

# TRICARE OTHER HEALTH INSURANCE (OHI) COVERAGE QUESTIONNAIRE

Providers: Please provide this form to eligible beneficiaries

## 1 - General Information

**TRICARE Sponsor Name:** \_\_\_\_\_ **TRICARE Sponsor SSN:** \_\_\_\_\_

Do you or any of your family members currently have Other Health Insurance (OHI) coverage?  Yes  No

Have you or any of your family members had Other Health Insurance (OHI) coverage in the past 12 months?  Yes  No

**If you answered yes to question 1 or 2 above, please complete the remainder of the form (duplicate form for multiple policies). Regardless of your answers above, please read and sign the form at the bottom and submit the form to the address or fax number below.**

## 2 - Current OHI Status - Complete only if you or any of your family members currently have OHI.

Policy Holder Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group/Plan Number: \_\_\_\_\_

Name of Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Carrier Address and Phone No.: \_\_\_\_\_

Please indicate the type of coverage:  HMO/PPO  Medicare  Single  Group  Supplemental  Private  Medicaid/MediCal  Other: \_\_\_\_\_

Does this coverage include pharmacy benefits?  Yes  No Does this coverage provide any other benefit riders?  Yes  No

If Yes, please indicate which one(s): \_\_\_\_\_

Name of Covered Member:	Member ID:	Date of Birth:	Sex:	Effective Date (If different)	Expiration Date (If different)

## 3 - Prior OHI Status - Complete only if you or any of your family members have had OHI within the last 12 months.

Policy Holder Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group/Plan Number: \_\_\_\_\_

Name of Carrier: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Carrier Address and Phone No.: \_\_\_\_\_

Please indicate the type of coverage:  HMO/PPO  Medicare  Single  Group  Supplemental  Private  Medicaid/MediCal  Other: \_\_\_\_\_

Does this coverage include pharmacy benefits?  Yes  No Does this coverage provide any other benefit riders?  Yes  No

If Yes, please indicate which one(s): \_\_\_\_\_

Name of Covered Member:	Member ID:	Date of Birth:	Sex:	Effective Date (If different)	Expiration Date (If different)

The statements made above are true and correct to the best of my knowledge. I understand that federal laws [8 U.S.C. and 100] 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 TRICARE Sponsor

\_\_\_\_\_  
Date

**Please Note: Incomplete forms may result in a claims payment delay.**

**Mail Form to:**  
Humana Military Healthcare Services  
P.O. Box 740061, Louisville, KY 40201-7461

**Fax Form to:**  
(866) 836-9535