



DOMESTIC AND INTERNATIONAL CLAIM FORM

MACoHCT Claims PO Box 1966 Missoula, MT 59806-1966 Ph. (888) 883-3233 Fax: (406) 523-3111

1. Patient Information 1A. Identification number 1B. Patient's name 1C. Patient's date of birth 1D. Patient's sex 1E. Name of participant 1F. Participant's date of birth 1G. Patient's relationship to participant 1H. Participant's current mailing address 2. Other Health Insurance - Is the patient covered under other health insurance, including Medicare A or B? 2A. Name and address of insuring company 2B. Type of policy 2C. Effective date 2D. Termination Date 2E. Policy or identification number of other coverage 2F. Type of coverage: Medical: Yes No Dental: Yes No Vision: Yes No Rx: Yes No 2G. Name of participant 2H. Date of birth 2I. Employer of Participant 2J. Employment Status Active employee Retired employee COBRA 2K. If patient is covered under Medicare, complete the following: Medicare Part A: Yes No Medicare Part B: Yes No Effective date: Effective date: 3. Diagnosis 3A. Describe illness, injury, or symptoms requiring treatment 3B. Was patient's treatment due to a work-related accident or condition? Yes No 3C. Complete for care related to accidental injuries Date of accident Location: At home Auto Other If the accident was caused by someone else, attach a statement describing the accident. 4. Charges - Use a separate line to list each type of service or provider and attach itemized bills for all the services. 4A. Type of provider 4B. Name of provider making charges 4C. Description of service 4D. Dates of service or purchase 4E. Charges 5. 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 participant or patient Date

Domestic and International Claim Form Instructions

Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable). Special care should be taken when completing the following items:

2. Other Health Insurance

If the patient holds other insurance coverage, please complete items A through K as completely as possible. It is especially important to indicate the name and address of the other insurance company and the policy or identification number of that coverage, as well as the name and birth date of the person who holds that policy.

In addition, if the patient is someone other than the subscriber and has received benefits from any other health insurance plan held by reason of law or employment, the Explanation of Benefits Form furnished by the other carrier pertaining to these charges must be included with the claim. A clear photocopy of the other carrier's Explanation of Benefits Form is acceptable in place of the original document.

4. Charges

Please list here the bills that are being included on this claim. Although itemized bills must also be submitted, your listing will enable us to process the claim more quickly and accurately. If additional space is needed for listing charges, please use a separate sheet of paper to list the following information.

4A. Type of provider – for example: hospital, nurse, physician, clinic, physical therapist, etc.

4B. Name of provider – as indicated on the 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.

4C. Description of service – for example: hospital admission, office visit, chest x-ray, lipid levels, appendectomy, acupuncture, etc.

4D. Date of service or purchase – inclusive dates may be indicated for bills containing multiple dates of service.

4E. Charge – bills must be itemized to show a separate charge for each service. If the bill has already been paid, please indicate the date it was paid. Charges must be listed in U.S. currency.

5. Signature – The Domestic and International Claim Form must be signed and dated by the participant, spouse, or the patient.

Itemized Bill Information

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

- The letterhead indicating the name and address of the person or organization providing the service
- The full name of the patient receiving the service
- The date of each service
- A description of each service
- The charge for each service

This completed claim form, together with itemized bills and supporting documentation, should be submitted to:

MACoHCT Claims
PO Box 1966
Missoula, MT 59806-1966

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