



TRICARE Other Health Insurance Questionnaire

Do you or any member of your family have Other Health Insurance coverage or have you had Other Health Insurance in the last 12 months? (TRICARE supplements are not OHI) YES NO

If YES, please complete the following for each insurance policy. THIS FORM MAY BE COPIED

Type of coverage: HMO/PPO Single Group Individual Medicare Supplemental Medicaid Other

Policy Holder's Name: SS #:

Name of Insurance Company:

Insurance Company's Address / Phone Number:

Policy / Group / Plan Number:

Effective Date: Expiration Date:

Does this Policy provide Pharmacy, Dental, Mental Health or Durable Medical Equipment (DME) benefits? (circle all that apply)

Please list who is covered by this policy

Table with 5 columns: Name, Sex, Relationship to Policy Holder, Date Of Birth, SS#. Includes four rows for listing covered individuals.

(If additional people are covered please attach a separate listing. This form may be copied.)

PRIVACY ACT section containing legal text regarding information use and disclosure for TRICARE beneficiaries.

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 knowingly or making any false, fictitious or fraudulent statement or claim in any matter within the 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 Health Benefit Advisors.

Signature Sponsor's SSN Relationship to Sponsor Date

Please mail this form to our claims processing subcontractor at the address below.

TRICARE North - OHI Questionnaires
P.O. Box 870159
Surfside Beach, SC 29587-9759