

TRICARE Other Health Insurance (OHI) Form

Section I: Personal Information

BENEFICIARY* DoD ID: _____ Date of Birth: _____ (MM/DD/YYYY)
Last Name: _____ First Name and Middle Initial: _____
SPONSOR* DoD ID: _____ Date of Birth: _____ (MM/DD/YYYY)
Last Name: _____ First Name and Middle Initial: _____
Mailing Address: _____ City: _____ State: _____ ZIP: _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Sponsor's E-mail Address: _____

Section II: OHI Information

Does anyone in your family have OHI? Yes No Does this OHI include pharmacy benefits? Yes No
Is this OHI through: Sponsor's Employer Spouse's Employer Other
OHI Policyholder's Full Name: _____ Relationship to Sponsor: _____
Name of Insurance Company: _____
Insurance Company Address: _____ City: _____ State: _____ ZIP: _____
Phone Number: (_____) _____
Names of anyone else covered under this policy: 1: _____ 2: _____
3: _____ 4: _____

Prescription ID Card Information:

ID Number: _____ RxBIN: _____ RxPCN: _____
Rx Group Number: _____ Issuer: _____ Claim Type (PPO, HMO, Rx only): _____
Effective Date: _____ (MM/DD/YYYY)

Do you have more than the one OHI provided above? Yes ___ No ___ If yes, please provide the information in Section II for any other additional OHI on a separate piece of paper and include it when you return this form.

Section III: Authorization

The statements made above are true and correct to the best of my knowledge. I understand Federal Law 18 U.S.C. 1001 provides for criminal penalty 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 law cited may be obtained from the Uniformed Services legal offices, public libraries and any beneficiary counseling and assistance coordinator. Please return to Express Scripts, PO Box 60903 Phoenix, AZ 85082-0903.

Your Signature: _____ Your Relationship to Sponsor: _____
Today's Date: _____

*Important Definitions:

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

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.