



## **BMI Benefits, LLC.**

**P.O. Box 511**

**Matawan, NJ 07747**

**Phone: 800.445.3126**

**Fax: 732.583.9610**

**Email: BMI@bobmccloskey.com**

**www.bobmccloskey.com**

## **Student Accident Insurance Claim Filing Checklist**

**PLEASE NOTE – THIS POLICY IS SECONDARY TO PARENTAL/GUARDIAN MEDICAL/DENTAL 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.**

- School – Complete Part 1A of the BMI Benefits Accident/Injury Claim Form.
- Parent/Guardian – Complete Part 1B and Parent/Guardian Information Sections of the Accident Claim Form
  - i. If student/claimant has NO medical/dental coverage, please indicate under Part 1B of the Claim form and complete the Statement of No Other Insurance Document which is included in this packet. ONLY Complete statement of no other insurance if you have no other insurance.
  - ii. **Please notify all health care providers that you have secondary coverage for the accident/injury.** You should provide them with a copy of the accident claim form and instruct the provider to bill BMI Benefits directly after primary insurance has processed the claim. It is still your responsibility to file the accident claim form directly with BMI Benefits.
- Submit completed and signed accident claim form to BMI Benefits, LLC. Please retain a copy for your records.  
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. You will have medical claims/bills to submit to BMI for payment. We recommend NOT paying any bills upfront, but to allow BMI to process the medical claim/bill and we will pay the medical provider directly. BMI will NOT be able to process and pay claims based on balance due statements. The insurance requires itemized bills and primary insurance Explanation of Benefit (EOBs), if applicable, to be submitted for any covered claim to be processed and paid. **We recommend that you contact the medical providers and provide the BMI information as the secondary insurance so the provider can bill BMI directly with the required insurance documents.** If you paid a bill out of pocket, we would need the receipt or statement of account showing payment, **along with the itemized bill and primary EOBs.** See the enclosed materials for additional information.

### **Enclosed Documents**

- Provider Letter with Insurance Information Card
- Statement of No Other Insurance
- Claim Instructions
- Claim Frequently Asked Questions (FAQ)
- Sample Itemized Bills

## Student Accident Claim Form



**BMI Benefits, LLC.**  
**P.O. Box 511**  
**Matawan, NJ 07747**  
**Phone: 800.445.3126**  
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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/dental providers where treatment was received, submit BMI's billing information as your secondary insurance, and ask for BMI to be billed directly.** You should provide them with a copy of this form. You may also obtain from the medical/dental 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.** Please reference the attached claims instruction document for additional information.

### PART 1A - POLICYHOLDER

School/Organization/Policyholder Name				Policy#	
School/Organization/Policyholder Mailing Address (Street, City, State, Zip)					
Student's Name			Date of Birth		Male      Female
Date of Injury	Time	Name of Activity or Sport Type	Body Part Injured		Left Body Part    Right Body Part
At the time of the accident, was the student involved in an activity sponsored and supervised by the Policyholder?    YES    NO					
Sport/Activity Situation:      Game    Practice    Conditioning    Travel    PE    Recess    Classroom    Cafeteria    Club    Bus					
How did Injury occur?					
Name of School Official:			Title of School Official:		
Signature of Supervisor/Official					Date

**NOTE: Part 1A – Policyholder section must be signed by an official of the policyholder or the claim cannot be processed**

### 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)	
Is the Student covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> If Yes, Name of Ins. Carrier: _____ Policy #: _____	
Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare? <b>YES</b> <input type="checkbox"/> <b>NO</b> <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"/>

**Medical Information Authorization:** I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organization 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 behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claims communication between us as privileges are hereby expressly and voluntarily waived. A photostat of this authorization shall be considered as valid and as the original. Payments will be made to the providers of service unless a paid receipt/statement accompanies the medical claim submitted.

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

**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 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.)

Claimant or Authorized Person's Signature	Date
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## 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.



