Uninsured Claim for COVID-19 (testing and/or treatment)

Date: _____

To: Hospital Program Officer

From: Provider Name: _____

Provider NPI: _____

Provider TIN: _____

Provider Phone Number: _____

Provider Fax Number: _____

Number of claims: _____

Mail or Fax to:

DPHHS
Health Resources Division, A206
Attn: Hospital Program Officer
PO Box 202951
Helena, MT 59620-2951
Fax: (406) 444-1861
Phone: (406) 444-4834