Service Availability Form

Employer Name: Sibanye-Stillwater Health Partners

If a medically necessary service is not available in your EPO network, please complete this form and send it to:

Allegiance Benefit Plan Management
Attn: Claims-Sibanye-Stillwater Health Partners Team
PO Box 3018
Missoula, MT 59806

Fax to 406-523-3111

All fields required. Incomplete forms will not be honored.

Employee Name (Please Print) _____

Member ID number: _____

Patient Name: _____

Service Required: _____

Treatment date: _____

Specialist Required: _____

Provider Name: _____

I, _____, hereby certify that I have checked the website directory www.askallegiance.com/smc to determine if an In-Network provider is available within my EPO for the service I need. After checking, I have determined that this situation would apply. This form does not guarantee this procedure will be approved, services will also need to have a prior authorization submitted by your provider.

Employee signature_____
Date_____