Allegiance®

P.O. Box 3018
Missoula, MT 59806-3018

406-721-2222
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DOMESTIC AND INTERNATIONAL CLAIM FORM

1. Patient Information **1A. Identification number**		
1B. Patient's name (First, middle, last)	**1C. Patient's date of birth** MM/DD/YY	**1D. Patient's sex** Female ☐ Male ☐
1E. Name of participant (First, middle initial, last)	**1F. Participant's date of birth** MM/DD/YY	**1G. Patient's relationship to participant** Self ☐ Spouse ☐ Child ☐
1H. Participant's current mailing address (Street, city, state, and country or ZIP code)		

2. Other Health Insurance **- Is the patient covered under other health insurance, including Medicare A or B?**
Yes ☐ No ☐ ***If yes, complete 2A through 2K below.***

2A. Name and address of insuring company			
2B. Type of policy Family ☐ Individual ☐	**2C. Effective date** MM/DD/YY	**2D. Termination date** MM/DD/YY	**2E. Policy or identification number of other coverage**
2F. Type of coverage: Medical: Yes ☐ No ☐ Dental: Yes ☐ No ☐ Vision: Yes ☐ No ☐ Rx: Yes ☐ No ☐		**2G. Name of participant**	**2H. Date of birth** MM/DD/YY
2I. Employer of participant		**2J. Employment status** Active employee ☐ Retired employee ☐ COBRA ☐	

2K. If patient is covered under Medicare, complete the following: Medicare Part A: Yes ☐ No ☐ Effective date: _____ Medicare Part B: Yes ☐ No ☐ Effective date: _____

3. Diagnosis **3A. Describe illness, injury, or symptoms requiring treatment**	**3B. Was patient's treatment due to a work-related accident or condition? Yes ☐ No ☐**

3C. Complete for care related to accidental injuries

Date of accident _____ Location: At home ☐ Auto ☐ Other _____

If the accident was caused by someone else attach a statement describing the accident.

4. Charges **- Use a separate line to list each type of service or provider and attach itemized bills for all the services.**

4A. Type of provider	4B. Name of provider making charges	4C. Description of service	4D. Dates of service or purchase	4E. Charges

5. Signature **- I verify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, which participated in any way in the patient's care, to release to the participant's Plan any medical information which they deem necessary to adjudicate this claim.**

Signature of participant or patient _____ **Date** _____

Domestic and International Claim Form Instructions

Please complete all items on the claim form. If the information requested does not apply to the patient, indicate N/A (Not Applicable). Special care should be taken when completing the following items:

2. Other Health Insurance

If the patient holds other insurance coverage, please complete items A through K as completely as possible. It is especially important to indicate the name and address of the other insurance company and the policy or identification number of that coverage, as well as the name and birth date of the person who holds that policy.

In addition, if the patient is someone other than the subscriber and has received benefits from any other health insurance plan held by reason of law or employment, the Explanation of Benefits Form furnished by the other carrier pertaining to these charges must be included with the claim. A Clear photocopy of the other carrier's Explanation of Benefits Form is acceptable in place of the original document.

4. Charges

Please list the bills that are being included with this claim. Although itemized bills must also be submitted, your listing will enable us to process the claim more quickly and accurately. If additional space is needed for listing charges, please use a separate sheet of paper to list the following information.

4A. Type of provider - for example: hospital, nurse, physician, clinic, physical therapist, etc.

4B. Name of provider - as indicated on the bill. Multiple bills from the same provider may be included on the same line, as long as they are for the same type of service.

4C. Description of service - for example: hospital admission, office visit, chest x-ray, lipid levels, appendectomy, acupuncture, etc.

4D. Date of service or purchase - inclusive dates may be indicated for bills containing multiple dates of service.

4E. Charge - bills must be itemized to show a separate charge for each service. If the bill has already been paid, please indicate the date it was paid. Charges must be listed in U.S. currency.

5. Signature - The International Claim Form must be signed and dated by the participant, spouse, or the patient.

Itemized Bill Information

Each provider's original itemized bill must be attached and must contain:

- The letterhead indicating the name and address of the person or organization providing the service
- The full name of the patient receiving the service
- The date of each service
- A description of each service
- The charge for each service

Completed forms and information should be submitted to Allegiance at the mailing address below or you may fax the claim to Allegiance at (406) 523-3111.

Allegiance Benefit Plan Management
P.O. Box 3018
Missoula, MT 59806-3018

Claims in foreign languages or currency must be translated into English and United States currency.