WEST MILFORD PUBLIC SCHOOLS

46 Highlander Drive, West Milford, New Jersey 07480
Phone: 973-697-1700 www.wmtps.org Fax: 973-697-8351

Brian Kitchin, Ed.D.
Superintendent

William Scholts, CPA, PSA
Business Administrator/Board Secretary

Daniel Novak
Director of Education

Derek Ressa, Ed.D.
Director of Special Services

"Success Starts Here"

August 2024

Dear Parents/Guardians:

The West Milford Board of Education has purchased **Student and Athletic Accident Insurance** coverage for the **2024-2025** school year, to protect all students against accidental injury during all school-sponsored and supervised activities, whether at the school or away. This coverage is provided by The Hartford.

This insurance plan is **Excess** coverage: i.e., you must submit all bills to your own insurance carrier first. The Student Accident policy will pick up the unpaid balances, up to the limits of the policy and per the coverage terms.

Although this coverage is very broad, there are restrictions, limitations and exclusions in this policy. In some situations, medical bills may not be covered in full. Parents should understand that medical expenses are their own responsibility not the school's responsibility.

All injuries should be immediately reported to a coach, nurse or faculty advisor. Claim forms will be provided by the school, but it is the parents' responsibility to:

1. Submit the Statement of claim for Medical Expense Benefits with Parts I and II filled out completely (any omissions will delay the processing of the claim).
2. Statement of No Other Insurance (if applicable).
3. Submit all itemized bills (monthly statements will not do).
4. Submit the statements (EOB- Explanation of Benefits) received from your own insurance Carrier showing amounts paid and balance due or a letter of denial stating the claim is not covered. One of these letters is required for any payment to be made if you have medical insurance.

If you don't have any other medical insurance, you will receive a letter from NAHGA Claim Services. Fill the form out and return it to them immediately, and the claim will be processed. Failure to return this letter will result in a delay or denial of the claim.

It is your responsibility, and to your benefit, to submit the necessary papers as soon as possible as the claim cannot be paid until all papers are submitted. Only one claim form per accident is required.

All claim forms, bills and the letters from other insurance carriers are to be forwarded to, and questions regarding the coverage answered by:

NAHGA Claim Services
PO Box 189
Bridgeton, ME 04009

Phone: 800-952-4320
Fax: 207-647-4569

OPTIONAL ADDITIONAL INSURANCE:

If you wish to purchase 24-hour Accidental Medical Insurance coverage, please visit www.agadministrators.com to review your options. Around The Clock – 24 Hour Accident Coverage with a $250,000 maximum benefit is available for purchase at an additional cost. Participation in this plan is strictly optional. Should you have any questions, please call **1-610-933-0800** and a representative at **A-G Administrators LLC** will be happy to assist you with the process.

Sincerely,

William Scholts
Business Administrator/Board Secretary

WS:tl
Attachments

S:\WS-TL\Insurance\ParentLetter-StudentAccidentFY25

NAHGA
CLAIM SERVICES
WHERE STELLAR SERVICE IS NO ACCIDENT

Dear Parent or Guardian:

The School District has purchased insurance coverage to protect all students against accidental injury occurring during all school-sponsored and supervised activities, whether at the school or away. This coverage is provided by NAHGA Claim Services.

This policy is **Excess** to any other valid and collectible insurance – it is a secondary policy and all claims must be submitted to the student's primary insurance first. All claims are subject to the policy limits and guidelines and are not guaranteed coverage. ***Please review the following page for benefits specific to your school district.*** Some important limitations to note from the plan:

- A completed Accident report form must be filed before benefits can be considered.
- Treatment must occur within the first 90 days from the date of injury for benefits to be considered.
- Physical Therapy Treatment including Chiropractic has a $10,000 limit with a letter of Medical Necessity required.
- Benefits are payable for up to 3 years from the date of injury.

