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 providers where treatment was received, submit BMI's billing information as your secondary insurance, and ask for BMI to be billed directly. You may also obtain from the medical providers **all itemized bills** and **primary insurance explanation of benefits (EOBs)**. Itemized bills are considered **HCFA1500** Forms (physician's office) or **UB-04** Forms (hospitals), **not balance due statements**. Please reference the attached claims instruction document for additional information.

PART 1A: POLICYHOLDER

School/Organization/Policyholder Name Paterson BOE	Policy# BAP 480801
School/Organization/Policyholder Mailing Address (Street, City, State, Zip)	

Student's Name	Date of Birth	Male ☐ Female ☐
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)		

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 must be signed by an official of the policyholder or the claim cannot be processed

INSURANCE INFORMATION

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 Insurance 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-Mal
Is the Parent/Guardian Employed?	YES ☐ NO ☐	Is the Parent/Guardian Employed?	YES ☐ NO ☐
Employer		Employer	

MEDICAL INFORMATION AUTHORIZATION & ASSIGNMENT OF BENEFITS: 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.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant or Authorized Person's Signature	Date

CLAIM FORM FRAUD NOTICE

Arkansas	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.
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.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
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.
Kansas	A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Louisiana	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.
Maine	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 denial of insurance benefits.
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.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
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.
New York	General: All applications for commercial insurance, other than automobile insurance: 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. All applications for automobile insurance and all claim forms: Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation. Fire: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.
Ohio	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.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Pennsylvania	All Commercial Insurance, Except As Provided for Automobile Insurance: 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. Automobile Insurance: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.
Puerto Rico	Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.
Rhode Island	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.
Tennessee	All Commercial Insurance, Except As Provided for Workers' Compensation It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Workers' Compensation: It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.
Utah	Workers' Compensation: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.
Virginia	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
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 include imprisonment, fines and denial of insurance benefits.
West Virginia	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.
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).

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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 school and 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 provider the BMI Benefits billing information, they should bill BMI directly after they bill your primary health insurance. You may also obtain and attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills, known as HCFA 1500s (physician billing form) and UB-04s (hospital billing form). The itemized medical bills should show the ICD-10 and CPT codes for the services provided, as well as other necessary information for insurance processing. Balance due statements are NOT itemized bills and cannot be processed and paid by BMI Benefits. The insurance policy is an excess insurance, which means benefits are provided after any other valid and collectible insurance has processed the medical claims.**

3. In regards to claims for a dental injury, the policy will cover accidental injury to sound, natural teeth. The claim must be submitted to both the dental insurance and the medical insurance if available. In regards to reimbursement for prescription expenses, we will need a copy of the itemized prescription bill. Cash register receipts only will not suffice.

4. If you have already paid the medical service provider and wish to be reimbursed directly, please attach a paid receipt or statement that verifies the payment along with the itemized bills and primary EOBs. 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	clerk@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.

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Student Accident Insurance Frequently Asked Questions

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

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

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

Does the accident insurance policy pay for out-of-pocket expenses such as co-pays and deductibles?
Yes. These charges can be submitted to the accident insurance policy to provide reimbursement.

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

- **Fully completed BMI Benefits Accident Claim Form**
- **Itemized Bill – <u>in the form of a HCFA or UB04</u>**. This can be obtained through the medical 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.

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.

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Statement of No Other Insurance
Please complete this form in its entirety and submit to BMI Benefits, LLC. along with the completed accident claim form.

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.

ITEMIZED BILL FOR PHYSICIAN BILLING - HICFA 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 MM DD YY QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. ID# 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM

1	2	3a PAT. CNTL # / b MED REC #	4 TYPE OF BILL
		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

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. IND.	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												68

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI				73

74 PRINCIPAL PROCEDURE CODE / DATE	c OTHER PROCEDURE CODE / DATE	b OTHER PROCEDURE CODE / DATE	75
d OTHER PROCEDURE CODE / DATE	e OTHER PROCEDURE CODE / DATE	f 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		

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

UB-04 CMS-1450 APPROVED OMB NO.

