# Youth Programs
# Emergency Management Planning



UNIVERSITY OF OREGON | Safety and Risk Services


Contact:
Safety and Risk Services
(541) 346-8070
1260 University of Oregon Eugene, OR 97403
Office: 1715 Franklin, Suite 2A
uoem@uoregon.edu


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This document was adapted with permission from the Penn State Office of Ethics and Compliance.

# Youth Program Information

| | |
|---|---|
| Program Name | Program Director E-mail |
| Program Director Name | Program Director Emergency Phone |
| Program Director Work Phone | Program Location |
| Campus Location:<br>Eugene Main Campus<br>Other Location (If Applicable): | Sponsoring Department: |

**Safety and Risk Services**
Office: (541)346-8070
Email: uoem@uoregon.edu

**Departmental Contact**
Name:
Office:
Mobile:
Email:

**Police / Emergency Numbers**

By Phone:
For emergencies, life-threatening situations, or crimes in progress, **call 9-1-1 on- or off-campus**. Non-emergency assistance and information is available on campus by calling UOPD at (541)346-2919. Off-campus, for non-emergencies, call Eugene Police at (541)682-5111, or Springfield Police at (541)726-3714.

In Person:
You may make a report at the UOPD Station, 2141 E. 15th Ave. in Eugene (at the corner of 15th Avenue and Walnut Street) during business hours, 8:00 a.m.-5:00 p.m., Monday-Friday excluding holidays. After hours, call (541)346-2919 and let the dispatchers know that you would like to come to the station to make a report, so that an officer can be present to let you in.

**To report facilities emergencies for non University Housing or Athletics locations:**

**Campus Planning & Facilities Management - Work Control Center**
Phone: (541) 346-2319
Email: workcontrolcenter@uoregon.edu

After Hours (after 4:30 PM) and Weekends (typically Saturday and Sunday), call UO Dispatch at (541)346-2919.

**Orientation and staff training plans for my program:** (Check when completed)

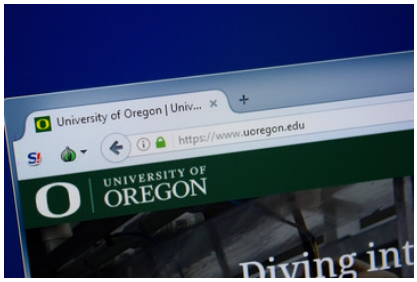
- ☐ Fire Safety and evacuation plans (stop, drop & roll, evacuation routes)
- ☐ A communication plan that involves a signal/alarm to notify program staff of an emergency
- ☐ Severe weather plan and communications (Emphasize wildfire smoke and wildfire safety)
- ☐ Knowledge of designated emergency evacuation routes
- ☐ Knowledge of appropriate shelter-in-place locations
- ☐ Missing child procedures
- ☐ Tips for changing location (head counts, take attendance, predictable routes, etc.)
- ☐ Remind program staff of obligation to report suspected child abuse (and that notifying supervisor is NOT one of the University recommended procedures)

If your youth program is being facilitated by paid employees of the University of Oregon, you are a Campus Security Authority (CSA). A one time training is required for all CSAs. You can access the training here: https://uomytrack.pageuppeople.com/learning/3230

Please insert your notes for your Orientation and Training Plan in the box below:


# ADDITIONAL RESOURCES

**In an emergency, urgent, or crime situation that requires police, firefighter, and/or ambulance assistance, calling 9-1-1 should be your first response.**




**For the most up to date information regarding emergencies on campus, visit: https://safety.uoregon.edu/alerts**


**For more information on weather related emergencies, visit the University of Oregon's WeatherSTEM page, https://laneweatherstem.com/uo the University of Oregon's Severe Weather Planning Guide at https://safety.uoregon.edu/sites/safety1.uoregon.edu/files/safety_sheet_-_events_severe_weather_planning_v2.pdf or The Department of Homeland Security's website at https://www.ready.gov/**

# COMMUNICATION PLAN

It is important to make sure that everyone is prepared and informed in the event of an emergency within your youth program. Staff may not always be together when these events take place and plans should be developed to make sure they are able to contact one another. In addition, there may be times when an emergency event will include communicating to individuals outside program operations, including Senior Leadership and Strategic Communications. A communications plan should include contact information for all individuals that may need to be notified in the event of an emergency.

Questions to consider:

- Who is in charge of notifying staff and Program Director in the event of an emergency?

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- How do you contact this person? Additional contacts if unavailable?

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- Based on the severity of the emergency, at what point should I contact UOPD? Do the youth participants parents need contacted? Who initiates this contact and when (how promptly)?

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- Who is responsible for tracking camp roster and taking attendance in the event of and directly following an emergency?

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- Who will let the participants know about the emergency and how will it be communicated?

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- Develop an agreed upon emergency signal for your program. Who is responsible for activating signal?

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- How will you notify program staff and program director of type of emergency (life threatening, non-life threatening, evacuation, shelter-in-place, etc.)?

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- In times of transition (travel, lunch break, change of facility, etc.), who is responsible for ensuring a proper head count and/or attendance?

---

Roles of program staff during the Emergency Management Process:

- Provide predictable routes and routines during programs as much as possible as a form of routine communication,this step can help during an after and emergency.
- Provide emotional support and important emergency information to youth participants.

Emergency Communication Plan for My Program (Add your specific notes and questions in the box below):

# MEDICAL EMERGENCY

When using a facility for a program, locate the facility's Emergency Evacuation Plan (typically posted in hallways), Automated External Defibrillator (AED), and Emergency First Aid Kit.

- **Call 911 immediately**
- Provide
  - location
  - nature of injury or illness
  - current condition of the victim and other requested information
- Remain on the phone until directed to hang up.
- **If the medical emergency occurred on the main Eugene Campus, please contact the UO Police Department at (541) 346-2919.**
- Stay with the patient
- Contact patient's parent or guardian to inform them of the incident
- Do not move the victim unless he/she is in immediate danger
- If it appears an individual may cause harm to themselves or to others, **call 911 immediately**
- **If patient is taken to the hospital, staff must stay with them until family arrives or is released**
- Be sure to inform the Emergency Medical Team that arrives of any additional medical information the patient needs listed on their medication treatment authorization form. The form should be taken with to any medical treatment facility they are going to.
- If a camper is injured, and it is related to camp activities please complete the insurance claim form and provide a copy to the parents/guardian. Scan a copy to: riskmanagement@uoregon.edu
- If any staff are certified in any procedures (CPR, certified nurse etc), please list in the information below

Specific Information for My Program (consider after emergency care for responders such as the Employee Assistance Program or resources for students at the University of Oregon):

# WILDFIRE SMOKE

Wildfire smoke collects in the Southern Willamette Valley due to a combination of factors, including the geography of the valley, the location of wildfires, and weather patterns during nearby active fires. Wildfire smoke can cause negative health effects to employees who are exposed while working.

When conducting youth programs, the UO follows the actions items outlined below which are more stringent than the Oregon OSHA requirements for exposure to wildfire smoke. Oregon OSHA implemented rules to limit employee exposure to wildfire smoke. The rules communicate certain actions that should be taken, by outdoor workers, when the Air Quality Index (AQI) reaches specific thresholds. The university has developed a Wildfire Smoke Exposure Control Plan to outline the roles and responsibilities of all employees to help reduce exposure.

