Blue Cross Blue Shield of Montana

Live Smart. Live Healthy.®

Montana University System Vision Hardware 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).
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 7982
   Helena, MT 59604

Health Plan ID #	Group # V58005	Subscriber Name	Date of Birth
Patient Name	Date of Birth	Relationship to Subscriber	
Patient Street Address		City, State, Zip Code	
Date of Service		Payee (Circle One) Member Provider	

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

_____ _____

Signature of person completing this form Date