MONTANA UNIVERSITY SYSTEM
OFFICE OF THE COMMISSIONER OF HIGHER EDUCATION
Benefits Department

2500 Broadway ◊ PO Box 203203 ◊ Helena, Montana 59620-3203 ◊ (406) 444-2574 ◊ (877) 501-1722 ◊ FAX (406) 444-0222

MEDICAL MASSAGE THERAPY MEDICAL NECESSITY APPLICATION

This form is to assist you and your Primary Care Provider in sending in the applicable information required to determine approval for Medical Massage Therapy services. Under certain circumstances, your MUS medical plan may approve reimbursement for Medical Massage Therapy services if you meet medical necessity criteria as set forth by the Montana University System. The patient must be covered on the MUS *Choices* medical plan at the time of service. To be considered for this benefit, you must submit the information requested below. For further questions, contact the MUS Benefits Office at 1-877-501-1722.

Mail completed form to: MUS Benefits Office
PO Box 203203, Helena, MT 59620-3203 **OR**

Fax completed form to: 406-444-0222

Patient Information – To be Completed by Subscriber/Patient		
Patient's Name		Phone Number ( )
Mailing Address		
City	State	Zip
E-mail Address for Notification of Approved or Denied Services		
Health Plan ID Number	Medical Insurance Administrator (circle one) Allegiance BCBSMT PacificSource	Birthdate
****REQUIRED INFORMATION**** To be Completed by Primary Care Provider		
Physician's Name		Phone Number ( )
Mailing Address		
City	State	Zip
Diagnosis of Patient Referenced Above		
Please describe the diagnosed medical condition and medical necessity for Medical Massage Therapy.		
Name of Massage Therapist the patient is being referred to (complete name, address, and phone number).		
Primary Care Provider's Signature		Date