Claim Submission Quick Reference Guide

BEST RE

The BEST Re Claim Department's primary goal is to process your claims quickly and accurately.

This Quick Reference Guide provides a checklist of items to submit with your claim request. If you have any questions, please contact Joanna Wilmot at **(877) 868-5775 ext.360** or email at **jwilmot@bestre.net.** For your convenience, claims and notifications may be submitted via regular mail, email or fax.

Mail to: BEST Re
Attention: Stop Loss Claim Department
2700 West Cherry Lane, Suite 130
Meridian, ID 83642

Fax: (208) 893-5040

Email: jwilmot@bestre.net

Notification of Catastrophic Claim Requirement

Written notice must be given to BEST Re when an Individual Specific Claim has reached 50% of the Specific Attachment Point, or immediately upon the Administrator's notification of a claimant diagnosed with any of the catastrophic medical conditions outlined below, regardless of the Specific Attachment Point or question of coverage.

The following diagnosis and/or guidelines represent potential high cost/catastrophic cases for which case management should also be utilized:

- Amputations or permanent loss of limb(s) Renal failure
- Cancers
- Cerebral vascular accidents High risk pregnancies
- Chronic blood disorders
- Chronic medical conditions (requiring long term treatment or rehabilitation)
- Crushing or massive internal injuries
- Degree or 20% of the body with second degree burns)
- Diabetes
- Eating disorders (anorexia, bulimia) Heart surgery
- Head traumas or brain injuries HIV/AIDS and related conditions
- Hospitalizations of more than 15 days and multiple hospital confinements
- Infusion therapies
- Loss of sight or hearing
- Major organ transplants (including stem cell or bone marrow)
- Multiple or serious fractures
- Neonatal high risk infants
- Premature birth or significant congenital defects
- Serious burns, (10% of the body with third
- Serious psychoneurotic impairment
- Specific/Notification Claim Form
- Spinal cord injuries
- All other injuries or sickness which may, in the opinion of the administrator, develop sufficient loss to reach the Specific Deductible

Specific Claim Advance Provision

For questions regarding Advance Funding provisions, please contact the BEST Re Claim Office at **(877) 868-5775 ext.360** or email: **jwilmot@bestre.net**

BEST Re Cost Control Claim Service

BEST Re offers Cost Control Claim Services with no added monthly cost, but a reduction to the client's bottom line:

- ☑ Claim Re-pricing
- ☑ Bill Negotiation
- ☑ U & C Audit Review
- ☑ Medical Necessity Review
- ☑ Specialty Cancer Care Review
- ☑ Specialty Dialysis Care Review

The BEST Re Cost Control Claim Service includes access to several national re-pricing vendors. These vendors contract with providers throughout the nation to offer discounts on both out-of-network and in-network claims. BEST Re has attained an average claim savings of 22.5% of billed charges and some claim savings have been as high as 75% of the billed charges. This benefit not only reduces the bottom line for some plans, it has had a positive impact on an employer's renewal.

How to Reprice Claims

Claim Re-pricing for out of network claims will have a turnaround time of 2-3 business days. All facility (UB92) bills need to include the itemization.

Bill Negotiation, Medical Necessity, U&C Audit, and Specialty Cancer Care/Dialysis reviews will need to include:

1. Itemization and UB92 (facility)
2. Operative Report
3. Medical Records (on a requested basis only)
4. Case Management Report
5. Treatment Plan for Cancer Care (chemotherapy)
6. Implant invoices as requested

The normal turnaround time is 5 to 7 business days.

All Bill Negotiations will include a copy of the sign-off from the provider. Medical Necessity and U&C Audit reviews will include a sign-off from the provider (if obtained) or instructions of what messages must appear on the Explanation of Benefit statement to the provider and the amount of discount to apply to the bill. All vendor fees for this service are fully reimbursable under the specific and aggregate coverage's, and are subject to the normal policy plan/limits.

We encourage you to use these services for your entire group's eligible (as defined in the plan document) out-of-network claims over $1,000 and in-network claims over $5,000 with discounts of 10% or less.

Attach the BEST Re Cost Control Claim Form and forward it either by fax to **(877) 868-5775 ext.360** or email: **jwilmot@bestre.net**

Specific Claim Submission

Include the following material with both new or supplemental specific excess reimbursement and advance requests:

- ☑ A BEST Re Specific Coverage Verification and Claims Calculation form, completed and signed
- ☑ A copy of Employee's signed and dated enrollment form and all other information related to the participant's eligibility or coverage continuation.
- ☑ Claim calculation worksheets/explanation of benefits (EOB)
- ☑ A copy of the Employee's completed claim form or similar documentation showing dependent's employment status or other insurance coverage status
- ☑ Copies of any applicable investigation documents, medical records, case management notes, accident reports, subrogation/recovery details, eligibility determinations, and HIPAA certifications or pre-ex investigations.
- ☑ A detailed claims payment report that includes the following:
  - Claimant name
  - Claimant DOB
  - Provider name
  - Provider tax ID
  - Dates of service (from and through)
  - CPT/HCPCS codes for each item being billed
  - ICD-9 codes
  - Charged amount
  - Discount amount
  - Paid amount
  - Date paid
- ☑ Copies of all itemized bills that are greater than $1,000.00.