Upon an injury occurring it should be immediately reported to a coach, nurse or faculty advisor. Accident report forms will be provided by the school, it is the parents' responsibility to:

1. Submit the claim form to NAHGA Claim Services, please ensure the form is complete with the necessary signatures. This form can be sent a few different ways, please bottom of letter for contact details.
2. For best accurate submissions of bills it's very important to provide NAHGA's information as the secondary insurance at the time the student is seen at a medical provider's office. Medical billing forms (referred to as HCFA1500 & UB04) are needed to consider bills for benefits, balance due statements will not suffice.
3. Submit any Primary explanation of benefits (EOB) received to NAHGA that is in relation to the injury as well as any receipts if you made payments on any medical charges for the injury so that you can be reimbursed directly.

If there is no primary medical insurance for the student please note such on the accident report form and provide NAHGA's information as the primary when seen at a medical provider's office for treatment.

All claim forms, bill, letters from other insurance carriers and any claims questions should be forwarded to NAHGA Claims Services.
Mail:
PO Box 189
Bridgton, ME 04009

Email & fax for submission of documents:
claims@nahga.com
207-647-4569

Email & phone for questions:
ncsp@nahgaclaims.com
1-800-952-4320

Electronic payer ID to provide to medical providers for electronic billing:
Payer ID- 67788

West Milford Board of Education
Accident Insurance Referral Letter

Dear Participant,

You are enrolled in West Milford Board of Education's Student & Athletic Excess Accident Plan. Please use this information when seeking medical care.

Specifics of the coverage:

1. Deductible - $0 per injury
2. Coinsurance – 100% of Usual and Customary
3. Accident Medical Expense – Excess/Secondary Plan
4. Accident Medical Maximum – up to $25,000 Per Injury
5. Benefit Period – 156 weeks from the date of the reported injury
6. Physical Therapy treatment including Chiropractic has a $10,000 limit
7. All claims should be submitted to primary insurance first.
8. Once medical charges have been processed by primary insurance, please submit itemized bills along with primary insurance EOB's (Explanation of Benefits) to NAHGA, the claims administrator.
9. Please do not submit balance due, balance forward or past due statements for payment. Sending in these types of statements will only delay payment. Only itemized bills from a doctor or hospital will be acceptable for payment.

Insurance Carrier:	Hartford
Policy #:	13-BSR-103191
Effective Dates:	8/1/23 – 8/1/24
Claims Administrator:	NAHGA

THIS IS AN EXCESS POLICY
The following must be received to process a claim:

1. Accident details - submitted by school
2. Provider itemized bill
3. Primary insurance EOB's

Submit claims to:
NAHGA Claim Services
PO Box 189
Bridgton, ME 04009-0189

EDI Payer ID #: 67788

Phone: (800) 952-4320
Fax: (207) 647-4569

Possession of this form does not guarantee coverage

NAHGA CLAIM SERVICES

WHERE STELLAR SERVICE IS NO ACCIDENT

Student Accident Insurance
Claim Filing Instructions

1. **Hartford Participant Accident Statement of Claim Form:** Part I must be completed and 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 complete the enclosed form – 'Statement of No Other Insurance'.

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 Hartford Claim Form, they should bill NAHGA 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 NAHGA Claim Services. 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 NAHGA Claim Services. Claims can be submitted via mail, fax, or e-mail.

FAX	MAIL	E-MAIL
207-647-4569	NAHGA Claim Services PO Box 189 Bridgton, ME 04009	claims@nahga.com

6. You may contact NAHGA at 800.952.4320 to discuss your claim. Please be aware that settlement of your claim may take several weeks to process. When contacting NAHGA, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

NOTE: When NAHGA processes a submitted claim, an Explanation of Benefits (EOB) will be mailed to the medical provider ofservice 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 NAHGA to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to NAHGA for reprocessing and payment of the medical claim.

