

Northwest University's Student Accident 'Excess' Insurance Information

Northwest University provides 'excess' medical coverage for all students, and it is very important that Parents and Students understand the 'excess' insurance coverage program.

In order to be eligible for coverage, each student MUST have their own primary health insurance coverage (in their name as policyholder OR be covered under their parent/guardians health insurance), and MUST submit all appropriate forms, and injury claims MUST be filed through your primary medical insurance PRIOR to any potential 'excess' coverage being made available.

PLEASE NOTE: PARENTS/GUARDIANS/STUDENTS ARE RESPONSIBLE FOR TIMELY NOTIFICATION. NORTHWEST UNIVERSITY WILL NOT BE HELD LIABLE FOR ANY DELAY, DISRUPTION OR ADDITIONAL CHARGES TO YOUR PRIMARY MEDICAL INSURANCE OR OUT OF POCKET EXPENSES.

NOTE: THIS PLAN IS INTENDED TO ASSIST WITH ANY OUT OF POCKET EXPENSES RELATING TO INJURIES THE STUDENT SUSTAINS WHILE ON CAMPUS. THE PLAN IS NOT INTENDED TO COVER INDIVIDUAL OFFICE CALLS.

Procedure to Obtain 'Excess' Insurance Benefits

If your student is injured, you will receive an email from Northwest University advising you of the injury and sending you to the claim packet. **IT IS THE RESPONSIBILITY OF THE PARENT/GUARDIAN/STUDENT FROM THIS POINT FORWARD TO FOLLOW UP AND FILE A CLAIM WITH BMI BENEFITS DIRECTLY. YOU WILL NOT RECEIVE FOLLOW UP CONTACT REGARDING INSURANCE COVERAGE FROM NORTHWEST UNIVERSITY.**

If you have received medical or physical therapy care and may need Northwest University's 'excess' insurance coverage, please do the following:

1. Your notice from Northwest University that your Student was injured contained a copy of Student Accident Claim Packet.
 - a. Fill out the appropriate sections of the BMI Benefits Claim form.
 - i. Part 1 B
 - ii. Parent/Guardian Information
 - iii. Section A and Section B
 - b. Send copy of form to BMI Benefits*:
 - i. Mail to: BMI Benefits, LLC, PO Box 511, Matawan NJ 07747
 - ii. Fax to: 732-583-9610
 - iii. Email to: Holly Becroft, hollyb@bobmccloskey.com
2. Keep a chronological list of ALL appointments related to a specific injury, for your records.
3. Take a copy of the included Northwest University's Provider Information form to ALL medical/therapy providers involved with your injury.
 - a. This form provides instructions for the provider(s) to bill your primary insurance and send secondary billing to BMI directly.
4. If you receive a bill that was not submitted to BMI Benefits by the Provider:
 - a. Email, mail or fax (*See 1b):
 - i. All ITEMIZED bills and their associated Explanation of Benefits (EOB), including those bills under your primary medical insurance deductible and bills paid partially or in full by other collectable insurance. *NOTE: Bills showing only "Balance forward" or "Balance Due" are not acceptable.*
 - ii. If any or all benefits are denied, please send a copy of the denial letter showing the reason the charges were denied.

TO ASSURE QUICK PROCESSING, PLEASE BE SURE THAT THE BILL AND THE INSURANCE EOB STATEMENTS SUBMITTED ARE FOR THE SAME ITEM. FEEL FREE TO OFFER BMI BENEFITS TOLL FREE NUMBER TO ANY PROVIDER WHO WISHES TO CONTACT THEM DIRECTLY.
BMI BENEFITS CAN BE REACHED AT: 800-445-3126

HMO/PPO Benefits

If an injured athlete has these types of insurance plans, we recommend you **refer them to their primary care physician** or obtain authorization that will allow you to use a non-network provider if needed.

Date Filed: _____
Please file with Student Development (11220 Building) within 24 hours of the injury

NORTHWEST UNIVERSITY STUDENT REPORT OF INJURY

Print Legibly:

Name of person injured: _____

Home/Cell Ph. # _____ NU Ext. # _____

Northwest University student I.D. # _____

Student ___ Visitor ___ Other (specify) _____

Date/time occurred _____ Date/time reported _____

Did the injury occur while working at Northwest University? Yes ___ No ___ (if yes, consult with HR for new form)

Location: _____

What were you doing at the time of the injury? _____

To whom was the incident reported? _____ Ph. Ext. # _____

Witness #1 _____ Ph. # home _____ Bus. _____

Witness #2 _____ Ph. # home _____ Bus. _____

First-aid treatment? Yes ___ No ___ | By whom? _____ Date/time _____

Seen by University nurse? Yes ___ No ___

Missed class due to injury? Yes ___ No ___ | Name of professors of missed class(es)? _____

