



Department of Veterans Affairs

CHAMPVA Other Health Insurance (OHI) Certification

Chief Business Office Purchased Care, PO Box 469063, Denver CO 80246-9063
Customer Service Center: 1-800-733-8387 | FAX: 303-331-7808 | Website: <http://www.va.gov/purchasedcare>**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	
Surname	Veteran	I	234234234	
Street Address (Number, Street name/PO Box, Apt #)		City	State	Zip Code
456 Street Circle		Anyburg	AK	12323
Phone Number (with area code)	<input checked="" type="checkbox"/> Check if this is a new address			Gender
3331233456				<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female

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

Part A: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Part B: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Part D: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Effective Date (mm-dd-yyyy) 2010-01-01	Effective Date (mm-dd-yyyy) 2010-01-01	Effective Date (mm-dd-yyyy) 2010-01-01
Part A Carrier Name	Part B Carrier Name	Part Carrier Name
Test A Carrier	Test B Carrier	Test D Carrier
Does your Medicare coverage provide pharmacy benefits? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Do you have health insurance other than MEDICARE? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Did you choose a Medicare Advantage Plan for your Medicare coverage? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		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	Primary Provider		Only input the termination date if the policy is inactive.
Effective Date (mm-dd-yyyy) 2010-01-01	Termination Date (mm-dd-yyyy) 2010-01-01		
Is this insurance through employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Does the insurance cover prescriptions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Does the insurance provide an explanation of benefits for prescriptions? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
What type of insurance is it? <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Medicaid / State Assistance <input checked="" type="checkbox"/> Medigap (if Medigap, specify [A-J]) <input type="checkbox"/> Prescription Discount <input type="checkbox"/> Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)			
Comments:	Additional primary comment		

Name of insurance #2	Secondary Provider		Only input the termination date if the policy is inactive.
Effective Date (mm-dd-yyyy) 2010-01-01	Termination Date (mm-dd-yyyy) 2010-01-01		
Is this insurance through employment? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Does the insurance cover prescriptions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Does the insurance provide an explanation of benefits for prescriptions? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
What type of insurance is it? <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Medicaid / State Assistance <input checked="" type="checkbox"/> Medigap (if Medigap, specify [A-J]) <input type="checkbox"/> Prescription Discount <input type="checkbox"/> Other (specialty, limited coverage, or exclusively CHAMPVA supplemental)			
Comments:	Additional secondary comment		

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): Certifier Jones

DATE: 2010-01-01