## AQI ACTION LEVELS FOR YOUTH PROGRAMS – FROM WILDFIRE SMOKE

| AQI Levels | UO Action |
|---|---|
| AQI>100 | Recommend that outdoor youth programs be suspended or moved indoors. |
| AQI>150 | Members of the campus community are expected to use their best judgement in assessing the risk of smoke exposure related to coming and going to campus and participation in outdoor activities on campus, based on individual circumstances. When the AQI in Eugene reaches this level, a message will be posted to the UO Alerts blog. |
| AQI>200 | Recommend that departments and units suspend or move outdoor events and activities indoors.[1] |
| AQI>250 | UO hosted outdoor activities **shall** be suspended or moved indoors. If suspension or relocation is not possible, physically strenuous outdoor activity shall either be limited to 15 minutes per hour and 1 hour per day or shall provide participants a N95 respirator and recommend its use. |

[1] Taking the following into account: Events and activities that involve prolonged or heavy exertion are higher risk. The following populations are at higher risk during these periods: people with heart and lung disease, children, pregnant women and older adults. If the event or activity continues, consider the impact for these groups.

## WHAT TO DO:

- Supervisors of outdoor workers may reassign employees to indoor work where possible
- Take the Wildfire Smoke Safety Training on MyTrack.
- Visit safety.uoregon.edu to read the Wildfire Smoke Exposure Control Plan.
- Download the free AirNow app or visit AirNow.gov to monitor the Air Quality Index (AQI).
- Decide if you want to voluntarily wear an N95.
- Report smoke effects injuries and illnesses to your program manager. (Burning and tearing of eyes, sore throat, coughing,difficulty breathing, wheezing, fatigue, headache, irregular heartbeat, chest pain.)
- Call 911 and UOPD (541-346-2919) for an emergency.

For the complete memorandum on Campus Wildfire Smoke Air Quality Guidelines, please go to: https://safety.uoregon.edu/sites/safety1.uoregon.edu/files/aqi_memo_120822.pdf

## HEAT ILLNESS PREVENTION

Exposure to extreme heat caused by weather can increase the likelihood of a person suffering from a heat related illness such as heat exhaustion or heat stroke.

**HEAT EXHAUSTION** – Symptoms: headaches, dizziness, light-headedness, weakness, personality changes, irritability or confusion, stomach upset, vomiting, fainting, pale clammy skin. Actions: move person to cool, shaded area, lay on their back, loosen/remove heavy clothing, have them drink cool water, cool them by fanning. If condition worsens, call 911 for emergency help.

**HEAT STROKE** – Symptoms: Dry, pale skin (no sweating), hot red skin (looks like a sunburn), personality changes such as irritability, confusion, not making sense, seizures, collapse. THIS IS A MEDICAL EMERGENCY! Actions: call 911 for medical help. Move person to shaded area, loosen/remove heavy clothing, have them drink cool water, cool them by fanning, mist with cool water, apply wet cloth or ice to armpits and groin area.

Oregon OSHA has regulations in place to prevent heat related illnesses to employees. These regulations do not apply employees with incident exposures (less than 15 min per hour), to those who work in buildings with temperature controls, or to people conducting emergency work. The requirements are listed below although employees whose work is defined as 'rest' or 'light' work are subject only to the high heat practices.

| Temperature | |
|---|---|
| >80° F | Routine Practices:<br>• Access to shade (close to work area, large enough to accommodate everyone)<br>• Access to water (cool or cold – below 77° F, enough for 32 oz/person/hour)<br>• Ample opportunity to drink water |
| >90° F | High Heat Practices:<br>• Effective communications for all affected employees<br>• Ability to access emergency medical services<br>• Determine heat index in buildings without temperature control<br>• Implement Work Rest Schedule (See below) |

| **Work Rest Schedule – Required after Heat Index of 90° or greater** | |
|---|---|
| **Heat Index** | **Rest Break Duration and Intervals** |
| 90° or greater | 10 minutes, every 2 hours |
| 100° or greater | 15 minutes, every hour |

What To Do:

- Download the NIOSH heat app to have real time heat index for your work area on your phone.
- Take the Heat Illness Prevention training, available online on MyTrack.
- Print, hand out, and review, the Heat Stress Card with employees so they can monitor signs and symptoms of heat illness amongst employees and program participants and take actions to provide aid to those who exhibit any heat illness symptoms.
- Be familiar with the UO Heat Illness Prevention Plan.
- If you do not feel better in one hour, seek emergency care.
- **In an emergency, call 911 and UOPD (541-346-2919), for immediate assistance!**

Specific Information for My Program:

# FIRE

The youth program director is expected to review fire safety protocols and procedures with their staff during the youth program training session. These procedures include reviewing exit routes, designating meeting areas, and transporting children during an emergency. Remind youth participants the importance of **STOP, DROP, & ROLL.**

- Yell **FIRE** and **pull the fire alarm**.
- Leave the building with youth participants immediately using the closest emergency exit. Help those that need assistance including young children and people with disabilities.
- **If unable to exit the building, go to the nearest exit stairwell or assisted evacuation staging area and call 911 to report your location.**
- **Do not use elevators.**
- If trained, use a fire extinguisher if the fire is small and contained and room is not filled with smoke.
- Close doors behind you **(DO NOT LOCK)**.
- Move to a safe location away from buildings or to your program's Designated Meeting Site.
    - Once here, take attendance of youth participants and program staff.
- **Call 911 when safe to do so.** Provide information on location and if anyone is still inside the building.
- Call the University of Oregon Police Department at (541) 346-2919. Be prepared to provide your current location.
- Call Program Director to inform them of the incident.
- Re-enter the building only when instructed by Designated Public Safety Official(s).

Specific Information for My Program/Facility (including meeting sites and exits, and how fire/evacuation drills will be practiced during youth program orientation?)

# FLOODING AND WATER LINE BREAKS

Flooding is a temporary overflow of water onto land that is normally dry. Floods are the most common natural disaster in the US. Floods may:

- Result from rain, snow, severe storms, and overflow of various water systems (inside and outside buildings)
- Accumulate slowly or rapidly.
- Lead to power outages, slow or even stop transportation, damage buildings, and contribute to landslides.

In the event that flooding occurs:

- Seek high ground and try to remain out of any standing or moving water. **Turn Around, Don't Drown**. **SIX INCHES** of moving water can knock a person down, **ONE FOOT** of moving water can sweep away vehicles.
- Regroup with the rest of program staff and participants at a safe, predetermined meeting location.
- **If flooding happens inside a building**, please quickly exit the building with your belongings and do not re-enter until you have been given the "all clear" sign by an electrician or other authorized technical specialist on site.

**Notify UOPD at (541)346-2919.**

Specific Information for My Program

# EARTHQUAKE

The following are some helpful tips that should be practiced routinely to help prepare for an earthquake:

- Drop to the ground, take cover under a sturdy object, and hold on until shaking stops.
- If a sturdy object is not available, move to an inside corner of the room, crouch down, and cover face and head with arms.
- Stay away from glass, outside walls or anything else that could fall.
- Once the ground stops shaking, evacuate the building.
- **If outdoors**, stay outdoors
  - Move to an open area away from trees, buildings, utility poles and lines, and large signs
  - If you are near a tall building, get inside the lobby to protect from possible falling debris
- **After** an Earthquake
  - Be prepared for aftershocks
  - Check self and youth for injuries
    - Provide First Aid if needed
    - Do not move seriously injured people, unless they are in imminent danger
  - Check the immediate area for dangerous conditions that include fires, downed powerlines, and structural damages
  - Evaluate if evacuation is necessary
- Call UOPD at (541) 346-2929.
- **Do not re-enter the building until a damage assessment is complete.**

Specific Information for My Program:

# EVACUATION AND SHELTERING

In advance of an emergency, determine the nearest exits from your location and the best route to follow. Refer to building emergency evacuation plans and corresponding maps for further information (these are posted on posters throughout the University of Oregon facilities). Be sure to take attendance each time you arrive at a new location.

