



TRICARE® Other Health Insurance Questionnaire

UnitedHealthcare Military & Veterans offers TRICARE West Region beneficiaries access to a secure account to manage their health care online at any time. Visit www.uhcmilitarywest.com to set up your account. Already registered? Log in and update your information online. For more information regarding other health insurance, please check out our FAQs at www.uhcmilitarywest.com.

Sponsor's Name: _____

Sponsor's SSN or DBN: _____ Sponsor's Date of Birth: _____

Sponsor's Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Sponsor's Home Phone: _____ Sponsor's Work Phone: _____

Have you or any of your family members been covered by health insurance other than TRICARE within the past three years? Yes No

If you answered yes above, complete the remainder of this questionnaire. Regardless of your answer above, please read, sign on page 2, and return the questionnaire to the address indicated on page 3 of this questionnaire.

TRICARE pays after commercially purchased health care plans and Medicare, but is the primary payer over State Medical Assistance plans (*Medicaid*) and policies specifically sold as TRICARE supplemental plans. You or your provider should submit health care claims to any primary payers **before** submitting claims to TRICARE with proof of what the primary insurance paid and your remaining liability.

Reference:

OHI INFORMATION					
Covered Beneficiary 1: EXAMPLE	First Name	Last Name	Year of Birth	SSN or DBN	
	<i>Jane</i>	<i>Doe</i>	<i>1964</i>	<i>001122334-01</i>	
Health Insurance Carrier Name	Phone	Policy Number	Coverage Type*	Original Start Date of Policy	Expiration Date (if applicable)
<i>1. Blue Cross</i>	<i>1-800-555-1234</i>	<i>Xhj123456789a</i>	<i>1</i>	<i>1/1/2009</i>	<i>N/A</i>
<i>2. M.O.A.A.</i>	<i>1-800-555-1234</i>	<i>123456789A</i>	<i>2</i>	<i>1/1/2005</i>	<i>N/A</i>

* Use the following coverage types when completing the questionnaire:

1 = Employer-Sponsored Health Plan	2 = TRICARE Supplement	3 = Private—Not Through Employment	4 = Medicaid/State Medical Assistance Plan	5 = Student Plan
6 = Medicare Supplement	R = Pharmacy	C = Medicare	H = Medicare HMO or Medicare Advantage Plan	

OHI INFORMATION

Covered Beneficiary 1:	First Name	Last Name	Year of Birth	SSN or DBN	
Health Insurance Carrier Name	Phone	Policy Number	Coverage Type*	Original Start Date of Policy	Expiration Date (if applicable)
1.					
2.					
Covered Beneficiary 2:	First Name	Last Name	Year of Birth	SSN or DBN	
Health Insurance Carrier Name	Phone	Policy Number	Coverage Type*	Original Start Date of Policy	Expiration Date (if applicable)
1.					
2.					
Covered Beneficiary 3:	First Name	Last Name	Year of Birth	SSN or DBN	
Health Insurance Carrier Name	Phone	Policy Number	Coverage Type*	Original Start Date of Policy	Expiration Date (if applicable)
1.					
2.					
Covered Beneficiary 4:	First Name	Last Name	Year of Birth	SSN or DBN	
Health Insurance Carrier Name	Phone	Policy Number	Coverage Type*	Original Start Date of Policy	Expiration Date (if applicable)
1.					
2.					

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If you have more covered beneficiaries, please use an additional sheet of paper.

Are any of these policies limited to a specific coverage such as cancer, nursing home, dental, vision, pharmacy, etc.?

Yes No

If yes, please list the insurance name and specific coverage: _____

Do any of these policies have exclusion(s)? Yes No

If yes, please list the name of the insurance and the exclusion(s): _____

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.

Name: _____ **Relationship to Sponsor:** _____
(please print)

Signature: _____ **Sponsor SSN or DBN:** _____ **Date:** _____

Please review Important Definitions and Information on page 3.

Important Definitions and Information

Sponsor

The uniformed service member—either active duty, retired, or deceased—whose relationship to you (*spouse, parent, etc., as reflected in DEERS*) makes you eligible for TRICARE.

Beneficiary

Active duty military personnel, military retirees, survivors, and family members who are eligible for TRICARE benefits.

Employer-Sponsored Health Plan

A policy purchased by an employer that is offered to eligible employees of the company as a benefit of working for that company.

TRICARE Supplement

Coverage plans specifically designed to cover any copayment, cost-shares, or deductibles that are not covered by TRICARE. Unlike other health insurance plans, TRICARE supplemental plans are frequently available from military associations and other private organizations and firms.

Private—Not Through Employment

Health insurance plans purchased by individuals directly from an insurer. Coverage of specific types of medical services can vary. Plan types may be hospital indemnity policies, which pay a fixed daily, weekly, or monthly benefit.

Medicaid

A public health care program, administered by states, for certain people and families with low income and resources.

Student Plan

A school-sponsored individual policy covering students meeting eligibility requirements.

Medicare Supplement

Medicare supplement insurance, also called a Medigap policy, is a health insurance policy sold by private insurance companies to cover expenses not covered by the Original Medicare Plans (*Medicare Part A and Part B*).

Pharmacy

A policy plan that covers the costs of prescription drugs purchased from a pharmacy.

Medicare

The national health program that pays certain medical and hospital expenses. The program is open to individuals over age 65 and individuals with permanent disabilities. Learn more about Medicare at www.medicare.gov. If you are eligible for Medicare Part A, you must purchase Part B to retain TRICARE eligibility unless your sponsor is active duty. When you are eligible for TRICARE and have Medicare Part A and Part B, you are using TRICARE for Life (www.TRICARE4u.com).

Medicare HMO/Medicare Advantage Plan

A Medicare health plan choice you may have as part of Medicare. Medicare Advantage Plans, sometimes called Part C or MA Plans, are offered by private companies approved by Medicare.

Department of Defense Benefits Number (DBN)

An 11-digit number used to determine benefits eligibility. The first nine digits are common to the sponsor but is not their Social Security Number; the last two digits identify the specific person, much like with a commercial benefit plan.

You can also update your other health insurance information online through your secure www.uhcmilitarywest.com account. If you have any questions about this questionnaire, please call UnitedHealthcare Military & Veterans at 1-877-988-WEST (1-877-988-9378).

Return **completed** Questionnaire to:

**TRICARE West Region
Claims Department
P.O. Box 7064
Camden, SC 29021-7064**