



BMI Benefits, LLC.

P.O. Box 511
Matawan, NJ 07747
Phone: 800.445.3126
Fax: 732.583.9610
www.bobmccloskey.com

Student Accident Insurance Claim Filing Instructions

1. **BMI Benefits Accident/Injury Claim Form:** Part 1A must be signed by the school/policyholder. All other sections must be completed by the school and parent/guardian. If you are employed, but do not have insurance, please state "NO INSURANCE" and provide us with a statement from your employer noting that the student/claimant has no insurance or complete the enclosed form – 'Statement of No Other Insurance'. Otherwise, our office may submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.
2. Please contact all medical providers where treatment was received and instruct them that you have secondary insurance. If you give the medical provider the BMI Benefits billing information, they should bill BMI directly after they bill your primary health insurance. You may also obtain and attach copies of your primary carrier's Explanation of Benefits (EOB) and all itemized medical bills, known as HCFA 1500s (physician billing form) and UB-04s (hospital billing form). The itemized medical bills should show the ICD-10 and CPT codes for the services provided, as well as other necessary information for insurance processing. Balance due statements are NOT itemized bills and cannot be processed and paid by BMI Benefits. The insurance policy is an excess insurance, which means benefits are provided after any other valid and collectible insurance has processed the medical claims.
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.

| FAX | MAIL | E-MAIL |
|--------------|--|------------------------|
| 732-583-9610 | BMI Benefits, LLC PO Box 511 Matawan, NJ 07747 | lisac@bobmccloskey.com |

6. You may contact BMI Benefits, LLC at 800.445.3126 to discuss your claim. Lisa Crupi at extension 149 manages the claims for this insurance program. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

NOTE: When BMI processes a submitted claim, an Explanation of Benefits (EOB) will be mailed to the medical provider of service with any check payment. A second copy is also mailed to the address on file for the claimant/student explaining the claim payment details. If any information is missing in order for BMI to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to BMI for reprocessing and payment of the medical claim. All submitted claims are subject to the policy terms, conditions and benefits as outlined in the coverage selected by the Policyholder.



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Student Accident Insurance Frequently Asked Questions

Why is my child's school providing student accident insurance?

Many health insurance plans have high deductibles and plan limits that leave parents with high bills resulting from an unexpected accident. This excess policy, provided by the school, protects students and families from the costs associated with school-time and/or sports related accidents depending on your school's chosen policy coverage.

Who is BMI Benefits?

BMI Benefits, LLC. is the claims administrator on behalf of the insurance carrier.

Does primary insurance always have to pay first?

Yes. Medical claims must always be submitted initially to your primary insurance policy. Any remaining balance of expenses not covered by your primary will be submitted to the excess policy. The policy will cover the remaining balance of eligible expenses up to the plan maximum.

Does the accident insurance policy pay for out-of-pocket expenses such as co-pays and deductibles?

Yes. These charges can be submitted to the accident insurance policy to provide reimbursement.

What documents are needed to process a claim?

If your student is involved in a school-related accident, the following documents are needed to properly process a claim:

- **Fully completed BMI Benefits Accident Claim Form**
- **Itemized Bill – in the form of a HCFA or UB04.** This can be obtained through the medical provider. **DO NOT SEND** cash receipts, balance due, balance forward, or past due statements for claims processing or payment. An itemized bill (HCFA or UB04) contains the following information:
 - Provider's Name, Provider's Address, Tax ID Number
 - Date(s) of Service, Type of Service(s) Rendered including CPT and ICD-9 Codes
 - The Fee for Each Procedure
- **Primary Insurance Explanation of Benefits (EOB)** – you should receive a copy of this from your primary insurance carrier.

Where do I send all of these documents?

Please send all claim forms, itemized bills, primary EOBs, other insurance information and claims correspondence to BMI Benefits, LLC. **It might be easier to contact your medical provider, submit BMI's information as the secondary insurance, and the provider will bill BMI directly with the itemized bills and primary EOBs.**

What insurance information do I have to give a provider?

When you go to hospital, Doctor's office, PT clinic, etc, you must remember to tell them you have secondary insurance through your school's student accident medical insurance policy. Instruct the provider to bill your primary insurance first and then send the primary EOB and the itemized bill to BMI Benefits, LLC. **If you did not submit the secondary insurance information upon your first visit, please call the provider and give them the secondary insurance information for BMI Benefits.** If the provider bills the school's student accident insurance policy directly, this should prevent a balance due statement from being sent to the student/parent.

