

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
12-10-14

Anthony Doe
600.000.0000
Chicago, IL 60601

Customer Service: 1-800-851-6888

Member Name: Anthony Doe
Group No: 987654321
Identification No: C002100190
Claim No: 00000000252X
Patient Name: Anthony Doe

Summary

Total Billed	\$42.00
Total Benefits Approved	\$14.00
Amount you may owe provider	\$28.00

The following shows how this claim was adjusted:

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
IMAGING RADIOLOGIC LLC MEDICALURG XRAY	11/08/14	42.00	27.00 (1)	14.00
Totals		42.00	27.00	14.00

Coverage Information

Service Description	Amount Billed	Not Covered	Covered
Totals	42.00	27.00	14.00
PARTICIPATING PROVIDER OPTION (PRODUCTION)		-27.00	

Acceptable Prescription Drug Receipts

A Provider Name

B Patient Name

C Date of Service

D Expense Amount

E Insurance Approval
(Copy, Coins, Applied Deductible)
AND/OR
Prescription Drug Name

GR 05-06-2003 PROMISED: 05:00p
05-06-2003
Scripts: 01
CUSTOMER RECEIPT

A ABC pharmacy #4427 706-706-123-4567

B GREENTREE, JANE DOE
4545 1ST STREET, COLUMBUS, OH 43260-0000
Ph: 603-123-4567 DOB: 08-10-1988
[DRUG NAME PRINTED BELOW]
TAKE 1 TABLET EVERY WEEK

C Date: 05-06-2003

D Rx: 518189 00
Ins: 00-06-2008
PAT: 518189 00
Qty: 30

E ADVANCE PCL 81800000

Note: Appearance of "Ins: \$0.00" does not meet Requirement E for Insurance Approval. However, since this receipt also includes the Drug Name, Requirement E is fulfilled and this is an acceptable receipt.

GR 07-23-2003 PROMISED: 05:00p
07-23-2003
Scripts: 01
CUSTOMER RECEIPT

A ABC pharmacy #4457 706-706-123-4567

B GREENTREE, JANE DOE
4545 1ST STREET, COLUMBUS, OH 43260-0000
Ph: 603-123-4567 DOB: 08-10-1988
[NOT PRINTED - FEE ONLY]

C Date: 07-23-2003

D Rx: 595999 00
Ins: 00-06-2008
PAT: 595999 00
Qty: 4

E ADVANCE PCL 81800000

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		10/15/14	\$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	CHARGE \$	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



- A** Provider Name
- B** Date of Service
- C** Expense Amount
- D** Drug Name
(Drug name must be clearly indicated on register receipt.)

D1, not acceptable:
Pharmacy is not an acceptable description. If the expense was for a prescription drug purchase, please see examples for prescription drugs.

MARSHA & CINDY'S
DISCOUNT DRUGS

WE ARE DELIGHTED YOU ARE HERE

YOUR CUSTOMER CARE PROMISE

DATE: 10/15/14 **B**

<p>D1 → <input checked="" type="checkbox"/> PHARMACY</p> <p>D2 → <input checked="" type="checkbox"/> OVER THE COUNTER</p> <p>D3 → <input checked="" type="checkbox"/> ANIMAL CARE</p> <p><input type="checkbox"/> VET</p> <p><input type="checkbox"/> MAXIMUM</p> <p><input type="checkbox"/> CASH</p> <p><input type="checkbox"/> CHANGE</p> <p>TOTAL NUMBER OF ITEMS SOLD: 5</p> <p>UNIVERSITY MICROFILMS 330 80 100 99</p> <p style="text-align: center;">THANK YOU FOR SHOPPING</p> <p style="text-align: center;">IF YOU HAVE ANY COMMENTS ABOUT YOUR SHOPPING EXPERIENCE, PLEASE CALL CINDY BRAY AT 909-123-4567</p>	<p>10.00</p> <p>2.99</p> <p>4.50</p> <p>0.50</p> <p>17.98</p> <p>20.00</p> <p>2.50</p> <p>5</p>
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- C1**
- C2**
- C3**

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)

Unacceptable Documentation

Does not include description of item or service being billed.

Does not include the date of service, only the payment date.

ABC Medical

555 Anywhere
Chicago, IL 60010
773-945-4569

STORE: REGISTER003
CASHIER: 194
ASSOCIATE: 00126

CUSTOMER RECEIPT

ORIGINAL TRANSACTION INFO

STORE: 0032
REGISTER: 001
DATE: 12/31/2014
NUMBER: 5194

259.00

SUBTOTAL: 259.00
SALES TAX: 21.45
TOTAL: 281.44

AMOUNT TENDERED: 281.44
VISA
ACCT#: *****1245
EXP: *****
APPROVAL 5999
CARDHOLDER: JANE SMITH
TOTAL PAYMENT: 281.44

TRANSACTION: 1/3/20052:40 PM
CARDHOLDER SIGNATURE:

Unacceptable Documentation

Does not include original date of service.

Does not include description of item or service being billed.

ABC Dental

325 Greenway Drive
Suite #552
Chicago, IL 60164

Phone: (773) 436-0001
Fax: (773) 436-0002
Email: jpp@abcdental.com

STATEMENT

Statement #: 22587941
Date: December 21, 2014
Customer ID: 254739

Bill To: Dr. Dale Jones
ABC Dental
325 Greenway Drive
Suite #552
Chicago, IL 60164

Date	Type	Invoice #	Description	Amount	Payment	Balance
12/10/14		3458674103	Balance Forward	125.00		125.00
				Total		\$125.00

Reminder: Please include the statement number on your check.
Terms: Balance due in 30 DAYS.

Customer Name: Jon G. Castro
Statement #: 22587941
Date: 12/21/14
Amount Due: \$125.00

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