

**AUTHORIZATION FOR RELEASE OF CREDITABLE COVERAGE  
INFORMATION**

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

I hereby authorize you to release to Blue Cross Blue Shield of Montana, its employees, authorized agents or representatives, a creditable coverage certificate or any and all other information that demonstrates the existence of and length of time either I or my dependents were covered by insurance or group health plan coverage issued by your company under plan or policy no. \_\_\_\_\_.

Please direct the certificate or other creditable coverage information to Blue Cross Blue Shield of Montana at: P.O. Box 4309, Helena, MT 59604 or to fax no. (406) 444-8432.

\_\_\_\_\_  
Print name: \_\_\_\_\_