NUBC National Uniform Billing Committee

LIC9213257

BMI Benefits, LLC.
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Formulario De Reclamo De Accidente Estudiantil

Porfavor de completar este formulario en su totalidad y presente los beneficios de BMI dentro de los 90 días a partir de la fecha del accidente. Por favor, guarde una copia para sus archivos. Comuníquese con los proveedores médicos donde se recibió el tratamiento, envíe la información de facturación de BMI como su seguro secundario y solicite que BMI se facture directamente. También puede obtener de los proveedores médicos **todas las facturas detalladas y la explicación de beneficios del seguro primario (EOB).** Las facturas detalladas se consideran Formularios **HCFA CMS 1500** (consultorio médico) o Formularios **UB-04** (hospitales), **sin saldos vencidos**. Por favor consulte el documento de instrucciones de reclamaciones adjunto para obtener información adicional.

PARTE 1A: TITULAR DE LA PÓLIZA

Escuela/Organización/Nombre del titular de la póliza	Ubicación/Nombre De La Escuela Individual	Póliza #
Paterson BOE		BAP 480801

Dirección Postal De La Escuela/Organización/Titular De La Póliza (Calle, Ciudad, Estado, Código Postal)

El Nombre Del Estudiante	Fecha De Nacimiento	Masculino □ Femenino □
Número De Seguro Social Del Estudiante (SSN debe ser provisto según lo requiera el Centro de Servicios de Medicare)		

Dirección De La Casa De El Estudiante (Calle, Ciudad, Estado, Código Postal)

Fecha De Accidente	Tiempo/Hora	Nombre De La Actividad o Tipo De Deporte	Parte Del Cuerpo Lesionada	□ Izquierda o □ Parte Derecha Del Cuerpo

En el momento del accidente, Estuvo el alumno involucrado en una actividad patrocinada y supervisada por el titular de la póliza?	SI □ NO □
En el momento del accidente, viajaba el estudiante hacia o desde una actividad escolar programada regularmente?	SI □ NO □

Cómo ocurrió la lesión?

Nombre Del Funcionario Escolar:	Fue él/ella un testigo del accidente?	SI □ NO □

Firma del supervisor/Oficial	Título	Fecha

NOTA: La parte 1A debe estar firmada por un funcionario del titular de la póliza o la reclamación no puede ser procesada

INFORMACIÓN DEL SEGURO

El Está Estudiante cubierto por cualquier otra póliza de seguro, ya sea como dependiente, o bajo un grupo, individuo, automóvil, médico o pasivo?

Política? SI □ NO □

En caso afirmativo, nombre de la Póliza de Seguros: _____ Número De Póliza: _____

El seguro anterior es un Plan de Medicaid o un Seguro Militar como Tricare? **SI □ NO □**

INFORMACIÓN DE PADRES / TUTORES

Nombre De Madre/Tutor/Guardian		Nombre De Padre/Tutor/Guardian	
Teléfono	Correo Electrónico	Teléfono	Correo Electrónico
El Padre/Tutor/Guardian Está Empleado?	SI □ NO □	El Padre/Tutor/Guardian Está Empleado?	SI □ NO □
Empleador		Empleador	

