TRICARE Other Health Insurance (OHI) 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 informational 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 (HIPAA) 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@humana.com

Mail: TRICARE East Region
P.O. Box 8923
Madison, WI 53708-8923

Fax: (608) 221-7536

Visit **HumanaMilitary.com** and ***TRICARE.mil/OHI*** for more information on OHI.

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 (OHI) 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**, complete the questionnaire for each 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. **Coverage type:**

☐ HMO/PPO ☐ Medicare ☐ Single ☐ Group ☐ Supplemental ☐ Private ☐ Medicaid/MediCal ☐ Student health plan

☐ Other: _____ Policy #: _____

Policyholder name: _____

Group/Plan #: _____ SSN/DBN #: _____

Sponsor ID #: _____ Name of carrier: _____

Carrier address: _____

Carrier phone #: _____ Effective date: _____ Expiration date: _____

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

☐ Pharmacy ☐ Dental ☐ Vision ☐ Behavioral health ☐ Durable Medical Equipment (DME)

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

Name of covered member: _____

Relationship to policyholder: _____ Gender: _____

DOB (dd/mm/yyyy): _____ SSN/DBN: _____ Effective date: _____

Name of covered member: _____

Relationship to policyholder: _____ Gender: _____

DOB (dd/mm/yyyy): _____ SSN/DBN: _____ Effective date: _____

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: _____ Sponsor SSN: _____

Name (printed): _____ DOB: _____ Date: _____

Relationship to sponsor: _____

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