Potential Large Claim Alert / 50% Notification

Date: _____

Policyholder/Employer Name _____

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** _____

Claim Information:

Diagnosis _____ **Code** _____

Prognosis _____

Inpatient Dates _____ **Discharge** _____ **Is this an In Network Hospital?** _____

YTD Paid Amount _____ **Estimated Future Cost** _____

Pended Charges _____ **Has CM been implemented?** ☐ Yes ☐ No

Case Manager/Phone _____

If non-providers, are discounts being negotiated? ☐ Yes ☐ No **Is Claim due to an Accident?** ☐ Yes ☐ No

Provider Contacts:

(1) Provider Name _____ **Phone No.** _____

Provider in Plan's PPO Network ☐ Yes ☐ No

(2) Provider Name _____ **Phone No.** _____

Provider in Plan's PPO Network ☐ Yes ☐ No

Please submit this form and required documentation to:

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

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