ALLEGIANCE
LIFE & HEALTH INSURANCE COMPANY, INC.

P.O. Box 3507
Missoula, MT 59806-3507

800-737-3137
Fax 406-523-3124

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, 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, B or D?**
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:_____ Medicare Part D: Yes___ No___ Effective date: _____

3. Diagnosis **3A. Describe illness, injury, or symptoms requiring treatment**	**3B. Has a claim for benefits under Workers' Compensation or similar law been filed? Yes___ No___ * If yes, name of carrier.**

3C.Complete for care related to accidental injuries, including body parts(s) affected.

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 / CPT Procedure Code**	**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 or claims processor any information which they deem necessary to adjudicate this claim.**

Signature of Participant or Patient _____ **Date** _____

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.

3.Diagnosis/Accident/General Liability/Other Liability/Work Related

If another party is liable for this accident or injury or if the accident or injury occurred while the patient or participant was working, please list details. Describe how the accident or injury occured. List body part(s) that was/were affected. If the accident or injury is work related, provide the name of the employer, answer whether the employer has been notified of the accident or injury and if a claim for benefits has been filed under Workers' Compensation or similar laws. Please also provide the name of the workers' compensation carrier. If an attorney has been hired, please provide name, address and phone number of attorney.

4.Charges

Please list here the bills that are being included o 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.

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 AL&H 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

This completed claim form, together with itemized bills and supporting documentation, should be submitted to:

Allegiance Life & Health Insurance Company, Inc.
P.O. Box 3507
Missoula, MT 59806-3507

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