

# Insurance Mass Marketing Systems, Inc

A Division of The Heusinkveld Group

## INITIAL NOTIFICATION OF POTENTIAL LOSS/ 50% CLAIMANT FORM

Complete only for initial reporting

Date: \_\_\_\_\_

TPA Name: \_\_\_\_\_

Name of Insured Group: \_\_\_\_\_

Carrier name & Policy #: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Policy Basis: \_\_\_\_\_

Name of Claimant: \_\_\_\_\_

Specific Retention: \$ \_\_\_\_\_

Employee's ID#: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary DX Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Prognosis and last date of service: \_\_\_\_\_

Amount of claims paid to date: \$ \_\_\_\_\_ Incurred From / To: \_\_\_\_\_/\_\_\_\_\_

Paid Through: \_\_\_\_\_

Employee's Work Status: \_\_\_Active \_\_\_Retired \_\_\_Disabled \_\_\_Cobra

(submit proof of Cobra payments)

Amount of Pending Claims: \$ \_\_\_\_\_

Expected Future Costs: \$ \_\_\_\_\_

Hospital Name, Address and dates of Confinement: \_\_\_\_\_

### Cost Containment Features:

LCM Implemented? \_\_\_Yes \_\_\_No Date: \_\_\_/\_\_\_/\_\_\_

Large Case Management Firm: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Subrogation: \_\_\_Yes \_\_\_No (if applicable)

Completed by: \_\_\_\_\_