



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

O. (800) 952-4320 | F. (207) 647-4569
88 MAIN STREET | P.O. BOX 189 | BRIDGTON, ME 04009
NAHGACLAIMSERVICES.COM



Montgomery Township Board of Education Accident Insurance Referral Letter

Dear Participant,

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

Specifics of the coverage:

1. Deductible - \$500 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-103201
Effective Dates: 8/1/24 – 8/1/25
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



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 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.



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 – 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 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.



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
(Insured's Name)
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 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

<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PICA										PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>									
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"/>									
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"/>									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code) ()										CITY STATE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO									
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)									
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. CLAIM CODES (Designated by NUCC)									
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.										11. INSURED'S POLICY GROUP OR FECA NUMBER									
SIGNED DATE										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.										b. OTHER CLAIM ID (Designated by NUCC)									
SIGNED DATE										c. INSURANCE PLAN NAME OR PROGRAM NAME									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.									
15. OTHER DATE MM DD YY QUAL.										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. 17b. NPI									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
A. B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.									
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										23. PRIOR AUTHORIZATION NUMBER									
F. \$ CHARGES G. DAYS OR UNITS H. EPSTD 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 <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.									
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.)										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO									
SIGNED DATE										28. TOTAL CHARGE \$									
32. SERVICE FACILITY LOCATION INFORMATION										29. AMOUNT PAID \$									
a. NPI b.										30. Rsvd for NUCC Use									
33. BILLING PROVIDER INFO & PH # ()																			
a. NPI b.																			

[illegible]

ADA American Dental Association® Dental Claim Form

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) A _____ C _____
(Primary diagnosis in "A") 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

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

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

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

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

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" **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"