



Immunization Claim Form

Blue Cross and Blue Shield of Montana
 P.O. Box 5004
 Great Falls, Montana 59403

Customer Information Line
 1-800-447-7828
 www.bcbsmt.com

Please complete this form for any preventative immunization services provided by a Health Department, Health Fair, Pharmacy, etc. and submit it with your receipts to the address listed below.

Instructions:

1. Submit one form per member
2. Receipt must be attached and itemized. The receipt must include procedure code(s) and/or a description of service(s) rendered.
3. Charges must be indicated for each billed procedure(s).
4. Sign and date the form. Include receipt and make a copy for your records.
5. Mail the completed form and receipt to:

Blue Cross and Blue Shield of Montana
 P.O. Box 5004
 Great Falls, MT 59403

Health Plan ID	Patient Name	Date of Birth
Member's Address		
Date of Service		
Name of Provider		

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

 Signature of Person Completing This Form

 Date