



P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
www.bobmccloskey.com

Claim Filing Instructions
Student Accident Insurance
Chabot-Las Positas CCD -
Chabot Campus

PLEASE NOTE – THIS POLICY IS SECONDARY TO OTHER VALID AND COLLECTIBLE INSURANCE INCLUDING PARENT/GUARDIAN MEDICAL INSURANCE. THERE ARE SPECIFIC REQUIREMENTS AND SPECIFIC DOCUMENTS NEEDED IN ORDER FOR A CLAIM TO BE PROCESSED AND PAID UNDER THIS POLICY. PLEASE REVIEW THE CLAIMS PACKET IN ITS ENTIRETY.

- Policyholder/Organization/School – Complete Part 1A of the BMI Benefits Accident/Injury Claim Form.

- Claimant/Parent/Guardian – Complete Part 1B and Parent/Guardian Information Sections
 - i. If claimant or parent/guardian has NO medical coverage, please indicate under Part 1B of Claim form, ‘no other insurance’ and complete Statement of No Other Insurance Document
 - ii. Please notify all health care professionals that you have secondary coverage for the accident/injury and ask the provider to bill BMI Benefits directly after primary insurance has processed the claim

- Submit completed and signed accident claim form to BMI Benefits, LLC.
 BMI Benefits, LLC.
 PO Box 511
 Matawan, NJ 07747
 Fax: 732.583.9610
 Email: BMI@bobmccloskey.com

- See Claim Filing Instructions page for additional information.

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Student & Sports Accident Claim Form

Please complete this form in its entirety and submit to BMI Benefits within 90 days from the date of accident. Please retain a copy for your records. Please contact the medical providers where treatment was received, submit BMI's billing information as your secondary insurance, and ask for BMI to be billed directly. You may also obtain from the medical providers **all itemized bills** and **primary insurance explanation of benefits (EOBs)**. Itemized bills are considered **HCFA1500** Forms (physician's office), **UB-04** Forms (hospitals), and **ADA Dental Claim Forms** (dentist) **not balance due statements**.

PART 1A - POLICYHOLDER					
College/University (Policyholder Name)				Policy#	
Student's Name			Date of Birth		Male Female
Date of Injury/Accident	Name of Sport (if applicable)	Body Part Injured		Left Body Part	Right Body Part
Type of Sport/Activity: <input type="checkbox"/> Intercollegiate Sport <input type="checkbox"/> Club Sport <input type="checkbox"/> Intramural Sport <input type="checkbox"/> General Accident					
Sport/Activity Situation: <input type="checkbox"/> Game <input type="checkbox"/> Practice <input type="checkbox"/> Conditioning <input type="checkbox"/> Travel <input type="checkbox"/> Other: _____					
Was the student involved in an activity sponsored and supervised by the Policyholder? YES <input type="checkbox"/> NO <input type="checkbox"/>					
How did Injury occur? Please Provide Details of What Happened.					
Name of College/University Official:			Title of College/University Official		
Signature of College/University Official				Date	
<i>NOTE: Part 1A – Policyholder section must be signed by an official of the policyholder or the claim cannot be processed</i>					
PART 1B - INJURED PERSON INFORMATION & INSURANCE INFORMATION					
Student's Social Security Number (SSN Must be provided as required by the Center for Medicare Services)					
Student's Home Address (Street, City, State, Zip)					
Student's Phone #			Student's E-Mail		
Is the Student covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy? YES <input type="checkbox"/> NO <input type="checkbox"/> If Yes, Name of Ins. Carrier: _____ Policy #: _____					
Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare? YES <input type="checkbox"/> NO <input type="checkbox"/>					
PARENT/GUARDIAN INFORMATION					
Parent/Guardian Name			Parent/Guardian Name		
Phone	E-Mail		Phone	E-Mail	
Is the Parent/Guardian Employed?		YES <input type="checkbox"/> NO <input type="checkbox"/>	Is the Parent/Guardian Employed?		YES <input type="checkbox"/> NO <input type="checkbox"/>
Employer			Employer		
<p>Medical Information Authorization: I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organization to furnish at the request of BMI Benefits, LLC. or the underwriting companies with which it works, information which you may possess including, findings and treatments rendered and copies of all hospital and medical records for professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claims communications between us as privileges are hereby expressly and voluntarily waived. A photostat of this authorization shall be considered as valid and effective as the original. Payments will be made to the providers of service unless a paid receipt/statement accompanies the medical claim submission. Important Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p> <p>For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Fraud language varies by state, for additional state specific fraud warning language, please see below.)</p>					
Student or Authorized Person's Printed Name & Signature				Date	

IMPORTANT NOTICE

For residents of Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For residents of California: For your protection California law requires the following to appear on this form, Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For residents of Kansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of Ohio and Oklahoma: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oregon: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.



