# DOT Member Claim Form

Please print all information clearly

Claim is for (Please check): ☐ Subscriber/Employee ☐ Dependent

| **MEMBER/EMPLOYEE INFORMATION** (Person who holds the MACo HCT policy) | | | | |
|---|---|---|---|---|
| Group Name (on ID card) | | Group Number (on ID card) | | |
| Participant ID (on ID card) | Last Name | First Name | | Middle Initial |
| Mailing Address | | City | State | Zip Code |

| **PATIENT INFORMATION** (*ONLY* if different than above) | | | | |
|---|---|---|---|---|
| Last Name | First Name | Middle Initial | Date of Birth | |
| Mailing Address | | City | State | Zip Code |

## DIRECTION OF PAYMENT:

☐ Pay Provider (√ if you did not pay at the time of service)

☐ Pay Member/Employee (√ if you paid up at the time of service and need to be reimbursed)

**DOT Physical Information Required**

Attach a copy of the receipt, including the bill from the provider that includes:

- Patient's name, date of birth
- Provider's name, address, tax identification number, date of service, CPT code(s), diagnosis code(s), charge for each service

**OFFICE USE ONLY:**

- Put in code "99455" and use RC

**PATIENT SIGNATURE:** _____ **DATE:**_____

Please mail form & copies of paid receipts to:

MACo HCT Benefits Claims
P.O. Box 1966
Missoula, MT 59806-1966
Fax: 406-523-3111