BlueCross BlueShield of Montana

Bitterroot Health
Vision Claim Form

Please complete this form for any of the following services and submit it with your receipts to the address listed below:

Instructions:

1. Submit one form per member.
2. Receipt must be attached and itemized.
   The receipt must include procedure code(s) and/or a description of the service(s) rendered.
3. Charges must be indicated for each billed procedure(s). The receipt must include diagnosis code(s).
4. Sign and date the form. Include receipt and make a copy for your records.
5. Mail the completed form and receipt to:

   Blue Cross and Blue Shield of Montana
   P.O. Box 660255
   Dallas, TX 75266-0255

Health Plan ID #	Group # 238937	Subscriber Name	Date of Birth
Patient Name	Date of Birth	Relationship to Subscriber	
Patient Street Address		City, State, Zip Code	
Date of Service		Payee (Check One) Member ☐ Provider ☐	

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

Signature of person completing this form _____ Date _____