

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 <input type="checkbox"/> Female <input type="checkbox"/>
Date of Injury	Time	Type of Sport/Activity	Part of body injured
How did Injury occur?			
Accident Type: Interscholastic <input type="checkbox"/> Classroom <input type="checkbox"/> PE Class <input type="checkbox"/> Recess <input type="checkbox"/> Other <input type="checkbox"/>			
At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
Name of Supervisor		Was he/she a witness to the accident?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NO <input type="checkbox"/>	
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 <input type="checkbox"/> NO <input type="checkbox"/>	Is the Mother Employed? YES <input type="checkbox"/> NO <input type="checkbox"/>

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 contact 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 Gail Gray at 864-672-1345 at BB&T Insurance Services with any question you may have.

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 – in the form of a HCFA or UB92/UB04.** 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

APPROVED OMB-0938-0008

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

HEALTH INSURANCE CLAIM FORM										PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)	
5. PATIENT'S ADDRESS (No., Street)										CITY	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										STATE	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										STATE	
10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.	
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEM 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 2. _____ 3. _____ 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
24. A DATE(S) OF SERVICE To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE											
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>										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.)										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 #											
SIGNED DATE										PIN# GRP#	

