



## HEALTH FAIR CLAIM FORM

|   |                                |
|---|--------------------------------|
| <b>Provider Name</b>                      |                                |
| <b>Provider Tax ID Number</b>             |                                |
| <b>School District</b>                    |                                |
| <b>MUST Member Social Security 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:** \_\_\_\_\_

**Submit to:**

**MUST Claims  
PO Box 3777  
Missoula, MT 59806-3777**

**or Fax to: (406) 523-3111**