

USBenefits Insurance Services, LLC

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

Specific Excess Reimbursement Request Form

Specific Deductible:	<input type="checkbox"/> Initial <input type="checkbox"/> Supp. <input type="checkbox"/> Advance Funding	Claim Basis: <input type="checkbox"/> 12/12 <input type="checkbox"/> 12/15 <input type="checkbox"/> 12/18 <input type="checkbox"/> 24/12 <input type="checkbox"/> Other
Group Name:	Co-Insurance: plan deductible:	COB: <input type="checkbox"/> Yes <input type="checkbox"/> No
TPA:	Plan effective date:	COBRA: <input type="checkbox"/> Yes <input type="checkbox"/> No effective date
Employee:	EE effective date:	EE date of hire:
Patient:	Plan Year:	Subrogation or third party recovery potential: <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Birth:	Original plan effective date:	Date accident/illness occurred:
		Is claimant deceased? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>				
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:
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Your reimbursement request should include the following information (If applicable):

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| Investigative materials for: | Copies of: | |
| 1. COB | 1. Enrollment form (Initial/current) | 9. Deductible/Coinsurance Proof |
| 2. Large case management reports | 2. Employee claim form (current) | 10. Precertification Form |
| 3. Physician's statements | 3. COBRA election form/payments | 11. Hospital Audits/Reviews |
| 4. Subrogation | 4. HIPAA documentation | 12. Hospital Records |
| 5. Worker's compensation | 5. EOBs/Claim checks/Registers | 13. Divorce/Separation Decrees or Court Orders |
| 6. Accident details/Police report | 6. Hospital & surgical bills, OP notes | 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: _____