**Assigned Emergency Evacuation Plan For Program/Facility**:
Where is the evacuation plan of the facility being used for the Youth Program (if applicable)?

_____

- Walk, do not run.
- Do not use elevators. Assist people with special needs.
- Determine and assemble at the designated meeting site.
- Do not re-enter spaces to retrieve personal items.
- Wait for instructions from the Designated Public Safety Official(s).

**Designated Shelter in Place During Youth Program**:
What facility is the designated Shelter in Place location during the Youth Program (if applicable)?

_____

Safe areas include:

- Enclosed buildings
- Fully enclosed metal vehicles with a hard metal roof and windows up
- Low ground areas as a last resort (ditches, bottom of hill) – assume a crouched position – minimize your body area – do not lie flat

Safe locations may be situationally dependent. Youth Programs should consider each type of incident to determine the safest locations given the situation.

Unsafe areas include:

- Open fields
- Golf carts or gators
- Metal bleachers (on or under)
- Fences
- Umbrellas, flag poles, light poles
- Tall trees
- Pools of standing water

**Fire or Smoke and You Cannot Evacuate**:

- **Call 911** and tell them your name, your location, that you are unable to evacuate, and why you are unable to evacuate the building.
- If safe to do so, go to the nearest stairwell and tell someone who is evacuating to notify emergency personnel of your location and that you are unable to evacuate the building.

Specific Information for My Program (including meeting sites and exits, the types of situations we may need to consider, and how communication would happen between the program and parents/guardians)

# MISSING OR KIDNAPPED CHILD

- Stay Calm
- Stop the current activity and ask assigned buddy or group where they last saw the child and if they know where they went
    - Begin to call for assistance so proper youth program ratios are upheld, this will allow for an immediate search of the area to begin
- **Contact University Police at (541) 346-2919, to assist in search.**
    - If you are not at the main Eugene campus location, call 911 and report to the UOPD non-emergency line.
- Provide the following information to emergency officials:
    - Name
    - Hair Color
    - Age
    - Size/Height
    - Weight
    - Unique characteristics
    - Clothes they were last seen wearing
    - When and where they were last seen
    - Document the actions taken
- Call the Program Director to notify them of the start of search, provide them with child's information replayed to the police.
- Continue search of the surrounding area/facility (check cupboards, closets, other rooms, etc.)
    - Notify parent/guardian of search for their child
- If the child is found, follow-up with all contacts to call off the search.

In order to prevent a youth participant from becoming missing or kidnapped. Program staff should:

- Routinely count the number of participants they are responsible for
- Communicate to the participants that they are to notify program staff if they cannot find their assigned "buddy"

Specific Information for My Program (Consider who you would need to contact if your program is not located on the main Eugene campus, how you can utilize the forms listed in the appendix):

# REUNIFICATION PLAN

In the event of an emergency, evacuation, or unforeseen disaster, it is important to have a reunification plan that guides us in reconnecting youth participants with their parents/guardians when needed.

Steps of Reunification plan:

- Prior to the start of your program, consider: your alternate location to reconnect families with youth program participants, how you would communicate to program participants and families, how staff would gain access to emergency contact information, and how you would ensure the identity of those authorized to pick up a program participant.
    - Consider using the planning resources listed in the appendix.
- Once an event has occurred:
    - Notify Program Director and UOPD of utilization of Emergency Management Plan
    - Program Director assesses situation and determines that additional steps need to be taken (severity of the current situation prompts the need for the reunification process)
    - Communication (calls, texts, emails) to youth participants parents/guardians/emergency contact
    - Selection, gathering, and advertising of a meeting place where participants will wait until picked up by a parent, guardian, and/or emergency contact
    - Confirmation of the adult via Photo ID and registration form to pick up their child
    - Collaborate with local emergency personnel if additional steps are required

Specific Information for My Program (Consider contacting UOPD to review your reunification plans prior to the start of your program):

# FIELD TRIPS OR TRAVEL

- Prior to departure, program staff needs:
  - Child list by assigned vehicle
  - Counselor/supervisor list by assigned vehicle
  - Map of intended route
  - Participants emergency and medical information/supplies
  - Name and contact information
  - First aid kit
  - To be seated throughout the vehicle, this is to ensure proper supervision in case of injury due to an emergency
- Call 911 if emergency medical treatment or the police are required
  - Attend to any immediate medical needs if there are any injuries
- Contact campus and provide updates and actions being taken on-scene
  - Program Director will contact parents/guardians and provide updates and future meeting or pick-up locations

Specific Information for My Program (Consider pick-up location and child care times):

# SUSPICIOUS PACKAGE

Mail and packages can be used to deliver suspicious and potentially hazardous materials. Before opening, take care to examine the item for anything unusual. Examples of issues that might raise concern:

- Oily or stained
- Excessive tape or sting
- Strange odor
- Misspelled words or names
- Lopsided or uneven package
- Excess postage, no postage, or uncanceled postage.
- No return address or nonsensical return address.
- Handwritten or restrictive notes such as “To be opened in the privacy of”, “Confidential”, “Your Lucky Day is Here”, or “Prize enclosed”
- Objects or packages arriving before or after suspicious calls.

If a package is unusual or as stated above:

- Do not open, smell, touch, or taste any contents of the package.
- Leave the area, isolate it by shutting doors behind you, as you leave.
- Do not use your cell phone within 300 feet.
- Treat it as dangerous.
- Call UOPD at (541) 356-2919. (Or 911 if your program is not occurring on the main Eugene campus.)

After:

- Instruct those who have had contact with the suspicious object to wash their hands with soap and water.
- Make a list of everyone who has had contact with the package, including their contact information.

Specific Information for My Program (including what type of identifying marker will program staff use on bags used by the program?):

# BOMB THREAT

Stay calm and obtain as much information as possible from the caller and report the threat immediately to 911. **DO NOT HANG UP.**

Be sure to note:

- Precise time of the call.
- Caller's exact words.
- Noticeable characteristics of the caller (gender, age, calm/angry, excited/slow, etc.).
- Information regarding the device and possible location.
- Background sounds (machine, voices, street noises, music, etc.).
- Threat language (well spoken, taped, irrational, foul, incoherent, etc.).

Ask the person questions, such as:

Where is the bomb located? _____

When will the bomb explode? _____

What does the bomb look like? _____

What kind of bomb is it? _____

What will cause the bomb to explode? _____

Specific Information for My Program

# ACTIVE THREAT - RUN, HIDE, FIGHT

## Call 911

**Run, Hide, Fight**

The University's Active Threat Response is based upon three action steps: run, hide, and fight. Please note that run, hide, and fight action steps may not always occur in this order, so memorizing them all as possible options regardless of order is a key to quick response. Run Hide Fight video: https://www.youtube.com/watch?v=Kah27w-t2GA&t=3s

**Run**

- Have an escape route and plan in mind.
- Make sure it is safe to leave the area you are in. Use your eyes and ears to determine if it is safe to run.
- Leave your belongings behind.
- Keep your hands visible.
- Once in a safe place, call police and give detailed information about what is happening. Don't assume someone else has already called the police.

**Hide**

- If unable to run from the danger, your second option should be to hide.
- Find a place that's out of the attacker's sight and remain quiet.
- Avoid huddling together in hiding spaces if possible. Spread out and make sure you are hidden completely.
- Lock and barricade doors with whatever is available.
    - Desks, chairs, door wedges, etc.
- Shut off lights.