AUTORIZACIÓN DE INFORMACIÓN MÉDICA Y ASIGNACIÓN DE BENEFICIOS: Autorizo a cualquier proveedor de atención médica, centro médico, médico, compañía de seguros u organización a que lo proporcionen a solicitud de BMI Benefits, LLC. O las compañías aseguradoras con las que trabaja, la información que usted puede tener, incluidos los hallazgos y los tratamientos prestados, y copias de todos los registros hospitalarios y médicos de servicios profesionales y atención hospitalaria prestados en mi nombre. La autorización anterior se otorga en el entendimiento de que cualquier derecho legal que pueda tener para reclamar comunicaciones entre nosotros como privilegios se renuncia expresamente y voluntariamente. Un fotostático de esta autorización se considerará válido y efectivo como el original. Los pagos se realizarán a los proveedores del servicio, a menos que un recibo / estado de cuenta pagado acompañe el envío del reclamo médico.Toda persona que intencionalmente y con la intención de defraudar a cualquier compañía de seguros u otra persona presente una declaración de reclamo que contenga información materialmente falsa u oculte con fines de información engañosa sobre cualquier material factual de la misma, comete un acto de seguro fraudulento, que es delito, y también estará sujeto a una multa civil que no exceda los cinco mil dólares y el valor declarado del reclamo por cada violación.

Firma Del Reclamante o De La Persona Autorizada	Fecha

CLAIM FORM FRAUD NOTICE

Arkansas	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.
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.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
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.
Kansas	A "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Louisiana	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.
Maine	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 denial of insurance benefits.
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.
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
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.
New York	General: All applications for commercial insurance, other than automobile insurance: 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. All applications for automobile insurance and all claim forms: Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation. Fire: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.
Ohio	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.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Pennsylvania	All Commercial Insurance, Except As Provided for Automobile Insurance: 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. Automobile Insurance: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.
Puerto Rico	Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.
Rhode Island	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.
Tennessee	All Commercial Insurance, Except As Provided for Workers' Compensation It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. Workers' Compensation: It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.
Utah	Workers' Compensation: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.
Virginia	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
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 include imprisonment, fines and denial of insurance benefits.
West Virginia	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.
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
Teléfono: 800.445.3126
Fax: 732.583.9610
www.bobmccloskey.com

Seguro de Accidente Estudiantil Instrucciones para presentar una reclamación

1. **Formulario de reclamo de accidente/lesión de beneficios de BMI:** La parte 1A debe estar firmada por la escuela/titular de la póliza. Todas las demás secciones deben ser completadas por la escuela y el padre/guardián. Si está empleado, pero no tiene seguro, por favor mencione "SIN SEGURO" y proporciónenos una declaración de su empleador que indique que el estudiante/reclamante no tiene seguro o complete el formulario adjunto: "Declaración de No Otro Seguro". De lo contrario, nuestra oficina puede enviar un cuestionario de seguro a su empleador para ser utilizado como verificación de no cobertura de dependientes.

2. **Comuníquese con todos los proveedores médicos donde se recibió el tratamiento y dígales que tiene un seguro secundario. Si Usted le brinda a su proveedor de atención médica la información de facturación de BMI Benefits, debe facturarle directamente a BMI una vez que facturen a su seguro de salud primario. También puede obtener y adjuntar copias de la Explicación de beneficios (EOB) de su compañía de seguros principal y todas las facturas médicas detalladas, conocidas como HCFA CMS 1500 (formulario de facturación médica) y UB-04 (formulario de facturación del hospital). Las facturas médicas detalladas deben mostrar los códigos ICD-10 y CPT para los servicios prestados, así como otra información necesaria para el procesamiento del seguro. Las declaraciones de saldos adeudados NO son facturas detalladas y no pueden ser procesadas y pagadas por BMI Benefits. La póliza de seguro es un seguro excedente, lo que significa que los beneficios se brindan después de que cualquier otro seguro válido y cobrable haya procesado los reclamos médicos.**

3. En cuanto a las reclamaciones por lesiones dentales, la política cubrirá lesiones accidentales a dientes sanos y naturales. El reclamo debe presentarse tanto al seguro dental como al seguro médico, si está disponible. En lo que respecta al reembolso de los gastos de medicamentos recetados, necesitaremos una copia de la factura de medicamentos recetados detallada. Los recibos de caja registradora solos no serán suficientes.