Statement of No Other Insurance

Please complete this form in its entirety and submit to BMI Benefits, LLC. along with the completed accident claim form

I, _____, declare that I was not covered by any other
(Insured's Name)
insurance policy, through myself, my parents or my guardian for the accident dated _____ which occurred at my school. Should any insurance become effective during my treatment I will notify BMI Benefits and will forward all eligible bills to the new insurance carrier. I understand BMI Benefits coverage is excess to all other insurance and will pay after all collectible insurance. I understand that if any of these statements are false it could deem my claim ineligible.

(Insured Name or Parent/Guardian Name if insured is a minor) (Date)

(Insured Signature or Parent/Guardian Signature if insured is a minor) (Date)

SCHOOL/POLICYHOLDER NAME: _____

FRAUD WARNING:
ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS, FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.

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Student Accident Insurance Claim Filing Instructions

1. **BMI Benefits Accident/Injury Claim Form:** Please complete the accident claim form in its entirety and sign. If there is no primary insurance, please state “NO INSURANCE” on the accident claim form and complete the ‘Statement of No Other Insurance’ document and return it to BMI with the accident claim form.
2. Please contact all medical providers where treatment was received and instruct them that you have secondary insurance. If you give the medical provider the BMI Benefits billing information, they should bill BMI directly after they bill your primary health insurance. You may also obtain and attach copies of your primary carrier’s Explanation of Benefits (EOB) and all itemized medical bills, known as HCFA 1500s (physician billing form) and UB-04s (hospital billing form). The itemized medical bills should show the ICD-10 and CPT codes for the services provided, as well as other necessary information for insurance processing. **Balance due statements are NOT itemized bills and cannot be processed and paid by BMI Benefits.** The insurance policy is an excess insurance, which means benefits are provided after any other valid and collectible insurance has processed the medical claims.
3. In regards to claims for a dental injury, the policy will cover accidental injury to sound, natural teeth. The claim must be submitted to both the dental insurance and the medical insurance if available. In regards to reimbursement for prescription expenses, we will need a copy of the itemized prescription bill. Cash register receipts only will not suffice.
4. If you have already paid the medical service provider and wish to be reimbursed directly, please attach a paid receipt or statement that verifies the payment along with the itemized bills and primary EOBs. Claims paid via a HSA or FSA are reimbursable, however claims paid via a HRA are not reimbursable.
5. Submit the completed claim form, itemized bills and primary insurance Explanation of Benefits to BMI Benefits, LLC. Claims can be submitted via mail, fax, or e-mail. You may contact BMI Benefits to discuss your claim. Please be aware that settlement of your claim may take several weeks to process.

Mail

BMI Benefits, LLC
PO Box 511 Matawan, NJ 07747

Assigned Claims Examiner

Examiner Name: Heidi Piskin
Examiner Email: heidi@bobmccloskey.com
Examiner Fax: 732.210.9738
Examiner Phone: 800.445.3126 x 56045

NOTE: When BMI processes a submitted claim, an Explanation of Benefits (EOB) will be mailed to the medical provider of service with any check payment. A second copy is also mailed to the address on file for the claimant/student explaining the claim payment details. If any information is missing in order for BMI to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to BMI for reprocessing and payment of the medical claim. All submitted claims are subject to the policy terms, conditions and benefits as outlined in the coverage selected by the Policyholder.



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Frequently Asked Questions (FAQs) Document

Q. What is “excess insurance” and why does the school have a policy?

The school purchases a policy with BMI Benefits to help cover accident-related medical expenses. The concept of it is to prevent students from incurring excessive expenses due to related accidents and injuries. An “excess” policy covers expenses that the student would otherwise be responsible for in the absence of this policy i.e., co-pays, deductibles, and other amounts denied by primary insurance and shown as the patient responsibility on the primary Explanation of Benefits (EOB).

Q. What expenses does the Excess Student Accident Insurance policy cover?

The policy is designed to cover most expenses beyond your primary insurance coverage for student related accidents and injuries, up to charges of 100% Usual & Customary. This includes amounts shown as the patient responsibility on the primary insurance EOB: co-pays, co-insurance, etc.

Q. What documents are needed in order for BMI Benefits to process a claim?

- 1) **Itemized bill** – This is called a **HCFA 1500 (physicians billing)** or **UB04/UB92 (hospital/facility billing)**, and it contains the following information:
 - Provider’s Name
 - Provider’s Address
 - Tax ID Number
 - Date(s) of Service
 - Type of Service(s) Rendered
 - The Fee for Each Procedure
- 2) **Primary Explanation of Benefits (EOB)** – This is a statement from your primary insurance company that outlines what charges will be covered and what the patient might owe. If a primary insurance company denies charges for one reason or another, a **DENIAL** will be sent instead of an EOB.
- 3) **Completed and Signed BMI Accident Claim Form**

Q. What can cause a delay in processing and paying a claim?

BMI Benefits cannot process a claim that is missing one or more of the following documents: the BMI accident claim form, the Itemized Bill or the Primary EOB / denial. **We cannot accept balance due, balance forward, or past due statements for claims processing.**

Q. I just got what looks like a medical bill statement in the mail. What should I do?

If the bill is related to a student injury, please **call the billing department phone number on the statement.** The reason you are most likely receiving the bill is because the provider does not have BMI Benefits’ secondary insurance info on the account. Inform the billing department that there is secondary insurance, and they have to send BMI Benefits a copy of the claim and primary EOB.

