



TRICARE Other Health Insurance (OHI) Form

REQUIRED FORM - TO BE COMPLETED BY THE OHI POLICY HOLDER



Instructions & Explanations for Completing the TRICARE Other Health Insurance Form

The information on this page is provided to help you complete the other health insurance (OHI) form on the back of this page. Please be sure to refer to this information for clarification when completing the form. This form is to be completed by the OHI policy holder.

Federal regulations require that you notify TRICARE if you are also the beneficiary of any OHI plan. Please note that TRICARE will provide you with benefits even if you have OHI. If you or your family members are currently receiving benefits through another health insurance plan, or have received OHI benefits in the past five years, you need to complete the form on the back of this page and return it to

TriWest Healthcare Alliance • P.O. Box 42048 • Phoenix, AZ 85080

If you decide to cancel your OHI, cancel with your carrier, complete an OHI form and mail it to TriWest. Please note: Medicaid is not OHI and does not need to be reported.

Important Definitions and Information

Sponsor

The uniformed service member—either active duty, retired or deceased—whose relationship to you (spouse, parent, etc.) makes you eligible for TRICARE.

Beneficiary

Family members of active duty military personnel and military retirees and their families who are eligible for TRICARE benefits.

Health Maintenance Organization (HMO)

An HMO is a “prepaid” plan (such as TRICARE Prime) that uses a highly qualified, select network of health care providers. An HMO usually offers a full range of services, and often emphasizes preventive care.

Preferred Provider Organization (PPO)

A PPO (such as TRICARE Extra) is a network of health care providers who agree to provide patient care at a discounted or fixed cost to a health plan or beneficiaries in order to be a part of the network of providers. Generally, beneficiaries can choose from any of the providers in the network.

Basic Insurance

Insurance that usually carries a deductible and pays benefits according to a percentage plan. This could be any plan that is not a PPO or HMO.

Medicare

The national health program through which certain medical and hospital expenses are paid for from Federal (mainly Social Security) funds. The program is open to individuals over the age of 65 and individuals with permanent disabilities. If you are eligible for Part A, you **must** purchase Part B to retain TRICARE eligibility unless your sponsor is active duty.

Medicare Supplement

Medicare supplemental insurance, also called a Medigap policy, is a health insurance policy sold by private insurance companies to help you pay the medical costs the Original Medicare Plan does not cover. Medigap policies may be offered by organizations like USAA, TROA and AARP. Through supplemental insurance, you may be able to get extra benefits like prescription drugs or additional days in the hospital.

Privacy Act Statement

Authority: 10 U.S.C. Section 1086(d); 10 U.S.C. Section 1095; and E.O. 9397.

Purpose: Information provided is used to update your entitlement in the TRICARE program and to check or correct our records with respect to your Medicare and other health insurance coverage.

Routine Use(s): To the Social Security Administration to verify an applicant's eligibility; to the Department of Health and Human Services consistent with their statutory responsibilities for monitoring Government health care programs; and, to health insurance providers for coordination of coverage benefits.

Disclosure: Voluntary; however, failure to provide requested information may cause delay in payment of your medical claims.

Agency Disclosure Notice

The public reporting burden for this collection of information is estimated to average five minutes per response, 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 DoD, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0025), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA, 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

If you have questions about this form or need an additional form, please call TriWest at 1-888-TRIWEST (874-9378).



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Section I: Personal Information

Beneficiary's Social Security number:		Beneficiary's date of birth:	
Beneficiary's last name:		Beneficiary's first name & middle initial:	
Sponsor's Social Security number:		Sponsor's date of birth:	
Sponsor's last name:		Sponsor's first name & middle initial:	
Sponsor's mailing address:		City	State ZIP
Sponsor's home telephone number:	Sponsor's work telephone number:	Sponsor's e-mail address:	

Section II: OHI Information

Does anyone in your family have OHI? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, what is the coverage type (See cover page for details)? <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Basic Insurance <input type="checkbox"/> Medicare <input type="checkbox"/> Medicare Supplement		
Does this OHI include pharmacy benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO	Does this OHI include any mental health benefits? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this OHI through sponsor's employer or spouse's employer? <input type="checkbox"/> Sponsor's employer <input type="checkbox"/> Spouse's employer	
OHI policy holder's name:		Relationship to sponsor:	
Names of anyone else covered under this policy:			
1.		2.	
3.		4.	
If OHI is through an employer, please provide:	Name of insurance company:		
Insurance company address:	City	State	ZIP
Employer name:			
Employer address:	City	State	ZIP
Policy number:	Group number:	Effective date:	Termination date:

Section III: Medicare Information

Complete the following if you have Medicare coverage:	Medicare health insurance number:	Effective date-Hospital (Part A):	Effective date-Medical (Part B):
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Section IV: Authorization

The statements made above are true and correct to the best of my knowledge. I understand Federal Law 18 U.S.C. 1001 provides 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 law cited may be obtained from the Uniformed Services legal offices, public libraries and any beneficiary counseling and assistance coordinator.

Your signature:	
Relationship to sponsor:	Today's date:

Please complete this form and mail it to TriWest at
TriWest Healthcare Alliance • P.O. Box 42048 • Phoenix, AZ 85080