Notification of Aggregate Claim Data

Monthly aggregate reports must be submitted to BEST Re by the 25th of the following month, regardless of the Aggregate Attachment Point or question of coverage. For your convenience, Monthly Aggregate Reports may be mailed, faxed or emailed to the BEST Re Stop Loss Claims Department.

Aggregate Claim Submission

Submit the following when requesting a Year-End Aggregate Reimbursement.

- ☑ A completed and signed Reimbursement Request.
- ☑ A Paid Claims Report or a list of paid claims for the reporting period which includes:
  a. Name of employee/participant
  b. Name of patient
  c. Incurred dates of service for each payment
  d. Accumulated total for each individual.
- ☑ A Check Register which includes:
  a. Check numbers
  b. Amount of each check
  c. Date of payment
  d. Name of Payee
- ☑ A complete Census Report for the excess Contract year
- ☑ An Aggregate Excess Loss Report
- ☑ Copies of the Prescription Card Program invoice statements (if your Contract covers prescription card service or similar drug coverage)
- ☑ Identify administrative fees, non-contractual payments and any exception payments made by the plan
- ☑ A listing/report that indicates voids and refunds for the contract year.
- ☑ Aggregate Request Form

Aggregate Accommodation Option

Although the stop-loss contract is a reimbursement contract and is not to be deemed "insurance", Aggregate Advance Funding is an optional feature that can be added to the Excess Risk Reimbursement Contract we issue. This option is designed to provide the employer with funding assistance, subject to premiums being current and to the appropriate pro-rated aggregate retention amount.

When requesting an aggregate advance on behalf of your client, the administrator must agree to the following terms and conditions:

- Only one advance will be made per calendar month and subject to a minimum of $5,000.
- The aggregate retention must be paid prior to any advance.
- Checks issued by the Plan, which accumulate towards the employer's aggregate retention, must be released to the payees prior to requesting an advance.
- All claims submitted for advance funding, must be identified as such.
- A list of payments to which the advance applies must be provided with your request.
- Advanced funds must be paid directly to the provider for which the advance payment was requested.
- Once the advance is received and claims are paid, the check numbers, dates and amounts, if not previously provided, must be reported to BEST Re.
- It is imperative that administrator checks, which have been issued for the claims in which the advance request is made, can be verified.
- The Administrator will provide all services and satisfy all reporting requirements as if the claim has been funded/paid.
- Requests for an advance must be made no later than 20 days after the month for which the advance is being requested
- Provide all documents required with a year-end request.
- Aggregate Request Form

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COST CONTROL CLAIM FORM

RUSH HANDLING

Date**:**

Return to**:** TPA**:**

Fax**:** Email**:**

Patient Name: Patient Social Security:

Insured Name: Insured Social Security:

Group Name: Claim Dollar Amount**:**

☐ **Network Provider** ☐ **Out of Network Provider**

Client's Turnaround Time Requirements:

- ☐ **Claim Repricing**
- ☐ **Bill Negotiation**
- ☐ **U&C Audit**
- ☐ **Medical Necessity Review**
- ☐ **Specialty Cancer Care/Dialysis Review**

(UB92's must include an itemization)

Comments:

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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 ____

BEST RE
FOCUSING ON YOUR NEEDS

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

REIMBURSEMENT REQUEST
FOR AGGREGATE STOP-LOSS CLAIM

Group Policy holder	☐ Year End Claim	☐ Month End Claim Mo. of
Policy No.	Original Effective Date	
Current Policy Year	Aggregate includes: ☐ Medical ☐ Rx ☐ Run In ☐ Dental ☐ Vision	
Monthly Factors: Employees: $ -	Dependents: $ -	
Minimum Annual Attachment Point: $ -		

Total Claims paid during the policy year: $ -

Less Adjustments:

I. Claims paid outside the benefit plan

Voids & Returns	$ -
Pending Add'l Info	$ -
Not Covered	$ -
Payment Errors	$ -
Add'l Adjustments	$ -
Underfunded	$ -
Misc.	$ -

Total Adjustments $ -

Total Eligible Paid Claims $ -

II. Specific claims paid and pending

a.)		$ -	
b.)		$ -	
c.)		$ -	
d.)		$ -	
e.)		$ -	$ -

	Net claims subject to annual deductible	$ -
Less:	Aggregate deductible for the year	$ -
	Previous month reimbursement	$ -
	Reimbursement Requested	$ -

ATTACHMENTS:

1. Contract year-to-date monthly check register showing all payments, voids, reissues, and refunds; identifying any non-claim payments (e.g. administration fees, etc.). The register should show check number, date of check, name of claimant, incurred date, and check amount.
2. Contract year-to-date claim listing by coverage's and claimant (by month, if monthly). Only include those coverage's eligible for the aggregate.
3. Listing of all specific stop loss claims for the agreement period.
4. Policy year eligibility listing by month.
5. Attachment point calculation.
6. Prescription Drug Card registers.
7. Check register report.

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: ______________________

Email: ______________________

Telephone : ______________________ Fax: ______________________

Authorize Signature: ______________________

Title: ______________________