Gallagher

Insurance | Risk Management | Consulting

Program Manager
Gallagher Benefit Services
of California Insurance Services

Bob McCloskey Insurance
BMI BENEFITS - FULL TPA SERVICES

Managing General Agent & Claim Administrator
Bob McCloskey Insurance & BMI Benefits
P.O. Box 511 | Matawan, NJ 07747

QBE

QBE Insurance Corporation

Description of Coverage

California Student Accident Insurance Program (CSAIP)

PreK-8 or K-8: Mandatory School-Time Coverage Including Interscholastic Sports and Football
PreK-12 or K-12: Mandatory School-Time Coverage Including Interscholastic Sports and Football

Accident Medical Maximum Expense Benefit (AME)	$25,000
Deductible	$0
Loss Period – Treatment Must Begin	Within 90 days after a Covered Accident
Benefit Period	1 year from the date of the Covered Accident
Coverage	100% Usual & Customary (U&C) Charges
Plan Design	Full Excess
Inpatient	
Hospital Room & Board	100% of the average semi-private room rate
Hospital Intensive Care	100%, up to two times the average semi-private room rate
Hospital Miscellaneous	100% U&C Charges
Outpatient	
Ambulatory Medical Center	100% U&C Charges
Emergency Room Treatment	100% U&C Charges
Physician Services	
Surgical	100% U&C Charges
Assistant Surgeon	100% U&C Charges
Physician's Assistant	100% U&C Charges
Anesthesiologist	100% U&C Charges
Physical Therapy	100% U&C Charges
Physician's Surgical Facilities	100% U&C Charges
Other Services	
Registered Nurses' Services	100% U&C Charges
Prescriptions	100% U&C Charges
Laboratory Tests, X-rays and Interpretation	100% U&C Charges
Diagnostic Imaging (MRI, CAT Scan, etc.)	100% U&C Charges
Air/Ground Ambulance	100% U&C Charges
Durable Medical Equipment	100% U&C Charges
Dental Treatment to Sound Natural Teeth	100% U&C Charges, $2,500 Extended Dental Benefit
Concussion Extended Benefit Period	Included, additional 2-year benefit period
Volunteer Coverage	Included
Accidental Death & Dismemberment Benefits	
Accidental Death Benefit	$25,000
Accidental Dismemberment Benefit Maximum	$50,000
Accidental Paralysis Maximum	$50,000
Aggregate Limit of Indemnity	$1,000,000
Crisis Death Benefit	$10,000 / $100,000 Max per incident

Common Exclusions:

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. Intentionally self-inflicted Injury, suicide, or any attempt thereat while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. Declared or undeclared war or act of war;
6. Flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
7. Travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
8. Participation in any motorized race or contest of speed;
9. An accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
10. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
11. Travel or activity outside the United States or Canada;
12. The Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
13. Voluntary ingestion of any narcotic, drug, poison, gas, or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
14. Injuries compensable under Workers' Compensation law or any similar law;

We will not pay benefits for:

15. Services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by the Policyholder; b. living in the Covered Person's household; c. who is a parent, sibling, spouse, or child of the Covered Person;
16. Any Hospital Stay or days of a Hospital Stay that are not Appropriate Treatment for the condition and locality.
17. A Covered Person's Covered Loss if:
    a. he was driving a private passenger automobile at the time of the Covered Accident that resulted in the Covered Loss; and b. he was intoxicated, as that term is defined by the law of the jurisdiction in which the Covered Accident occurred.

Excluded Expenses: None of the following will be considered Covered Expenses unless coverage is specifically provided.

1. Blood, blood plasma or blood storage except expenses by a Hospital for processing or administration of blood.
2. cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to: a. surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Accident; b. reconstruction incidental to or following surgery resulting from a Covered Accident.
3. Any elective or routine treatment, surgery, health treatment or examinations.
4. Examination or prescriptions for, or purchase of, eyeglasses, contact lenses or hearing aids.
5. Treatment in any Veterans' Administration, Federal or state facility unless there is a legal obligation to pay.
6. Services or treatment provided by persons who do not normally charge for their services unless there is a legal obligation to pay.
7. Rest cures or custodial care.
8. Repair or replacement of existing dentures, partial dentures, braces, or bridgework.
9. Personal services such as television and telephone, or transportation.
10. Expenses payable by any automobile insurance policy without regard to fault.
11. Services or treatment provided by an infirmary operated by the Policyholder.
12. Treatment or service provided by a private duty nurse.

Note: Once coverage is accepted, a Policy will be issued to your school. This information is a brief description of certain benefits and features of the California Student Accident Insurance Program underwritten by QBE Insurance Corporation. It is not a contract and does not extend or alter the coverage afforded by the Policy. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations, and exclusions, are set forth on the applicable policy form. To the extent there is any discrepancy between the descriptions in this brochure and the terms, conditions, limitations and exclusions of the Policy, the Policy shall prevail.

