MACo Health Care Trust
DOT Provider Claim Form

Please print all information clearly

MEMBER/COUNTY INFORMATION:	
Group Name (on ID card)	
Group Number (on ID card)	
Participant ID (on ID card)	
Participant Name	
Patient Name (if different than above)	
Patient Date of Birth	

PROVIDER INFORMATION:			
Provider Name			
Provider Tax Identification Number			
Assignment of Benefits	***REMIT PAYMENT DIRECTLY TO PROVIDER***		
Date of Service	**Screening CPT Code**	**Diagnosis Code**	**Charge**
	99455		
		TOTAL	**$**

Provider's Signature ______________________________ Date _______________

Employee's Signature ______________________________ Date _______________

Submit this claim form to:

MACo HCT Benefits Claims
Allegiance Benefit Plan Management
P.O. Box 1966, Missoula MT 59806
Fax: 406-523-3181