P.O. Box 19721, Irvine, CA 92623-9721 (877) 868-5775 – FAX (949) 222-1004

Specific Claim

☐ **Claim Notification(50% Notice/Trigger Diagnosis)** ☐ **Initial Claim** ☐ **Subsequent Claim** ☐ **Advance Funding**

ACCOUNT INFORMATION

Group Name ___________________________ Policy Year _________________________ Specific Deductible ____________________

Contract Basis ☐12/12 ☐12/15 ☐12/18 ☐24/12 ☐Other____________________________

EMPLOYEE INFORMATION

Employee Name _______________________ Gender ☐ M ☐ F Social Security Number _______________________________

Date of Birth ____/____/____ Date of Hire ____/____/____ Original Effective Date ____/____/____

CLAIMANT INFORMATION

Patient Name __________________________ Gender ☐ M ☐ F Social Security Number _________________________________

Dependant Relationship _________________ Date of Birth ____/____/____ Effective Date ____/____/____ Term Date ____/____/____

Full-time Student ☐ Yes ☐ No **(If Yes, provide full-time student status verification form)**

ELIGIBILTY STATUS

Actively Working Full-time ☐ Yes ☐ No Retirement Date ____ / ____ / ____ Last Date Worked ____ /____ / ____

If not actively at work, provide breakdown how coverage is being continued: (Complete each section that applies)

Sick Leave: from ____/____/____ Vacation Leave: from ____/____/____ Leave of Absence: from ____/____/____

FMLA: from ____/____/____ Disability Leave: from ____/____/____ Date Returned back to work ____/____/____

Coverage Terminated ☐ Yes ☐ No If Yes, Date ____/____/____ COBRA Elected ☐ Yes ☐ No

COBRA Effective Date ____/____/____ Date COBRA Premium paid to ____/____/____ COBRA Termination Date ____/____/____
(Include COBRA Verification form and premium verification)

COB INFORMATION

Is Claimant covered by any other insurance plan? ☐ Yes ☐ No (Group Plan, Medicare, Auto, Work Compensation)

Effective Date ____/____/____ Carrier Name: ___________________________

Medicare Eligible ☐ Yes ☐ No Effective Date: ____/____/____ Disabling Condition if under 65 ______________________

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CLAIM INFORMATION

Diagnosis ______________________________ Prognosis ___________________________ Case Management ☐ Yes ☐ No

Vendor Name ___________________________ Claimant Deceased ☐ Yes ☐ No Date of Death ____/____/____

Accident Claim ☐ Yes ☐ No Date of Accident ____/____/____ Accident Details ____

____

(Include copy of Police report and all other related documentation)

Subrogation ☐ Yes ☐ No **(Include copy of signed lien and all other related documentation, if applicable)**

STOP LOSS REIMBURSEMENT INFORMATION

Claims Paid LTM $______________ Claims Pending YTD $_________________ Expected Claim Liability YTD $_________________

SUBMISSION REQUEST:

TOTAL TPA PAID: $_____________________

LESS SPECIFIC DEDUCTIBLE: $_____________________

ADVANCE FUNDING: $_____________________

REIMBURSEMENT REQUESTED: $_____________________

FRAUD WARNING

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.

YOUR REIMBURSEMENT REQUEST MUST INCLUDE THE FOLLOWING INFORMATION (IF APPLICABLE):

INVESTIGATIVE MATERIALS FOR:

1. COB
2. Full-Time Student Status
3. Pre-Existing
4. Large Case Management Reports
5. Physician's Statements
6. Subrogation
7. Workers' Compensation
8. Accident Details/Police Report

COPIES OF:

1. Enrollment Form (Initial/current)
2. Employee Claim Form (current)
3. COBRA Election Form/payments
4. HIPAA Documentation
5. EOBs/Claim Checks/Registers
6. Hospital & Surgical Bills, OP Notes
7. Deductible/Coinsurance Proof
8. Precertification Form
9. Hospital Audits/Reviews
10. Hospital Records
11. Divorce or Separation Decrees or Court Orders
12. Itemized bills greater than 1,000

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

TPA/Company Name ____

Address ____

Telephone (   ) __________ Fax (   ) ______________ Email ______________________________

Authorized Signature ____

Title ______________________________ Date ______________________________