Student Accident Insurance  
Provider Letter & Insurance Information Card

**To:** Medical Provider

**From:** BMI Benefits, LLC.

**Subject:** Excess Student Accident Insurance

To Whom It May Concern:

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

The insurance policy is through Bob McCloskey Insurance and BMI Benefits, LLC. You should not collect any payment from the student at the time of service. Any primary insurance deductible amount/copay amount will be eligible to be submitted under the policy with BMI, and will be processed according to the policy terms, conditions, benefits and limitations.

The itemized bills (HCFA 1500, UB04 or ADA Dental) along with the primary E.O.B.(if there is primary insurance) 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

BMI@bobmccloskey.com

www.bobmccloskey.com

**INSURANCE INFORMATION CARD**

**Policy #:** Student Initials & D.O.B. **Group #:** School Name

**CLAIM FILING INSTRUCTIONS**

**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 90 days

from the date of the accident. Claims must be submitted to BMI Benefits LLC within 90 days after the date of treatment. Mail, Fax or E-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:

**BMI Benefits, LLC**

**P O Box 511, Matawan, NJ 07747**

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**Fax: 732-583-9610**

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**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 **ONLY IF** you have no other insurance

**Insured Name:** \_\_\_\_\_

**School/Policyholder Name:** \_\_\_\_\_

**Date of Accident:** \_\_\_\_\_

I declare that I was not covered by any other insurance policy, through myself, my parents, or my guardian, for the accident dated above. Should any insurance become effective during my treatment I will notify BMI Benefits and forward all eligible bills to the other insurance carrier. I understand the coverage through BMI Benefits is excess to all other insurance and will pay after all collectible insurance has adjudicated my claims. I understand that if any of these statements are false it could deem my claim ineligible.

\_\_\_\_\_  
(Insured Name or Parent Name if insured is a minor) (Date)

\_\_\_\_\_  
(Insured Signature or Parent Signature if insured is a minor) (Date)

**Fraud Warning:**

Any person who knowingly and/or with intent to injury, defraud or deceive an insurance company or other person, 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:** Part 1A must be completed and signed by the school/policyholder. All other sections must be completed by the parent/guardian. If you are employed, but do not have insurance, please state “NO INSURANCE” and complete the enclosed form – ‘Statement of No Other Insurance’. Otherwise, our office may submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.
2. **Please contact all medical providers where treatment was received and instruct them that you have secondary insurance. If you give the medical/dental provider a copy of the BMI Accident Claim Form and the Provider Letter, 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), UB-04s (hospital billing form) and ADA Dental Claim Form (dentist 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 regard 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. HSAs and FSAs are reimbursable, however HRAs 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.

FAX	MAIL	E-MAIL
732-583-9610	BMI Benefits, LLC PO Box 511 Matawan, NJ 07747	BMI@bobmccloskey.com

6. You may contact BMI Benefits, LLC at 800.445.3126 or BMI@bobmccloskey.com 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, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

**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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## **Student Accident Insurance Frequently Asked Questions**

### **Why is my child's school providing student accident insurance?**

Many health insurance plans have high deductibles and plan limits that leave parents with high bills resulting from an unexpected accident. This excess policy, provided by the school, protects students and families from the costs associated with school-time and/or sports related accidents depending on your school's chosen policy coverage.

### **Who is BMI Benefits?**

BMI Benefits, LLC. is the claims administrator on behalf of the insurance carrier.

### **Does primary insurance always have to pay first?**

Yes. Medical claims must always be submitted initially to your primary insurance policy. Any remaining balance of expenses not covered by your primary will be submitted to the excess policy. The policy will cover the remaining balance of eligible expenses up to the plan maximum.

### **Does the accident insurance policy pay for out-of-pocket expenses such as co-pays and deductibles?**

Yes. These charges can be submitted to the accident insurance policy to provide reimbursement.

### **What documents are needed to process a claim?**

If your student is involved in a school-related accident, the following documents are needed to properly process a claim:

- **Fully completed BMI Benefits Accident Claim Form**
- **Itemized Bill – in the form of a HCFA, UB04 or ADA Dental Claim**. These can be obtained through the medical/dental provider. **DO NOT SEND** cash receipts, balance due, balance forward, or past due statements for claims processing or payment. An itemized bill (HCFA or UB04) contains the following information:
  - Provider's Name, Provider's Address, Tax ID Number
  - Date(s) of Service, Type of Service(s) Rendered including CPT and ICD-9 Codes
  - The Fee for Each Procedure
- **Primary Insurance Explanation of Benefits (EOB)** – you should receive a copy of this from your primary insurance carrier. If your health insurance coverage is a state or federal government funded plan such as a Medicaid, Medicare, or Military insurance such as Tri-Care, the primary EOB is not required.

