BlueCross BlueShield of Montana

PROVIDER COMPLAINT FORM

Provider Name _____ **Date** _____

Practice/Clinic/Facility Name _____

Email Address _____

Phone Number _____ **Fax Number** _____

Physical Address _____

City _____ **State** _____ **ZIP Code** _____

NPI _____ **Tax ID** _____

Name of Person Completing Form _____

Date Incident Occurred _____ **Complaint Type**_____

Complaint Summary:

How can BCBSMT resolve your issue?

Please submit form to:
PO Box 4309 Attn: Network Management Helena, MT 59604
OR Email to: HCS-x6100@bcbsmt.com