



P.O. Box 7982 • Helena, Montana 59604-8600

Each item on this form needs to be completed. Instructions for completion are listed on the reverse side.

Please print or type.

1 Insured/Subscriber Name (Last, First, Middle Initial) Mailing Address City and State ZIP Code Insured Employed? Date of Retirement: Month Day Year
2 Group Number Insured/Subscriber Identification Number (from ID card) Patient's Full Name (Last, First, Middle) Patient's Sex Patient's Date of Birth Month Day Year Patient's Relationship to Insured

3 Type of treatment received: Check only one type and attach itemized statements. Please use a separate claim form for each different type of treatment. Provider information Month Day Year
Please note: Preventive care includes immunizations, routine well baby care, routine physical examinations, vision and hearing exams.

4 Describe: Diagnosis, symptoms of illness or injury or explain preventive or routine care received.

5 If you experienced an injury or illness, is another party responsible for your treatment? (i.e., worker's compensation, motor vehicle accident, medical malpractice, slip-and-fall, etc.) If you selected 'yes', please provide the name and address of your Attorney and/or Carrier information.

6 Is patient covered under any other health benefits plan (besides Medicaid, Medicare or CHAMPUS)? Insurance Co. Address Employer Insured name Policy # Effective date of coverage Sex of Insured Date of birth of insured Relationship to patient

7 Medicare - Is the patient: a) Entitled to benefits under Medicare insurance (Part A)? b) Entitled to benefits under Medicare insurance (Part B)? c) Entitled to benefits under Medicare due to a disability? Patient's Medicare Identification Number. (From Medicare ID card)

8 I certify the above is complete and correct to the best of my knowledge and belief and that I am claiming benefits only for charges incurred by the patient named above. Signature of Insured Date Daytime telephone number

9 Total amount for ALL covered services and supplies received. \$ Itemized Bill(s) for covered services and supplies must be attached. (See Instructions on reverse side.)



**INSTRUCTIONS**

**Important: DO NOT file this form if your provider of service is submitting these charges to Blue Cross and Blue Shield of Montana.**

**Please complete every item on claim form.**

<b>1</b>	Insured/subscriber's name, address and employment status	Please show the insured/subscriber's name exactly as it appears on the Blue Cross and Blue Shield of Montana identification card and specify the current address including the ZIP code. Check appropriate box indicating the insured/subscriber's employment status. If retired, give date of retirement.
<b>2</b>	Patient information	Make sure the group number and identification number are exactly as shown on the insured's identification card. List patient's full name; no nicknames or initials. Check the appropriate blocks for the patient's sex and relationship to the insured. Ensure the patient's correct date of birth is shown.
<b>3</b>	Type of treatment received	Check only one treatment type (injury, illness, pregnancy or preventive care) and specify date of injury, date of first symptom, date of conception or date preventive care was received. You may attach multiple itemized statements if they are for one type of treatment (example: illness only, preventive care only).
<b>4</b>	Diagnosis or symptoms of illness or injury	Give diagnosis or a brief description of symptoms. If preventive care services were received, state the type of care (routine physical, hearing exam, vision exam, immunization or diagnosis, etc.).
<b>5</b>	If illness or injury is in any way work-related	Check appropriate box and enter name and address of employer.
<b>6</b>	If motor vehicle injury	Check appropriate box.
<b>7</b>	Other insurance	Please check appropriate box. If "yes," complete the required information.
<b>8</b>	Medicare information	Please check appropriate box concerning Medicare eligibility. If "yes," show effective date and give Medicare identification number.  Medicare enrollees should include a copy(s) of the Medicare Explanation of Benefits form(s) (EOB) with their itemized statements unless patient is actively employed and Medicare requires the patient's group coverage to pay before Medicare pays.
<b>9</b>	Insured's signature, date and daytime telephone number	Please sign and date this form and attach your physician's itemized letterhead statement(s). The itemized statement(s) should contain all the information shown in the following example:

**Example of Itemized Bill — Please remember to attach the original bill(s) to the claim form and make a copy for your records. Itemized bills cannot be returned.**

**10**

Name of the person or organization providing the services or supplies.