What can cause a delay in processing and paying a claim?

The claims administrator cannot process a claim that is missing one or more of the following documents: the accident/injury claim form, the Itemized Bill or the Primary EOB / denial. We cannot accept balance due, balance forward, or past due statements for claims processing.

Who can I contact if I have any questions? If you have questions after you submit your claims to BMI Benefits, LLC. please contact them at 800-445-3126. Please be aware that settlement of your claim may take several weeks to process. When contacting BMI Benefits, please have your claim form available, as well as the name of the school, school district, or Policyholder to ensure prompt assistance.

NOTE: When BMI processes a submitted claim, an Explanation of Benefits (EOB) will be mailed to the medical provider of service with any check payment. A second copy is also mailed to the address on file for the claimant/student explaining the claim payment details. If any information is missing in order for BMI to process and pay an outstanding claim, an EOB will be mailed stating what needs to be submitted to BMI for reprocessing and payment of the medical claim.



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Statement of No Other Insurance

Please complete this form in its entirety and submit to BMI Benefits, LLC. along with the completed accident claim form.

Statement of No Other Insurance

I, _____, declare that I was not covered by any other insurance policy, through
(Insured's Name)
myself or my parents for the accident dated _____. Should any insurance become effective
during my treatment I will notify BMI Benefits and forward all eligible bills to the new carrier. I understand
BMI Benefits coverage is excess to all other insurance and will pay after all collectible insurance. I understand that
if any of these statements are false it could deem my claim ineligible.

(Insured Name or Parent Name if insured is a minor)

(Date)

(Insured Signature or Parent Signature if insured is a minor)

(Date)

SCHOOL/POLICYHOLDER NAME: _____

FRAUD WARNING:

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

ITEMIZED BILL FOR PHYSICIAN BILLING - HICFA 1500 FORM



HEALTH INSURANCE CLAIM FORM

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

| | | | | | | | | | | | | | | | |
|---|--|---------------------|--------------------------------------|--------|---|--|--|---|---|--|--------------------|------------------|-----------------------|-------------|-----------------------------|
| PICA | | | | | | | | | | PICA | | | | | |
| 1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/> | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | 7. INSURED'S ADDRESS (No., Street) | | | | | | | |
| CITY | | | STATE | | 8. RESERVED FOR NUCC USE | | | CITY | | | STATE | | | | |
| ZIP CODE | | | TELEPHONE (Include Area Code) () | | | | ZIP CODE | | | TELEPHONE (Include Area Code) () | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO | | | b. INSURED'S DATE OF BIRTH MM DD YY | | SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | |
| b. RESERVED FOR NUCC USE | | | | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | b. OTHER CLAIM ID (Designated by NUCC) | | | | | | | |
| c. RESERVED FOR NUCC USE | | | | | c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | 10d. CLAIM CODES (Designated by NUCC) | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i> | | | | | | | |
| 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 other to myself or to the party who accepts assignment below. | | | | | | 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 _____ DATE _____ | | | | | | SIGNED _____ | | | | | | | | | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | | | | | 15. OTHER DATE QUAL: MM DD YY | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | | | | | 17a. NPI | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | | | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. | | | | | | 22. RESUBMISSION CODE ORIGINAL REF. NO. | | | | | | | | | |
| A. _____ B. _____ C. _____ D. _____ | | | | | | 23. PRIOR AUTHORIZATION NUMBER | | | | | | | | | |
| E. _____ F. _____ G. _____ H. _____ | | | | | | | | | | | | | | | |
| I. _____ J. _____ K. _____ L. _____ | | | | | | | | | | | | | | | |
| 24. A. DATE(S) OF SERVICE | | B. PLACE OF SERVICE | | C. EMG | | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | | E. DIAGNOSIS POINTER | | F. \$ CHARGES | | G. DAYS OR UNITS | H. HSPST PLAN PAY | I. ID. QUAL | J. RENDERING PROVIDER ID. # |
| From MM DD YY To MM DD YY | | MM DD YY | | | | | | | | | | | | | |
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| 6 | | | | | | | | | | | | | | | |
| 25. FEDERAL TAX I.D. NUMBER | | | | | 25. PATIENT'S ACCOUNT NO. | | 27. ACCEPT ASSIGNMENT? (For gov. claims, see notes) <input type="checkbox"/> YES <input type="checkbox"/> NO | | 28. TOTAL CHARGE \$ | | 29. AMOUNT PAID \$ | | 30. Rsvd for NUCC Use | | |
| 25. SSN FIN <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | | | | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) | | | | | | 32. SERVICE FACILITY LOCATION INFORMATION | | | 33. BILLING PROVIDER INFO & PH # () | | | | | | |
| SIGNED _____ DATE _____ | | | | | | a. _____ b. _____ | | | a. _____ | | b. _____ | | | | |

