TRICARE®

EXPRESS SCRIPTS®
Federal Pharmacy Services

Express Scripts
P.O. Box 60903
Phoenix, AZ 85082-0903

Urgent: TRICARE® needs information about your other health insurance (OHI)

Dear TRICARE® Beneficiary:

Recently, Express Scripts learned that you have other health insurance (OHI). Under your TRICARE plan, you're required to provide full disclosure of OHI; doing so helps to protect the benefit for everyone. Be advised that it's a violation of federal law to fill a prescription only through TRICARE when OHI is in place for you.

To avoid delays and complications in processing your benefits, please complete the form on the other side of this letter and return it to:

Express Scripts
P.O. Box 60903
Phoenix, AZ 85082-0903

You may need to contact your insurance company directly to obtain this information.

IMPORTANT: You'll need to send us a Confirmation of Termination or an Explanation of Benefits (EOB) from the primary health insurance company if any of the following conditions apply:

- You no longer have other prescription insurance coverage
- Your primary insurance did not cover this medication
- Your primary insurance benefits have been exhausted

You may contact the Customer Contact Center at **877.363.1303** with any questions.

Express Scripts is proud to serve you and your fellow beneficiaries, and we look forward to serving your future prescription benefit needs.

Sincerely,
Express Scripts

Privacy Act Statement from the Department of Defense

Authority: 5 U.S.C. 301 (Departmental Regulations); 10 U.S.C. §§1095b-1095c, and §1097 (Medical and Dental Care); 45 C.F.R. Part 160 and Subparts A and E of Part 164 (Health Insurance Portability and Accountability Act); DTMA 04 (Medical/Dental Claim History Files); and, E.O. 9397, as amended (SSN). **Purpose:** Information is being collected to provide pharmacy services to all TRICARE beneficiaries **Routine Uses:** In addition to those disclosures generally permitted under 5 U.S.C. 552a of the Privacy Act, this information may specifically be used to verify beneficiary eligibility, to provide contracted pharmacy benefits services, to authenticate and identify DoD affiliated personnel, and to register new DoD civilian and military personnel and their authorized dependents for the purpose of obtaining medical benefits or other benefits for which they are qualified.

Disclosure: Submission of this information is voluntary. However, failure to provide the requested information may result in delayed processing of pharmacy services.

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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.