



# NAVAL HOSPITAL BREMERTON

## THIRD PARTY COLLECTION PROGRAM

### OTHER HEALTH INSURANCE FORM

Patient Name: \_\_\_\_\_

Visit Related to Accident:  Yes Information: \_\_\_\_\_

Check:  TriCare  Medicare  TriCare For Life  Medicaid

Do you have Other Health Insurance?  YES  NO (Please sign below.)

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_)\_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group Name/#: \_\_\_\_\_

Pharmacy Insurance: \_\_\_\_\_  Self-Only  Family

Phone Number: (\_\_\_\_)\_\_\_\_\_

Policy #: \_\_\_\_\_ Group Name/#: \_\_\_\_\_

**QUESTIONS, PLEASE CALL 475-4459 \* COMPLETE FORM ANNUALLY**

#### PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sec. 1095; EO 9397.

PRINCIPAL PURPOSE: Information will be used to collect from private insurers for medical care provided to the Military Treatment Facility (MTF) patient. Such monetary benefits accruing to the MTF will be used to enhance health care delivery in the MTF.

ROUTINE USE(S): The information on this form will be released to your insurance company.

#### CERTIFICATION

I certify that the above information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by 18 USC 1001, which provides for a maximum of \$10,000 or imprisonment for five years, or both.

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\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

NHBREM 12800/5 (REV 8/08)  
NAVHOSPBREMINST 7000.1C CH-1