HOW TO FILE A CLAIM:

1. Complete this form within 90 days.
2. Attach Itemized Bills and Primary Carrier Statements
3. Mail to: BMI Benefits, LLC. PO Box 511, Matawan, NJ 07747 Fax: 732-583-9610 / Phone: 800-445-3126

BMI Benefits, LLC. Accident Claim Form

ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION, MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.

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

PART 1A: POLICYHOLDER

School/District | School Location

School Mailing Address | City, State, Zip

Injured Person's Name | Birth date | Male □ Female □

Date of Injury | Time | Type of Sport/Activity | Part of body injured

How did Injury occur?

Accident Type: Interscholastic ☐ Classroom☐ PE Class ☐ Recess ☐ Other ☐

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

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

Signature of Supervisor/Official | Title | Date

PART 1 B: INJURED PERSON'S INFORMATION
THE INJURED PERSON'S SOCIAL SECURITY NUMBER MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES

Injured Person's Social Security Number

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

Are you covered by any other insurance policy, either as a dependent, group, individual, automobile medical or liability YES ☐ NO ☐

If Yes: Name of Insurance Carrier _____ Policy #: _____

PARENT/GUARDIAN INFORMATION

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

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

MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS:

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

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

Claimant or Authorized Person's Signature | Date

BMI BENEFITS, L.L.C

Student Accident Insurance
Claims Filing Instructions

1. **BMI Benefits Accident/Injury Claim Form:** Part 1A must be completed and signed by the school. 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. Otherwise, our office may submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

2. **You must attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills (known as HCFA's, UB-04's or UB-92's - samples attached). The itemized medical bills should show the ICD-9 and CPT codes for the services provided, as well as other necessary information for insurance processing. Balance due statements are not itemized bills. The insurance policy is an excess insurance, which means benefits are provided after any other valid and collectible insurance has processed the medical claims. You can also contat the medical provider, tell them you have secondary insurance, and give our billing information to bill BMI directly.**
3. 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.

4. 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**	**Email**
732-583-9610	**BMI Benefits, LLC** **PO Box 511** **Matawan, NJ 07747**	gayle@Bobmccloskey.com

5. You may contact BMI Benefits, LLC at 800-445-3126 to discuss your claim. Gayle is the claims Examiner at BMI for Bob Jones Academy. BJA's policy numbers are L004020011601 and US946150. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available to ensure prompt assistance. You may also contact Barbara Moore at BB&T Insurance Services with any question you may have at Barbara.Moore@BBandT.com or 864-442-4032.

Student Accident Insurance Program FAQs

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 related accidents/injuries.

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 up front 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 an athletic injury, the following documents are needed to properly process a claim:

- **Fully completed Insurance Accident Claim Form**
- **Itemized Bill – <u>in the form of a HCFA or UB92/UB04</u>**. This can be obtained through the provider. **DO NOT SEND** cash receipts, balance due, balance forward, or past due statements for claims processing or payment. An itemized bill (HCFA or UB92/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.

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 schools 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 will 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 DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CMS 1500 also know as HCFA: Universal form used for billing purposes for Health Care Professionals.

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | 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. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

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

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

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

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID 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 Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

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. BALANCE DUE $

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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

UB04: Uniform institutional provider billing form used by hospitals.
Provides necessary information to process your claim efficently.

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

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
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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								A
B							57 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	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	

80 REMARKS	81CC			
	a			
	b			
	c			
	d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

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