P.O. Box 3018
Missoula, MT 59806-3018
(406) 721 -2222
Fax (406) 523-3111

CLAIM FORM

1. Patient Information (Use the identification number from your insurance card or policy holder's Social Security Number.)			
2. Patient's name (First, middle and last of person receiving services)		**3. Patient's date of birth** (mm/dd/yyyy)	
4. Participant's current mailing address (Policy holder's mailing address: street, city, state, and zip code.)			
5. Diagnosis (Briefly describe the illness, injury, or symptoms requiring treatment.)			
5a. Name of provider (List the name of the provider as indicated on your bill. Multiple bills from the same provider may be included on the same line as long as they are for the same type of service.)	**5b. Description of services** (i.e. hospital admission, chest x-ray, appendectomy, acupuncture, etc.)	**5c. Dates of service or purchase** (Inclusive dates may be indicated for bills containing multiple dates of service.)	**5d. Charge** (Bills must be itemized to show a separate charge for each service. If the bill was already paid, please indicate the date it was paid.)

Signature- I verify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, which participated in any way in the patient's care, to release to the participant's Plan any medical information which they deem necessary to adjudicate this claim.

Signature of patient_____ **Date** _____

Itemized Bill Information

Each provider's itemized bill must be attached and must contain:

- The provider's Tax ID number
- The letterhead indicating the name and address of the person or organization providing the service
- The full name of the patient receiving services
- A description of each service
- The charge for each service

Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable).

If other insurance is primary, please submit the explanation of benefits from the primary insurance company.

Claims in foreign languages or currency must be translated into English and United States currency.

Completed forms and information should be submitted to Allegiance at the mailing address below or you may fax the claim to Allegiance at (406) 523-3111.

Allegiance Benefit Plan Management, Inc.
P.O. Box 3018
Missoula, MT 59806