4. Si ya pagó al proveedor de servicios médicos y desea que se le reembolse directamente, adjunte un recibo o extracto pagado que verifique el pago junto con las facturas detalladas y los EOB principales. Las HSA y las FSA son reembolsables, sin embargo, las HRA no son reembolsables.

5. Envíe el formulario de reclamo completo, las facturas detalladas y el seguro primario Explicación de beneficios a BMI Benefits, LLC. Las reclamaciones pueden enviarse por correo postal, fax o correo electrónico.

FAX	CORREO	CORREO ELECTRÓNICO
732-583-9610	BMI Benefits, LLC PO Box 511 Matawan, NJ 07747	clerk@bobmccloskey.com

6. Puede comunicarse con BMI Benefits, LLC al 800.445.3126 para analizar su reclamo. Tenga en cuenta que la resolución de su reclamo puede tardar varias semanas en procesarse. Cuando contacte a BMI Benefits, tenga a mano su formulario de reclamo, así como el nombre de la escuela, el distrito escolar o el titular de la póliza para asegurar una pronta asistencia.

NOTA: Cuando BMI procesa un reclamo presentado, se enviará por correo al Proveedor de servicios médicos una Explicación de Beneficios (EOB) junto con el pago de cualquier cheque. También se envía por correo una segunda copia a la dirección que figura en el archivo para que el reclamante / estudiante explique los detalles del pago del reclamo. Si falta información para que BMI procese y pague un reclamo pendiente, se enviará un EOB por correo indicando lo que debe enviarse al BMI para su reprocesamiento y pago del reclamo médico. Todos los reclamos presentados están sujetos a los términos, condiciones y beneficios de la póliza según se describen en la cobertura seleccionada por el titular de la póliza.

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Seguro de Accidente Estudiantil
Preguntas Frecuentes

Por que la escuela de mi hijo proporciona seguro de accidentes para estudiantes?
Muchos planes de seguro de salud tienen deducibles altos y límites del plan que dejan a los padres con facturas altas resultantes de un accidente inesperado. Esta poliza de exceso, proporcionada por la escuela, protege a los estudiantes y las familias de los costos asociados con los accidentes relacionados en el tiempo escolar y/o los deportes, según la cobertura de póliza elegida de su escuela.

Que es BMI Benefits?
BMI Benefits, LLC. Es el administrador de reclamaciones en nombre de la compañía de seguros.

El seguro primario siempre tiene que pagar primero?
Sí. Los reclamos médicos siempre deben enviarse inicialmente a su póliza de seguro primaria. Cualquier saldo restante de los gastos no cubiertos por su primaria se someterá a la política de exceso. La póliza cubrirá el saldo restante de los gastos elegibles hasta el máximo del plan.

Paga la póliza de seguro de accidentes los gastos de bolsillo como copagos y deducibles?
Sí. Estos cargos pueden enviarse a la póliza de seguro de accidentes para proporcionar el reembolso.

Qué documentos son necesarios para procesar un reclamo?
Si su estudiante está involucrado en un accidente relacionado con la escuela, se necesitan los siguientes documentos para procesar adecuadamente un reclamo:

- **Formulario de reclamo de accidente de beneficios de BMI completo**
- **Factura detallada - <u>en forma de HCFA CMS1500 o UB04.</u>** Esto se puede obtener a través del proveedor médico. **NO ENVÍE** recibos de efectivo, saldo adeudado, saldos adeudados o estados de cuenta vencidos para el procesamiento o pago de reclamaciones. Una factura detallada (HCFA o UB04) contiene la siguiente información:
  o Nombre del proveedor, dirección del proveedor, número de identificación fiscal
  o Fecha (s) del servicio, tipo de servicio prestado, incluidos códigos CPT e ICD-9
  o La tarifa por cada procedimiento
- **Explicación de beneficios (EOB) del seguro primario** - debe recibir una copia de esto de su compañía de seguros principal.

