**Claim Filing Checklist**

- **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.**
  
  BMI Benefits, LLC.
  
  PO Box 511
  
  Matawan, NJ 07747
  
  Fax: 732.583.9610
  
  Email: BMI@bobmccloskey.com

- **See Claim Filing Instructions page for additional information.**
### PART 1A - POLICYHOLDER

<table>
<thead>
<tr>
<th>School/Organization/Policyholder Name</th>
<th>Policy#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne Arundel County Public Schools</td>
<td>9908-9115</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School/Organization/Policyholder Mailing Address (Street, City, State, Zip)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Date of Birth</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Injury</th>
<th>Time</th>
<th>Name of Activity or Sport Type</th>
<th>Body Part Injured</th>
<th>Left or Right Body Part</th>
</tr>
</thead>
</table>

At the time of the accident, was the student involved in an activity sponsored and supervised by the Policyholder?  
YES □  NO □

At the time of the accident, was the student traveling to or from a regularly scheduled school activity?  
YES □  NO □

How did Injury occur?

Name of School Official:  
Was he/she a witness to the accident?  
YES □  NO □

Signature of Supervisor/Official  
Title  
Date

**NOTE:** Part 1A – Policyholder section must be signed by an official of the policyholder or the claim cannot be processed

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

<table>
<thead>
<tr>
<th>Student’s Social Security Number (SSN Must be provided as required by the Center for Medicare Services)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Student’s Home Address (Street, City, State, Zip)</th>
</tr>
</thead>
</table>

Is the Student covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability policy?  
YES □  NO □  
If Yes, Name of Ins. Carrier:  
Policy #:  
Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare?  
YES □  NO □

### PARENT/GUARDIAN INFORMATION

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Parent/Guardian Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>E-Mail</th>
<th>Phone</th>
<th>E-Mail</th>
</tr>
</thead>
</table>

Is the Parent/Guardian Employed?  
YES □  NO □  
Employer  
Is the Parent/Guardian Employed?  
YES □  NO □

Medical Information Authorization: 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. Important Notice: 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. For residents of New York: 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. (Fraud language varies by state, for additional state specific fraud warning language, please see below.)

Claimant or Authorized Person’s Printed Name & Signature  
Date

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/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.
IMPORTANT NOTICE

For residents of Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For residents of California: For your protection California law requires the following to appear on this form, Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of 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.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of 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.

For residents of Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For residents of Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

For residents of Kentucky: 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.

For residents of 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.

For residents of Maine, Tennessee, Virginia and 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 may include imprisonment, fines or a denial of insurance benefits.

For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For residents of 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.

For residents of New York: 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. (Fraud language varies by state, for additional state specific fraud warning language, please see below)

For residents of Ohio and Oklahoma: 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.

For residents of Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.

For Resident of 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).
Statement of No Other Insurance

I, ____________________________, declare that I was not covered by any other insurance policy, through 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.
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.

<table>
<thead>
<tr>
<th>FAX</th>
<th>MAIL</th>
<th>E-MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>732-583-9610</td>
<td>BMI Benefits, LLC PO Box 511 Matawan, NJ 07747</td>
<td><a href="mailto:BMI@bobmccloskey.com">BMI@bobmccloskey.com</a></td>
</tr>
</tbody>
</table>

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.
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

1. MEDICARE [ ] 
   [Medicare] [Medicaid] [ ] 
   [Medicaid] [ ]

2. PATIENT’S NAME (Last Name, First Name, Middle Initial)
   [ ]

3. PATIENT’S DATE OF BIRTH
   [ ]

4. INSURED’S NAME (Last Name, First Name, Middle Initial)
   [ ]

5. PATIENT’S ADDRESS (No., Street)
   [ ]

6. PATIENT’S RELATIONSHIP TO INSURED
   [ ]

7. INSURED’S ADDRESS (No., Street)
   [ ]

8. RESERVED FOR NUCC USE
   [ ]

9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)
   [ ]

