BE Fit
PHYSICAL THERAPY

Explanation of Klais/Multiplan Benefits for Physical Therapy Services

All healthcare services undertaken off campus are billed through Klais, and are not part of your tuition itself (like services at Dick's House). In order to receive the highest level of benefits through Klais **you are required to have a referral in place from a provider at Dick's House** prior to being seen off campus. Without a referral, your out-of-pocket cost will be higher ($400.00 Deductible/30% Co-Insurance).

The Klais benefits are as follows:

The benefit plan year runs September 1st-August 30th each year.

$200 deductible – Beginning September 1st of each year that you are enrolled you will be required to pay the first $200.00 out-of-pocket. If your Deductible has not been met off campus, 100% of cost for first two visits at BE Fit will likely go to deductible, and thus be passed directly to the student.
**If your coverage includes other members of you family you may have a higher deductible each year.*

After the $200 deductible is met, further visits/charges are covered 80% by insurance, with **20% of the total charges** being applied as co-insurance, again covered by the student. We are unable to verify the amount of your out-of-pocket that has been met.
Follow-up visits range in cost between $60 and $120 depending on length of visit and the specific procedures performed. Thus the student's out-of-pocket cost is 20% of those charges. An average ½ hour follow-up visit at BE Fit will cost between **$15 and $25 per visit** when applied to your co-insurance portion.

** Each individual insured through Klais will pay up to a total out-of pocket of $1,000/plan year.*
** If you have additional insurance Klais will always act as a secondary coverage to it.*

Please consider paying your deductible upfront if you know it will be applied. We also recommend paying $15.00 each follow-up visit after your deductible to avoid receiving a large bill once everything processes through the insurance. If the charges are greater than what you paid at the time of service you will receive a statement for the remaining balance. Sometimes it can take up to 4-6 months to fully process your claims through Klais. It is important to always respond to any request for more information from Klais to expedite payment of your claims. Keeping in touch about your billing and current address is important to avoid additional out of pocket cost.

Please feel free to discuss any questions that you might have with our office staff. You may also call Klais or The Dartmouth Student Group Health Plan representatives at Dick's House with any questions regarding your coverage.

Dartmouth Student Group Health Plan
Medical Claim Form

Klais & Company, Inc.
1867 West Market Street
Akron, OH 44313-6977
Telephone: 800-331-1096

TO BE COMPLETED BY STUDENT

1. School Name: Dartmouth College Policy # _____
2. Insured Student _____ Group # SH404
3. Local Address _____
4. Home Address _____
5. Date of Birth: ____ / ____ / ____ Local Phone _____ Home Phone: _____
6. Patient Status: ☐ Male ☐ Female ☐ Single ☐ Married
   Is this claim for a dependent? ☐ Yes ☐ No If yes, give name: _____
   Relationship: _____ Date of Birth: ____ / ____ / ____

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

7. Is this claim the result of an accident? ☐ Yes ☐ No If yes, give date of accident: ____ / ____ / ____ Time of Accident: ____
8. Is this claim the result of a work-related injury? ☐ Yes ☐ No
   Is this claim the result of an auto accident? ☐ Yes ☐ No
   Is this claim the result of sports participation? ☐ Yes ☐ No If "yes" ☐ intercollegiate ☐ intramural ☐ club ☐ other
9. Where did the accident occur? _____
   How did the accident happen? _____

COMPLETE THIS SECTION FOR SICKNESS CLAIM

10. Name of physician: _____ Date of initial service ____ / ____ / ____
11. Description of Illness: _____
12. Has the patient been treated for the above condition(s) in the last 12 months? ☐ Yes ☐ No
    If "yes" give condition(s) treated for and date(s) of treatment: _____

COMPLETE THIS SECTION FOR ALL CLAIMS (ACCIDENT OR SICKNESS)

13. Is patient covered for benefits by any Group Health, Employer, Union, Welfare Plan or Parent Health Plan? ☐ Yes ☐ No
    Other coverage provided through: Name of Person _____ Relationship _____
    If answered "yes" please complete the following:
    Insurance Co. or Benefit Plan _____ Employer or Sponsor _____
    Address _____ Address _____
    Telephone: _____ Telephone _____
    Policy # _____ Please include a photocopy of other plan identification card, if available
14. To be completed regardless of age of patient:
    Is patient covered under MEDICARE Hospital Insurance (Part A) ☐ Yes Eff. Mo. ____ /Day ____ /Yr. ____ ☐ No
    Is patient covered under MEDICARE Hospital Insurance (Part B) ☐ Yes Eff. Mo. ____ /Day ____ /Yr. ____ ☐ No
15. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.

    It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial of benefits and/or civil damages. Please refer to the following page for your state of residence fraud language.

Signature of Insured Student _____ Date _____ 20 ____

Patient's or Authorized Person's Signature _____ Date _____ 20 ____

COMPLETE THIS SECTION ONLY IF YOU WISH THE BENEFITS TO GO DIRECTLY TO THE PROVIDER(S)

Authorization to Pay Benefits: I hereby authorize payment directly to: any physician or provider of service for which I am submitting attached billings and charges. For the expenses provided under my Group Medical Expense Benefits, I understand I am financially responsible for charges not covered by this authorization.

Signature