Required Substantiation for Benefit Card Transactions & Claims

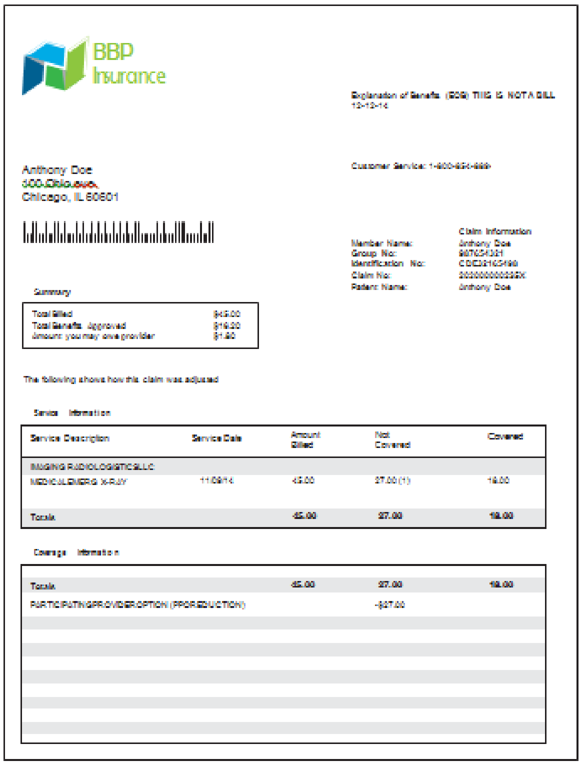
HRA

Always use the Universal Claim Form with the documentation you send in so your claim is processed in a timely matter

http://www.bbpadmin.com/docs/Participant/Universal_Claim_Form.pdf

The Explanation of Benefits (EOB) from your insurance provider is the only documentation we will accept for Doctor, Hospital or Laboratory charges

For prescriptions, we will only accept the Prescription slip, Pharmacy itemized list or EOB



BBP Insurance

Explanation of Benefits (EOB) THIS IS NOT A BILL
12-12-14

Anthony Doe
100 Ohio ave.
Chicago, IL 60601

Customer Service: 1-800-856-888

Claim Information

Member Name:	Anthony Doe
Group No:	987654321
Identification No:	CDE32165498
Claim No:	3000000000055X
Patient Name:	Anthony Doe

Summary

Total Billed	$45.00
Total Benefits Approved	$16.20
Amount you may owe provider	$1.80

The following shows how this claim was adjusted

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
IMAGING RADIOLOGISTICS LLC				
MEDICAL EMERG X-RAY	11/09/14	45.00	27.00 (1)	18.00
Totals		45.00	27.00	18.00

Coverage Information

Totals		45.00	27.00	18.00
PARTICIPATING PROVIDER OPTION (PPO REDUCTION)			-$27.00	

FSA

BEST - The Explanation of Benefits (EOB) from your insurance provider is the best documentation to submit for approval of your charge (See HRA approved examples)

BETTER - A detailed invoice or statement from your provider. It must show patient name, date of service, provider name, amount due (after insurance, if applicable) and services performed. If all 5 are not included, your charge will not be approved.

Make Checks Payable to

Chicago Medical Group
PO BOX 202
Chicago, IL 60012

FOR BILLING INQUIRIES: 773-302-9874

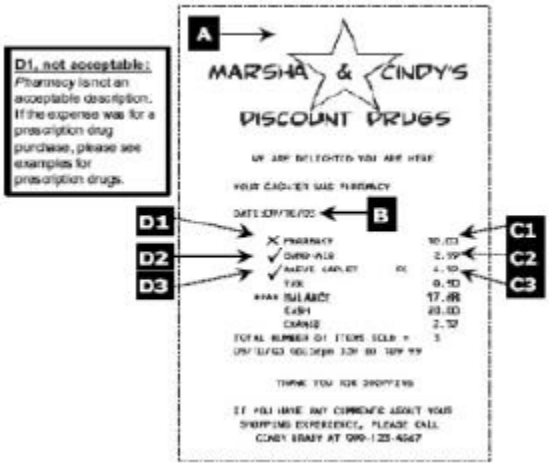
10/18/14	$65.00	123584

John Doe
324 Main St.
Chicago, IL 60011

Chicago Medical Group
PO BOX 202
Chicago, IL 60012

DATE OF SERVICE	CODE	DESCRIPTION OF SERVICE	CHARGES	INSURANCE PAYMENTS	BALANCE
10/10/14	XXXX4	OFFICE VISIT, 25 MIN	$200.00	$140.00	$60.00
10/10/14	XXXX5	BLOOD DRAW	$20.00	$15.00	$5.00