**Fight**

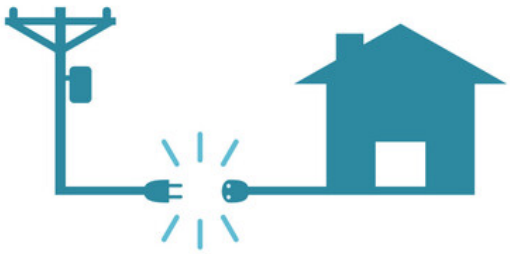
- Fighting is a last resort to be used only when your life is in imminent danger. (However, sometimes fighting may be the first and only option.)
- Find an object to use as a weapon, such as a fire extinguisher, backpack, book, or chair.
- Attempt to incapacitate the attacker; commit to your actions; work with other to disable the assailant.

Specific Information for My Program (including meeting sites and exits, reunification plans, missing children, and when program staff will need to make a choice for all program participants):

# THREATENING PHONE CALLS

- Threats made against program staff or participants are usually received by telephone. Most of these threats are made by callers who wish to create an atmosphere of anxiety and panic, **but all such calls must be taken seriously and handled as though the individual intends to harm the individuals whom they are threatening.**
- **Get another person to call 911 or UOPD while they are on the line.**
- Keep the caller on the line by asking questions.
- **Ask a lot of questions**- Permit the caller to say as much as possible without interruption.
  - **Take notes on everything said and on your observations about background noise, voice characteristics, etc.**
- Make the appropriate notifications to the Youth Program Director **and** to the UO Behavioral Evaluation and Threat Assessment (BETA) Team: https://betateam.uoregon.edu/report-a-concern

Specific Information for My Program:



# POWER OUTAGE AND UTILITY FAILURES

In the event of a power outage or utility failure, many campus facilities are equipped with emergency generators to power critical operations. Most buildings are provided with emergency lighting to aid in the safe evacuation. Report the outage to the appropriate authorities for your location. (This is UOPD if your are at the main Eugene campus.)

**Be prepared:**

- Keep a flashlight with spare batteries immediately accessible.
- Know how to locate the closest exit

**In the event of a large-scale power outage:**

- Remain calm.
- Building evacuation may become necessary.
- Do not light candles or any other types of flames for lighting.

Utility failures include power outages, gas leaks/unusual odors, or broken or malfunctioning life-safety equipment. If the utility emergency poses a public safety threat or emergency, contact UOPD at (541) 346-2919.

Be prepared to provide failure type, location, and approximate time of the failure. Officials may decide to evacuate a building due to utility failures. If not on University property, be aware of the procedures for that building in case of a utility emergency.

Specific Information for My Program:

# ELEVATOR ENTRAPMENT

**DO NOT EXIT** a stalled elevator until help arrives.

Press the **EMERGENCY PHONE BUTTON** to connect to Police. **If unable to connect, call UOPD at (541)346-2919.**

PUSH the ALARM BUTTON.

**REMAIN** in the Elevator.

WAIT for the Elevator Technician and/or Designated Public Safety Official(s).

This is the only time during a program when a youth participant(s) may truly be by themselves. Please educate your youth participants on the steps and procedures when stuck in an elevator. Remind youth participants that **NO JUMPING** is tolerated while riding in an elevator.

Specific Information for My Program:

# HAZARDOUS MATERIALS SPILL

- Do not attempt to clean unless properly trained in managing chemical spills.
- **Secure the area, call 911** and provide information on location and type of release or spill.
  - If safe, shut doors to help contain the spill in the room it occurred.
- Report the incident to the University of Oregon Police Department by calling (541) 346-2919.
  - Additionally, make a report to the Risk Management and Insurance Office by calling (541) 346-8316
- Evacuate all personnel from the immediate work and/or laboratory area; if the release or spill has the potential to impact a larger area, activate the building's fire alarm and follow evacuation procedures.
- Use safety showers and/or eye rinses if you or your participants comes into physical contact with a hazardous materials spill.

For more information about this subject please contact the Hazardous Materials Group at (541) 346-3192.

Specific Information for My Program:

# REPORTING SUSPECTED CHILD ABUSE

**University of Oregon Employees are required to report child abuse and neglect.**

Employees of Oregon higher education institutions are by law subject mandatory reporters of child abuse and neglect. For a current and complete list of public or private officials who are mandatory reports please refer to Oregon Revised Statute 419B.005 (3).

The university recognizes both its institutional and legal obligations to ensure the safety and wellbeing of minor children that are on campus, in university facilities, participating in university-sponsored events, or involved with university affiliated individuals. Visit the Youth Programs webpage for required actions, tools, and resources for comply with the university's Protection of Minors Policy.

Pursuant to the Oregon Child Abuse Reporting Statutes and university Protection of Minors policy, all university employees have a duty to make a report to the Oregon Department of Human Services or a law enforcement agency when there is reasonable cause to believe any child with whom the employee comes in contact has suffered abuse or that any person with whom the employee comes in contact has abused a child. **For instances that related to UO authorized activities, UO employees are expected to make the report immediately to the University of Oregon Police Department. (541) 346-2919.**

The university will conduct criminal background checks for any university employee or volunteer working in youth programs consistent with university policy on background checks and applicable Collective Bargaining Agreements. If a criminal background check reveals information that could affect the individual's suitability for their role in the youth program, the university will follow its usual policies and procedures regarding confidentiality, assessing the results, informing the youth program and the individual, and any other processes. Background checks are required every two years.

**Make a Report**:

- Follow the instructions provided on the Department of Human Services website.
- Submit reports to the Oregon Department of Human Services at **1-855-503-SAFE (7233)**.
- If the individual is also an UO student, you may also need to file a report with the Office of Investigations and Civil Rights Compliance and to meet your Clery Act obligations.

For more information on your reporting obligations, the **Office of Equal Opportunity and Access (OEOA)** website (https://investigations.uoregon.edu/) and the **Clery Act** website (https://clery.uoregon.edu/) have further information on meeting your reporting obligations.

For questions about UO Mandatory Reporting of Child Abuse and Neglect, please visit the HR webpage, https://hr.uoregon.edu/mandatory-reporting-child-abuse-and-neglect.

Specific Considerations for My Program:

# CLERY ACT & REPORTING RESPONSIBILITIES

**About the Clery Act**

In 1990, the federal government enacted the Jeanne Clery Disclosure of Campus Security Police and Crime Statistics Act (Clery Act), which requires any college or university that receives federal student financial aid to report certain crime statistics, issue campus alerts, and provide a detailed annual security report, among other compliance requirements. The Clery Act is named after Jeanne Clery, who in 1986, was raped and murdered in her dorm room at Lehigh University. Following her death, Jeanne's parents fought for legislative reform to enhance campus safety. They felt that students and their families had a right to know more information regarding the safety of college campuses. The goal of the Clery Act is to provide transparency and ensure that students, prospective students, parents and employees have access to accurate information about crimes committed on campus and campus security procedures.

**Who Are Campus Security Authorities (CSAs)?**

CSAs are employees in positions where students or others might reasonably report crimes to them. Under federal law, CSAs must report incidents shared with them in their official role.

CSAs include:

- Individuals with responsibility for campus security (e.g., law enforcement)
- Officials with significant responsibility for student and campus activities (e.g., student housing, discipline, judicial processes)

**At the University of Oregon, all Youth Program Administrators are designated as CSAs.**

**What do CSAs do?**

CSAs must report certain crimes to the university's Clery Coordinator when they learn about them in their official roles. CSAs are not required to report information shared indirectly, such as during a classroom discussion or at public awareness events like Take Back the Night. Under the Clery Act, only specific crimes must be reported, and only when they occur within the university's Clery geography or during university-sponsored overnight trips. (It is still recommended that CSAs report any incident of a criminal nature to the Clery Coordinator, who will determine whether it must be included in the university's Clery statistics.)

