/programs/veterans/fmp/

Veteran Information - Please Print

Veteran Last Name	Veteran First Name	MI

Social Security Number	VA Claim File Number	Date of Birth

Physical Address (Residence)	Mailing Address
Country	Country
Telephone Number	Email Address

Federal law provides criminal penalties, including a fine and/or imprisonment, for any materially false, fictitious, or fraudulent statement or representation (See 18 U.S.C. 287 and 1001).

Veteran Signature (Required)	Date (Required)

I certify that the above information is correct and true to the best of my knowledge and belief.

If eligible, an FMP Benefits Authorization Letter will be issued to you at your above mailing address.

Privacy Act and Paperwork Reduction Act Information: The information requested on this form is solicited under the **Authority:** Title 38, U.S.C. 1724. The Systems of Records that apply are 23VA10NB3, Non-VA Care (Fee) Records-VA (FR 80 No.146 July 30, 2015) and 54VA10NB3, (FR 80 No. 41, Mar 3, 2015) "Veterans and Beneficiaries Purchased Care Community Health Care Claims, Correspondence, Eligibility, Inquiry and Payment Files --VA". **Purpose:** Records may be used to establish, determine, and monitor eligibility to receive VA benefits and for authorizing and paying Non-VA healthcare services furnished to veterans and beneficiaries and to process claims for medical care and services, and to process stipends. **Principle:** Veterans, Beneficiaries, Pensioned members of the allied forces and Healthcare providers treating individuals who receive care under 38 U.S.C. Chapters 1 and 17. **Routine Use:** Routine use disclosures are in accordance with the Privacy Act of 1974 (as amended) and the applicable system of records notice. **Disclosure:** Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security number (SSN) (the SSN will be used to locate records) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. Not supplying the SSN may delay processing your claims. VA may disclose the information as a routine use disclosure outlined in applicable Privacy Act Systems of Records Notice. **The Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 4 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.