MUS_EB
Montana University System
Employee Benefits

MEDICAL MASSAGE THERAPY CLAIM FORM

To be completed by Patient or Massage Therapist:

HEALTH PLAN ID _____

PATIENT NAME_____

PATIENT DATE OF BIRTH_____

MEDICAL SYMPTOMS REQUIRING TREATMENT_____

PROCEDURE CODE	DATE OF SERVICE	CHARGE
97124		
97124		
97124		
97124		
97124		
97124		

TOTAL CHARGE: $_____

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

_____ _____

Signature of person completing this form Date

Please attach the receipt(s) from a licensed massage therapist, including the therapist's complete name, address, phone number, and license number.

Remittance of this form is not a guarantee of payment. All claims are subject to review of the service(s) submitted and requires that the patient is a covered MUS *Choices* medical plan member on the date of service. The patient will be reimbursed the allowed amount, minus a $25 copay/visit. The patient is responsible for a $25 copay/visit, which is subject to out-of-pocket and outpatient rehabilitative services visit maximums, and any balance above the allowed amount/visit. There is a maximum of 30 outpatient rehabilitative services visits per plan year (July 1-June 30). **NOTE:** Payment in full may be required at the time of service.

Massage therapy claims should be submitted to your medical plan claims administrator (Allegiance, Blue Cross Blue Shield, or Pacific Source). See the mailing address on the back of your medical plan identification card. Keep a copy of this completed form and the receipt(s) for your records.

7/1/17