ODS Rx Pharmacy Discount Card

Enrollment Application and Change of Information Form

Please complete this form and sign at the bottom. Please type or print legibly in ink. Thank you!

Name First M.I. Last	Birth date	Gender	Social Security #
		☐ M ☐ F	

Mailing Address Address City State Zip	Home Phone Number
	( )

Coverage:

Are you Medicare eligible?

☐ Yes ☐ No

Type of Application:

☐ **New Enrollment**

Effective Date: ____________

☐ **Renewal** ____________

Changes:

☐ **Address Change**

☐ **Reissue ID Card**

☐ **Name Change**

Effective Date: ____________

New Name: ____________

Old Name: ____________

Please read and sign below.

I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law (For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available by calling the Privacy Office at 503-243-4492).

Health information requested or disclosed may be related to treatment or services performed by:

• A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
• A clinic, hospital, long term care or other medical facility;
• Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
• An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, Psychotherapy Notes, Alcohol/Drug and Genetic Testing. A separate authorization will be used for information related to these health conditions.

Please note that ID cards will carry unique ID numbers and your social security number will not be used for this purpose.

Fees:

☐ New Enrollment: $10.00

☐ Renewal: $5.00

Method of Payment:

☐ Check

☐ Money Order

☐ Cashier's Check

REQUIRED

X ______________________________ Date: ______________________________

Mail completed form and check to:

The ODS Companies
Eligibility Department
601 SW Second Ave, Suite 900
Portland, OR 97204-9747