Innovative Stop Loss Solutions

Notification Form

Policyholder:

Specific Deductible: Contract: Policy Year:

Employee: Employee D.O.B: Employee ID#:

Claimant: Relationship to employee: Claimant D.O.B:

Active: ☐ Yes ☐ No If "No" termination date:

COBRA: ☐ Yes ☐ No If "Yes" effective date:

Retiree: ☐ Yes ☐ No If "Yes" effective date:

Medicare: ☐ Yes ☐ No If "Yes" effective date:

Is the claimant covered under any other Insurance? If ☐ Yes ☐ No

yes, please describe:

Date claim incurred: Subrogation applicable? ☐ Yes ☐ No

If injury, please describe:

Has Large Case Management been initiated? ☐ Yes ☐ No Name of LCM Firm:

Primary Diagnosis ICD-10 Code:

Secondary Diagnosis ICD-10 Code:

Prognosis:

Total claims paid to date: Estimated future claims:

Is the provider in a Network? ☐ Yes ☐ No Network:

Additional comments:

TPA/Company name:

Address:

Contact: Title:

Phone: Ext:

Email: Fax:

Signature: Date:

This form may be used for trigger diagnosis, early/potential notices, or 50% notices. Any questions regarding the use of this please reach out to us.
Please send to:claims@getisls.com