

**INDEPENDENCECARE™ UNDERWRITING SERVICES – MINNEAPOLIS L.L.C.**

**100% SPECIFIC EXCESS LOSS CLAIM FORM (page 1 of 2)**

Initial Claim     Supplemental Claim # \_\_\_\_\_     Advance Funding     Other \_\_\_\_\_

Policyholder Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Effective Date of Coverage: \_\_\_\_\_

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Effective Date of Coverage: \_\_\_\_\_

Current Employment Status:    Active \_\_\_\_\_    Retired \_\_\_\_\_

Last date worked: \_\_\_\_\_    Date returned to work: \_\_\_\_\_

Please advise how eligibility was maintained and submit supporting documentation:

FMLA effective date: \_\_\_\_\_    *Please provide a copy of the FMLA request form*

Leave of Absence (effective date): \_\_\_\_\_    Employment Termination Date: \_\_\_\_\_

COBRA Participant (effective date): \_\_\_\_\_    Other: \_\_\_\_\_

*If claim is for a dependent, please reference the required information on page 2 regarding Coordination of Benefits.*

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

Relationship to Employee: \_\_\_\_\_    Birth Date: \_\_\_\_\_

Effective Date of Coverage: \_\_\_\_\_    Termination Date of Coverage: \_\_\_\_\_

Diagnosis: \_\_\_\_\_    First date of treatment: \_\_\_\_\_

Prognosis: \_\_\_\_\_

Comments: \_\_\_\_\_

**TOTAL PAYMENTS:**    \$ \_\_\_\_\_

**LESS SPECIFIC DEDUCTIBLE:**    \$ \_\_\_\_\_

**LESS PREVIOUS SUBMISSION/REIMBURSEMENT(S):**    \$ \_\_\_\_\_

**TODAY'S REIMBURSEMENT REQUEST:**    \$ \_\_\_\_\_

***AN INCOMPLETE REQUEST MAY DELAY THE CLAIM PROCESS.***

**100% SPECIFIC EXCESS LOSS CLAIM FORM (page 2 of 2)**

**Please submit a detailed paid claims report for Policy Year. If satisfaction of deductible and/or out of pocket is for prior calendar year or a carryover, also submit a detailed paid claims report for the calendar year.**

Include pertinent forms: (Enrollment Form, Certificate of Creditable Coverage, Change Forms) Yes\_\_\_No\_\_\_

Include proof that Deductible & Coinsurance requirements have been satisfied: Yes\_\_\_No\_\_\_

Enclose legible copies (*in paid order*) of bills, EOB's, PPO repricing sheets and check copies: Yes\_\_\_No\_\_\_

Adjust all voided payments & refunds from the total paid claims: Yes\_\_\_No\_\_\_

Enclose Evidence of Insurability for late enrollees: Yes\_\_\_No\_\_\_

Enclose proof that pre-existing conditions have been investigated: Yes\_\_\_No\_\_\_

For possible Subrogation, enclose accident details, police report, subrogation agreement and third party liability documents. Yes\_\_\_No\_\_\_

For possible Coordination of Benefits, enclose verification that there is or is not other insurance: Yes\_\_\_No\_\_\_

For dependents enrolled as full time students, enclose Full Time Student verification: Yes\_\_\_No\_\_\_

If Large Case Management is in place, enclose report: Yes\_\_\_No\_\_\_  
Name of Firm: \_\_\_\_\_

If Out of Network hospital bills were pre-screened for audit or discounted, include re-pricing information and negotiated discount amount/percentage: Yes\_\_\_No\_\_\_

Include name of the PPO network, if applicable: Yes\_\_\_No\_\_\_

If Insured or Claimant is enrolled through COBRA, provide a copy of the signed COBRA election form and proof of COBRA premium payments. Include effective/termination dates: Yes\_\_\_No\_\_\_

If Insured or Claimant is enrolled in MEDICARE, please provide a copy of the MEDICARE Award Letter. Include effective date and whether MEDICARE is the Primary or Secondary payer to this Plan Yes\_\_\_No\_\_\_

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

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Stop loss Coordinator: \_\_\_\_\_ Email address: \_\_\_\_\_

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

***AN INCOMPLETE REQUEST MAY DELAY THE CLAIM PROCESS .***

**Please submit this form to:**

IndependenceCare Underwriting Services – Minneapolis L.L.C.  
15 South Fifth Street, Suite 1200  
Minneapolis, MN 55402  
Phone: (612) 338-0718 Fax: (612) 338-1763