

Please submit claim forms

to:

ODS

Attn: Medical

P.O. Box 40384

Portland, OR 97240-0384

Tobacco Cessation Claim Form

Subscriber ID Number

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 Group # _____

Subscriber Name _____
(Please Print or type) First Middle Last

Street City State ZIP

Patient Name _____
First Middle Last

Patient Birth Date _____ Male Female Relationship to subscriber (check one) Self Spouse Child Domestic partner

Does this patient have other coverage under any other group insurance plan? Yes No

If yes, provide the name of the insurance company and other employer.

Name of other employer _____ Name of insurance company _____
Street City State ZIP

Note: Use a separate claim form for each covered patient of the family.

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 the claim.

Signature of patient (or parent if patient is a child under age 18) _____

**Check all boxes that you are claiming for reimbursement. Please attach ALL receipts and fill out the next two sections, if applicable:
(Refer to your member handbook for tobacco cessation benefits and limitations)**

Services

- Counseling
- Phone coaching
- Other _____

Supplies

- Gum Patches
- Lozenges
- Other _____

Prescription Drugs

- Chantix
- Bupropion
- Other _____

Total amount of reimbursement requested \$ _____

Reimbursement for services: Fill out the following or have your provider complete and sign the section below.

Diagnosis 305.1 Tobacco use dependence	Date(s) of Service	Name of Provider	NPI	Rendering Provider ID
Procedure (CPT/HCPCS)		Modifier	Diagnosis Pointer	Days or limits
Billing Provider Info and Phone		Charges	Signature of Provider	

Reimbursement for prescription drugs: Fill out the following or have your pharmacist complete and sign the sections below.

Rx number	Date filled	Check one <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx directions	Days supply
Medication name, dosage, form and strength				Physician's name and DEA/NPI #	
NDC Number (11-digit)			Rx price including tax \$	Amount Paid \$	
Rx number	Date filled	Check one <input type="checkbox"/> New <input type="checkbox"/> Refill	Quantity	Rx directions	Days supply
Medication name, dosage, form and strength				Physician's name and DEA/NPI #	
NDC Number (11-digit)			Rx price including tax \$	Amount Paid \$	
Signature of Pharmacist					