Name of the patient receiving the services or supplies

**NOTE:** Bills for Private Duty Nursing Service must show the professional status of the nurse (R.N. — Registered Nurse, L.V.N. — Licensed Vocational Nurse), the nurse's license number, and must be accompanied by a statement from your physician indicating medical necessity and daily nurse's progress notes.

Dayton Penridge, M.D.  
101 Fourth Street  
Healthville, U.S.A.

For Professional Services Rendered To: Virginia E. Warowes      Diagnosis Code: (78659) Chest pain, other

3/1/15	G0206 Mammogram	\$XXX
3/1/15	19120 Excision of Cyst	\$XXX
3/1/15	19083 Biopsy, breast w/Ultrasound	\$XXX
<del>3/6/15</del>	<del>90659 Flu Vaccine</del>	<del>\$XXX</del>
<del>3/6/15</del>	<del>G0008 Flu Vaccine Administration</del>	<del>\$XXX</del>

If you are submitting itemized bills for a variety of services please use a separate claim form for each different type of treatment (one for illness, another for an injury, etc.).

Please cross out those charges which were included on a previous claim.

Date each service or supply was provided

Description of the services or supplies provided

Charge for each service or supply

**FOR OTHER THAN PRESCRIPTION DRUG CARD HOLDERS:** Bills for Prescription Drugs must show the name of each drug, the prescription number, the quantity dispensed, the date of purchase, and the amount charged for each drug. If drug is generic then the pharmacist must also indicate on itemized bill.

This completed form, together with the itemized bills, should be submitted to:

Blue Cross and Blue Shield of Montana  
P.O. Box 7982  
Helena, Montana 59604-8600

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il servizio clienti al numero riportato sul lato posteriore della tua tessera di socio. Se non sei socio o non possiedi una tessera, puoi chiamare il numero 855-710-6984.
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.
Diné Navajo	T'áá ni, éi doodago ła'da biká anánílwo'ígíí, na'idíłkídgo, ts'ídá bee ná ahóótí'i' t'áá níłk'e níká a'doolwoł. Ata' halne'í bich'í' hadeesdizh nínizingo éi kwe'é da' iníishgi áká anídaalwo'ígíí bich'í' hodííłnih, bee nééhózinii bine'déé' bikáci'. Kojí atah naaltsos ná hadít'éeégoó éi doodago bee nééhózinígíí ádingo kojí' hodííłnih 855-710-6984.
Norsk Norwegian	Hvis du, eller noen du hjelper, har spørsmål, har du rett til å få hjelp og informasjon på ditt språk uten kostnad. For å snakke med en tolk, ring kundeservicenummeret bakpå medlemskortet ditt. Hvis du ikke er medlem, eller ikke har kort, ring 855-710-6984.
Pennsilfaanisch Deutsch Pennsylvanian-Dutch	Wann du, odder ebber as du an helfe bischt, Questions hoscht, hoscht du's Recht fer Hilf un Information griege in dei eegni Schprooch as nix koschte zellt. Wann du en Dolmetscher mitschweze wetscht, kansch du die Customer Service Nummer an deinre Glied-Kard dahinner uffrue. Wann du net en Glied bischt, odder kee Kard hoscht, kansch du 855-710-6984 uffrue.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อฝ่ายบริการลูกค้าที่หมายเลขตามที่ระบุด้านหลังบัตรสมาชิก หากไม่ใช่สมาชิกหรือไม่บัตร กรุณาติดต่อที่หมายเลข 855-710-6984
Українська Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання, у Вас є право отримати безкоштовну допомогу та інформацію Вашою рідною мовою. Щоб зв'язатися з перекладачем, телефонуйте за номером обслуговування клієнтів, який зазначено на звороті вашої картки учасника. Якщо ви не учасник програми, або у вас немає картки, телефонуйте за номером 855-710-6984.
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.



**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance.  
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hcsc.net](mailto:CivilRightsCoordinator@hcsc.net)

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>