CALIFORNIA STUDENT ACCIDENT INSURANCE PROGRAM

Student Accident Insurance Plan Summary
2023-2024

Program & Claim Administrator
BMI Benefits, LLC.
Matawan, NJ 07747

Bob McCloskey Insurance
BMI BENEFITS - FULL TPA SERVICES

Program Manager

Gallagher
Insurance | Risk Management | Consulting

Gallagher Benefit Services of California Insurance Services

Claim Procedures
Always keep a copy of all claim related documents. Written proof of loss must be submitted within 90 days from the date of such loss.

1) Contact Your school to obtain an accident claim form. Complete the claim form in its entirety and submit to BMI Benefits, within 90 days from the date of the accident.
2) Submit all itemized bills and primary insurance E.O.Bs to BMI Benefits for processing of outstanding balances due to a Covered Accident.

SUBMIT TO:
BMI Benefits, LLC.
PO Box 511
Matawan, NJ 07747
PH: 800.445.3126
FAX: 732.583.9610
EM: lisac@bobmccloskey.com

The California Student Accident Insurance Program is pleased to provide a student accident insurance plan for the 2023-2024 school year. Enrolled students participating in school sponsored and supervised activities are covered for Accident Medical Expense Benefits and Accidental Death and Dismemberment Benefits subject to the terms, conditions, limitations and exclusions of the Policy. It covers certain medical expenses for the treatment of injuries that are the direct and independent result of a Covered Accident during the policy period. See "Benefits," "Definitions" and "Exclusions" in the Policy for further details.

Accident Medical Expense Benefits:
Benefits are payable for treatment of injuries that result from a Covered Accident, while coverage is in effect, up to the Maximum Benefit summarized below, subject to the terms, conditions, limitations and exclusions of the Policy. Eligible medical expenses must be incurred within the 52-week Benefit Period; with the first eligible expense incurred within 90 days of the Covered Accident. Benefits are payable for eligible expenses that are in excess of benefits paid by any other health care plan.

Schedule of Benefits

Accident Medical Expense Maximum	$25,000
Deductible	$0
Benefit Period	52 weeks from the date of the Covered Accident
Coinsurance	100% of Usual & Customary Charges
Dental Benefit	Up to 100% of Accident Medical Expense Maximum; Sound & Natural Teeth Only
Accidental Death & Dismemberment Benefit (AD&D)	$25,000 Principal Sum
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	200% of the Principal Sum
Loss of Sight of Both Eyes	200% of the Principal Sum
Loss of One Hand or Foot and Sight in One Eye	200% of the Principal Sum
Loss of Speech & Hearing	200% of the Principal Sum
Loss of One Hand or Foot	100% of the Principal Sum
Loss of Sight in One Eye	100% of the Principal Sum

Covered Expenses Include

- Inpatient Hospital Services
- Intensive Care Room and Board
- Hospital Miscellaneous Treatment
- Outpatient Pre-admission Testing
- Outpatient Hospital Emergency Room
- Surgical Benefits
- Doctors' Visits
- X-Ray and Laboratory Tests
- Nursing Services
- Physiotherapy
- Ambulance
- Medical Equipment Rental Charges
- Medical Services and Supplies
- Outpatient Prescription Drug Benefit
- Dental Services

General Definitions

The terms listed below have the following meanings. Please note that the Policy contains other defined terms in addition to the definitions set forth below.

Appropriate Treatment means care, services or supplies, provided by or at the direction of a Physician that are appropriate, according to accepted standards of medical practice, for the Covered Person's injury and are provided during the course of treatment of an injury sustained in a Covered Accident. Appropriate Treatment must be provided no less frequently than monthly unless the Covered Person's Physician specifies in writing to Us that such treatment of injuries sustained in a Covered Accident can be provided at less frequent intervals.

Benefit Percentage means the percentage of Covered Expenses We pay that are Incurred by the Covered Person after he satisfies any applicable Deductible. Benefit Percentages are shown in the *Schedule of Benefits.*

Company or We, Us, Our, means QBE Insurance Corporation domiciled in Pennsylvania.

Covered Accident means a sudden, unforeseeable external event that results, directly and independently of all other causes, in an injury or loss and meets all of the following conditions: 1) occurs while the Covered Person is insured under this Policy; 2) is not contributed to by disease, sickness, or mental or bodily infirmity; and 3) is not otherwise excluded under the terms of this Policy.

Covered Expense means the lesser of the Usual and Customary Charge and the maximum benefit shown, for services or supplies listed, in the *Schedule of Benefits* and described in the *Accidental Medical Expense Benefits* section of the policy. Covered Expenses must be Incurred by a Covered Person for Appropriate Treatment for injuries sustained in a Covered Accident.

Covered Person means an Eligible Person, as defined in the *Schedule of Benefits*, whom for required premium has been paid when due and for whom coverage under this Policy remains in force.

Deductible means the amount of Covered Expenses that each Covered Person must Incur before benefits are paid under this Policy. The Covered Person may use Covered Expenses paid under another Health Care Plan to satisfy the Deductible under this Policy only if so indicated in the *Schedule of Benefits*.

