



Risk Services Division
Employee Benefits Program

CITY OF EUGENE

QUICK CLAIM FORM

For Reimbursement Of Claims - Please check if self-paid the claim in full

Employee/Subscriber Name (Last, First, MI) if different		Subscriber's Member ID #	Patient is: Subscriber <input type="checkbox"/> Dependent <input type="checkbox"/>
Patient Name (Last, First, MI)		Patient Date of Birth	Is claim related to an accident? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is claim related to an On-the-Job Injury? Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please describe below)			
Does patient have double coverage under another health plan? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If "Yes," Name of Carrier: _____ Policy Number: _____			
Patient diagnosis or condition for which claim is being submitted:			
Claim is for (select all that apply): Tobacco Cessation <input type="checkbox"/> Name of Tobacco Cessation Program _____ Hospital-based Education Class <input type="checkbox"/> Name of Class _____ Prescription <input type="checkbox"/> Alternative Care <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Other <input type="checkbox"/> Explain _____			
Additional Comments:			
Authorization to Reimburse Employee/Subscriber or Provider			
_____ Signature (Employee/Subscriber or Authorized Person)			_____ Date

Additional Instructions For Filing a Claim

<u>Attached Bills or Receipts should include:</u>	<u>Prescription Claims should include:</u>	<u>Massage Therapy Claim should include</u>
Patient's name Name of person or firm making the charge Diagnosis Total charge Type of service, including surgery Date of service	Pharmacy Prescription Receipt (Do not include cash register receipt, unless needed for other reimbursement) Prescription Number Illness Total Charge	Patients name and subscriber ID # Diagnosis/Condition Must state reason receiving the service, e.g. pulled muscle, back pain, etc... Receipt Must Include: Procedure Code (if known) Dates of service Description and cost of service Length of treatment Providers name and address Provider Tax ID (if known) Signed by the provider

Submit Claims to:

<p>Medical, Pharmacy or Vision Claims</p> <p>Attn: City of Eugene Claims PacificSource PO Box 7068 Springfield, OR 97475</p> <p>Fax: 541.225.3632 (Medical/Vision) 541.225.3665 (Prescription) Email: claimsmailsort@pacificsource.com Phone: 541.225.2650 or 888.532.5332</p>	<p>Dental Claims</p> <p>Delta Dental (a Moda Health affiliated company) PO Box 40384 Portland OR 97240-0384</p> <p>Email: dental@modahealth.com Telephone: 888.217.2365</p>
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