

Department of Veterans Affairs

VA Health Administration Center

9-15-2012

3773 Cherry Creek North drive, STE 450

Denver, Colorado 80209-3812

William Bechtel 303-398-5135 william.becht@va.gov

White
Paper

Proposed
Correction

CHAMPVA
Claim Form -
VA Form
10-7959a
Collection
2900-0219

The image shows a scan of the CHAMPVA Claim Form (VA Form 10-7959a). The form is titled "CHAMPVA Claim Form" and includes the Department of Veterans Affairs logo. It contains several sections: "Section I - Patient Information", "Section II - Sponsor Information", and "Section III - Claimant Certification". The form is filled out with various fields and checkboxes, including a "Check if new" box. The form number "10-7959a" is visible at the bottom right.

**Error found
in recent
OMB
approved**

REASON FOR CHANGE:

We have discovered a text error and wish to make a correction to this recently OMB approved form. The change is necessary because the form is asking for incorrect information that may confuse the beneficiary.

DESCRIPTION:

Within **Section III – Sponsor Information**, we have a box asking the Sponsor for **“CHAMPVA Member Number (this is a mandatory field)”**

This was changed on the last OMB collection review from a box asking for the Social Security Number (SSN). A similar change was made, at the same time, within **Section I – Patient**

**Stomp out
SSN**



Information. Because the VA has an initiative to reduce the use of SSN's it was decided to remove the two requests for SSN's and replace them with this statement: "[CHAMPVA Member Number \(this is a mandatory field\)](#)"

www.privacy.va.gov/ssn.asp

(live link to Web Page - Social Security Number (SSN) Reduction Effort)

The ERROR:

Asking for "[CHAMPVA Member Number](#)" information of the Patient is OK, but asking this information of the Sponsor is not. A sponsor is a Veteran, **not** a beneficiary or a member.

THE FIX:

We concluded that since the claim form is sent in by a CHAMPVA beneficiary and the Sponsor's information (SSN) is already in our data base, there is no reason to ask for this information (SSN) again. It is prudent to decrease the use of Veteran's SSNs for privacy protection (Stomp Out Initiative).

**The FIX -
action:**

We fixed the form by eliminating the text and box asking for the Sponsor SSN (On the current form – eliminating the incorrect box asking for "[CHAMPVA Member Number](#)"). This should not affect the burden hours of this form as it is a minimal change.

We did leave the boxes requesting the Sponsor's name because it was determined this may be useful information in discerning the correct beneficiary if a claim was submitted by a similar named individual (e.g. John Johnson, Mary Ford, etc.).

Blow-up views showing the existing form and the proposed correction:

CURRENT FORM - showing error:

outside of work? <input type="checkbox"/> yes <input type="checkbox"/> no	OHI Policy Number		OHI Telephone Number (include area code)	
• Is patient covered by other primary health insurance to include coverage through a family member (supplemental or secondary insurance excluded)? <input type="checkbox"/> Yes (check type below and provide coverage information on the right) <input type="checkbox"/> employer sponsored (group) <input type="checkbox"/> private (non group) <input type="checkbox"/> Medicare (Part A or B) <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> no (proceed to Section III)	Name of Other Health Insurance (OHI)			
	OHI Policy Number		OHI Telephone Number (include area code)	
Section III - Sponsor Information				
Last Name		First Name		CHAMPVA Member Number (this is a mandatory field)
Section IV - Claimant Certification				
Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious, or fraudulent statements or claims.				
I certify that the above information and attachments are correct and represent actual services, dates, and fees charged. (Sign and date on right.) If certification is signed by a person other than the patient, complete the information the signature and date.		Signature (type if electronic)		Date
		Last Name		MI

CORRECTED FORM - Proposed:

outside of work? <input type="checkbox"/> yes <input type="checkbox"/> no	OHI Policy Number		OHI Telephone Number (include area code)	
• Is patient covered by other primary health insurance to include coverage through a family member (supplemental or secondary insurance excluded)? <input type="checkbox"/> Yes (check type below and provide coverage information on the right) <input type="checkbox"/> employer sponsored (group) <input type="checkbox"/> private (non group) <input type="checkbox"/> Medicare (Part A or B) <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> no (proceed to Section III)	Name of Other Health Insurance (OHI)			
	OHI Policy Number		OHI Telephone Number (include area code)	
Section III - Sponsor Information				
Last Name		First Name		MI
Section IV - Claimant Certification				
Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious, or fraudulent statements or claims.				
I certify that the above information and attachments are correct and represent actual services, dates, and fees charged. (Sign and date on right.) If certification is signed by a person other than the patient, complete the information the signature and date.		Signature (type if electronic)		Date
		Last Name		MI