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
Fax: 732.583.9610
www.bobmccloskey.com

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#
MAHWAH BOE	AHP1201251-251

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? **YES** ◯ **NO** ◯ If Yes, Name of Ins. Carrier: _____ Policy #: _____

Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare? **YES** ☐ **NO** ☐

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name		Parent/Guardian Name	
Phone	E-Mail	Phone	E-Mail
Is the Parent/Guardian Employed?	YES ◯ NO ◯	Is the Parent/Guardian Employed?	YES ◯ NO ◯

Medical Information Authorization: I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organizatio furnish at the request of BMI Benefits, LLC. or the underwriting companies with which it works, information which you may possess inclu 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 submi
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 appli insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information conce 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 t dollars and the stated value of the claim for each such violation. (Fraud language varies by state, for additional state specific fraud warni language, please see below.)

Claimant or Authorized Person's 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.

BMI Benefits
FULL TPA SERVICES

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
Phone: 800-445-3126
Fax: 732-583-.9610
E-Mail: BMI@bobmccloskey.com

BMI Benefits
FULL TPA SERVICES

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

Got You Covered

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 adjudicate 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 guilt of insurance fraud and subject to criminal and substantial civil penalties.

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

Got You Covered

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.

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

Got You Covered

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 – <u>in the form of a HCFA, UB04 or ADA Dental Claim</u>**. 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

PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (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 F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

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

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES 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? YES NO ***If yes***, complete items 9, 9a, and 9d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

SIGNED _____ DATE _____

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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

	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

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

SAMPLE

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	a	9 PATIENT ADDRESS	a
b		b	c / d / e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	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

CONDITION CODES

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	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									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		PAGE _____ OF _____	CREATION DATE		TOTALS				23

SAMPLE

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

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
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

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		

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC® National Uniform Billing Committee

LIC9213257

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) (Primary diagnosis in "**A**")
A _____ C _____
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

SAMPLE

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746
or go online at adacatalog.org