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
1390 N. McDowell Blvd
Suite G-283
Petaluma, CA 94954
reporting@altrisk.biz

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