Physician means a licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not: 1) employed or retained by the Policyholder; or 2) living in the Covered Person's household; or (3) a parent, sibling, spouse or child of the Covered Person.

Usual and Customary Charge means the normal charge, in the absence of insurance, made by the provider of any Appropriate Treatment, but not more than the prevailing charge in the area; 1) for a like service by a provider with similar training or experience; or 2) for a supply that is identical or substantially equivalent.

Common Exclusions

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface, except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
7. travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
8. participation in any motorized race or contest of speed;
9. an accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in Driver's Education Program;
10. sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
11. travel or activity outside the United States or Canada;
12. the Covered Person's intoxication as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
13. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
14. injuries compensable under Workers' Compensation law or any similar law;

We will not pay benefits for:

15. services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by the Policyholder; b. living in the Covered Person's household; c. who is a parent, sibling, spouse or child of the Covered Person;
16. any Hospital Stay or days of a Hospital Stay that are not Appropriate Treatment for the condition and locality.
17. A Covered Person's Covered Loss if: a. he was driving a private passenger automobile at the time of the Covered Accident that resulted in the Covered Loss; and b. he was intoxicated, as that term is defined by the law of the jurisdiction in which the Covered Accident occurred.

Excluded Expenses - None of the following will be considered Covered Expenses unless coverage is specifically provided.

1. Blood, blood plasma or blood storage except expenses by a Hospital for processing or administration of blood.
2. cosmetic surgery or care, or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to: a. cosmetic surgery resulting from an accident, if initial treatment of the Covered Person is begun within 12 months of the date of the Accident; b. reconstruction incidental to or following surgery resulting from a Covered Accident.
3. Any elective or routine treatment, surgery, health treatment or examinations.
4. Examination or prescriptions for, or purchase of, eyeglasses, contact lenses or hearing aids.
5. Treatment in any Veterans' Administration, Federal or state facility unless there is a legal obligation to pay.
6. Services or treatment provided by persons who do not normally charge for their services, unless there is a legal obligation to pay.
7. Rest cures or custodial care.
8. Repair or replacement of existing dentures, partial dentures, braces or bridgework.
9. Personal services such as television and telephone, or transportation.
10. Expenses payable by any automobile insurance policy without regard to fault.
11. Services or treatment provided by an infirmary operated by the Policyholder.
12. Treatment or service provided by a private duty nurse.

This information is a brief description of certain benefits and features of the Blanket Accident Medical Insurance underwritten by QBE Insurance Corporation. It is not a contract and does not extend or alter the coverage afforded by the Policy. Full terms and conditions of coverage, including effective dates of coverage, benefits, limitations and exclusions, are set forth on the applicable policy form. To the extent there is any discrepancy between the descriptions in this brochure and the terms, conditions, limitations and exclusions of the Policy, the Policy shall prevail. Any policy QBE issues will be subject to the laws of the jurisdiction in which it is issued.

BMI Benefits, LLC.
P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
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 parent/guardian has NO medical/dental coverage, please indicate under Part 1B of the Claim form and complete the Statement of No Other Insurance Document which can be obtained from the school district.
ii. Please notify all health care professionals 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.

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

Student 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/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	Individual School Location/Name	Policy#
CA Student Accident Insurance Program	Carmel Unified	KHH200156

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 or ☐ Right Body Part

At the time of the accident, was the student involved in an activity sponsored and supervised by the Policyholder?	YES □ NO □
At the time of the accident, was the student traveling to or from a regularly scheduled school activity?	YES □ NO □

How did Injury occur?

Name of School Official:	Was he/she a witness to the accident?	YES □ NO □

Signature of Supervisor/Official	Title	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 □
Employer		Employer	

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. **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.)

Claimant 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 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)

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.

For Resident of All Other States: Any person who knowingly and willfully presents false information in an application for insurance may be guilty of insurance fraud and subject to fines and confinement in prison. (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties).

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 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)

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.

For Resident of All Other States: Any person who knowingly and willfully presents false information in an application for insurance may be guilty of insurance fraud and subject to fines and confinement in prison. (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties).

BMI Benefits, LLC.
P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
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.

Statement of No Other Insurance

I,_____, declare that I was not covered by any other insurance policy, through
(Insured's Name)
myself or my parents for the accident dated_____. Should any insurance become effective during my treatment I will notify BMI Benefits and forward all eligible bills to the new 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 Name if insured is a minor) **(Date)**

_____ _____
(Insured Signature or Parent 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.

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

Student Accident Insurance Claim Filing Instructions

1. **BMI Benefits Accident/Injury Claim Form:** Part 1A must be 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 provide us with a statement from your employer noting that the student/claimant has no insurance or 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, 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 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. 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
732-844-8704	**BMI Benefits, LLC PO Box 511 Matawan, NJ 07747**	**Lisac@bobmccloskey.com**

6. You may contact BMI Benefits, LLC at 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, 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
www.bobmccloskey.com

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 might 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?
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.

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. 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

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.

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 MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

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

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.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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	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

	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

ADA American Dental Association®

America's leading advocate for oral health

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"