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		
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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 receipt(s) from a licensed massage therapist, including the therapist's complete name, address, phone number, and license number, and submit with this form.

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 be a covered MUS *Choices* Medical Plan member on the date of service. The patient will be reimbursed the allowed amount/visit, minus the applicable massage therapy copay/visit. The patient is responsible for the applicable 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 combined maximum of 60 outpatient rehabilitative services visits per plan year (July 1 – June 30). ***No exceptions will be made for requests for additional rehabilitative services visits.***
NOTE: Payment in full may be required at the time of service.

Massage therapy claims should be submitted to the MUS *Choices* Medical Plan Claims Administrator (BlueCross BlueShield of Montana (BCBSMT)). See the mailing address on the back of your BCBSMT Medical Plan identification card. Keep a copy of this completed form and the receipt(s) for your records.