BlueCross BlueShield of Montana

MUST Immunization Submission Form

Please complete this form for any of the following services and submit it with your receipts to the address listed below:

- Immunization services provided by a Health Department, Pharmacy or at a Health Fair

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 the 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 660255
Dallas, TX 75266-0255

Health Plan ID #	Group #	Subscriber Name	Date of Birth
Patient Name	Date of Birth	Relationship to Subscriber	
Patient Street Address		City, State, Zip Code	
Date of Service		Payee (Check One) Member ☐ Provider ☐	

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

Signature of Person Completing This Form _____ Date _____