Innovative Stop Loss Solutions

claims@getisls.com

Request for Reimbursement

☐ Initial Claim ☐ Supplemental Claim # ☐ Advanced Claim ☐ Other

Employer name:

Policy number: Policy period: Plan type:

Employee name: Employee ID: Employee D.O.B.:

Employee effective date: Hire date: Termination date:

Last day worked: COBRA date: Premium paid to:

Current status: Lifetime maximum paid to date:

Claimant name: Claimant D.O.B.: Relationship:

Claimant effective date:

Diagnosis/ICD-10:

Prognosis:

Case Management ☐ Yes ☐ No Vendor:

Total amount paid last year	
Total eligible benefits this submission	
Less specific deductible	
Balance	
Percent to be reimbursed	
Reimbursement requested	
Estimated future liability	

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

☐ Enrollment form (initial/current)
☐ COBRA election form/payments
☐ EOBs/claim detail report
☐ Deductible/coinsurance proof
☐ Continued eligibility
☐ Precertification forms
☐ Hospital bills over $250,000
☐ Ancillary bills over $100,000
☐ Worker compensation
☐ Coordination of benefits
☐ Pre-Existing
☐ LCM reports
☐ Subrogation
☐ Accident details/police reports

* Additional information may be required depending upon the nature of the claim request.

TPA/Company name:

Address:

Contact: Title:

Phone: Ext.:

Email: Fax:

Authorized signature Date:

I certify that the above information is correct and that the claims have been paid in accordance with the plan document.