Insurance Mass Marketing Systems, Inc.

A Division of the Heusinkveld Group

REIMBURSEMENT REQUEST FOR AGGREGATE CLAIM

SECTION I- GENERAL INFORMATION

Name of Insured Group:_____

Carrier Name / Policy Number: _____ _____

Coverage Period: ___/____/_____ through ___/____/_____

TPA INFORMATION

TPA Name		
Address		
City	**State**	**Zip**
Telephone Number	**Fax Number**	

1. Annual Aggregate Deductible $_____
2. Minimum Attachment Point for the Policy Period $_____

A. Total Claims Year-to-date $_____

B. Less Specific Claims (Paid or Payable) $_____

C. Less Ineligible or Extra-Contractual Claims $_____

D. Less Refunds/Recoveries/Voids $_____

E. Total Eligible toward Aggregate $_____

F. Attachment Point (Either the Year-to-Date Attachment Point or the Minimum Attachment Point, whichever is higher $_____

G. Amount Requested (total of E & F) $_____

Note: See page two of this form for additional information that is required for this submission.

Please do not submit photocopied forms. Use original prints only.

ATTACHMENTS

Your reimbursement request should include the following information:

1. Census listing for all individuals covered during the policy period. The list must contain all types of coverages (single, family, COBRA, etc.) and must contain all additions, terminations and changes. Please supply Coordination of Benefits information.

2. Copies of third party liability inquiries for all accident claims paid. This documentation must also contain subrogation information for all applicable claims, including copies of signed Subrogation Agreements, the name and address of the agency engaged to pursue recovery, if applicable and any other relevant documentation regarding the recovery status of claims.

3. Copies of COBRA election forms including enrollment card(s), dates of coverage and proof of payment of premiums for all people who elected COBRA.

4. Claim detail report showing employee name, patient/claimant name, incur date, paid date, provider information, amount paid, check number, payee name and diagnosis code for all claims declared under the Aggregate policy.

5. List of all refunds received for this account.

6. List of all non-contractual payments/pay by exceptions that were made during the policy period with a comprehensive explanation of the payment.

7. List of all claims and the dollar amounts that exceeded the Specific Deductible, if applicable.

8. Proof of funding, including banking or funding reports that substantiate that the group has funded all claims.

TPA SIGNATURE

We certify that the above information is correct and that the claims have been paid in accordance with the document.

Authorized Signature	**Date**
Title	

Send Claims to: IMMS Claims Department
14673 Midway Road, Suite 220
Addison, TX 75001
Phone: 972-458-2833
Fax: 972-458-1461