**How to Report**

- Emergency / immediate threat: Call 9-1-1
- Crime occurring or officer response needed: Call UOPD at 541-346-2919
- Non-emergency Clery report: Email clery@uoregon.edu or submit online
  Include (if known): incident type, date/time, and location

Specific Considerations for My Program:

# UO ALERTS

The program director of the youth program staff should always be monitoring the UO Alerts system for any immediate or impending emergencies and campus security threats. The University of Oregon employs a comprehensive, coordinated, and collaborative crisis and emergency management system to protect lives (human and animal), the environment, and property, and to continue necessary critical functions by building, sustaining, and improving the capability to mitigate against, prepare for, respond to, continue operations during, and recover from natural disasters, acts of terrorism, or other human-caused crises or disasters.

The ALERTS page is part of the University of Oregon's Crisis and Emergency Notification System.

The ALERTS page is used to provide emergency related information to the campus community, when and if it becomes available. The main webpage can be altered to provide incident specific information or simple alerts.

The ALERTS page allows the university to disseminate information beyond those directly associated with the university.

Parents/Guardians can opt into receiving UO Alerts throughout the duration of the camp. To sign up for Alerts texts, text UOEUG, UOPDX, UOOIMB to 333111. To receive Summer only alerts for Eugene campus, use code UOSummer.

**The UO ALERTS page can be found at: https://alerts.uoregon.edu/**

Specific Information for My Program (Consider who will monitor the UO alerts page in the absence of the program director, the circumstances you will adapt your program based on alerts received, and how you will communicate those changes to families of program participants):

# HEALTH SAFETY PLAN

The Youth Program health safety plan is designed to provide information on how to assist with different programming aspects such as design, training, and response to promote the positive health of our staff and participants. This health safety plan may include CPR and First Aid Training.

First aid refers to a wide range of initial treatment given to an injured individual at the site of the incident. This can cover minor cuts and abrasions to larger responses such as CPR. In-depth training and knowledge is not required to give first aid. However, First aid training is important to give you the tools to best help the injured party and protect yourself from contact with potential bloodeborne pathogens in the process. Training is required for certain positions at the University and encouraged for all others.

CPR stands for cardiopulmonary resuscitation and is a form of first aid. It is a emergency procedure combining chest compressions and often rescue breaths for individuals in cardiac arrest. If done correctly, CPR can help to preserve brain function until normal heart rhythm can be re-established through the use of an AED (automated external defibrillator). Prior training is important to understand the mechanics of giving effective, life saving CPR in an emergency.

You can sign up for CPR and First Aid training through Physical Education and Recreation at: https://rec.uoregon.edu/firstaid. Additionally, your health plan should include the location of the first aid kit and the closest AED to your program area.

If there is a child attending a youth program who carries an anaphylaxis and epinephrine auto-injector, there must be a trained program staff member in the immediate vicinity (an area in which an individual is physically present and can see, hear, direct, and assess the activities of the child) of the youth participants at all times. This American Red Cross training will teach you the signs and symptoms of anaphylaxis and how to care for a person having a severe allergic reaction, including how to administer epinephrine using an auto-injector device. The course, which includes video, activities that reinforce key information and a learning assessment, will take approximately 30 minutes to complete. The cost of this course is $35.00.

Specific Information for My Program:

# Appendix of Helpful Documents

UNIVERSITY OF OREGON

**Youth Program Child Sign-in and Sign-out**
**Program Name: _____**

| Date | Name of Child | Drop-off Parent/Authorized Individual's Signature | Time In | Pick- up Parent/Authorized Individual's Signature | Time Out |
|---|---|---|---|---|---|
| | | | | | |
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# Emergency Contact Information Form

| | |
|---|---|
| Child's Name | Date of Birth M ☐ F ☐ Non-Binary ☐ |
| Parent's/Guardian's Name | Parent's/Guardian's Name |
| Cell Phone Work Phone | Cell Phone Work Phone |
| Address: | Address: |
| City, ST ZIP Code | City, ST ZIP Code |
| Email Address | Email Address |
| Is there a legal document affecting child custody rights? Yes ☐ No ☐ | |

**Emergency Contacts**

In the case of an emergency, we always try to contact parent/guardian first. However, we are requiredto have an emergency contact other than the parent(s).

| | |
|---|---|
| Primary Emergency Contact | Secondary Emergency Contact |
| Cell Phone Work Phone | Cell Phone Work Phone |
| Address | Address |
| City, ST ZIP Code | City, ST ZIP Code |

**Additional Pick-up Authorization**

These people are authorized to pick up your child and must show photo ID.

| | | |
|---|---|---|
| Name: | Phone number: | Relationship: |
| Name: | Phone number: | Relationship: |
| Name: | Phone number: | Relationship: |

**Stay Connected with Campus**

The University of Oregon places the security and safety of its students, employees and visitors as its highest priority. Parents and Guardians can stay informed by bookmarking the UO alerts page. https://alerts.uoregon.edu/

# Health Permissions and Medical Information Form

Child's Name: Date:

## Allergies

**** Allergies may require an allergy plan on file prior to program participation****

Does your child have any food allergies? Yes☐ No☐

If you answered yes, please provide details below:

| Please check mark the following places your child can be around the allergen? | Does your child have any non-food allergies? Please list below: |
|---|---|
| Table ☐ | |
| Room ☐ | |
| Building ☐ | |

Is medication needed? If so, explain:

University of Oregon does not have Epi Pens on site for general emergency use. An allergy plan should be on file prior to program participation.

## Medications

Is your child currently taking any medications? Yes ☐ No☐

Please list if applicable:

Special health considerations we should be aware of:

My child may be given prescribed medication with written parent consent Yes ☐ No☐

My child may be given non-prescribed medication with written parent consent Yes ☐ No☐

Parent's/Guardian's Signature Date

## Medical Information

In the event of an emergency, staff members will call 911. The parent or guardian of the child is notified as soon as possible.

Hospital/Clinic Preference

Physician's Name Physicians Phone #

Insurance Company Insurance Phone #

Policy Number

## Sick child policy

I understand that if my child becomes ill, I will find alternative care until my child is symptom-free (of fever, diarrhea, vomiting, communicable disease as defined by Lane County Health department) for 24 hours.

Parent's/Guardian's Signature Date

## Assumption of Risk / Release & Indemnification of All Claims / Covenant Not to Sue

PLEASE PRINT

| **Activity Information** | |
|---|---|
| Group: | Date(s): |
| Activity: | |
| Activity Description: | |
| Activity Leader (name, title and phone number): | |
| Department: | |

| **Participant Information** | |
|---|---|
| Name: | Date: |
| Email address: | Phone number: |
| Emergency Contact (name and phone number): | |

In consideration of being permitted to participate in any way in the above-described activity (hereinafter called the "Activity"), I, for myself, my heirs, personal representatives and assigns, do hereby release, waive, discharge, and covenant not to sue the State of Oregon, the Board of Trustees of the University of Oregon, and the University of Oregon (collectively, hereafter called the "University"), their officers, employees, and agents from liability from any and all claims including the negligence of the University, its officers, employees and agents, resulting in personal injury, accidents or illnesses (including death), property loss, economic loss, emotional distress, psychic injury, pain or suffering of any kind, and damages arising from, but not limited to, participation in the Activity.

