

MEDICAL MASSAGE THERAPY CLAIM FORM

To be c	ompleted by Patient or Massage	Therapist:	
HEALT	TH PLAN ID		
PATIE	NT NAME		_
PATIE	NT DATE OF BIRTH		
MEDIC	CAL SYMPTOMS REQUIRING	TREATMENT	
	PROCEDURE CODE	DATE OF SERVICE	CHARGE
	97124		
	97124		
	97124		
	97124		
	97124		
	97124		
	TOTAL CHARGE: \$		
By sign	ing, I am certifying that the abov	re 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, <u>and</u> 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