OMB Control Number: 2900-0219
Estimated Burden: 10 minutes
Expiration Date: 10/31/2024

Department of Veterans Affairs

CHAMPVA Claim Form

Chief Business Office Purchased Care, CHAMPVA, PO Box 469064, Denver CO 80246-9064 | Customer Service Center: 1-800-733-8387

ATTENTION: Refer to the following information for instructions and assistance completing this form in its entirety (print or type only). Return the form and any additional, requested information to the address shown above.

Claim form usage: This form is to be completed by the patient, sponsor or guardian and is mandatory for all beneficiary claims. This claim form is **NOT** to be used for provider submitted claims.

Other Health Insurance (OHI): By law, other coverage must be reported. Except for CHAMPVA supplemental policies, CHAMPVA is always the secondary payer. If OHI exists, attach an Explanation of Benefits (EOB) from the other health insurance to the provider's itemized billing statement(s). Dates of service and provider charges on the EOB must match billing statements.

Timely filing requirement: Claims must be received no later than one year after the date of service or, in the case of inpatient care, within one year of the discharge date.

Itemized billing statements: An itemized statement must be attached and contain:
- patient name, date of birth, and CHAMPVA Identification Card Member Number (same as patient's Social Security number);
- provider name, degree, tax identification number (TIN), address and telephone number; and
- service dates, itemized charges and appropriate procedure/diagnosis codes for each service (i.e., CPT-4, HCPCS, and ICD-9-CM codes), including narrative descriptions.

Pharmacy claims must include name, quantity, strength, and National Drug Code (NDC) of each drug.

SECTION I – PATIENT INFORMATION

Last Name *(required field)*	First Name *(required field)*	MI	CHAMPVA Member Number *(required field)*

Street Address		Date of Birth *(mm/dd/yyyy)*
	☐ Check if new address	

City	State	ZIP Code	Phone Number *(include area code)*

SECTION II – OTHER HEALTH INSURANCE (OHI) INFORMATION

If more space is needed, please continue in the same format on a separate sheet.

Was treatment for a work-related injury/condition? ☐ Yes ☐ No | Was treatment for an injury or accident outside of work? ☐ Yes ☐ No

Is patient covered by OHI, to include coverage through a family member? *(Supplemental or secondary insurance excluded)*

☐ Yes (check type and provide coverage information below) ☐ No (proceed to Section III)

◯ employer sponsored (group) ◯ private (non group) ◯ Medicare (Part A or B) ◯ other: (specify) _____

Name of Other Health Insurance (OHI)	Name of Other Health Insurance (OHI)
Policy Number	Policy Number
Phone Number *(include area code)*	Phone Number *(include area code)*

SECTION III – SPONSOR INFORMATION

Last Name	First Name	MI

SECTION III – CLAIMANT CERTIFICATION

I certify that the information on this form and any attachments are correct and represent actual services, dates, and fees charged. 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. *(Sign and date below.)*

If certification is signed by a person other than the patient, complete the following:	Signature _____	Date

Last Name	First Name	MI	Relationship to Patient

Street Address	City	State	Zip Code	Phone Number *(with area code)*

NOTICE: Termination of marriage by divorce or annulment to the qualifying sponsor ends CHAMPVA eligibility as of midnight on the effective date of the dissolution of marriage. Changes in status should be reported immediately to CHAMPVA, ATTN: Eligibility Unit, PO Box 469028, Denver, CO 80246-9028 or call 1-800-733-8387.

Privacy Act Information: Information on this form is collected in accordance with the System of Records Notice 54VA10NB3, Veterans and Beneficiaries Purchased Care Community Health Care Claims, Correspondence, Eligibility, Inquiry and Payment Files-VA (Published March 3, 2015, FR 80, number 41). **Category:** Records maintained in the system include program applications, eligibility information concerning the Veteran, family members, caregivers, other health insurance information to include information regarding eligibility or entitlement to other federal medical programs. **Authority:** 38 USC 501 and 1781. **Purpose:** Records may be used for purposes of establishing and monitoring eligibility to receive VA benefits, processing claims for medical care and services, and processing stipends. **Routine Use:** The Privacy Act permits VA to disclose information about individuals without their consent under the Privacy Act Routine Use Disclosure when the information will be used for a purpose that is compatible with the purpose for which VA collected the information. **Disclosure**: Voluntary. You do not have to provide the requested information on this form but if any or all of the requested information is not provided, it may delay or result in denial of your request for CHAMPVA benefits. Failure to furnish the requested information will have no adverse impact on any other VA benefit to which you may be entitled.

VA Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-0219, and it expires 10/31/2024. Public reporting burden for this collection of information is estimated to average 10 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-0219 in any correspondence. Do not send your completed VA Form 10-7959a to this email address. Questions about completing this form may be addressed by calling the CHAMPVA Help Line at 1-800-733-8387.