Insurance Mass Marketing Systems Inc.

A Division of The Heusinkveld Group

Guidelines for Claims Review and Reimbursement

Claims Submission Information
Large Loss Notification

One of the most important responsibilities of the administrator is the timely notification to IMMS of any claim with large loss potential. You are required to provide timely notices **(within 24 hours)** of such.

Large Loss is defined as: 1) Any claim on which the total is expected to exceed or has reached 50% of the deductible; 2) Any claim noted in the categories listed below; or 3) Any transplant. Transplant notification is required whether or not the claim is expected to reach 50% of the deductible. As soon as you are aware of a potential transplant, you are required to provide 24-hour notice of that potential claim.

A form titled 50% Claim Notification (see attached specimen) is required to be completed **within 24 hours** when the loss has reached 50% of the deductible or is *expected to* exceed *the deductible,* Forward the Large Loss Form to Insurance Mass Marketing Systems, Inc, 14673 Midway Road, Suite 220, Addison, TX 75001, or via fax at 972-458-1461,

Non-Notification may result in ultimate denial of the claim. Typically, you should received notice through pre-certification or reviewing the diagnosis of a submitted claim. If you use personnel outside your firm for pre-certification, advise them of the importance of immediate notification to you.

To assure prompt response to your request for claim reimbursement, the Claims Examiners at IMMS require certain documentation. The proper submission of this information will enable them to make a speedy decision regarding the claim. Before a claim is submitted, you should have completed and sent a Large Loss Notice of the claim. The information required for claim reimbursement is as follows:

1. The Specific Excess Claim Reimbursement request Form (see attached specimen)
2. Enrollment and eligibility documentation including COBRA or Medicare.
3. Disclosure Form
4. If not previously submitted, a copy of the policy, and summary plan description.
5. A list of all bills paid or denied that make up the request. These should be in spreadsheet format and include the following by each provider: Dates of Service; Provider Name; CPT or Revenue Codes; Charges; R&C calculations; PPO discounts, Audit reductions and net payments made.

6. Copies of all itemized bills.
7. COB detail, including summary of your investigation for other coverage, copies of EOB’s from the primary carrier or denials,
8. Subrogation information when applicable; including accident details, liability investigation, attorney name, address, and phone when they are involved.
9. Hospital audits or negotiations for discounts when PPO is not involved,
10. Case management reports,
11. Proof of payment of all claims filed with this request, which should include EOB's, check registers copies of claim checks or drafts.
12. Any other detail that you believe will assist us in processing your request.