Please submit claim forms to:
ODS
Attn: Medical
P.O. Box 40384
Portland, OR 97240-0384

Tobacco Cessation Claim Form

Subscriber ID Number ☐☐☐☐☐☐☐☐☐ 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
- ☐ Buproprion
- ☐ 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 ☐ New ☐ 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 ☐ New ☐ 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					

Insurance products and administrative services provided by ODS Health Plan, Inc.