BlueCross BlueShield of Montana

Massage Therapy Claim Form
Marsh & McLennan Agency LLC

To be completed by Patient or Massage Therapist:

Health Plan ID: _____

Group Number: _____

Patient Name: _____

Patient Date of Birth: _____

Procedure Code	Date of Service	Charge
97124		
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

Please attach the receipt from a licensed massage therapist, including the therapist's complete name, address and phone number.

Remittance of this form is not a guarantee of payment. All claims are subject to review of the service submitted and requires that the patient is a covered member at the time of service.

Massage therapy claims should be submitted to Blue Cross and Blue Shield of Montana. See the mailing address on the back of your identification card. Keep a copy of this completed form and the receipt for your records.