Name of Participant (please print legibly): _____

Signature of Participant: _____ Date: _____

**Assumption of Risks:** Participation in the Activity carries with it certain inherent risks that cannot be eliminated regardless of the care taken to avoid injuries. Authorization to participate should not be construed as a requirement to participate. The specific risks vary from one activity to another, but the risks range from (1) minor injuries such as scratches, bruises, and sprains (2) major injuries such as eye injury or loss of sight, joint or back injuries, heart attacks, and concussions to (3) insect bites, parasites, and other diseases, to (4) catastrophic injuries including paralysis and death. In-person activity during the COVID-19 pandemic carries enhanced risks that cannot be eliminated regardless of the care taken to avoid illness or injuries. The University cannot guarantee safety or immunity from the coronavirus. Given the extraordinary coronavirus pandemic, in addition to the above, there is the risks of:

- Contracting, exposure to, and infection resulting from the coronavirus, other viruses or bacteria;
- Quarantine or other inability to travel.

I acknowledge that the above list is not inclusive of all possible risks of participating in the Activity, and I am aware of the risks involved whether described or not. I am aware of how to access information from the Center for Disease Control, the Oregon Health Authority, Lane County Public Health, and similar government agencies to understand updated risks related to the coronavirus pandemic. I agree to make sure that I know how to safely participate in the Activity, and I agree to observe any rules and practices that may be employed to minimize the risk of injury. I have read the previous paragraphs and I know, understand, and appreciate

## Assumption of Risk / Release & Indemnification of All Claims / Covenant Not to Sue

these and other risks that are inherent in the Activity. I hereby assert that my participation in the Activity is voluntary and that I knowingly assume all such risks.

**Indemnification and Hold Harmless:** I also agree to INDEMNIFY, DEFEND, AND HOLD the University and its officers, employees, and agents HARMLESS from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees brought as a result of my involvement in the Activity and to reimburse them for any such expenses incurred.

**Medical Treatment Authorization:** I understand that an emergency may develop which necessitates the administration of medical care. In the event of injury or illness, I authorize the University to secure appropriate treatment including the administration of an anesthetic and surgery. I understand that such treatment shall be solely at my expense. Notwithstanding this paragraph, I understand and agree that the University has no obligation to provide or seek out any medical treatment for me.

**Severability:** The undersigned further expressly agrees that the foregoing waiver and assumption of risks agreement is intended to be as broad and inclusive as is permitted by the law of the State of Oregon and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

**Acknowledgment of Understanding:** I have read this waiver of liability, assumption of risk, and indemnity agreement, fully understand its terms, and understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing the agreement freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

**PLEASE READ THE ENTIRE AGREEMENT BEFORE SIGNING.**

Name of Participant (please print legibly): _____

Signature of Participant: _____ Date: _____

**IF THE PARTICIPANT IS UNDER 18 YEARS OF AGE, A PARENT OR LEGAL GUARDIAN MUST AGREE TO AND SIGN BELOW.**

NAME OF PARENT OR LEGAL GUARDIAN (please print legibly):_____

PARENT OR LEGAL GUARDIAN SIGNATURE:_____DATE: _____

UNIVERSITY OF OREGON

## Model Release

I, the undersigned, irrevocably grant the University of Oregon permission to publish, republish, adapt, exhibit, reproduce, modify, make derivative works, distribute, or display my name, image, voice, written testimony, and biographical information in connection with any university product or service. This permission applies to all markets and in any media or technology now known or hereafter developed. The university may exercise any of these rights itself or through any commercial or nonprofit successors, transferees, or licensees.

I waive any right to inspect or approve any work that bears my name, image, voice, written testimony, and biographical information.

Please indicate agreement by signing below. Any releasee under age eighteen must have parent or guardian cosignature.

Name (please print) _____

Phone _____

E-mail address _____

Signature _____

Parent or guardian cosignature (if releasee is under age eighteen)

_____

Notes

_____

Office use

Date _____

Artist _____

Project _____

MC0910

UNIVERSITY OF OREGON

## Model Release

I, the undersigned, irrevocably grant the University of Oregon permission to publish, republish, adapt, exhibit, reproduce, modify, make derivative works, distribute, or display my name, image, voice, written testimony, and biographical information in connection with any university product or service. This permission applies to all markets and in any media or technology now known or hereafter developed. The university may exercise any of these rights itself or through any commercial or nonprofit successors, transferees, or licensees.

I waive any right to inspect or approve any work that bears my name, image, voice, written testimony, and biographical information.

Please indicate agreement by signing below. Any releasee under age eighteen must have parent or guardian cosignature.

Name (please print) _____

Phone _____

E-mail address _____

Signature _____

Parent or guardian cosignature (if releasee is under age eighteen)

_____

Notes

_____

Office use

Date _____

Artist _____

Project _____

MC0910

# Youth Program Child Self-Check in/Out Permission Slip

**I give my permission for** _____

**To** _____

**On (date)** _____

**Comments / notes** _____

_____

**Signed** _____ **Date**_____/_____/_____
**(Parent / Guardian)**

**Parent / Guardian's phone number (home)** _____

**Parent / Guardian's phone number (cell phone)** _____

# University of Oregon Camps Accident Insurance Program 2026-2027

*Welcome to the University of Oregon Camp Accident/Injury Medical Expense plan administered by BMI Benefits on behalf of Federal Insurance Company. This policy is designed to provide primary accident medical benefits. Please see the following schedule of benefits, frequently asked questions and instructions for submitting a claim. Additional terms, conditions and limitations may apply.*

## Schedule of Benefits

| Accident Medical Expense Benefits | $25,000 |
|---|---|
| **Benefit Period** | 52 weeks from the date of the covered accident |
| **Deductible applies to each covered accident** | $0 |
| **Scope of Coverage** | Primary |
| **Covered Expense** | **Benefit Amount, Percentage, Other Limits** |
| **In-Patient Hospital Services** | |
| Daily ICU or CCU Benefit | 100%, up to two times the average semi-private room rate |
| Daily In-Hospital Benefit | 100% of the average semi-private room rate |
| Miscellaneous Services | 100% |
| **Ambulatory Medical Center** | 100% |
| **Emergency Room Treatment** | 100% |
| **Physician Services** | |
| Surgery Benefit | 100% |
| Assistant Surgeon | 100% |
| Physician's Surgical Facilities | 100% |
| Second Opinion or Consultation | 100% |
| Physician's Assistant | 100% |
| Anesthesia Benefit | 100% |
| Inpatient Visits | 100% |
| Office Visits | 100% |
| **Outpatient X-Ray, CT Scan, MRI and Laboratory Tests** | 100% |
| **Outpatient Physiotherapy** | 100% |
| **Outpatient Nursing Services** | 100% |
| **Ambulance Services** | 100% |
| **Medical Equipment Rental** | 100% |
| **Medical Services and Supplies** | 100% |
| **Dental Services** | 100% |
| **Prescription Drug Benefit** | 100% |
| **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS** | |
| Principal Sum | $10,000 |
| Loss must occur within | 365 days of the Covered Accident |
| **Schedule of Covered Losses** | |
| **Covered Loss** | **Benefit** |
| Loss of Life | 100% of the Principal Sum |
| Loss of Speech and Loss of Hearing | 100% of the Principal Sum |
| Loss of Speech and either Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% of the Principal Sum |
| Loss of Hearing and either Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% of the Principal Sum |
| Loss of Hands (both), Loss of Feet (both), Loss of Sight or a combination of any two of Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 100% of the Principal Sum |
| Loss of Hand, Loss of Foot or Loss of Sight of One Eye | 50% of the Principal Sum |
| Loss of Speech or Loss of Hearing | 50% of the Principal Sum |
| Loss of Thumb and Index Finger of the Same Hand | 25% of the Principal Sum |

## Frequently Asked Questions:

### "What do I do if I am injured during a UO Camp or Clinic?"

Seek appropriate medical care and notify the UO camp or clinic representative of the incident.

