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. <u>If you receive a bill that was not submitted to BMI Benefits by the Provider:</u>
    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

<u>HMO/PPO Benefits</u>
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.

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.

Got You Covered

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

PART 1A: POLICYHOLDER

School/Organization	Policy#
Northwest University - ICS & MSA	MSA - US566689 ICS - US566690
School Mailing Address	City, State, Zip
5520 108th Ave NE	Kirkland, WA 98033

Injured Person's Name | Birth date | Male □ Female □

Date of Injury | Time | Type of Sport/Activity | Part of body injured

How did Injury occur?

Sport Designation: Intercollegiate ☐ Intramurals☐ Practice ☐ Game ☐ General Accident ☐ Other ☐

At the time of the injury, was the injured involved in an activity sponsored and supervised by the policy holder? YES ☐ NO ☐

Name of Supervisor | Was he/she a witness to the accident? YES ☐ NO ☐

Signature of Supervisor/Official | Title | Date

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 ☐ NO ☐ If yes, please fill out Section A below.

Is the injured Person Married? YES ☐ NO ☐ Spouse's Name

Is the Spouse Employed? YES ☐ NO ☐ 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 ☐ NO ☐
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 □ NO □	Is the Mother Employed? YES □ NO □

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

THE WELLNESS CENTER
Northwest University
5520 108th Ave. NE
Kirkland, WA 98033

Northwest University
Provider Information Form

Dear Provider,

The patient you are treating today is a student of Northwest University. Northwest University has provided its 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, then submit itemized bills, the primary carrier's Explanation of Benefits, and your W-9/TIN to BMI via:

Mail:	Fax:	Email:
BMI Benefits P.O. Box 511 Matawan, NJ 07747	732-583-9610	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