10. PATIENT’S CONDITION RELATED TO
    [ ]

11. INSURED’S POLICY GROUP OR FECA NUMBER
    [ ]

12. OTHER INSURED’S POLICY GROUP OR FECA NUMBER
    [ ]

13. IS THERE ANOTHER HEALTH BENEFIT PLAN?
    [ ]

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)
    [ ]

15. OTHER DATE
    [ ]

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    [ ]

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
    [ ]

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE
    [ ]

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
    [ ]

20. OUTSIDE LAB?
    [ ]

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    [ ]

22. CODE
    [ ]

23. PRIORITY AUTHORIZATION NUMBER
    [ ]

24. A. DATE(S) OF SERVICE
    [ ]

25. FEDERAL TAX ID NUMBER
    [ ]

26. PATIENT’S ACCOUNT NO.
    [ ]

27. ACCEPT ASSIGNMENT
    [ ]

28. TOTAL CHARGE
    [ ]

29. AMOUNT PAID
    [ ]

30. Resolved for NUCC Use
    [ ]

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
    [ ]

32. SERVICE FACILITY LOCATION INFORMATION
    [ ]

33. BILLING PROVIDER INFO & PH #
    [ ]


PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)
ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM

<table>
<thead>
<tr>
<th>CODE</th>
<th>AMOUNT</th>
<th>VALUE CODES</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

The certifications on the reverse apply to this bill and are made a part hereof.
### ADA American Dental Association® Dental Claim Form

#### Header Information
1. Type of Transaction (Mark all applicable boxes)
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [ ] EPSDT/TITle XIX

2. Predetermination/Preauthorization Number

#### Insurance Company/Dental Benefit Plan Information
3. Company/Plan Name, Address, City, State, Zip Code

#### Other Coverage
4. Dental? [ ] Medical? [ ] (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
8. Policyholder/Subscriber ID (SSN or ID#)

#### Patient Information
9. Plan/Group Number
10. Patient's Relationship to Person named in #5

#### Other Insurance Company/Dental Benefit Plan Information
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

#### Record of Services Provided

<table>
<thead>
<tr>
<th>#</th>
<th>Description</th>
<th>Fee</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<td>2</td>
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<td>[ ]</td>
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<tr>
<td>10</td>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>39. Description</th>
<th>31a. Other Fee(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td></td>
</tr>
</tbody>
</table>

#### Authorizations
38. I have been informed of the treatment plan and associated costs. 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 oral health care 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.

#### Billing Dentist or Dental Entity
48. Name, Address, City, State, Zip Code

#### Ancillary Claim/Treatment Information
39. Enclosures (Y or N)
40. Is Treatment for Orthodontics? (Use “Place of Service Codes for Professional Claims”)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment
43. Replacement of Prosthesis
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

#### Treating Dentist and Treatment Location Information
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

#### Additional Information
54. NPI
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code
57. Phone Number
58. Additional Provider ID

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To reorder call 800.947.4746 or go online at adacatalog.org
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”

**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.

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dentist</strong></td>
<td></td>
</tr>
<tr>
<td>A dentist is 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.</td>
<td>122300000X</td>
</tr>
<tr>
<td><strong>General Practice</strong></td>
<td></td>
</tr>
<tr>
<td>1223G0001X</td>
<td></td>
</tr>
<tr>
<td><strong>Dental Specialty (see following list)</strong></td>
<td>Various</td>
</tr>
<tr>
<td><strong>Dental Public Health</strong></td>
<td>1223D0001X</td>
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<tr>
<td><strong>Endodontics</strong></td>
<td>1223E0200X</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td>1223X0400X</td>
</tr>
<tr>
<td><strong>Pediatric Dentistry</strong></td>
<td>1223P0221X</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td>1223P0300X</td>
</tr>
<tr>
<td><strong>Prosthodontics</strong></td>
<td>1223P0700X</td>
</tr>
<tr>
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Provider taxonomy codes listed above are a subset of the full code set that is posted at “www.wpc-edi.com/codes/taxonomy”