Individual Excess Loss Reimbursement Request Form

Date: _____

Policyholder/Employer Name _____

Policy Period: **From** _____ **To** _____

Employee Name _____ **Employee ID No.** _____

Date of Birth _____ **Gender** _____ **Date of Hire** _____

Original Effective Date of Coverage _____ **Coverage Termination Date** _____

COBRA Effective Date _____ **COBRA Termination Date** _____

Claimant Name _____ **Is Claimant Employed? (check one)** ☐ Yes ☐ No

Date of Birth _____ **Gender** _____ **Other Insurance? (check one)** ☐ Yes ☐ No

Original Effective Date of Coverage _____ **Coverage Termination Date** _____

COBRA Effective Date _____ **COBRA Termination Date** _____

Reimbursement Request:

Total TPA Paid Amount	**$**
Less Specific Deductible	**$**
Less Benefits Paid Outside Plan	**$**
Less Previous Reimbursement Amount	**$**
Reimbursement Request Amount	**$**
***Advanced Funding Request Amount**	**$**

*PLEASE CHECK THE EXCESS LOSS POLICY SCHEDULE PAGE TO DETERMINE IF THIS BENEFIT IS ELECTED

Please attach:

Detailed Paid Claim Report Which Includes:

- ☐ Claimant Name or Identifier (such as Social Security Number and relationship to the employee)
- ☐ Diagnosis (ICD9) Code(s)
- ☐ Dates of Service - Incurred (From-To)
- ☐ Type of Service or Procedure Codes (CPT, HCPCS & Hospital Revenue Codes)
- ☐ Provider Identification
- ☐ Payment Calculation: Charge Amount, Allowable Amount, Deductible, Co-Pay, Discount, Ineligible Amounts & Paid Amounts
- ☐ Processed and / or Paid Date
- ☐ Copies of bills over $20,000

Eligibility Information:

- ☐ Copy of Enrollment Card or screen print with Hire Date, Original Coverage Effective Date, Termination & Cobra Effective Date
- ☐ Copy of Cobra Election Form, If applicable
- ☐ If the claimant is an employee: Work status (Active-FMLA-Medical Leave of Absence, last date actively at work, date leave began, return to work date, dates of FMLA)
- ☐ Identify Other Insurance if applicable (Medicare, Worker's Comp., Auto Insurance, Other)
- ☐ If illness or injury is accident related, please provide date and details of accident with applicable subrogation information

Please submit this form and required documentation to:

Alternative Risk Solutions, LLC
Attn: **Claims Department**
8232 W. Cactus Road, Suite 122
Peoria, AZ 85381
(866) 515-3881 Ph
(623) 412-2722 Fax
claims@altrisk.biz

I certify that the information is correct and claim has been paid in accordance with the covered person's benefit plan.

Third Party Administrator Completed By (Print) _____
Email Address _____
Phone Number _____
Fax Number _____