



**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? \_\_\_\_\_

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)             | Hospital Records                          |
| Employee Claim Form                           | Large Case Management Reports             |
| COBRA Election form & Proof of payment        | Cumulative paid claims report             |
| Medicare Election Form/Medicare Card          | Investigative materials to support claim: |
| EOB/Claim checks/Registers                    | • COB                                     |
| Deductible/Coinsurance Proof of satisfaction  | • Full time student status                |
| Divorce or Separation Decrees or Court Orders | • Pre-existing                            |
| Itemized Bills                                | • Physician's Statements                  |
| R&C Calculations                              | • Subrogation information                 |
| Precertification Forms                        | • Work Comp information                   |
| Hospital Audits/Reviews                       | • 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.

**\*\*\*NOTICE – See State-Specific Fraud Notices on Last Page\*\*\***

**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: \_\_\_\_\_

**FRAUD NOTICE: For the states of AL, AZ, AR, CA, CO, DE, DC, FL, IN, KS, KY, LA, MD, ME, NC, NE, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA and WV, please refer to the following fraud notices:**

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

**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.

**Arkansas, Louisiana, Rhode Island, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of 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.

**California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**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.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**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.

**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.

**Kansas, Oregon, Vermont:** 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 may be guilty of insurance fraud.

**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.

**Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine, Tennessee, 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.

**Nebraska:** 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 materially false or deceptive statement is guilty of insurance fraud.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**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 guilty of a crime and may be subject to civil fines and criminal penalties.

**North Carolina:** Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**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.

**Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.