Pope John XXIII Regional High School

Secondary Insurance information

Dear Parent/Guardian,

Your son/daughter sustained an injury during a Pope John event, which qualifies them to receive our supplemental health insurance. This health insurance works as a secondary insurance. If you choose to use this additional coverage, please complete the personal information page, which is the fourth page in this packet.

Pope John ***is not*** responsible for filing the claim. *As a reminder, the claim must be filed within **90 days** of the injury.* If you choose not to use the supplemental insurance, please complete the denial form, which is the last page in this packet.

Kindly fax or email a copy of either the completed denial form or the completed personal information form to the Pope John Athletics Department. The fax number is 973-729-0384.

If you have any questions, please contact either Pope John's Business or Athletic Training Departments.

Thank you,
Gerard Graziano, ATC

gerardgraziano@popejohn.org

Diocese of Paterson

Student Accident Claim Form Instruction Sheet

The Diocese of Paterson carries student accident insurance that is intended to cover costs not covered by your primary health insurance carrier. You are eligible to file a claim for accidents involving your child that occurred during a school related activity. Coverage also extends to CCD students, CYO participants and volunteer workers. Please complete the attached form and include the requested documents when submitting your claim.

1. **Part 1 of claim form:** Please complete the claimant information, date and description of the injury. The school will complete all other fields in this section.

2. **Part 2 of claim form:** Please complete all requested information regarding the student and each parent along with the primary insurance policy information.

3. The claim form must b e signed by the parent or guardian.

4. **You must attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills (known as HCFA's, UB-04's or UB-92's). The medical bills should show the ICD-9 codes form the services provided.**

5. 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.

6. Submit the completed claim form, itemized bills and primary insurance Explanation of Benefits to the insurance company, BMI Benefits, LLC.

7. You may contact BMI Benefits at 1-800-445-3126 to discuss your claim. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available to ensure prompt assistance.

8. Please feel free to contact or send all inquiries to:

Lisa Crupi
Claims Examiner
Bob McCloskey Insurance/BMI Benefits LLC.
PO Box 511
Matawan, NJ 07747
Phone: 800-445-3126 ext 56350 (OFFICE)
Fax: 732-844-8704
Email: lisac@bobmccloskey.com
www.bobmcclokey.com

Updated 2023

HOW TO FILE A CLAIM:

1. Complete this form within 90 days.
2. Attach Itemized Bills and Primary Carrier Statements
3. Mail to: BMI Benefits, LLC, P O Box 511, Matawan, NJ 07747/1-800-445-3126

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.

This part must be completed and signed by an official of the policyholder or the claim cannot be processed

PART 1A: POLICYHOLDER

School/Organization: Diocese of Paterson　　Policy#: 11KTT8179700

School Mailing Address: 777 Valley Road Clifton, NY 07013　　City, State, Zip

Injured Person's Name　　Birth date　　Male ☐ Female ☐

Date of Injury　　Time　　Type of Sport or Activity　　Part of body injured

How did injury occur?

Accident Type: Interscholastic ☐　Intramurals ☐　School-Time ☐　Other ☐

At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder? YES ☐ NO ☐

Name of Supervisor　　Was he/she a witness to the accident? YES ☐ NO ☐

Signature of Supervisor/Official　　Title　　Date

PART 1 B: INJURED PERSON'S INFORMATION

THE INJURED PERSON'S SOCIAL SECURITY NUMBER MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES

Injured Person's Social Security Number

Injured Person's Home Address (Street, City, State, Zip)

Is the injured Person Employed? YES ☐ NO ☐　If yes, please fill out Section A below.

Is the injured Person Married? YES ☐ NO ☐　Spouse's Name

Is the Spouse Employed? YES ☐ NO ☐　If yes, please fill out Section B below.

Are you covered by any other insurance policy, either as a dependent, group, individual, automobile medical or liability YES ☐ NO ☐
If Yes: Name of Insurance Carrier ____________________ Policy #: ____________

PARENT/GUARDIAN INFORMATION

Father/Guardian Name	Mother/Guardian Name
Address (Street, City, State, Zip)	Address (Street, City, State, Zip)
Home Phone	Home Phone
Is the Father Employed? YES ☐ NO ☐	Is the Mother Employed? YES ☐ NO ☐

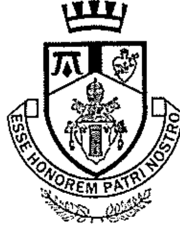
SECTION A (INSURED/FATHER)		SECTION B (SPOUSE/MOTHER)	
Employer		Employer	
Address (Street, City, State, Zip)		Address (Street, City, State, Zip)	
Business Phone		Business Phone	
Insurance Company	Policy#	Insurance Company	Policy#

MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS:

You are hereby authorized to furnish at the request of and to BMI Benefits, LLC or the underwriting companies with which it works, information which you may possess; including findings and treatment rendered, X-rays and copies of all hospital and medical records, all occasioned by 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 claim communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as effective and valid as the original, PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

New York: 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, 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.

Claimant or Authorized Person's Signature　　Date



POPE JOHN XXIII REGIONAL HIGH SCHOOL

Secondary Insurance Denial Sign Off Form

I____ am aware my child
parent's name

____ was injured during
child's name

a Pope John XXIII High School sponsored event. I acknowledge that the school's secondary insurance was offered to me, but I am declining to use it.

____ ____________________

parent's signature *date*