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:		