Parents contacted after injury occurred? Yes ___ No ___ | Parents' names _____ Phone # _____

Seen by a physician? Yes ___ No ___ | Doctor's name _____ Phone # _____

Refused to see a doctor? Reason _____

Ambulance called to scene? Yes ___ No ___ | Refused Ambulance? Reason _____

Vehicle involved? Yes ___ No ___ | Vehicle accident report made? Yes ___ No ___

Person making report _____ | University Department _____

Describe incident. Give full details. Include: *Where? What? When? How? Why? Name any others involved and explain their involvement.*

USE SUPPLEMENTAL INJURY REPORT FOR ADDITIONAL INFORMATION

Injured's Signature: _____ Date _____

Witness's Signature: _____ Date _____

(Acknowledging Receipt only)

HOW TO FILE A CLAIM:

1. Complete this form within 90 days.
2. Attach Itemized Bills and Primary Carrier Statements
3. Mail to: BMI Benefits, LLC. PO Box 511, Matawan, NJ 07747 800-445-3126 (P) 732-583-9610 (F)



ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION, MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.

This part must be completed and signed by an official of the policyholder or the claim cannot be processed

PART 1A: POLICYHOLDER

School/Organization Northwest University - ICS & MSA		Policy# MSA - US566689 ICS - US566690	
School Mailing Address 5520 108th Ave NE		City, State, Zip Kirkland, WA 98033	
Injured Person's Name		Birth date	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Injury	Time	Type of Sport/Activity	Part of body injured
How did Injury occur?			
Sport Designation: Intercollegiate <input type="checkbox"/> Intramurals <input type="checkbox"/> Practice <input type="checkbox"/> Game <input type="checkbox"/> General Accident <input type="checkbox"/> Other <input type="checkbox"/>			
At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Name of Supervisor		Was he/she a witness to the accident? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Signature of Supervisor/Official		Title	Date
		Head Athletic Trainer	

PART 1 B: INJURED PERSON'S INFORMATION

THE INJURED PERSON'S SOCIAL SECURITY NUMBER MUST BE PROVIDED AS REQUIRED BY THE CENTER FOR MEDICARE SERVICES

Injured Person's Social Security Number	
Injured Person's Home Address (Street, City, State, Zip)	
Is the injured Person Employed? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please fill out Section A below.	
Is the injured Person Married? YES <input type="checkbox"/> NO <input type="checkbox"/> Spouse's Name	
Is the Spouse Employed? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please fill out Section B below.	
Are you covered by any other insurance policy, either as a dependent, group, individual, automobile medical or liability YES <input type="checkbox"/> NO <input type="checkbox"/>	
If Yes: Name of Insurance Carrier	Policy #:

PARENT/GUARDIAN INFORMATION

Father/Guardian Name	Mother/Guardian Name
Address (Street, City, State, Zip)	Address (Street, City, State, Zip)
Home Phone	Home Phone
Is the Father Employed? YES <input type="checkbox"/> NO <input type="checkbox"/>	Is the Mother Employed? YES <input type="checkbox"/> NO <input type="checkbox"/>

SECTION A (INSURED/FATHER)

SECTION B (SPOUSE/MOTHER)

Employer		Employer	
Address (Street, City, State, Zip)		Address (Street, City, State, Zip)	
Business Phone		Business Phone	
Insurance Company	Policy#	Insurance Company	Policy#

MEDICAL INFORMATION AUTHORIZATION ASSIGNMENT OF BENEFITS:

You are hereby authorized to furnish at the request of and to BMI Benefits, LLC or the underwriting companies with which it works, information which you may possess; including findings and treatment rendered, X-rays and copies of all hospital and medical records, all occasioned by professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as effective and valid as the original. **PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.**

New York: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant or Authorized Person's Signature	Date
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Northwest University Provider Information Form

Dear Provider,

The patient that you are treating today is a student of Northwest University. Northwest University has provided their students with an excess accident medical plan that pays covered charges after the Student's primary insurance has been exhausted. BMI Benefits is the claims administrator for the excess plan. The following information is being supplied to you in an effort to assist the student in obtaining maximum benefits in a timely manner.

Please submit all charges through any other primary insurance available to the student first, and then submit itemized bills, the primary carriers Explanation of Benefits, and your W-9/TIN to BMI Benefits via:

Mail:
BMI Benefits
PO Box 511
Matawan, NJ 07747

Fax:
732-583-9610

Email:
Hollyb@bobmccloskey.com

The Northwest University policy number is US566689.

Should you have any questions, or need any additional information with relation to policy benefits or the submission of claims, please contact BMI Benefits at 800-445-3126.

This is not a guarantee of payment or benefits. All claims are subject to plan limitations and exclusions.

Thank You,



Northwest University
5520 108th AVE NE
Kirkland, WA 98033