MUS_EB
Montana University System
Employee Benefits

MEDICAL MASSAGE THERAPY CLAIM FORM

To be completed by Patient or Massage Therapist:

HEALTH PLAN ID _____

PATIENT NAME _____

PATIENT DATE OF BIRTH _____

MEDICAL SYMPTOMS REQUIRING TREATMENT _____

PROCEDURE CODE	DATE OF SERVICE	CHARGE
97124		
97124		
97124		
97124		
97124		
97124		

TOTAL CHARGE: $_____

By signing, I am certifying that the above information is true and accurate.

_____ _____

Signature of person completing this form Date

Remittance of this form is not a guarantee of payment. All claims are subject to review of the service(s) submitted and requires that the patient be a covered MUS *Choices* Medical Plan participant on the date of service. The patient will be reimbursed the allowed amount/visit, minus the applicable massage therapy copay/visit. The patient is responsible for the applicable copay/visit, which is subject to out-of-pocket and outpatient rehabilitative services visit maximums, and any balance above the allowed amount/visit. There is a combined maximum of 60 outpatient rehabilitative services visits per Plan Year (July 1 – June 30). ***No exceptions will be made for requests for additional outpatient rehabilitative services visits.*** **NOTE:** Payment in full may be required at the time of service.

Please attach receipt(s) from a licensed massage therapist, including the therapist's complete name, address, phone number, license number and submit with this form. Keep a copy of this completed form and the receipt(s) for your records.

Submit claims to:

BlueCross BlueShield of Montana
P.O. Box 660255
Dallas, TX 75266-0255