Deductible and out-of-pocket credit form

ODS Health will credit you for the amount you have paid toward your deducible or your out-of-pocket (OOP) maximum for your current plan year.* To establish the amount you have paid toward your deductible and OOP maximum, please fill out this form (one per family).

To find the amount you have paid toward your deductible and out-of-pocket maximum, please log in to your previous carrier's member portal and print off your most recent Explanation of Benefits (EOB). Please use the amounts shown on your EOB to fill out this form, and attach a copy of that EOB to this page. If you receive another EOB after submitting this one, please send a copy of the new EOB to ODS Health in order to receive credit for those amounts.

**May not apply to all groups. Please ask your employer if you are eligible for deductible and out-of-pocket credit.*

ODS Health member ID no. *(this can be found on the ID card mailed to you)*				ODS Health group no. *(this can be found on the ID card mailed to you)*
Company name				
Company address	Street/P.O. Box	City	State	ZIP code
Subscriber name				
Subscriber address	Street/P.O. Box	City	State	ZIP code

Please list, separately, the dollar amount met by each member of your family covered by the ODS Health plan.

Member's name *(list the name of each covered family member)*	**Date of birth** *(mm/dd/yyyy)*	**Deductible amount credited this year**	**OOP amount credited this year**
SUBSCRIBER		$	$
Spouse:		$	$
Child:		$	$
Child:		$	$
Child:		$	$
Child:		$	$
Child:		$	$
Other:		$	$

I certify that the above information is accurate and complete to the best of my knowledge. I have attachedthe most recent EOB from my previous carrier for each member listed on this form.

Signature X	Date

If you have questions, please contact ODS Health Customer Service toll free at 877-605-3229. (TTY users, please dial 711.)

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