



Please mail claims to:  
 UMR -0704  
 P.O. Box 2838, Clinton, IA 52733-2838  
 Fax: 866-899-0291



**SMOKING CESSATION CLAIM FORM**

1 - MEMBER/PATIENT	Employee's name (First, Middle, Last)		Employee's Social Security # / Alt ID		Group # 240104
	Present Address - Street		City	State	Zip Code ( )
	Patient's name (First, Middle, Last)		Patient's relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Handicapped dependent		Sex <input type="checkbox"/> M <input type="checkbox"/> F

2 - OTHER INSURANCE	<b>DOES THE PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>IF YES, COMPLETE SECTION 2.</b>			
	Policyholder's name (First, Middle, Last)		Birth Date ____/____/____	Policyholder's employment status <input type="checkbox"/> Active <input type="checkbox"/> Disabled <input type="checkbox"/> COBRA <input type="checkbox"/> Effective date: ____/____/____
	Policyholder's relationship to member <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Other insurance carrier's name	Identification #	Effective Date ____/____/____

Is the **patient** entitled to benefits under **Medicare** Part A or B?  YES  NO If YES, complete the rest of Section 2.  
 Medicare effective date \_\_\_\_/\_\_\_\_/\_\_\_\_ Medicare ID # \_\_\_\_\_  
**Member's** employment status  Active  Disabled

a. This claim is for the following service:  Smoking Cessation

b. **Attach an itemized bill or receipt which includes the dates of service, name of provider or place of service, name of product, amount of charge.**

c. In the table below complete the date of service and the amount of the charge.

DATE OF SERVICE (MM/DD/YY)	DESCRIPTION OF SERVICE / SUPPLIES	DIAGNOSIS OR SYMPTOMS YOU SOUGHT TREATMENT FOR	CHARGE
	Smoking Cessation (S9075, G9016, S9453, S4995, S4990, S4991)	305.1, V15.82	

4 - AUTHORIZATION	AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any Insurance Company, Prepayment Organization, Employer, Hospital, or Physician to release all information with respect to me or my dependents that may have a bearing on the benefits under this or any other plan providing benefits or services.
	<b>SIGNED (PATIENT, OR PARENT IF A MINOR)</b> _____ <b>DATE</b>

5 - DIRECTION OF PAYMENT	NOTICE - Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered a felony in some states.
	REIMBURSEMENT TO BE PAID TO (CHECK ONE) <input type="checkbox"/> PLAN MEMBER <input type="checkbox"/> PROVIDER OF SERVICE  <b>SIGNATURE REQUIRED (INSURED PERSON)</b> _____ <b>DATE</b>