Travel Reimbursement Claim Form

Patient's Name:
Patient's Date of Birth:
Employee's Name:
BCBSMT Health Plan ID Number:
Travel Date:

Referring Physician must complete this portion

Diagnosis: _____
_____

Was treatment due to an accident or medical emergency? Yes No

Can this treatment be performed locally? Yes No
If not, please explain: _____
_____

Can this surgical treatment be performed locally: Yes No
If not, please explain: _____
_____

Physician's Name (print):
Physician's Signature:
Physician's Address:
Physician's NPI #:

Attach all travel receipts and submit to:

Blue Cross Blue Shield of Montana
Blue Connection
PO Box 4309
Helena MT 59604