### "Who is covered?"

All Campers registered for sports and non-sports camp activities that are sponsored and supervised by UO.

### "What is Covered?"

Covered Accident means a sudden, unforeseeable event that results, directly and independently of all other causes, in an injury or loss and meets all of the following conditions: occurs while the Covered Person is insured under this Policy; and is not otherwise excluded under the terms of the Policy.

### "What are the benefits of this plan"

If you suffer a covered injury, the insurance plan will pay up to $25,000 for medical expenses incurred per covered injury.

### "How do I file a claim?"

BMI Benefits (BMI) is the plan administrator for the University of Oregon camps accident insurance program. All charges must be submitted to BMI on behalf of the camper. To be considered a valid claim and in order to make payment for a charge on a camper's claim, BMI must receive the following three pieces of information:

1. Completed and signed claim form;
2. HCFA/UB Forms- submitted from the camper, primary insurance carrier or medical Provider; and,
3. Explanation of Benefits (EOB) from the camper's primary insurance carrier.

In order to receive reimbursement for expenses incurred related to a valid claim you will need to submit the following information to BMI:

- An itemized bill (HCFA 1500 Forms, UB-04 Forms, ADA Dental Claim Forms)
- Copy of payment receipt
- Copy of canceled check or credit card transaction (please note credit card #'s should be redacted)
- The name and address of the person to whom reimbursement should be issued

### "Where do I get a claim form?"

Contact the camp or clinic organizer to obtain a copy of the claim form.

# Important Definitions & Key Terms:

## "What is BMI Benefits contact information?"

BMI Benefits
FULL TPA SERVICES

BMI Benefits, LLC.
PO Box 511
Matawan, NJ 07747
Phone: 800.445.3126 Fax: 732.583.9610
Email: bmi@bobmccloskey.com
Web: www.bobmccloskey.com

## Medical Bills (industry standard forms HCFA1500 or UB-04)

- Attach itemized copies of all applicable bills, including those bills under any deductible your plan may have. Also, include those bills paid partially or in full by other insurance. Bills showing only "Balance forward" or "Balance due" are not sufficient.
- An itemized bill indicates the provider of service's full name and mailing address, type of service, date of service, fee charged and diagnosis. Missing information will be requested from the medical service provider.
- To assure quick processing, please be sure that the bill and the insurance statements submitted are for the same item.
- Copies of any correspondence can/will be sent to those you identify as responsible.
- If any or all benefits are denied by other insurance, please provide a copy of the denial showing the reason charges were denied (include front and back of explanation of benefits when necessary).

## Explanation of Benefits (EOB from the camper's primary insurance if applicable:

What is an EOB? EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it be payment, denial, or pending) to a medical claim processed on your behalf. Often, this item is requested if we are processing a claim for you and you have any other insurance. EOBs are necessary to properly adjudicate excess insurance benefits.

**What is a HCFA, UB-404?** A HCFA is a specific medical billing form that is utilized by physician and outpatient offices to bill medical charges to insurance carriers or Third-Party Claim Administrators. A UB-04 is also a specific billing form; however, it is utilized exclusively by hospitals and outpatient surgical facilities.

UNIVERSITY OF OREGON

## Insurance Carrier Information:

University of Oregon Camp accident insurance plan is administered by BMI Benefits and underwritten by Federal Insurance Company.

**POLICY # 9912-74-15**

**EFFECTIVE DATES: 1/1/2026 – 1/1/2027**

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

# Claim Filing Instructions

**PLEASE NOTE – THIS POLICY IS EXCESS/SECONDARY TO OTHER VALID AND COLLECTIBLE INSURANCE INCLUDING PARENT/GUARDIAN MEDICAL INSURANCE.**
**THERE ARE SPECIFIC REQUIREMENTS AND SPECIFIC DOCUMENTS NEEDED IN ORDER FOR A CLAIM TO BE PROCESSED AND PAID UNDER THIS POLICY. PLEASE REVIEW THE CLAIMS PACKET IN ITS ENTIRETY.**

☐ Policyholder/Organization/School – Complete Part 1A of the BMI Benefits Accident/Injury Claim Form.

☐ Claimant/Parent/Guardian – Complete Part 1B and Parent/Guardian Information Sections

i. If claimant or parent/guardian has NO medical coverage, please indicate under Part 1B of Claim form, 'no other insurance' and complete Statement of No Other Insurance Document
ii. Please notify all health care professionals that you have secondary coverage for the accident/injury and ask the provider to bill BMI Benefits directly after primary insurance has processed the claim

☐ Submit completed and signed accident claim form to BMI Benefits, LLC.

BMI Benefits, LLC.
PO Box 511
Matawan, NJ 07747
Fax: 732.583.9610
Email: bmi@bobmccloskey.com

☐ See Claim Filing Instructions page for additional information.

BMI Benefits
FULL TPA SERVICES

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

# Participant Accident Claim Form

Please complete this form in its entirety and submit to BMI Benefits within 90 days from the date of accident. Please retain a copy for your records. Please contact the medical providers where treatment was received, submit BMI's billing information as your excess insurance, and ask for BMI to be billed directly. You may also obtain from the medical providers **all itemized bills** and **primary insurance explanation of benefits (EOBs)**. Itemized bills are considered **HCFA1500** Forms (physician's office), **UB-04** Forms (hospitals), **ADA Dental Claim Forms** (Dental) **not balance due statements**. BMI Benefits herein referred to as "Administrator"

## PART 1A - POLICYHOLDER

| **Policyholder/Organization Name** University of Oregon | | **Policy#** 9912-74-15 | |
|---|---|---|---|
| **Participant/Claimant's Name** | | **Date of Birth** | ◯ Male ◯ Female |
| **Date of Injury/Accident** | **Body Part Injured** | ☐ Left Body Part | ☐ Right Body Part |

**Was the Participant/Claimant involved in an activity sponsored and supervised by the Policyholder?** ◯ YES ◯ NO

**How did Injury occur? Please Provide Details of What Happened.**

| **Name of Policyholder Administrator/Official:** | **Title of Policyholder Administrator/Official** |
|---|---|
| **Signature of Policyholder Administrator/Official** | **Date** |

***NOTE: Part 1A – Policyholder section must be signed by an administrator/official of the policyholder or the claim cannot be processed***

## PART 1B - INJURED PERSON INFORMATION & INSURANCE INFORMATION

**Participant/Claimant's Last 5 Digits of Social Security # (Must be provided as required by the Center for Medicare Services)**

**Participant/Claimant's Home Address (Street, City, State, Zip)**

| **Participant/Claimant's Phone #** | **Participant/Claimant's E-Mail** |
|---|---|

**Is the claimant covered by any other insurance policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy?** ◯ YES ◯ NO **If Yes, Name of Ins. Carrier:** _____ **Policy #:** _____

**Is the above insurance a Medicaid Plan or a Military Insurance such as Tricare?** ◯ YES ◯ NO

## PARENT/GUARDIAN INFORMATION IF CLAIMANT IS A MINOR

| **Parent/Guardian Name** | | **Parent/Guardian Name** | |
|---|---|---|---|
| **Phone #** | **E-Mail** | **Phone #** | **E-Mail** |
| **Is the Parent/Guardian Employed?** ◯ YES ◯ NO | | **Is the Parent/Guardian Employed?** ◯ YES ◯ NO | |
| **Employer** | | **Employer** | |

