SPECIFIC EXCESS LOSS REIMBURSEMENT CLAIM FORM

☐ Initial Claim ☐ Supplemental Claim ☐ Claim Notification (50% or trigger diagnosis)

ACCOUNT INFORMATION:

Employer (Group) Name: ______________________________

Employer State: ______________

Policy Period: ______________ Contract Type: ______________ Specific Deductible: ______________

EMPLOYEE INFORMATION:

Employee Name: ______________________________

Social Security Number: ______________________________

Date of Birth: ______________ Date of Hire: ______________ Effective Date: ______________

EMPLOYEE'S WORK STATUS:

☐ Actively working – Date Last Worked: ______________ ☐ Retired – Retirement Date: ______________

☐ Disabled and unable to work from ______________ to ______________

☐ Not Actively working – Indicate how coverage is being continued (mark all that apply):

☐ Sick Leave ______________ to ______________ ☐ Vacation ______________ to ______________

☐ Leave of Absence ______________ to ______________ ☐ FMLA ______________ to ______________

☐ Coverage Terminated? ☐ Yes ☐ No Date: ______________

☐ COBRA applicable? ☐ Yes ☐ No COBRA Effective Date: ______________

COBRA Premium Paid Through: ______________ COBRA Termination Date: ______________

CLAIMANT INFORMATION:

Claimant Name: ______________________________

Social Security Number: ______________________________

Relationship to Employee: ______________ Date of Birth ______________

Claimant Effective Date: ______________ Coverage Terminated? ☐ Yes ☐ No Date: ______________

COBRA applicable? ☐ Yes ☐ No COBRA Effective Date: ______________

COBRA Premium Paid Through: ______________ COBRA Termination Date: ______________

Is Claimant covered by any other coverage?: ☐ Yes ☐ No If yes, type of coverage (Auto, Work Comp, Group plan, Medicare): ______________

Carrier: ______________ Effective Date: ______________

CLAIM INFORMATION:

Diagnosis: ______________ Prognosis: ______________

Case Management? ☐ Yes ☐ No Vendor Name & Phone: ______________

Claimant injured? ☐ Yes ☐ No Date of Injury: ______________

Place Injury Occurred: ______________________________

How did injury occur? ______________________________

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Subrogation applicable? ☐ Yes ☐ No If "Yes", please provide details: ______________

Total Eligible Benefits this Submission: $ ______________________________

Less Specific Deductible: $ ______________________________

Balance: $ ______________________________

Percent to be Reimbursed: ______________________________%

Reimbursement Requested: $ ______________________________

Simultaneous Funding Requested: ☐ Yes ☐ No

YOUR REQUEST SHOULD INCLUDE COPIES OF THE FOLLOWING INFORMATION: (IF APPLICABLE)

Enrollment Form (initial/current)
Employee Claim Form
COBRA Election form & Proof of payment
Medicare Election Form/Medicare Card
EOB/Claim checks/Registers
Deductible/Coinsurance Proof of satisfaction
Divorce or Separation Decrees or Court Orders
Itemized Bills
R&C Calculations
Precertification Forms
Hospital Audits/Reviews
Hospital Records
Large Case Management Reports
Cumulative paid claims report
Investigative materials to support claim:

- COB
- Full time student status
- Pre-existing
- Physician's Statements
- Subrogation information
- Work Comp information
- Accident Details (police report, etc.)

NOTE TO ALL PARTIES COMPLETING THIS FORM: Any person who, with intent to defraud or knowing that he or she 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.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

TPA/Claims Administrator Name: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________ E-Mail: ______________________

Authorized Signature: ______________________________ Date: ____________________