USBenefits Insurance Services, LLC

DBA: Employer Stop Loss Insurance Services LLC (CA Only)

Specific Excess Reimbursement Request Form

Specific Deductible:	☐ Initial ☐ Supp. ☐ Advance Funding		Claim Basis: ☐ 12/12 ☐ 12/15 ☐ 12/18 ☐ 24/12 ☐ Other
Group Name:	Co-Insurance: plan deductible:		COB: ☐ Yes ☐ No
TPA:	Plan effective date:		COBRA: ☐ Yes ☐ No effective date
Employee:	EE effective date:	EE date of hire:	Subrogation or third party recovery potential: ☐ Yes ☐ No
Patient:	Plan Year:		Date accident/illness occurred:
Date of Birth:	Original plan effective date:		Is claimant deceased? ☐ Yes ☐ No Date of death:

This form supplements our customary requirements for Proof of Loss. Some claims may require additional investigation by our staff or an outside agency.

SECTION A - Verification

Employee:	ID Number: - -	Contract effective date:	Date premium paid to:	Has employee/dependent terminated? If so, please give date:	
Dependent relationship:	ID Number: - -	Contract effective date:	Date premium paid to:	Employee:	Dependent:

Was employee active on the date of illness/injury? Yes ☐ No ☐

If not, please explain continuation of coverage:

SECTION B – Diagnosis: Please explain in detail

Total paid/payable to date:	Advance funding claims pending:	Ineligible amounts:	Amount requested:

Your reimbursement request should include the following information (If applicable):

Investigative materials for:
1. COB
2. Large case management reports
3. Physician's statements
4. Subrogation
5. Worker's compensation
6. 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
9. Deductible/Coinsurance Proof
10. Precertification Form
11. Hospital Audits/Reviews
12. Hospital Records
13. Divorce/Separation Decrees or Court Orders
14. 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: ______________________________

Phone: ________________ Fax: ________________ Email: ______________________________

Authorized Signature: ______________________________

Title:______________________________Date: ________________

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