**Authorization to Release Medical Information:** I hereby authorize any licensed physician; medical practitioner; hospital; clinic or other medical facility; insurance company; employer; Medical Information Bureau; Motor Vehicle Administration or other organization; or persons that have any records or knowledge of me or my physical or mental health condition to give the underwriting company with which it works, its authorized Administrator or their legal representative, and any agent acting on their behalf any such information. I understand that I may revoke this authorization at any time by providing written notice to the underwriting company or its authorized Administrator. I understand that I may revoke this authorization except to the extent that action has already been taken based upon this authorization. The revocation may not take effect before the date received by the underwriting company or its authorized Administrator. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for 24 months from the date below (In AZ, CA, CT, GA, HI, IL, ME, MA, MN, NV, NC, NJ, NM, OH, and VA authorization shall be valid during the duration of the claim. In WI, authorization is valid during the duration of the claim or 24 months, whichever is longer). I acknowledge that I, or my authorized representative, am entitled to receive a copy of this authorization upon request. I understand that the authorized Administrator may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed pursuant to this Authorization, the information will remain protected by the authorized Administrator in accordance with federal or state law. Payments will be made to the providers of service unless a paid receipt/statement accompanies the medical claim submission. **Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (Fraud language varies by state, for New York see the following, all other state specific states, please see below) **For residents of New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

| **Claimant or Authorized Person's Signature** | **Date** |
|---|---|

**FRAUD WARNING NOTICES**

**For residents of Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
**For residents of Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
**For residents of California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
**For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
**For residents of Delaware and Idaho:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.
**For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
**For residents of Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
**For residents of Kansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.
**For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
**For residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
**For residents of Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
**For residents of Minnesota**: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
**For residents of New Hampshire:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.
**For residents of New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
**For residents of New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTYOF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
**For residents of Ohio and Oklahoma:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
**For residents of Oregon:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.
**For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
**For residents of Vermont:** Any person who knowingly presents a false statement in a claim for proceeds of an insurancepolicy may be guilty of a criminal offense and subject to penalties under state law.

BMI Benefits
FULL TPA SERVICES

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

**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
(Insured's Name)
insurance policy, through myself, my parents or my guardian for the accident dated _____which occurred at my school. Should any insurance become effective during my treatment I will notify BMI Benefits and will forward all eligible bills to the new insurance 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/Guardian Name if insured is a minor) (Date)

_____ _____
(Insured Signature or Parent/Guardian Signature if insured is a minor) (Date)

**ORGANIZATION/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.**

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# Claim Filing Instructions

1. **BMI Benefits Accident/Injury Claim Form:** Part 1A must be completed and signed by the Policyholder. All other sections must be completed by the claimant or in conjunction with the Policyholder. If there is no primary insurance, please state "NO INSURANCE" on the accident claim form and complete the 'Statement of No Other Insurance' document and return it to BMI with the accident claim form.

2. **Please contact all medical providers where treatment was received and instruct them that you have excess 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. Claims paid via a HSA or FSA are reimbursable, however claims paid via a HRA 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. You may contact BMI Benefits to discuss your claim. Please be aware that settlement of your claim may take several weeks to process.

**Mail**
BMI Benefits, LLC
PO Box 511 Matawan, NJ 07747

**Assigned Claims Examiner**

| | |
|---|---|
| Examiner Name: | Lisa Crupi |
| Examiner Email: | lisac@bobmccloskey.com |
| Examiner Fax: | 732.844.8704 |
| Examiner Phone: | 800.445.3126 x 149 |

**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 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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# Frequently Asked Questions

**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 or payment directly to the provider.

**What documents are needed to process a claim?**

- **Fully completed BMI Benefits Accident Claim Form**
- **Itemized Bill – <u>in the form of a HCFA or UB04</u>**. 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 excess 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 excess insurance through your organization's participant 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.**

**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 organization, school, 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 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.**

# ITEMIZED BILL FOR PHYSICIAN BILLING - HICFA 1500 FORM

## HEALTH INSURANCE CLAIM FORM

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

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (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 ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

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) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ 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? YES ☐ NO ☐ ***If yes***, complete items 9, 9a, and 9d.

**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 either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

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 _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 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 | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT 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 ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

***PLEASE PRINT OR TYPE***

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

# ITEMIZED BILL FOR HOSPITAL & FACILITY CHARGES - UB04 FORM

| 1 | 2 | 3a PAT. CNTL # | | 4 TYPE OF BILL |
|---|---|---|---|---|
| | | b. MED. REC. # | | |
| | | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM | THROUGH | 7 |
| | | | | | |

| 8 PATIENT NAME | a | 9 PATIENT ADDRESS | a |
|---|---|---|---|
| b | | b | c d e |

| 10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 ACDT STATE | 30 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | |

CONDITION CODES

| 31 OCCURRENCE CODE | DATE | 32 OCCURRENCE CODE | DATE | 33 OCCURRENCE CODE | DATE | 34 OCCURRENCE CODE | DATE | 35 OCCURRENCE SPAN CODE | FROM | THROUGH | 36 OCCURRENCE SPAN CODE | FROM | THROUGH | 37 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |

| 38 | | 39 VALUE CODES CODE | AMOUNT | 40 VALUE CODES CODE | AMOUNT | 41 VALUE CODES CODE | AMOUNT |
|---|---|---|---|---|---|---|---|
| | a | | | | | | |
| | b | | | | | | |
| | c | | | | | | |
| | d | | | | | | |

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 11 | | | | | | | | | 11 |
| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
| 14 | | | | | | | | | 14 |
| 15 | | | | | | | | | 15 |
| 16 | | | | | | | | | 16 |
| 17 | | | | | | | | | 17 |
| 18 | | | | | | | | | 18 |
| 19 | | | | | | | | | 19 |
| 20 | | | | | | | | | 20 |
| 21 | | | | | | | | | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | ***PAGE ____ OF ____*** | ***CREATION DATE*** | | **TOTALS** | | | | 23 |

| | 50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL INFO | 53 ASG BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | | |
|---|---|---|---|---|---|---|---|---|---|
| A | | | | | | | 57 | | A |
| B | | | | | | | OTHER | | B |
| C | | | | | | | PRV ID | | C |

| | 58 INSURED'S NAME | 59 P REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO. | |
|---|---|---|---|---|---|---|
| A | | | | | | A |
| B | | | | | | B |
| C | | | | | | C |

| | 63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME | |
|---|---|---|---|---|
| A | | | | A |
| B | | | | B |
| C | | | | C |

| 66 DX | 67 I | A J | B K | C L | D M | E N | F O | G P | H Q | 68 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

| 69 ADMIT DX | | 70 PATIENT REASON DX | a | b | c | 71 PPS CODE | | 72 ECI | | | | 73 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |

| 74 PRINCIPAL PROCEDURE CODE | DATE | a. OTHER PROCEDURE CODE | DATE | b. OTHER PROCEDURE CODE | DATE | 75 |
|---|---|---|---|---|---|---|
| | | | | | | |
| c. OTHER PROCEDURE CODE | DATE | d. OTHER PROCEDURE CODE | DATE | e. OTHER PROCEDURE CODE | DATE | |
| | | | | | | |

| 76 ATTENDING | NPI | QUAL | |
|---|---|---|---|
| LAST | | FIRST | |
| 77 OPERATING | NPI | QUAL | |
| LAST | | FIRST | |
| 78 OTHER | NPI | QUAL | |
| LAST | | FIRST | |
| 79 OTHER | NPI | QUAL | |
| LAST | | FIRST | |

| 80 REMARKS | 81CC | | |
|---|---|---|---|
| | a | | |
| | b | | |
| | c | | |
| | d | | |

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee

LIC9213257

# ADA American Dental Association® Dental Claim Form

## HEADER INFORMATION

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

## 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 |
|---|---|

## 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 | |

## 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 |

ADA American Dental Association®

America's leading advocate for oral health

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**<br>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"