Tobacco cessation claim form

Please read carefully the following instructions before completing this form.
Claim forms with missing information cannot be processed and will be returned to the sender.

Member information (to be completed by the member)

1. Complete all information in Section 1. The member or subscriber ID number is located on your health plan ID card.
2. Please submit a separate claim form for each covered patient of the family. Payment and related correspondence will be sent to the primary subscriber unless you have made arrangements with Moda Health to send to an alternate address.

Section 1 > Member information

Primary member/subscriber ID number	Group number	Group/employer name	
Primary member/subscriber name (first, middle, last)	Member/subscriber date of birth (mm/dd/yyyy)	Relationship of patient to primary subscriber: ☐ Self ☐ Spouse ☐ Dependent ☐ Domestic partner	
Patient name (first, middle, last)	Patient date of birth (mm/dd/yyyy)		
Patient's address	Patient's city	Patient's state	Patient's zip code
Does this member have coverage under any other group health plan? ☐ Yes ☐ No	If yes, name of the health plan	If yes, name of the other employer	

I certify that the information on this claim form is true and correct to the best of my knowledge.
I authorize the release of any medical information necessary to process this claim.

Member signature X	Phone	Date (mm/dd/yyyy)

Indicate reason for filing a claim (select one):

Services
- ☐ Counseling
- ☐ Phone coaching
- ☐ Other ________________

Supplies
- ☐ Gum
- ☐ Lozenges
- ☐ Other ________________

Prescription drugs
- ☐ Patches
- ☐ Other ________________

Section 2 > Reimbursement for services

Fill out the following or have your provider complete and sign the section below.

Diagnosis *305.1 Tobacco use dependence*	Procedure (CPT/HCPCS)	Date(s) of service	
Modifier	Diagnosis pointer	Days or limits	Charges
Name of provider	NPI	Rendering provider ID	
Billing provider info and phone	Signature of provider X		

Ready to submit? Mail this form to Moda Health

Attn: Rx Claims Department
Mail: P.O. Box 40168 Portland, OR 97240-0168
Fax: 800-207-8235

modahealth.com