U.S. Department of Veterans Affairs
Veterans Health Administration

Veteran's last, First name: _____
(Last Name, First Name)

Last 4 SSN: _____
(Last 4 of SSN)

Street Address: _____
(Street Address)

City, State, Zip Code: _____ _____ _____
(City) *(State)* *(Zip Code)*

CHAMPVA Benefits Election Affirmation

Please fill in the section below if you elect to use your CHAMPVA benefits for this visit/appointment. In order to utilize your CHAMPVA benefits, you must elect to use them at each episode of care.

I _____, agree and elect to use my CHAMPVA Benefits for an
(Insert Veteran/Beneficiary's Full Name)

appointment on _____ at _____ .
(Insert Date) *(Insert Name of the Appropriate Medical Treatment Facility)*

I understand that any associated ancillary services (such as x-rays, laboratory, etc.) related to this visit are considered to be a part of this visit and will also be billed to CHAMPVA.

I understand that the US Department of Veterans Affairs (VA) medical facility where treatment is performed will submit claims on my behalf to CHAMPVA.

I also understand that if I have Other Health Insurance (OHI), VA will bill my OHI as my primary insurance carrier, and then bill CHAMPVA, as my secondary payer. CHAMPVA by law is always supplemental or the secondary payer of health care benefits except for Medicaid, State Victims of Crimes Compensation Programs, and policies purchased exclusively to supplement CHAMPVA benefits.

I further understand that this election applies only to this episode of care and that:

- **If I am a dual-eligible (CHAMPVA/Veteran Status) seeking care for a service-connected condition in a VA medical facility, I must receive that care using my Veteran's benefits, and CHAMPVA will not be billed.**

_____ _____
Patient's Signature (Sign in ink) **Date**