A dónde envío todos estos documentos?
Envíe todos los formularios de reclamación, facturas detalladas, EOB principales, otra información de seguro y correspondencia de reclamaciones a BMI Benefits, LLC. **Puede ser más fácil ponerse en contacto con su proveedor médico, presentar la información del IMC como el seguro secundario, y el proveedor facturará el IMC directamente con los recibos detallados y las EOB principales.**

Qué información de seguro tengo que darle a un proveedor?
Cuando vaya al hospital, al consultorio del médico, a la clínica de TP, etc., debe recordar que tiene un seguro secundario a través de la póliza de seguro médico para accidentes estudiantiles de su escuela. Indique al proveedor que primero le facture a su seguro primario y luego envíe la EOB principal y la factura detallada a BMI Benefits, LLC**. Si no envió la información del seguro secundario en su primera visita, llame al proveedor y bríndeles la información del seguro secundario para Beneficios de BMI.** Si el proveedor factura la póliza de seguro de accidentes estudiantiles de la escuela directamente, esto evitará que se envíe una declaración de saldos adeudados al estudiante/padre.

Qué puede causar un retraso en el procesamiento y el pago de un reclamo?
El administrador de reclamos no puede procesar un reclamo al que le faltan uno o más de los siguientes documentos: el formulario de reclamo de accidente / lesión, el proyecto de ley detallado o el rechazo / EOB principal. No podemos aceptar saldos vencidos, saldos a plazo o vencidos para el procesamiento de reclamaciones.

A quién puedo contactar si tengo alguna pregunta? Si tiene preguntas después de enviar sus reclamos a BMI Benefits, LLC. por favor contáctelos al 800-445-3126. Tenga en cuenta que la resolución de su reclamo puede tardar varias semanas en procesarse. Cuando contacte a BMI Benefits, tenga a mano su formulario de reclamo, así como el nombre de la escuela, el distrito escolar o el titular de la póliza para asegurar una pronta asistencia.

NOTA: Cuando BMI procesa un reclamo presentado, se enviará por correo al Proveedor de servicios médicos una Explicación de Beneficios (EOB) junto con el pago de cualquier cheque. También se envía por correo una segunda copia a la dirección que figura en el archivo para que el reclamante / estudiante explique los detalles del pago del reclamo. Si falta información para que BMI procese y pague un reclamo pendiente, se enviará un EOB por correo indicando lo que debe enviarse al BMI para su reprocesamiento y pago del reclamo médico.

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Declaraciòn de Ningùn Otro Sèguro
Porfavor de completar este formulario en su totalidad y presente los beneficios de BMI dentro de los 90 días a partir de la fecha del accidente, con Formulario De Reclamo De Accidente Estudiantil.

Declaraciòn de Ningùn Otro Sèguro

Yo,_____, declaro que no estaba cubierto por ninguna otra pòliza de Seguro,
(Nombre)
atraves de mì o mis Padres por el accidente fechado _____. Si algun otra pòliza de Seguro entra en vigencia lo notifcarè al seguro de BMI y Re-enviarè todas las facturas eligbiles a la nueva comopania de Seguro. Entiendo que la covertura de Beneficios BMI es el exceso de cualquier otro Seguro y pagara despue de el Seguro primario. Entiendo que si alguna de estas declaraciones son falsas, podria considerar mi reclamacion ineligible.

_____ _____
(Nombre Asegurado(a) nombre de Padre) **(Fecha)**

_____ _____
(firma del Asegurado(a) o firma del Padre si el Aseguardo es un menor) **(Fecha)**

Nombre de la Escuela/Asegurado: _____

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.

ITEMIZED BILL FOR PHYSICIAN BILLING - HICFA 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 TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 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

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.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. b.	a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b MED REC #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME a	b	9 PATIENT ADDRESS a	b	c	d	e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN 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
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20									20
21									21
22									22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. (Y/N)	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										68

69 ADMIT DX	70 PATIENT REASON DX			71 PPS CODE	72 ECI			73

74 PRINCIPAL PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	75
OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	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