NAHGA CLAIM SERVICES

WHERE STELLAR SERVICE IS NO ACCIDENT

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 NAHGA Claim Services?
NAHGA 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 Hartford Participant Accident Claim Form**
- **Itemized Bill – <u>in the form of a HCFA, UB04 or ADA Dental Claim</u>**. 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 NAHGA Claim Services. **It might be easier to contact your medical provider, submit NAHGA's information as the secondary insurance, and the provider will bill NAHGA 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 NAHGA**. 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 NAHGA.** 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 NAHGA please contact them at 800-952-4320. Please be aware that settlement of your claim may take several weeks to process. When contacting NAHGA, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

NOTE: When NAHGA 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 NAHGA to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to NAHGA for reprocessing and payment of the medical claim.

NAHGA
CLAIM SERVICES
WHERE STELLAR SERVICE IS NO ACCIDENT

Statement of No Other Insurance
Please complete this form in its entirety and submit to NAHGA along with the completed claim form.

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 NAHGA and forward all eligible bills to the new carrier. I understand NAHGA's 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's Name)

_____ _____
(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 - HCFA 1500 FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. 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) YES ☐ NO ☐

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ 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? YES ☐ NO ☐ ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. 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									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. 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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

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

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee

LIC9213257

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 (Mark applicable box and complete items 5-11. If none, leave blank.)

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 ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ 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 ☐ M ☐ 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 ☐ Self ☐ Spouse ☐ Dependent Child ☐ 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 ☐ M ☐ 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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "**A**") A _____ C _____ B _____ D _____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

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 a contractual 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

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)	41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) / 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ 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.)

48. Name, Address, City, State, Zip Code

49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

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.

X _____
Signed (Treating Dentist) Date

54. NPI	55. License Number
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"

Participant Accident
Statement of Claim for
Medical Expense Benefits

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Policyholder and Claimant:
We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read these important instructions regarding completion of these forms.

The information below constitutes a complete claim filed with The Hartford for purposes of claiming Medical Expense benefits under a Participant Accident policy.

Step 1: Submit a completed Notice of Claim to our office by fax or mail

Part I – Policyholder's Statement

☐ Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan.

☐ Provide any necessary attachments (see Section D).

Part II – Claimant's Statement

☐ Form is to be completed in its entirety and signed by the Claimant or their parent/guardian.

☐ Read and sign the Important Notice on page 4.

Step 2: Submit itemized medical bill(s) and supporting documentation (see below)

Helpful Information for submitting claims and expediting payment

- If the Participant Accident Policy provides coverage on an Excess basis, you must file your bills through your primary insurance carrier prior to filing for benefits under this Policy. The Explanation of Benefits (EOB) that corresponds with the medical bill(s) that have been processed by the other carrier must be submitted with your claim. Please consult the Policyholder or our office if you are unsure of the Policy's scope of coverage.
- A fully-completed Notice of Claim is required for each accident/injury a Claimant incurs. Submitting incomplete information will delay the processing of your claim.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date(s) of service, diagnosis, procedure code(s), amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough detail to process the charges. Accordingly, we recommend providers submit standardized billing statements, specifically, UB-04 forms for hospital charges and/or CMS-1500 forms for physician charges.
- Claim payment is sent directly to the medical providers unless proof that a Claimant has paid the bill in whole or in part (e.g., a copy of check or balance statement) is received.

Please detach this page and forward the completed Statement of Claim and supporting documentation to the address listed below. We recommend you retain copies of the items you have submitted for future reference.

Submit claim by mail to:

P.O. Box 189
Bridgton, ME 04009
Phone: 1-888-998-2240
Fax: 1-207-647-4569

Release of claim forms is not an admission of coverage under a policy for a policyholder, group, or organization.

Please verify if the insured qualifies for any other group benefits through The Hartford and submit the claim accordingly.

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED.

