



## HEALTH FAIR CLAIM FORM

<b>Provider Name</b>	
<b>Provider Tax ID Number</b>	
<b>School District</b>	
<b>MUST Member Number</b>	
<b>Patient Name</b>	
<b>Patient Date of Birth</b>	
<b>Assignment of Benefits</b>	<b>**Please Pay Claimant**</b>

DATE OF SERVICE	PLACE OF SERVICE	CPT CODE	ICD-9	CHARGE
			V70.0	
			V70.0	
			V70.0	

Benefits will be payable in accordance with the benefits provided by your MUST Plan. In order to maximize the benefits of your plan, it will be necessary to have the all blanks completed. Please submit a separate claim form for each family member.

**Member Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Mail to:** First Choice Health—MUST  
P.O. Box 12569  
Seattle, WA 98111-4659

**Or fax to:** (888) 206-3092