MACo HEALTH CARE TRUST

Massage Therapy Member Claim Form

Please print all information clearly

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

Please enter your County name: _____**County**

MEMBER/EMPLOYEE INFORMATION (Person who holds the MACo HCT policy)			
Participant ID (on ID card)	Group Number (on ID card)	Date of Birth	
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 Member/Employee

Total Billed Charges	Date of Service
Massage Therapy Information Required Attach a copy of the receipt/bill from the provider that includes: ▪ Patient's name, Provider's name, address, and date of service	**OFFICE USE ONLY:** ▪ Use CPT code 97124

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