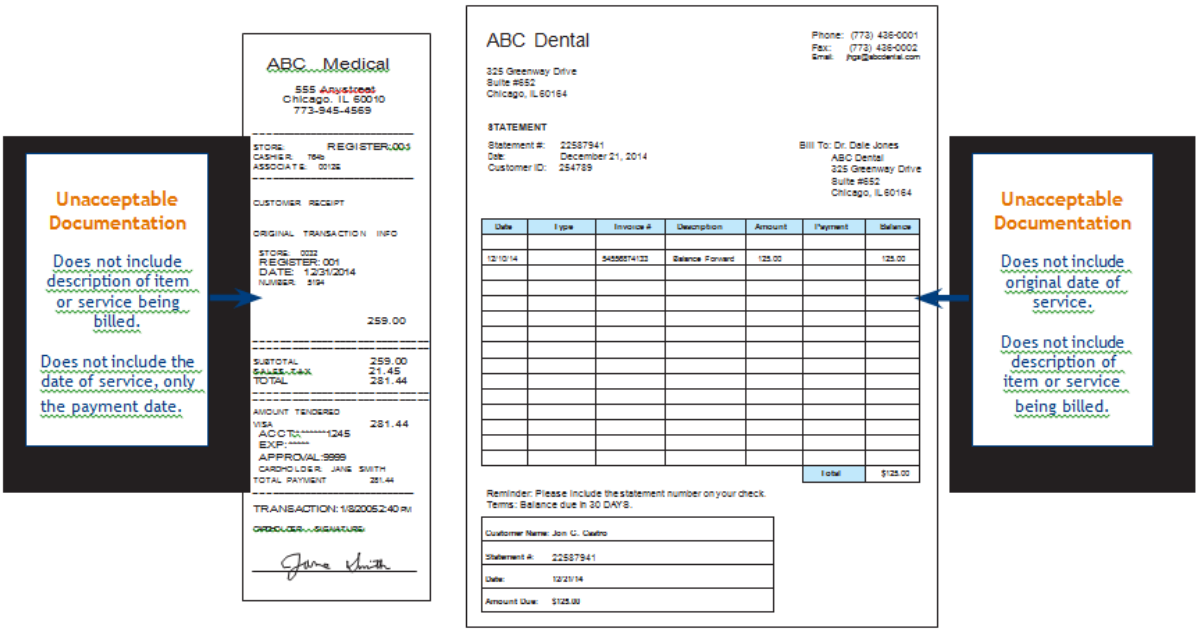
CURRENT	30-60 DAYS	60-90 DAYS	90-120 DAYS	90-120 DAYS	AMOUNT DUE:	$65.00
$65.00						



BAD - Credit Card receipts, Previous Balance/Balance Forward Statements, Statements that show payment only, Pharmacy receipts, Statement remit slip, Credit Card Statements, etc.

These are not eligible as they do not show all 5 requirements for approving transactions – if your documentation does not include all 5 requirements, it will not be approved.

1. Date of Service (not date paid)
2. Patient Name
3. Provider Name
4. Services Performed
5. Amount Due (after insurance, if applicable)



Summary of Documentation

			Patient Name	Date of Service	Provider Name	Services Performed	Amount Due
BEST	HRA FSA	Explanation of Benefits	X	X	X	X	X
	HRA FSA	Pharmacy Prescription Slip	X	X	X	X	X
BETTER	FSA only	Detailed Invoice from Provider	X	X	X	X	X
	FSA only	Pharmacy Receipt for OTC	Must specify	X	X	X must have Doctor's note for unspecified FSA items	X
BAD		Credit Card Receipt			X		X
		Statement Remit Slip	X		X		X
		Credit Card Statement			X		X
		Pharmacy Receipt for Prescriptions		X	X		X
		Balance Forward Statement	X		X		X
		Previous Balance Statement	X		X		X
		Cancelled Checks					X