Other Health Insurance (OHI) Questionnaire

TRICARE West Region

Use this form to report other health insurance (OHI) that might be available to you or your family members.

How To Report OHI

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 NO, have you experienced a denial of prior authorization or claims due to other health insurance (OHI)? ○ YES ○ NO

Reporting Your Other Health Insurance

If YES, you can report and update your other health insurance (OHI) to minimize delays in processing claims through one of the following methods:

- **Mail:** Fill out, print, and mail or fax Page 2 (and Page 3, if applicable) to:

  TRICARE West Region
  P.O. Box 202168
  Florence, SC 29502

- **Fax:** 877-989-0060
- **COMING SOON:** Online: Go to https://tricare.mil/west and log in to the self-service portal. Select Claims and then Other Health Insurance.
- **COMING SOON:** Mobile app: Use the TRICARE West Region mobile app to update OHI information.

Need help with this form? Call Customer Service at 888-874-9378 Monday-Friday from 8 a.m. to 6 p.m. in your time zone, excluding federal holidays. You can find more information about OHI at https://tricare.mil/ohi.

Privacy Act Statement

This statement serves to inform you of the purpose for collecting your personal information through a *TRICARE Other Health Insurance Questionnaire (OHI)* 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 https://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.

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All fields are required unless otherwise noted.

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Type of Coverage:
- ○ HMO/PPO
- ○ Supplemental
- ○ Employer-sponsored
- ○ Medicaid
- ○ Individual
- ○ Other
- ○ Medicare
- ○ Never had OHI

Policyholder Information

Last Name: _____ First Name: _____

Social Security Number (SSN) (XXX-XX-XXXX) or

Department of Defense Benefits Number (DBN) (XXXXXXXXX - XX): _____

Name of Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____ Policy/Group/Plan Number: _____

Effective Date (MM/DD/YYYY): _____ Expiration Date (MM/DD/YYYY): _____

(leave blank if policy is active)

This policy provides the following benefits (check all that apply):

- ☐ Dental
- ☐ Medical
- ☐ Vision
- ☐ Durable Medical Equipment
- ☐ Mental Health
- ☐ Pharmacy
- ☐ Long-term Health Care
- ☐ Skilled Nursing Facility Care

Please list who is covered by this policy (Only required if others besides policyholder are covered.):

Last Name: _____ First Name: _____

Sex: _____ Relationship to Policyholder: _____

Date of Birth (MM/DD/YYYY): _____ SSN (XXX-XX-XXXX) or DBN (XXXXXXXXX - XX): _____

Begin Coverage: _____ End Coverage: _____

(If additional people are covered, please list on Page 3.)

The statements made above (and on the attached, if applicable) 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.

_____ _____ _____

Signature Relationship to Sponsor Date (MM/DD/YYYY)

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Additional People Covered With Policy

Last Name: First Name:
Sex: Relationship to Policyholder:
Date of Birth (MM/DD/YYYY): SSN (XXX-XX-XXXX) or DBN (XXXXXXXXX - XX):
Begin Coverage: End Coverage:

Last Name: First Name:
Sex: Relationship to Policyholder:
Date of Birth (MM/DD/YYYY): SSN (XXX-XX-XXXX) or DBN (XXXXXXXXX - XX):
Begin Coverage: End Coverage:

Last Name: First Name:
Sex: Relationship to Policyholder:
Date of Birth (MM/DD/YYYY): SSN (XXX-XX-XXXX) or DBN (XXXXXXXXX - XX):
Begin Coverage: End Coverage:

Last Name: First Name:
Sex: Relationship to Policyholder:
Date of Birth (MM/DD/YYYY): SSN (XXX-XX-XXXX) or DBN (XXXXXXXXX - XX):
Begin Coverage: End Coverage:

Last Name: First Name:
Sex: Relationship to Policyholder:
Date of Birth (MM/DD/YYYY): SSN (XXX-XX-XXXX) or DBN (XXXXXXXXX - XX):
Begin Coverage: End Coverage: