NIKE HEALTH PLAN MEDICAL CLAIM

ODS HEALTH PLANS
PO Box 40384 Portland, OR 97240-0384
(503) 382-5337 OR (800) 960-4637

GROUP NUMBER
10001805

INSTRUCTIONS
1. Complete and sign this form.
2. Attach an itemized billing from your doctor. Billing must include: name and address of provider, diagnosis, dates of service, description and charge for every service.
3. Make copies of this form and your attachments for your files.
4. Mail to ODS at the address above.

ATTENDING PHYSICIAN'S STATEMENT

1. EMPLOYEE NAME (FIRST, M.I., LAST)	2. SUBSCRIBER ID NUMBER	3. DATE OF BIRTH

4. MARITAL STATUS
☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

5. RESIDENCE ADDRESS

6. WORK LOCATION	7. HAS YOUR EMPLOYMENT WITH NIKE BEEN TERMINATED? ☐ YES ☐ NO	IF **YES**, DATE TERMINATED

8. IF MARRIED, NAME OF SPOUSE	9. SPOUSE'S EMPLOYER

10. NAME OF PATIENT	11. PATIENT'S DATE OF BIRTH	12. RELATIONSHIP TO INSURED

13. IF CLAIM ON A DEPENDENT CHILD 19 YEARS OF OLDER, DOES DEPENDENT RELY SOLELY UPON YOU FOR SUPPORT?
☐ YES ☐ NO

IS DEPENDENT A FULL TIME STUDENT? ☐ YES ☐ NO IF **YES**, NAME OF SCHOOL CITY

14. IS THIS CLAIM WORK RELATED?
☐ YES ☐ NO

15. Brief description of each illness or accident (injury). Please state when, where and how accident occurred.

16. Is the patient also eligible for benefits under any:
(A) Other group health plan of any kind?
☐ YES ☐ NO
(B) Group prepayment arrangement providing for medical care and treatment?
☐ YES ☐ NO
(C) Coverage of medical care expenses provided by a school or by Medicare or other federal, state, provincial or governmental agency
☐ YES ☐ NO
(D) No fault automotive insurance as a result of injuries sustained in an automobile accident? (Please respond only if it applies to this claim.)
☐ YES ☐ NO
(E) Worker's Compensation or similar legislation?
☐ YES ☐ NO
If any of the above is answered **YES**, please indicate below the policy numbers and name and address of the insurance company or organization providing benefits.

17. **ASSIGNMENT OF BENEFITS**: If you complete this section, payment of medical benefits will be made directly to your physician. This method of claim payment is optional. If you do not complete this section, your benefit payment will go directly to your residence, payable to you.

I wish payment to be made to the provider. ▶ _____ _____
Signature Date

18. The above statements are correct to the best of my knowledge. If applicable, I also assign the benefits as shown in section 16. The ODS Health Plan is authorized to obtain a copy of my medical records pertaining to my medical care and expenses.

▶ _____ ▶ _____ _____
Employee's Signature Patient's Signature *(If over 18 years of age)* Date