U.S. law requires that all Other Health Insurance, including Medicare, process health insurance claims before TRICARE®, with the exception of Medicaid. In order for TRICARE to process your claim we must have evidence that your other insurance has processed the claim. To ensure we have up to date and accurate information regarding your Other Health Insurance please complete the attached form and mail to the address at the bottom of the form or go to www.TRICARE4u.com to update the information on-line.

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by this system of records and how it will be used.

AUTHORITY:	10 U.S.C. Chapter 55 – Medical and Dental Care; 32 CFR 199.17 – TRICARE Program; and E.O. 9397 (SSN), as amended.
PURPOSE:	To collect information from Military Health System beneficiaries in order to determine their eligibility for coverage under the TRICARE Program; to issue payment upon establishment of eligibility; to determine that the service/supplies received are authorized by law; and to check or correct records with respect to your Medicare and/or Other Health Insurance (OHI) coverage.
ROUTINE USES:	Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA 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 healthcare operations. Use and disclosure of your records outside of DoD may also occur in accordance with the DoD Blanket Route 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)).
DISCLOSURE:	Disclosure is voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

Instructions

1: Fill in either the Sponsor number OR the DoD Benefits Number. The DoD Benefits number can be found on the back of the newer Military IDs.

2: Primary Other Health Insurance

Name of Carrier: The name of the insurance company. Examples: Medicare, Aetna, Blue Cross/Blue Shield, etc.
Do NOT include TRICARE.

Carrier Address and Phone #: The address and phone number of your insurance company. This is usually given somewhere on your insurance card. For Medicare, this is only needed if you have a Medicare Advantage/Replacement/Cost plan.

Check either the YES or NO box for the following:

- Is your policy a Medicare Advantage/Replacement/Cost plan? Medicare Advantage/Replacement plans are plans that Medicare has approved to administer the same traditional Medicare benefits but members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare such as prescription drugs, dental care, vision care, etc.
- Does this coverage include pharmacy benefits? Does this plan cover prescription medications?
- Does this coverage have exclusions or limitations? Does your policy limit the types of services provided? Some examples would be cancer coverage only, or no heart disease coverage, etc. If you check the YES box, indicate what services are excluded or limited.

Name of Covered Member: Enter the first and last name of the person(s) covered by this plan.

Date of Birth: Enter the date of birth of the person(s) covered by this plan.

Policy Number: Enter the policy number of the plan. This can usually be found on your insurance card.

Effective Date: Enter the date the policy became effective for this person. For Medicare this is usually the first of the month of your birthday month.

Expiration Date: If you no longer have this coverage enter the date the policy expired. If the coverage is still in effect, write "current".

3: Additional Other Health Insurance

If you have more than one Other Health Insurance Policy, enter the information in this section. You would follow the same instructions as given in 2. If you have more than two Other Health Insurances, include an additional sheet with the additional insurance information and attach to this form. Provide the same information as given in 2.
Do NOT include TRICARE.

4: Read the consent information and if you agree fill in the following information.

Your Signature: Sign your name.

Relationship to Sponsor: Fill in your relationship to the sponsor. The sponsor is the person who served in the Military.

Date: Fill in the date you signed the form.

1 – Complete and sign the questionnaire below. An incomplete questionnaire may result in delay of payment.

Sponsor Number _____ **OR 11 – Digit Benefits Number** _____

2 – Primary Other Health Insurance

Name of Carrier _____

Carrier Address and Phone # _____

_____

Is your policy a Medicare Advantage/Replacement/Cost Plan? ☐ Yes ☐ No

Does this coverage include pharmacy benefits? ☐ Yes ☐ No

Does this coverage have exclusions or limitations? ☐ Yes ☐ No

If yes, please indicate which one(s): _____

Name of Covered Member	Date of Birth	Policy Number	Effective Date	Expiration Date

3 – Additional Other Health Insurance

Name of Carrier _____

Carrier Address and Phone # _____

_____

Is your policy a Medicare Advantage/Replacement/Cost Plan? ☐ Yes ☐ No

Does this coverage include pharmacy benefits? ☐ Yes ☐ No

Does this coverage have exclusions or limitations? ☐ Yes ☐ No

If yes, please indicate which one(s): _____

Name of Covered Member	Date of Birth	Policy Number	Effective Date	Expiration Date

4 - Signature

The statements made above are true and correct to the best of my knowledge. I understand that federal laws (18 U.S.C. 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 Relationship to Sponsor Date