



MEDICAL EXCESS CLAIM NOTIFICATION REPORT / CLAIM REIMBURSEMENT FORM

Check Appropriate Box	<input type="checkbox"/> 50% Notification	<input type="checkbox"/> Diagnosis Notification	<input type="checkbox"/> Initial Claim	<input type="checkbox"/> Subsequent Claim
Policyholder Name				Policy Number
Reinsurance Carrier		Deductible	\$	Policy Period

EMPLOYEE INFORMATION

Employee Name				Date of Birth	
Date of Hire		Original Effective Date		Coverage Termination Date	
Employee's Work Status	<input type="checkbox"/> Active	<input type="checkbox"/> Retired	<input type="checkbox"/> Disabled or LOA	<input type="checkbox"/> Other	Is COBRA applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No

CLAIMANT INFORMATION

Name				Date of Birth	
				Relationship to Employee	
Original Effective Date		Termination Date		Is COBRA applicable	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is claimant covered by any other insurance (Auto, Worker's Compensation, Group Plan)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is pre-existing condition applicable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is HIPPA certification applicable?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

DIAGNOSIS/ACCIDENT INFORMATION

Primary Diagnosis				ICD9 Code	
If accident, when, where and how did it occur? (Please provide complete accident details including date)					
Was this injury or illness caused by work?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Is there third party liability?	<input type="checkbox"/> Yes <input type="checkbox"/> No

CLAIM SUBMISSION INFORMATION

If Filing Initial Claim	Total Paid this Submission: \$				
	Less Deductible: \$				
	Total Reimbursement Requested: \$				
Subsequent Claim	Reimbursement Requested: \$				
Claims Pending Year to Date	\$	Estimated Future Liability	\$		

I hereby certify, to the best of my knowledge, after reasonable inquiry: (1) that the information stated herein is correct, (2) that the claim has been processed and is eligible in accordance with the Plan Document, and (3) that all the indicated expenses for which reimbursement is herein requested have been paid and funded.

Completed By				Date	
Address					
	City		State	Zip Code	
Phone		Email		Fax	

Please e-mail this form to mclaims@starlinegroup.com or fax it to 508-495-0708 or mail it to StarLine Group, Claims Dept, 180 Teaticket Highway, East Falmouth, MA 02536.