INSTRUCTIONS FOR:

TRICARE® Other Health Insurance Questionnaire

West Region

Privacy Act Statement

This statement serves to inform you of the purpose for collecting your personal information through a *TRICARE Other Health Insurance Questionnaire* and how that information will be used.

Authority: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

Purpose: To collect information from you in order to process your TRICARE medical claims under your TRICARE insurance and coordinate payment activities with other health insurance that may be available to you or members of your family.

Routine uses: Your records may be disclosed to the federal and state agencies and to other health insurers in order to coordinate your benefits and payments for health care received.

Use and disclosure of your records outside of the Department of Defense (DoD) may also occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and health care operations.

Disclosure: Voluntary. If you choose not to provide this information, no penalty may be imposed, but failure to provide the requested information may result in the delay or denial of payments and claims.

Reporting Your Other Health Insurance

You can report and update your other health insurance (OHI) to minimize any delay in processing claims through the following methods:

- **By phone:** Call Health Net Federal Services, LLC at 1-844-866-WEST (1-844-866-9378)
- **In person:** Visit your military hospital or clinic or a uniformed services identification card-issuing facility
- **By computer:** Go to www.tricare-west.com
- **By mail:** Please mail this questionnaire to our claims-processing subcontractor at the address below:

  TRICARE West - OHI Questionnaires
  P.O. Box 202102
  Florence, SC, 29502-2102
- **By fax:** Please fax this questionnaire to our claims-processing subcontractor at 1-844-730-1372

Visit www.tricare-west.com and www.tricare.mil/ohi for more information on OHI.

If you have received this correspondence in error, please notify 1-844-866-WEST (1-844-866-9378), then destroy completed documents and any copies you have made.

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TRICARE Other Health Insurance Questionnaire

Do you or any of your family members have other health insurance (OHI) coverage or have you had OHI in the last 12 months? (TRICARE supplements are not OHI) ☐ **YES** ☐ **NO**

If **YES**, report your OHI information online at **www.tricare-west.com** to minimize any delay in processing claims. You may also complete the questionnaire for each insurance policy and mail to the address provided on page 1. **This questionnaire may be copied.**

Important - If there was a break in OHI coverage, please include information about the previous OHI coverage.

Type of coverage: ☐ HMO/PPO ☐ Employer-sponsored ☐ Individual ☐ Medicare ☐ Supplemental ☐ Medicaid ☐ Other

Policyholder's name: ______________________________

Social Security number (SSN) or Department of Defense Benefits Number (DBN): ______________________________

Name of insurance company: ______________________________

Insurance company's address/phone number: ______________________________

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Policy/Group/Plan number: ______________________________

Effective date: ______________________________ Expiration date: ______________________________

This policy provides the following benefits (check all that apply):
☐ Medical ☐ Pharmacy ☐ Dental ☐ Vision ☐ Mental health ☐ Durable medical equipment
☐ Long-term health care ☐ Skilled nursing facility care

Please list who is covered by this policy:

Name	Gender	Relationship to policyholder	Date of birth	SSN or DBN
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

(If additional people are covered, please attach a separate list.)

The statements made above are true and correct to the best of my knowledge. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting or making false, fictitious, or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from uniformed services legal offices, public libraries, and many Beneficiary Counseling and Assistance Coordinators.

Your signature	Your relationship to the sponsor	Date
______________________	______________________	______________________

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