Tobacco Cessation Group Program

Member Claim Form

Dear Member:

Mercy Health Plans members may be eligible for reimbursement for one tobacco cessation group program per calendar year if offered by a Plan-Approved Provider through your benefits. Please review your Schedule of Coverage or plan document for more information and to determine any cost-sharing (Deductible, Coinsurance, or Copayment) you would be responsible for as well.

Mercy Health Plans Tobacco Cessation Group Program Member Claim Form	
Name:	Member Insurance ID#: (example: M01234567)
Program Dates:	Provider Name: Program Location:
Fee Paid for Program: *Your cost-share amount (Deductible, Coinsurance or Copayment) will be deducted from the total cost of the program for your reimbursement.	Member Signature:

To Receive Your Reimbursement:

- ☐ Complete and return this claim form with a paid receipt for the program. For reimbursement, the receipt must be dated during the current calendar year and received within 60 days of the program end date.
- ☐ Mark on the outside of the envelope "Tobacco Cessation Group Program Reimbursement".
- ☐ Mail the completed form and receipt to the address below:

Mercy Health Plans
PO Box 4568
Springfield, MO 65808

If we can be of further assistance, please contact the Customer Contact Center Monday – Friday, 8 a.m. – 5 p.m. (CT) at the number listed on the back of your insurance ID card or you may reach us on the web at mercy**health**plans.com.

For Office Use Only	Completed By:
DX Code: 305.1 CPT Code: S9453	NPI:
Date Received:	Date Submitted: