



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.

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PO Box 511
Matawan, NJ 07747
Fax: 732.583.9610
Email: clerk@bobmccloskey.com

- See Claim Filing Instructions page for additional information.



**Got You
Covered**

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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.

The Claim Form **MUST** be requested from the Athletic Director at the school.

Once the Coach/AD has completed their portion in its entirety of the claim form, you will need to complete your portion and submit.

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

	<p>crime and subjects such person to criminal and civil penalties.</p> <p>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.</p>
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	<p>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.</p> <p>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.</p>
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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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.



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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 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
732-583-9610	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 – in the form of a HCFA, UB04 or ADA Dental Claim**. 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

<input type="checkbox"/> PICA PICA <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#:DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (No., Street) CITY _____ STATE _____					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY _____ STATE _____				
ZIP CODE _____		TELEPHONE (Include Area Code) _____			8. RESERVED FOR NUCC USE		ZIP CODE _____		TELEPHONE (Include Area Code) _____		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:						
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER		12. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)		
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____			c. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.		
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
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.					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 _____ DATE _____					SIGNED _____						
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) MM DD YY QUAL. _____					15. OTHER DATE MM DD YY QUAL. _____						
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)					17b. NPI _____		20. OUTSIDE LAB? \$ CHARGES _____ <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate to service line below (24E) ICD Ind. _____					22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____						
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____					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 OFF WORK	H. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											
2											
3											
4											
5											
6											
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (if or govt. claim, see back) <input type="checkbox"/> YES <input type="checkbox"/> 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. NPI _____		b. _____	c. NPI _____	d. _____		

CARRIER ↑ PATIENT AND INSURED INFORMATION ↑ PHYSICIAN OR SUPPLIER INFORMATION ↑

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION																		
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> 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? <input type="checkbox"/> Medical? <input type="checkbox"/> (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 <input type="checkbox"/> M <input type="checkbox"/> F		8. Policyholder/Subscriber ID (SSN or ID#)														
9. Plan/Group Number		10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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	30. Diag. Code	31. Fee										
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
33. Missing Teeth Information (Place an "X" on each missing tooth.)					34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)					31a. Other Fee(s)								
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	34a. Diagnosis Code(s) A _____ C _____		32. Total Fee
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	(Primary diagnosis in "A") B _____ D _____		
35. Remarks																		
AUTHORIZATIONS					ANCILLARY CLAIM/TREATMENT INFORMATION													
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 an actual 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					38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")			39. Enclosures (Y or N) <input type="checkbox"/>										
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist named on this or dental entity. X _____ Subscriber Signature _____ Date					40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)			41. Date Appliance Placed (MM/DD/CCYY)										
					42. Months of Treatment			43. Replacement of Prosthesis <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)			44. Date of Prior Placement (MM/DD/CCYY)							
					45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> 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.)					TREATING DENTIST AND TREATMENT LOCATION INFORMATION													
48. Name, Address, City, State, Zip Code					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													
49. NPI		50. License Number			51. SSN or TIN			54. NPI		55. License Number								
52. Phone Number () - -					52a. Additional Provider ID					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"