USBenefits
Insurance Services, LLC

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: _____ COB: ☐ Yes ☑ No

Plan deductible: _____

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
7. Deductible/Coinsurance Proof
8. Precertification Form
9. Hospital Audits/Reviews
10. Hospital Records
11. Divorce/Separation Decrees or Court Orders
12. Itemized bills greater than $1,000
13. Work Status Form

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: _____

Clear Form

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dba Employer Stop Loss Insurance Services, LLC (CA only)

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