Q. What if I already paid the bills, I got from an covered accident/injury after my primary insurance paid? Can I get reimbursed?

Yes, you can get reimbursed for costs you have already paid. To do this you need to submit a receipt or some other proof of payment along with the EOBs and HCFAs/UBs. Keep in mind it usually takes longer for these to be reimbursed. For this reason, we try to have providers “bill” you for fees that are usually paid at the time of office visit. In other words, try to avoid paying any fees to providers up front, so they can be paid by the Excess Student Accident Policy instead.

The above information is a summary of coverage/benefits and may vary by policy/school. This summary is not a guarantee of coverage or benefits. Please refer to the master policy on file with the school to confirm specific coverage terms or contact BMI Benefits directly.

ITEMIZED BILL FOR PHYSICIAN BILLING - HICFA 1500 FORM



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																				
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1)															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)										
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)										
CITY					STATE					8. RESERVED FOR NUCC USE										
ZIP CODE					TELEPHONE (Include Area Code) () ()					CITY										
STATE					STATE					ZIP CODE										
TELEPHONE (Include Area Code) () ()					TELEPHONE (Include Area Code) () ()					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										
10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER															
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					b. OTHER CLAIM ID (Designated by NUCC)										
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. INSURANCE PLAN NAME OR PROGRAM NAME										
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>										
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment for services described below.										
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment for services described below.										
SIGNED _____ DATE _____										SIGNED _____										
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____					15. OTHER DATE MM DD YY QUAL. _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY										
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
17b. NPI _____					17c. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										
A. _____ B. _____ C. _____ D. _____										23. PRIOR AUTHORIZATION NUMBER _____										
E. _____ F. _____ G. _____ H. _____										23. PRIOR AUTHORIZATION NUMBER _____										
I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER _____										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1																				
2																				
3																				
4																				
5																				
6																				
25. FEDERAL TAX I.D. NUMBER					SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					
28. TOTAL CHARGE \$ _____					29. AMOUNT PAID \$ _____					30. Rsvd for NUCC Use										
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										
SIGNED _____ DATE _____										33. BILLING PROVIDER INFO & PH # ()										
a. NPI _____					b. _____					a. NPI _____					b. _____					

ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM

1													2													3a PAT. CNTL. #			4 TYPE OF BILL							
																										b. MED. REC. #										
																										5 FED. TAX NO.			6 STATEMENT COVERS PERIOD FROM THROUGH			7				
8 PATIENT NAME													9 PATIENT ADDRESS																							
b													b													c			d			e				
10 BIRTHDATE			11 SEX	12 DATE			ADMISSION 13 HR 14 TYPE 15 SRC			16 DHR			17 STAT			18			19			20			21			CONDITION CODES 22 23 24 25 26 27 28			29 ACDT STATE			30		
31 OCCURRENCE CODE DATE			32 OCCURRENCE CODE DATE			33 OCCURRENCE CODE DATE			34 OCCURRENCE CODE DATE			35 OCCURRENCE SPAN FROM THROUGH			36 OCCURRENCE SPAN FROM THROUGH			37																		
38													39 VALUE CODES AMOUNT			40 VALUE CODES AMOUNT			41 VALUE CODES AMOUNT																	
a													b			c			d																	
b																																				
c																																				
d																																				
42 REV. CD.			43 DESCRIPTION										44 HCPCS / RATE / HIPPS CODE			45 SERV. DATE			46 SERV. UNITS			47 TOTAL CHARGES			48 NON-COVERED CHARGES			49								
1																																				
2																																				
3																																				
4																																				
5																																				
6																																				
7																																				
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23			PAGE ____ OF ____										CREATION DATE			TOTALS																				
50 PAYER NAME													51 HEALTH PLAN ID			52 REL. INFO			53 ASG. BEN.			54 PRIOR PAYMENTS			55 EST. AMOUNT DUE			56 NPI								
A																									57 OTHER PRV ID											
B																																				
C																																				
58 INSURED'S NAME									59 P.REL.			60 INSURED'S UNIQUE ID			61 GROUP NAME			62 INSURANCE GROUP NO.																		
A																																				
B																																				
C																																				
63 TREATMENT AUTHORIZATION CODES									64 DOCUMENT CONTROL NUMBER									65 EMPLOYER NAME																		
A																																				
B																																				
C																																				
66 DX			67			A			B			C			D			E			F			G			H			68						
I			J			K			L			M			N			O			P			Q												
69 ADMIT DX			70 PATIENT REASON DX			a			b			c			71 PPS CODE			72 ECI									73									
74 PRINCIPAL PROCEDURE CODE DATE			a. OTHER PROCEDURE CODE DATE			b. OTHER PROCEDURE CODE DATE			75			76 ATTENDING NPI			QUAL																					
												LAST			FIRST																					
c. OTHER PROCEDURE CODE DATE			d. OTHER PROCEDURE CODE DATE			e. OTHER PROCEDURE CODE DATE						77 OPERATING NPI			QUAL																					
												LAST			FIRST																					
80 REMARKS			81CC a									78 OTHER NPI			QUAL																					
			b									LAST			FIRST																					
			c									79 OTHER NPI			QUAL																					
			d									LAST			FIRST																					

