Insurance Mass Marketing Systems, Inc.

A Division of the Heusinkveld Group

REIMBURSEMENT REQUEST FOR SPECIFIC EXCESS CLAIM

SECTION I- GENERAL INFORMATION

Name of Insured Group:_____

Carrier Name / Policy Number: _____ _____

Name of Employee and relationship to Claimant: _____

If claim is for dependent, give name: _____

Complete ONLY for INITIAL Claim	**Complete Only for CONTINUING Claim**
Illness: _____	**Previous Reimbursement**: _____
Date Claim Incurred: _____	**Additional Benefits Paid:** _____
Total Benefits/Pmts Paid by Plan: _____	**Coinsurance** _____%; **Amount**: _____
Less Specific Deductible: _____	**Reimbursement Requested**: _____
Coinsurance___%; **Amount**: _____	**Claimant is Now**: ____**Under Physicians Care**
Reimbursement Requested: _____	_____**Hospitalized** _____ **Fully Recovered**

SECTION II – SPECIFIC CLAIM INFORMATION

1. Name of Administrator: _____
2. Policy Period: _____
3. Date Insured Member Joined Plan:
4. Insured Member is: __Hourly; __ Salaried; __ Retired; __ Union; __ Non-Union
5. Date Insured Member commenced employment: _____
6. Name & Address of Claimant's family physician: _____

   _____
7. Date first consulted a physician for treatment of illness or accident for which this reimbursement request is made: _____
8. If accidental injury, did it occur at work? Yes__ No__
9. If an Illness, has claimant suffered from it at any time during the past two years? Yes__ No__

If yes, Name of Attending Physician: _____

Date of Treatment: _____

Briefly describe surgical/medical services rendered: _____

10. Is Claimant or Claimant's Sponsor still on the active payroll of the Policyholder? Yes___ No___

_____

_____

11. Give brief prognosis of claimant's continuing medical needs: _____

_____

12. Comments relative to any of the above or additional information: _____

_____

Please Note – Additional claims are limited to at least $500.00; end of contract, or final claim.

SECTION III – SUPPORTING DOCUMENTATION

*PLEASE BE SURE ALL COPIES ARE LEGIBLE!

Claim reimbursement requests cannot be processed without copies of the following supporting documents:

_____ Copy of Enrollment Card or Eligibility Screen

_____ Copies of All Bills or Electronic Submissions

_____ Copy of TPA's claim Calculation Work sheet

_____ Claimant and Attending Physicians Statement (if available)

_____ Copies of All Correspondence regarding Coordination efforts

_____ Copies of All Checks or Similar verification evidencing payment of claim

If you have any questions requesting substitute documentation, please contact our office.

SECTION IV – PAYMENT VERIFICATION

I certify that to the best of my knowledge the above information is correct and that the claim has been paid in accordance with the Insured's Plan Document which is attached to the Policy. I further certify that all expenses for which reimbursement is herein requested have been paid by the Insured.

By: _____ Phone#:_____ Title: _____ Date:_____