### **Where do I send all of these documents?**

Please send all claim forms, itemized bills, primary EOBs, other insurance information and claims correspondence to BMI Benefits, LLC. **It will be easier to contact your medical provider, submit BMI's information as the secondary insurance, and the provider will bill BMI directly with the itemized bills and primary EOBs.**

### **What insurance information do I have to give a provider? What is the policy # and Group #?**

When you go to hospital, Doctor's office, PT clinic, etc, you must remember to tell them you have secondary insurance through your school's student accident medical insurance policy. Instruct the provider to bill your primary insurance first and then send the primary EOB and the itemized bill to BMI Benefits, LLC. **If you did not submit the secondary insurance information upon your first visit, please call the provider and give them the secondary insurance information for BMI Benefits.** If the provider bills the school's student accident insurance policy directly, this should prevent a balance due statement from being sent to the student/parent. **Policy ID #: Student Initials & DOB (IE: TAM 1212002) Group #: School Name**

### **What can cause a delay in processing and paying a claim?**

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

**Who can I contact if I have any questions?** If you have questions after you submit your claims to BMI Benefits, LLC. please contact them at 800-445-3126 or BMI@bobmccloskey.com. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

**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.**



# ITEMIZED BILL FOR PHYSICIAN BILLING - HCFA 1500 FORM



## HEALTH INSURANCE CLAIM FORM

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

PICA <input type="checkbox"/>													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#)</small>					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					CITY		STATE	
ZIP 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			b. RESERVED FOR NUCC USE		c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME		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			c. RESERVED FOR NUCC USE		d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		b. OTHER CLAIM ID (Designated by NUCC)	c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. RESERVED FOR NUCC USE			d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		13d. CLAIM CODES (Designated by NUCC)		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME	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>	
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier 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 payment of medical benefits to the undersigned physician or supplier for services described below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier 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. _____		17b. NPI		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					22. RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.					22. RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER			
A. _____ B. _____ C. _____ D. _____					E. _____ F. _____ G. _____ H. _____					I. _____ J. _____ K. _____ L. _____			
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										NPI			
2										NPI			
3										NPI			
4										NPI			
5										NPI			
6										NPI			
25. FEDERAL TAX I.D. NUMBER			SSN EIN <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					33. BILLING PROVIDER INFO & PH # ( )			
SIGNED _____					DATE _____					a. NPI	b. _____	a. NPI	b. _____

CARRIER ↑ PATIENT AND INSURED INFORMATION ↓ PHYSICIAN OR SUPPLIER INFORMATION ↓



# 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		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																								
c										d																										
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																										1										
2																										2										
3																										3										
4																										4										
5																										5										
6																										6										
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20																										20										
21																										21										
22																										22										
23																										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										B				C		D		E		F		G		H												
B										C				D		E		F		G		H		I												
C										D				E		F		G		H		I		J												
58 INSURED'S NAME										59 P.REL.		60 INSURED'S UNIQUE ID				61 GROUP NAME				62 INSURANCE GROUP NO.																
A										B		C				D				E																
B										C		D				E				F																
C										D		E				F				G																
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME																						
A										B				C				D																		
B										C				D				E																		
C										D				E				F																		
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																																		
77 OPERATING NPI		QUAL																																		
LAST		FIRST																																		
78 OTHER NPI		QUAL																																		
LAST		FIRST																																		
79 OTHER NPI		QUAL																																		
LAST		FIRST																																		
80 REMARKS										81CC a																										
										b																										
										c																										
										d																										

# SAMPLE

# 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

## 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

## ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment  (e.g. 11=office; 22=O/P Hospital)      39. Enclosures (Y or N)   
 (Use "Place of Service Codes for Professional Claims")

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

## 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