COMMIT TO QUIT

Smoking Cessation Trust Application for Benefits

Main: (985) 873-5048

Toll Free: 1 (877) 288-0011

SCT Class Member Verification

Did you smoke a cigarette before September 1, 1988? ❑ Yes ❑ No

Are you a current resident of Louisiana? ❑ Yes ❑ No

Driver's License #, Government ID, or SSN:______________

Applicant Information PLEASE PRINT

Full Name : ____
Last *First* *M/*

❑ Male ❑ Female
Gender

Address : ____
Mailing Address

____
City *State* *ZIP Code*

Phone Number : ( ) ____________________

Alternate Number : ( ) ____________________

Date of Birth : ____________________

Email Address : ____________________

Race : ____________________

Attestation & Authorization

I certify that to the best of my knowledge, the above information is true and accurate. I hereby expressly authorize each and any of my health care provider(s) to release any of my medical or other information to the Smoking Cessation Trust (the "Trust"), SCT Management Services, L3C ("SCTMS"), or any of their authorized representatives. Without limiting the generalityof the foregoing, I authorize and consent to the release of any and all of my protected health information ("PHI"), as such term is defined by the Health Insurance Portability and Accountability Act ("HIPAA"), for the purpose(s) of contacting me, processing claims for payment of services related to smoking cessation program benefits, approval for funding of Trust claims, my treatment, SCTMS and Trust operations, counseling , and for the preparation and reporting of utilization data and quality improvement data. I further authorize the Trust and SCTMS to forward my information, including PHI, to other health care providers (such as the quit-line for telephone counseling, for example) who are directly or indirectly involved in treating mefor smoking cessation. By seeking to be approved to participate in the smoking cessation program as a Scott class beneficiary who meets the eligibility requirements of such program, I hereby expressly acknowledge, agree and irrevocably consent that SCTMS, the Trust and their authorized agents and representatives, may verify the information provided to them herein, including but not limited to my Louisiana residency status, social security number, driver's license number, medical history, and smoking history.

____
Signature of Applicant
(Authorized Release Electronic Signature Provided)

____
Date

____
Class Participation Approved by:

____
Date

____
SCTMS Member#

Once completed, please save a copy of this application and submit by Email or Fax to *committoquit@cardio.com* or *(985) 851-0780.*

Please provide the best time of day for return call: ❑ Morning 8-10AM ❑ Afternoon 1-3PM ❑ After Hours 5-7PM

SCTMS Form #v12 111612