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TRICARE OTHER HEALTH INSURANCE (OHI) COVERAGE QUESTIONNAIRE

1. General Information

TRICARE Sponsor Name: \_\_\_\_\_

TRICARE Sponsor SSN: \_\_\_\_\_

Do you or any of your family members have OHI coverage? YES\_\_\_ NO\_\_\_

Have you or any of your family members had OHI 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 below.

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

Policy Holder Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Name of Carrier: \_\_\_\_\_

Carrier's Address and Phone No: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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

Medicaid/MediCal\_\_\_ Other: \_\_\_\_\_

Does this coverage have pharmacy benefits? \_\_\_ Yes \_\_\_ No

Does this coverage have any other benefit riders? \_\_\_ Yes \_\_\_ No

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

Name of Covered Member:	Member ID:	Date of Birth:	Sex:	Effective:	Expiration: (if different)
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____
_____	_____	___/___/___	_____	_____	_____



## Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the PGBA, LLC (PGBA) and how it will be used.

<b>AUTHORITY:</b>	10 U.S.C. Chapter 55, Medical and Dental Care; 38 U.S.C. Chapter 17, Hospital, Nursing Home, Domiciliary, and Medical Care; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; 32 CFR 199.17, TRICARE Program; and E.O. 9397 (SSN), as amended.
<b>PURPOSE:</b>	To provide eligibility, enrollment, deductibles, catastrophic caps, claims processing, and customer service to individuals eligible for TRICARE benefits.
<b>ROUTINE USES:</b>	In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the Department of Defense as a routine use pursuant to 5 U.S.C. 552a(b)(3) as follows: to the Department of Veterans Affairs, the Department of Health and Human Services, the Department of Homeland Security, and to other federal, state, local, or foreign government agencies, and to private business entities, including 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.
<b>DISCLOSURE:</b>	Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays.