



HMO REINSURANCE/PROVIDER EXCESS CLAIM REIMBURSEMENT FORM

Check Appropriate Box	<input type="checkbox"/> Initial Claim	<input type="checkbox"/> Subsequent Claim
Client/MCO Name		Policy Number
Reinsurance Carrier		
Deductible	\$	Policy Period

MEMBER/SUBSCRIBER INFORMATION

Member/Subscriber Name		Social Security Number	
Initial Effective Date of Coverage		Date Coverage Termination	Date of Birth
Member/Subscriber Type	<input type="checkbox"/> Commercial	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Other

DEPENDENT INFORMATION (Complete only if claim is for dependent)

Dependent Name		Relationship	
Initial Effective Date of Dependent's Coverage		Date of Coverage Termination	Date of Birth

OTHER INSURANCE

Are there any hospital, medical, prescription or other services provided under any employer, group, school, state, federal, Medicare or other government plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Other Plan	Policy Number

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
Does this claim include services covered under a Transplant Network Agreement?			<input type="checkbox"/> Yes <input type="checkbox"/> No

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 member/subscriber coverage 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	E-mail	Fax	

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