



**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		Individual School Location/Name		Policy#
School/Organization/Policyholder Mailing Address (Street, City, State, Zip)				
Student's Name			Date of Birth	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Injury	Time	Name of Activity or Sport Type	Body Part Injured	<input type="checkbox"/> Left or <input type="checkbox"/> Right Body Part
At the time of the accident, was the student involved in an activity sponsored and supervised by the Policyholder?				YES <input type="checkbox"/> NO <input type="checkbox"/>
At the time of the accident, was the student traveling to or from a regularly scheduled school activity?				YES <input type="checkbox"/> NO <input type="checkbox"/>
How did Injury occur?				
Name of School Official:			Was he/she a witness to the accident?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Signature of Supervisor/Official		Title	Date	

**NOTE: Policyholder section above must be signed by an official of the policyholder or the claim cannot be processed**

**PART 1B - INJURED PERSON INFORMATION & INSURANCE INFORMATION**

Student's Social Security Number (SSN Must be provided as required by the Center for Medicare Services)	
Student's Home Address (Street, City, State, Zip)	
Is the Student covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy? YES <input type="checkbox"/> NO <input type="checkbox"/> If Yes, Name of Ins. Carrier: _____ Policy #: _____	
Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare? YES <input type="checkbox"/> NO <input type="checkbox"/>	

**PARENT/GUARDIAN INFORMATION**

Parent/Guardian Name		Parent/Guardian Name	
Phone	E-Mail	Phone	E-Mail
Is the Parent/Guardian Employed?	YES <input type="checkbox"/> NO <input type="checkbox"/>	Is the Parent/Guardian Employed?	YES <input type="checkbox"/> NO <input type="checkbox"/>
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
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**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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**Student Accident Insurance  
Claim Filing Instructions**

- 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.
- 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.**
- 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.
- 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.
- 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	<b>BMI Benefits, LLC PO Box 511 Matawan, NJ 07747</b>	<b>clerk@bobmccloskey.com</b>

- 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 or UB04**. 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 <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																													
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>					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)					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					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) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																			
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>										13. INSURED'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 for services described below.																			
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 for services described below.										13. INSURED'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 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. _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE					17a. _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
					17b. NPI _____					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										23. PRIOR AUTHORIZATION NUMBER																			
A. _____ B. _____ C. _____ D. _____																													
E. _____ F. _____ G. _____ H. _____																													
I. _____ J. _____ K. _____ L. _____																													
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																													
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3																													
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5																													
6																													
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, 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. _____										a. NPI _____ 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													9 PATIENT ADDRESS																							
b													b													c			d			e				
10 BIRTHDATE			11 SEX	12 DATE			ADMISSION 13 HR 14 TYPE 15 SRC			16 DHR			17 STAT			18			19			20			21			CONDITION CODES 22 23 24 25 26 27 28			29 ACCT STATE			30		
31 OCCURRENCE CODE DATE			32 OCCURRENCE CODE DATE			33 OCCURRENCE CODE DATE			34 OCCURRENCE CODE DATE			35 OCCURRENCE SPAN FROM THROUGH			36 OCCURRENCE SPAN FROM THROUGH			37																		
38													39 VALUE CODES AMOUNT			40 VALUE CODES AMOUNT			41 VALUE CODES AMOUNT																	
a													b			c			d																	
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									
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23		PAGE ____ OF ____											CREATION DATE						TOTALS								23									
50 PAYER NAME													51 HEALTH PLAN ID						52 REL. INFO		53 ASG. BEN.		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI									
A																									57 OTHER PRV ID											
B																																				
C																																				
58 INSURED'S NAME													59 P.REL.			60 INSURED'S UNIQUE ID						61 GROUP NAME						62 INSURANCE GROUP NO.								
A																																				
B																																				
C																																				
63 TREATMENT AUTHORIZATION CODES													64 DOCUMENT CONTROL NUMBER						65 EMPLOYER NAME																	
A																																				
B																																				
C																																				
66 DX	67		A		B		C		D		E		F		G		H		68																	
69 ADMIT DX			70 PATIENT REASON DX			a. OTHER PROCEDURE CODE DATE			b. OTHER PROCEDURE CODE DATE			71 PPS CODE			72 ECI			73																		
74 PRINCIPAL PROCEDURE CODE DATE																																				
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		FIRST											
																					77 OPERATING NPI		QUAL		FIRST											
																					78 OTHER NPI		QUAL		FIRST											
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