TRICARE Other Health Insurance Questionnaire

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by Humana Military Automated Information System and how your personal information will be used.

Authority:	*10 U.S.C. Chapter 55, Medical and Dental Care; 10 U.S.C. 1079 Contracts for Medical Care for Spouses and Children: Plans and 1086 Contracts for Health Benefits for Certain Members, Former Members, and Their Dependents; 38 U.S.C. Chapter 17 Hospital, Nursing Home, Domiciliary, and Medical Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS);* and *E.O. 9397 (SSN)*, as amended.
Purpose:	To obtain information from individuals to validate their eligibility as beneficiaries, grant access to the Humana Military website, and provide beneficiary services available through Humana Military to validated individuals, including physician referrals, healthcare authorizations, claims payment, assignment of beneficiaries to physicians, and informal contact with validated beneficiaries.
Routine Uses:	Information collected may be used and disclosed generally as permitted under *45 CFR Parts 160 and 164*, Health Insurance Portability and Accountability Act (HIPPA) Privacy and Security Rules, as implemented by *DoD 6025.18-R, the DoD Health Information Privacy Regulation*. Information may also be used and disclosed in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: ***dpcld.defense.gov/Privacy/SORNsIndex/Blanket-Routine-Uses***. Information collected from you may also be shared with the Departments of Health and Human Services and Homeland Security, and other Federal, State, local and foreign government agencies, private business entities under contract with the Department of Defense and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil or criminal litigation.
Disclosure:	Voluntary; however, failure to furnish all requested information will result in an individual not being able to access beneficiary services available through Humana Military.

Reporting Your OHI

You can report and update your OHI to minimize any delay in processing claims through the following methods:

Phone:	800-444-5445
In Person:	Visit your uniformed services identification card-issuing facility
Email:	TRICAREOHIUpdate@humanamilitary.com
Mail:	PGBA – Other Health Insurance P.O. Box 202151 Florence, SC 29502
Fax:	877-489-0038

Visit www.tricare.mil/OHI for more information.

If you have received this correspondence in error, please notify 800-444-5445, 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 coverage? **Yes** ☐ **No** ☐
Have you had OHI within the last 12 months? (TRICARE supplements are not OHI) **Yes** ☐ **No** ☐

If **Yes**, complete the questionnaire for the new insurance policy and fax/mail to the address provided on page one.

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

Is this a change in OHI Coverage? Yes ☐ **No** ☐ If Yes, what is the 'previous' OHI: _____

Effective Date:_____ Expiration Date:_____

TRICARE Sponsor Name: _____ TRICARE Sponsor SSN: _____

OHI Coverage type: Check all that apply:

☐ HMO/PPO ☐ Medicare ☐ Medicaid/MediCal ☐Student Health Plan ☐ Dental ☐ Vision

Policyholder Name: _____ SSN/DBN #: : _____ DOB: _____

Name of Carrier: _____ Policy #: _____ Group #: _____

Effective Date: _____ Expiration Date: _____ Carrier Phone:_____

Carrier Address: _____

Is TRICARE member covered under this policy: Yes ☐No ☐

List any other individual who is covered by this OHI policy (if additional people are covered, please attach a separate list):

Name: _____ DOB (dd/mm/yyyy): _____ Gender:_____
Relationship to Policyholder: _____ Effective Date: _____ Expiration Date: _____

Name: _____ DOB (dd/mm/yyyy): _____ Gender:_____
Relationship to Policyholder: _____ Effective Date: _____ Expiration Date: _____

Name: _____ DOB (dd/mm/yyyy): _____ Gender:_____
Relationship to Policyholder: _____ Effective Date: _____ Expiration Date: _____

Review OHI at Beneficiary Self-Service: https://infocenter.humana-military.com/beneficiary/service/Account/Login

FAQ can be found here: https://tricare.mil/About/Regions/East-Region/Claims/OHI

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.

Signature: _____ Name (Printed): _____

Date Signed: _____ Relationship to TRICARE Sponsor: _____

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