Participant Accident
Statement of Claim for Medical Expense Benefits

Mail forms to:
P.O. Box 189
Bridgton, ME 04009
Phone: 1-888-998-2240
Fax: 1-207-647-4569

THE HARTFORD

PART I - POLICYHOLDER'S STATEMENT – To be completed by the Official Representative of the Policyholder/Plan

A. Information About the Policyholder

Policy Number: 13-BSR-103191	Policyholder Name: West Milford Board of Education	
Policyholder Email Address:	Policyholder Telephone Number: ( )	Policyholder Fax Number: ( )
Policyholder Address (Street, City, State, & Zip Code):		
Participating Organization (or "n/a" if this does not apply):	Class (or "n/a" if this does not apply):	

B. Information About the Claimant

Claimant Name:	Claimant DOB:	Claimant Social Security Number:
Claimant Address (Street, City, State, & Zip Code):		Claimant Telephone Number: ( )

C. Information About the Claim

Medical Expense benefits claimed due to:

☐ Contagious and Infectious Disease ☐ Accidental Injury ☐ Heart or Circulatory Malfunction ☐ Sickness

For claims due to injury, complete the following:

Date of Accident:	Time of Accident (hh:mm): ☐AM ☐PM	Place of Accident:
Nature of injury(ies):		
Fully describe the circumstances of the Accident (Use a separate sheet of paper, if necessary):		

For claims due to illness, complete the following:

Nature of illness:	Date illness first commenced:
Fully describe the circumstances of the sickness (Use a separate sheet of paper, if necessary):	

D. Required Attachments and Signature

Please attach copies of the following documents as applicable:

- Medical information from the Claimant's file relating to this injury/illness, if available.
- Incident/police reports relating to the Incident.

I hereby certify the Insured is a member of the group insured under the above Policy and the loss was sustained under adequate supervision while participating in an official Covered Activity.

I certify that the information provided on the Policyholder's Statement is true and complete according to the records of the Policyholder. I agree that this information is subject to audit by The Hartford and/or its representative.

Title of Policyholder Official	Signature of Policyholder Official	Date

Participant Accident
Statement of Claim for Medical Expense Benefits

Mail forms to:
P.O. Box 189
Bridgton, ME 04009
Phone: 1-888-998-2240
Fax: 1-207-647-4569

THE HARTFORD

PART II – CLAIMANT'S STATEMENT – To be completed by the Adult Claimant or parent/guardian if Claimant is a minor

A. Information about the Claimant

Name: (Last, First, Middle Initial)	Date of Birth:	Social Security Number:
Address: (Street, City, State, & Zip Code)		Gender: ☐ Male ☐ Female

Name of Parent/Guardian and relationship to Claimant (if applicable):

Phone Numbers:
Daytime: (____)_____ Evening: (____)_____ Personal Cell Phone: (____)_____
E-mail Address: _____
May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐Yes ☐No
and/or request this by E-mail? ☐Yes ☐No

_____ _____
Signature Date

Please indicate any other sources of medical insurance under which the Claimant is covered:

Medicare	☐	Mother's Employer's policy*	☐
Medicaid	☐	Father's Employer's policy*	☐
Employer's policy*	☐	Guardian's Employer's policy*	☐
Spouse's Employer's policy*	☐	Any other medical policy*	☐

*If Yes and the Participant Accident Policy provides coverage on an Excess basis, please include the other carrier(s) Explanation of Benefits (EOB) for each medical bill submitted. Please consult the Policyholder or our office if you are unsure of the Policy's scope of coverage.

B. Information about the Claimant's condition

1. For injury, answer the following questions:

When, where, and how did the injury occur?

Name and address of law enforcement agency involved and Case Number (if applicable):

2. For illness, answer the following questions:

What were the first symptoms?	
When did the symptoms begin?	Has the claimant had this illness before? ☐ Yes ☐ No If Yes, when?

3. For injury or illness, answer the following questions:

Date of initial treatment:	Nature of treatment received to date:

Is further treatment anticipated? ☐ Yes ☐ No If Yes, nature and duration of expected treatment:

C. Certification

I certify the above information to be true and accurate to the best of my knowledge. I further certify I have read and signed the Important Notice on page 4 of this form. I also authorize any physician/hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.

_____ _____
Signature of Adult Claimant or Parent/Guardian Date

Important Notice - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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 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 Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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 Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or 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.

For residents of Maine, Tennessee, 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 and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and 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 New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing 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 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of 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.

For residents of Virginia: Any person who, with the 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 may have violated the state law.

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.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____