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | 5 FED. TAX NO. | | 6 STATEMENT FROM | | 7 COVERS PERIOD THROUGH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 PATIENT NAME | | | | | | | | | | 9 PATIENT ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 BIRTHDATE | | | | | | | | | | 11 SEX | | | | | | | | | | 12 DATE | | | | | | | | | | 13 HR | | | | | | | | | | 14 TYPE | | | | | | | | | | 15 SRC | | | | | | | | | | 16 DHR | | | | | | | | | | 17 STAT | | | | | | | | | | 18 | | | | | | | | | | 19 | | | | | | | | | | 20 | | | | | | | | | | 21 | | | | | | | | | | 22 | | | | | | | | | | 23 | | | | | | | | | | 24 | | | | | | | | | | 25 | | | | | | | | | | 26 | | | | | | | | | | 27 | | | | | | | | | | 28 | | | | | | | | | | 29 ACOT STATE | | | | | | | | | | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 31 OCCURRENCE CODE | | | | | | | | | | 32 OCCURRENCE DATE | | | | | | | | | | 33 OCCURRENCE CODE | | | | | | | | | | 34 OCCURRENCE DATE | | | | | | | | | | 35 OCCURRENCE SPAN FROM | | | | | | | | | | 36 OCCURRENCE SPAN THROUGH | | | | | | | | | | 37 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 38 | | | | | | | | | | 39 CODE | | | | | | | | | | 40 VALUE CODES AMOUNT | | | | | | | | | | 41 CODE | | | | | | | | | | 42 VALUE CODES AMOUNT | | | | | | | | | | 43 VALUE CODES AMOUNT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 42 REV. CD. | | | | | | | | | | 43 DESCRIPTION | | | | | | | | | | 44 HCPCS / RATE / HIPPS CODE | | | | | | | | | | 45 SERV. DATE | | | | | | | | | | 46 SERV. UNITS | | | | | | | | | | 47 TOTAL CHARGES | | | | | | | | | | 48 NON-COVERED CHARGES | | | | | | | | | | 49 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| PAGE | | | | | | | | | | OF | | | | | | | | | | CREATION DATE | | | | | | | | | | TOTALS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 50 PAYER NAME | | | | | | | | | | 51 HEALTH PLAN ID | | | | | | | | | | 52 REL. REF. # | | | | | | | | | | 53 ARG. DEN. | | | | | | | | | | 54 PRIOR PAYMENTS | | | | | | | | | | 55 EST. AMOUNT DUE | | | | | | | | | | 56 NPI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 58 INSURED'S NAME | | | | | | | | | | 59 REL. | | | | | | | | | | 60 INSURED'S UNIQUE ID | | | | | | | | | | 61 GROUP NAME | | | | | | | | | | 62 INSURANCE GROUP NO. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 63 TREATMENT AUTHORIZATION CODES | | | | | | | | | | 64 DOCUMENT CONTROL NUMBER | | | | | | | | | | 65 EMPLOYER NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 66 ICD-9-CM | | | | | | | | | | 67 ICD-9-CM | | | | | | | | | | 68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 69 ADMIT DX | | | | | | | | | | 70 PATIENT REASON DX | | | | | | | | | | 71 PPS CODE | | | | | | | | | | 72 ECI | | | | | | | | | | 73 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 74 PRINCIPAL PROCEDURE CODE | | | | | | | | | | 75 OTHER PROCEDURE CODE | | | | | | | | | | 76 ATTENDING NPI | | | | | | | | | | 77 QUAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 78 OTHER PROCEDURE CODE | | | | | | | | | | 79 OTHER PROCEDURE CODE | | | | | | | | | | 80 OTHER NPI | | | | | | | | | | 81 QUAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 80 REMARKS | | | | | | | | | | 81 ICD-9-CM | | | | | | | | | | 82 OTHER NPI | | | | | | | | | | 83 QUAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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