Montana Department of Public Health & Human Services
SUBSTANCE ABUSE MANAGEMENT SYSTEM

CLIENT INSURANCE INFORMATION FORM

Name:					Account #:				
Program #					Facility				

Account Opened Date *(mmddyyyy)*									
Company:									
Group Name:									
Group Number:									
Member Number:									
Begin Date *(mmddyyyy)*									
End Date *(mmddyyyy)*									
Status ☐ *Active* ☐ *Cancelled*									
Comments:									