

Quit Smoking Reimbursement Form



— IMPORTANT —

Please read and follow the instructions located on the front and back of this form. You are required to complete all unshaded areas of the form by printing clearly with a non-erasable ink pen. This form will be returned if: 1) The form is not completed with the required information and 2) original receipt(s) for the nicotine or non-nicotine replacement aid is not attached to the form. Please expect 6-8 weeks to process once Anthem Blue Cross and Blue Shield receives this request for reimbursement. Anthem Blue Cross and Blue Shield will send reimbursement to the subscriber when approved.

1. Member's name: (last) _____ (first) _____ (m.i.) _____		2. Member's Identification Number as shown on your ID card: _____ (Anthem Blue Cross and Blue Shield Members, include your 3-letter prefix)
3. Member's date of birth: Mo. _____ Day _____ Yr. _____	4. Member's sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
5. Group (Employer) name: _____ Division Number: _____		
6. Subscriber's name (if other than member): (last) _____ (first) _____ (m.i.) _____		
7. Subscriber's address: Street _____ City _____ State _____ Zip _____ <input type="checkbox"/> Check box if new address Telephone _____		
DO NOT WRITE IN SHADED AREAS		
8. Date of purchase (mo/day/yr): a) _____ b) _____ c) _____	9. Charges: a) \$ _____ b) \$ _____ c) \$ _____	10. Provider number: 69-75720Y0-NH-01
11. Place of service: OL	12. Diagnosis Code: 799.89	13. Please check type of Nicotine or Non-Nicotine Replacement Aid used: <input type="checkbox"/> Zyban S 0106 <input type="checkbox"/> Patch S 4991 <input type="checkbox"/> Gum S 4995 Attach your original receipt(s) to the Reimbursement Form. Keep copies for your records.
14. I authorize the release to Anthem Blue Cross and Blue Shield of any information necessary to process this request for reimbursement. I agree to the information written above. X _____ (Member signature)		15. Date form completed:

The person signing this form is advised that the willful entry of false or fraudulent information renders you liable to be withdrawn from this quit smoking program.

-Thank you -

- turn over for instructions -

Reimbursement Instructions

The Quit Smoking Reimbursement Form is completed by the member who is using the nicotine or non-nicotine replacement aid.

Please follow the instructions below when completing this Reimbursement Form:

1. Complete all sections.
2. Include your receipt(s) for the nicotine or non-nicotine replacement aids purchased.
3. Date the form when completed and retain a copy if you wish (form and receipt will not be returned to you).
4. Send the completed Quit Smoking Reimbursement Form and receipt(s) within one year of date of purchase, to:
Claims Department
Anthem Blue Cross and Blue Shield
PO Box 533
North Haven, CT 06473-0533
5. If you have any questions about this program, please call the Customer Service number listed on the back of your ID card.

Member reimbursement will be denied if:

1. The member was not a current or eligible Anthem Blue Cross and Blue Shield member when the nicotine or non-nicotine replacement aid was purchased, or;
2. The member submits receipts for nicotine or non-nicotine replacement aids that are not approved by Anthem Blue Cross and Blue Shield.

This form will be returned if:

1. The form is not completed with the required information and;
2. Nicotine or non-nicotine replacement aid receipts are not attached to the back of this form.