City of Portland – Portland Fire Fighters Association
Medical claims reimbursement form

Date of service (mm/dd/yyyy) _____ /_____ /_____ Member ID no. _____

Section 1 > Patient information

Subscriber last name	First	M.I.		
Gender ☐ Male ☐ Female	Date of birth (mm/dd/yyyy)			
Address/P.O. Box		City	State	ZIP code
Home phone	Cellphone			
Group ID no. 10002805	Employer City of Portland	Employer phone		

Section 2 > Provider and service information

Name of provider	Place of service ☐ Clinic ☐ Hospital ☐ Other _____	
Phone	Fax	Date of service (mm/dd/yyyy)
NPI no.	TIN no.	Primary diagnosis code **Z02.89**
Procedure code	Charged amount	
Procedure code	Charged amount	
Procedure code	Charged amount	

If additional CPT codes are billed, please provide a statement of the additional services completed.

Section 3 > Authorization

The information above is true to the best of my knowledge. I understand that I must complete this form in its entirety and provide the proper documentation from the provider in order to have Moda Health process the claim. I also authorize the physician or insurance company to release any information required to process my claims.

Subscriber signature X	Date

Ready to submit? Mail or email this form to:

Mail: Moda Health, Attn: Medical Claims, 601 S.W. Second Ave., Portland, OR 97204-3156
Email: Scan and send to COPfirephysicals@modahealth.com.

Questions? Call us toll-free at 855-466-6340. (TTY users, please dial 711.)

modahealth.com