OMB Number 2900-0823
Estimated burden: 10 minutes

Department of Veterans Affairs

Veterans Community Care Health Insurance Certification

VA Form 10-10143a is used by VA to obtain and update other health insurance information for the Veterans Community Care program.

For questions on completing this form, you may call XXXXXXX.

The term "Other Health Insurance" refers to insurance or benefits you may have other than VA.

VETERANS MUST COMPLETE ALL SECTIONS

Failure to complete all applicable sections will result in a denial of Veterans Community Care benefits.

Completing the form.

1. Read the Paperwork Reduction and Privacy Act Information.
2. Sign and Date the form.
3. Attach any continuation sheets, a copy of your health insurance member ID card (front and back), and a copy of your Medicare card to your form (do NOT send the original).

Submitting your information.
Mail the completed VA Form 10-10143a and any supporting materials to the XXX.

SECTION I: GENERAL INFORMATION

LAST NAME	FIRST NAME	MI

SOCIAL SECURITY NUMBER	GENDER Male ☐ Female ☐	PHONE # (INCLUDE AREA CODE)

ADDRESS (NUMBER, STREET, PO BOX, APT #)	CHECK IF NEW ADDRESS ☐

CITY	STATE	ZIP CODE

Do you have health insurance? YES ☐ NO ☐ IF NO, go to Section IV

SECTION II: MEDICARE INFORMATION

Part A: YES ☐ NO ☐	Part B: YES ☐ NO ☐	Part D: YES ☐ NO ☐
EFFECTIVE DATE (MMDDYYYY)	EFFECTIVE DATE (MMDDYYYY)	EFFECTIVE DATE (MMDDYYYY)
PART A CARRIER NAME	PART B CARRIER NAME	PART D CARRIER NAME

Does your Medicare provide prescription benefits? YES ☐ NO ☐

Did you choose a Medicare Advantage Plan for your Medicare coverage? YES ☐ NO ☐

Do you have health insurance other than Medicare? YES ☐ NO ☐ IF NO, go to Section IV

SECTION III: OTHER HEALTH INSURANCE INFORMATION *(Use a separate sheet for additional information)*

Name of insurance # 1

EFFECTIVE DATE (MMDDYYYY)	TERMINATION DATE (MMDDYYYY)	Only put in the termination date if the policy is inactive.

Is this insurance through employment? YES ☐ NO ☐ Does the insurance cover prescriptions? YES ☐ NO ☐

What type of insurance? ☐HMO ☐PPO ☐Medicaid/State Assistance ☐Prescription Discount

☐Medigap [if Medigap, specify ▼ (A-J)] ☐Other (specialty or limited coverage)

Comments

Veterans Community Care Health Insurance Certification *(Continued)*

SECTION III: OTHER HEALTH INSURANCE INFORMATION *Continued (Use a separate sheet for additional information)*

Name of insurance # 2

EFFECTIVE DATE (MMDDYYYY)	TERMINATION DATE (MMDDYYYY)	Enter the termination date if the policy is inactive.

Is this insurance through employment? YES ☐ NO ☐ | Does the insurance cover prescriptions? YES ☐ NO ☐

Does the insurance provide an explanation of benefits for prescriptions? YES ☐ NO ☐

What type of insurance? ☐HMO ☐PPO ☐Medicaid/State Assistance ☐Prescription Discount

☐Medigap [if Medigap, specify ▼ (A-J)] ☐Other (specialty or limited coverage)

Comments

SECTION IV: NON-DISCLOSURE OF INSURANCE INFORMATION

Did you decline to provide your other health insurance information? YES ☐ NO ☐

If you answered YES, by refusing to provide your other health insurance information to VA, you are not eligible to receive health care benefits under the Veterans Community Care program.

PAPERWORK REDUCTION AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 10 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Section 1703 in order for VA to determine your eligibility for the Veterans Community Care program. Information you supply may be verified from initial submission forward through a computer matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the Notice of Privacy Practices. Providing the requested information is required for eligibility for the Veterans Community Care program. If any or all of the requested information is not provided, it may delay or result in denial of your request for the Veterans Community Care program. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

SECTION V: CERTIFICATION BY VETERAN

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making false, fictitious or fraudulent statements of claims.

I declare under penalty of perjury that the foregoing is true and accurate to the best of my knowledge. I understand that any materially false, fictitious, or fraudulent statement or representation, made knowingly, is punishable by a fine and/or imprisonment pursuant to title 18, United States Code, Sections 287 and 1001.

If there is any change in my health insurance information, I agree to promptly notify XXXX of the new information within 60 days of when the change occurred.

SIGNATURE (type if electronic):	DATE: