

Required Substantiation for Benefit Card Transactions & Claims

HRA

Always use the Universal Claim Form with documentation you sent in to ensure 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) TIG IS NOT A BILL
12-13-14

Anthony Doe
500-2345-Ave
Chicago, IL 60601

Customer Service: 1-800-450-4569

Member Name: Anthony Doe
Group No: 987654321
Identification No: C000110100
Claim No: 00000000000000000000
Patient Name: Anthony Doe

Summary

Total Billed	\$45.00
Total Benefits Approved (Amount you may owe provider)	\$18.00

The following shows how this claim was adjusted:

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
IMAGING RADIOLOGIC/CT/CLLCC	11/08/14	\$2.00	\$7.00 (1)	\$8.00
Totals		\$2.00	\$7.00	\$8.00

Charge Information

Service Description	Amount Billed	Not Covered	Covered
PARTICIPATING PROVIDER OPTION (PRODUCTION)	\$2.00	\$7.00	\$8.00

Acceptable Prescription Drug Receipts

A Provider Name

B Patient Name

C Date of Service

D Expense Amount

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

GR
08-06-2003

A → **ABC/pharmacy**

B → **GREENTREE, JANE DOE**

C → 08-06-2003

D → \$18.00

E → TAKE 1 TABLET EVERY WEEK

PROMISED: 05:00p
08-06-2003
Scripts: 01

GR
07-23-2003

A → **ABC/pharmacy**

B → **GREENTREE, JANE DOE**

C → 07-23-2003

D → \$45.00

E → TAKE 1 TABLET EVERY WEEK

Note: Appearance of "Ins: \$30" 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.

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 John Doe 324 Main St. Chicago, IL 60011		 <table border="1"> <tr> <td>10/18/14</td> <td>\$65.00</td> <td>123554</td> </tr> </table>		10/18/14	\$65.00	123554
10/18/14	\$65.00	123554				
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 & CINDYS
DISCOUNT DRUGS

WE ARE DELIGHTED YOU ARE HERE
YOUR CUSTOMER SAC FRIENDLY

<p>DATE OF SERVICE ← B</p> <p><input checked="" type="checkbox"/> PHARMACY</p> <p><input checked="" type="checkbox"/> DISPENSE</p> <p><input checked="" type="checkbox"/> NAME CAPLET</p> <p><input type="checkbox"/> TAB</p> <p><input type="checkbox"/> STRIP</p> <p><input type="checkbox"/> EYE</p> <p><input type="checkbox"/> CREAM</p> <p>TOTAL NUMBER OF ITEMS SOLD = 3</p> <p>UNIVERSAL REGISTER 329 80 109 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 STRAY AT 606-123-4567</p>	<p>10/03</p> <p>0.99 ← C1</p> <p>4.99 ← C2</p> <p>9.99 ← C3</p> <p>17.99</p> <p>23.99</p> <p>2.50</p>
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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 AnyStreet
Chicago, IL 60610
773-945-4569

STORE: REGISTER005
CASHIER: 156
ASSOCIATE: 0032

CUSTOMER RECEIPT

ORIGINAL TRANSACTION INFO

STORE: 0022
REGISTER: 001
DATE: 12/31/2014
NUMBER: 514

259.00

SUBTOTAL: 259.00
SALES TAX: 21.45
TOTAL: 281.44

AMOUNT TENDERSO
VISA
A/C TO: *****1245
EXP: *****
APPROVAL: 9999
CARDHOLDER: JANE SMITH
TOTAL PAYMENT: 281.44

TRANSACTION: 1/520052-40 BY
OPERATOR: SIGNATURE:

Phone: (773) 438-0001
Fax: (773) 438-0002
Email: jpr@abcedental.com

ABC Dental

325 Greenway Drive
Suite #552
Chicago, IL 60164

STATEMENT

Statement #: 22587941
Date: December 21, 2014
Customer ID: 254769

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		34558574133	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: Jan C. Castro
Statement #: 22587941
Date: 12/21/14
Amount Due: \$125.00

Unacceptable Documentation

Does not include original date of service.

Does not include description of item or service being billed.

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