CITY OF EUGENE QUICKCLAIM FORM

Employee Resource Center | Employee Benefits Program

For Reimbursement of Claims - Please check if you self-paid the claim in full ☐

Employee/Subscriber Name (Last, First, MI)	**Subscriber's** Member ID #	**Patient is**: Subscriber ☐ Dependent ☐
Patient Name (Last, First, MI)	**Patient** Date of Birth	**Is claim related to an accident?** Yes ☐ No ☐

Is claim related to an On-the-Job Injury? Yes ☐ No ☐ (If yes, please describe below)

Does **patient** have double coverage under another health plan? Yes ☐ No ☐

If "Yes," Name of Carrier: _____ Policy Number: _____

Patient diagnosis or condition for which claim is being submitted:

Claim is for (select all that apply): Prescription ☐ Alternative Care ☐ Vision ☐ Dental ☐

Other ☐ Please explain _____

Tobacco Cessation ☐ Name of Tobacco Cessation Program _____

Hospital-based Education Class ☐ Name of Class _____

Additional Comments:

Authorization to Reimburse Employee/Subscriber or Provider

_____ _____

Signature (Employee/Subscriber or Authorized Person) **Date**

Additional Instructions for Filing a Claim

Attached Bills or Receipts should include:	Prescription Claims should include:	Massage Therapy Claims should include:
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:

Medical, Pharmacy or Vision Claims

PacificSource
Attn: City of Eugene Claims
PO Box 7068
Springfield, OR 97475

Fax: (541) 225-3632 (Medical/Vision) or
(541) 225-3665 (Prescription)

Email: cs@pacificsource.com

Phone: (541) 225-2650 or (888) 532-5332

Dental Claims

Delta Dental (a Moda Health affiliated company)
PO Box 40384
Portland OR 97240-0384

Email: dental@modahealth.com

Phone: (888) 217-2365

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