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

- Statement of Actual Services Request for Predetermination/Preauthorization
 EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? Medical? (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender
 M F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person named in #5
 Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY)

14. Gender

M F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above

Self Spouse Dependent Child Other

19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY)

22. Gender

M F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) A _____ C _____
 (Primary diagnosis in "A") B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Patient/Guardian Signature _____ Date _____

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X Subscriber Signature _____ Date _____

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (e.g. 11=office; 22=O/P Hospital)
 (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N)

40. Is Treatment for Orthodontics?

No (Skip 41-42) Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment

43. Replacement of Prosthesis

No Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from

Occupational illness/injury Auto accident Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI

50. License Number

51. SSN or TIN

52. Phone Number () -

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
 Signed (Treating Dentist) _____ Date _____

54. NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number () -

58. Additional Provider ID

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The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA's web site (ADA.org).

GENERAL INSTRUCTIONS

- A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the 'tick-marks' printed in the margin.
- B. Complete all items unless noted otherwise on the form or in the CDT manual's instructions.
- C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
- D. All dates must include the four-digit year.
- E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)

When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the "Remarks" field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING

The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

- Item 29a – Diagnosis Code Pointer ("A" through "D" as applicable from Item 34a)
- Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
- Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter "A")

PLACE OF TREATMENT

Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

- 11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

The full list is available online at "www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf" **Note: Obsolete URL - search online for "CMS Place of Service Code downloads"**

PROVIDER SPECIALTY

This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Provider taxonomy codes listed above are a subset of the full code set that is posted at "www.wpc-edi.com/codes/taxonomy"



To: Selected Provider

From: BMI Benefits, LLC.

Subject: Excess Student Accident Insurance

To Whom It May Concern:


The College or University carries an excess student accident insurance policy which insures students when medical claims are incurred as the result of a covered accident or injury.

This year, we have a new insurance agency Granite Student Insurance Services, Inc., managing our student insurance policy, and BMI Benefits, LLC, as our claims administrator. Our policy has a \$0 per injury deductible. You should not collect monies from the student at the time of service. Any deductible amount/copay amount will be eligible under the Chabot College policy with BMI Benefits for claims processing.

The itemized bills (HCFA 1500, UB04 or ADA Dental) along with the primary E.O.B. should be submitted directly to BMI. At any time, you can contact BMI Benefits for Student eligibility, benefits, or status questions at 800.445.3126.

Sincerely,

BMI Benefits
 P.O. Box 511
 Matawan, NJ 07747
 Phone: 800.445.3126
 Fax: 732.583.9610
 www.bobmccloskey.com
 BMI@bobmccloskey.com

<p>Chabot-Las Positas Policy #: US1929267 Group #: CLP CCD - Chabot Campus</p> <p>Attention Provider: This student is covered under a Student Accident Plan offered by his/her college or university.</p> <p>POLICY PERIOD: 7/1/23 - 7/1/24 BMI Benefits, LLC P O Box 511 Matawan, NJ 07747 Phone: 800-445-3126 Fax: 732-583-9610</p> <p>Policy is underwritten by United States Fire Insurance Co.</p>	<p style="text-align: center;">CLAIM FILING INSTRUCTIONS</p> <p>Coverage under this policy is Excess of all other insurance and claims must first be submitted to any other insurance. Initial medical treatment must be incurred within 180 days from the date of the accident. Claims must be submitted to BMI Benefits LLC within 180 days after the date of treatment. Mail all medical bills and primary insurance statements showing payment or rejection, please include the name of the insured and the name of the school that the student attended to:</p> <p style="text-align: center;">BMI Benefits, LLC P O Box 511, Matawan, NJ 07747 Phone: 800-445-3126, Fax: 732-583-9610</p> <p style="text-align: center;">  </p>
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