



SPECIFIC CLAIM NOTIFICATION / SPECIFIC CLAIM REIMBURSEMENT REQUEST FORM

Check appropriate box	<input type="checkbox"/> 50% Notification	<input type="checkbox"/> Diagnosis Notification	<input type="checkbox"/> Initial Claim	<input type="checkbox"/> Supplemental Claim	<input type="checkbox"/> Final Request
Employer Group Name				Specific Deductible	\$
Carrier				Contract Basis	
Policy Period					
Claims Administrator					

EMPLOYEE INFORMATION

Employee Name					
Social Security Number			Original Effective Date		
Date of Birth			Date of Hire		
Employee's work status	<input type="checkbox"/> Actively working the required number of hours per week to be considered full-time				
	<input type="checkbox"/> Retired		Date Retired		
	<input type="checkbox"/> Disabled or Other Status		Last Day of active work		
Coverage is being continued by the following	<input type="checkbox"/> Sick time	<input type="checkbox"/> Vacation	<input type="checkbox"/> Family Medical Leave Act	<input type="checkbox"/> Leave of Absence	
Coverage termination date			Is *COBRA applicable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
COBRA effective date			COBRA termination date		

CLAIMANT INFORMATION

Name				<input type="checkbox"/> Male	<input type="checkbox"/> Female
Relationship to Employee			Date of Birth		
Original Effective Date			Termination Date		
Is *COBRA applicable?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Occupation		
COBRA effective date			COBRA termination date		
Is claimant covered by any other insurance (Auto, Worker's Compensation, Group Plan)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Please provide details					
Effective date			Carrier		
Is pre-existing condition applicable?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If applicable, is HIPPA Certification attached?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If, Yes, please list condition.					

*If filing Initial claim, include COBRA election form and premium verification.

CLAIM DATA

Diagnosis (include ICD-9)	
Prognosis	
If accident, when, where and how did it occur? (Please provide complete accident details)	
Is Subrogation applicable?	<input type="checkbox"/> Yes <input type="checkbox"/> No :
Please Provide Details	

UTILIZATION REVIEW/CASE MANAGEMENT (UR/CM) INFORMATION

Has Case Management been implemented?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are CM reports included?	<input type="checkbox"/> Yes <input type="checkbox"/> No
UR/LCM Vendor name, address, contact name and phone number			

If filing initial claim	Total Paid this Submission: \$____ Less Specific Deductible: \$____ Total Reimbursement Requested: \$____ Important: Of the Total Reimbursement Requested, please advise: Paid and Funded Amount: \$____ Processed and Not Disbursed Amount: \$____
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Supplemental Claim	Reimbursement Requested: \$____ Important: Of the Reimbursement Requested, please advise: Paid and Funded Amount: \$____ Processed and Not Disbursed Amount: \$____
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Claims Paid Year to Date	\$____	Claims Pending Year to Date	\$____
Estimated Future Liability	\$____		

I hereby certify that, 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 Insured's Plan Document which is attached to the Policy (3) that all the indicated expenses for which reimbursement is herein requested have been paid and funded by the Insured.

Claims Administrator			
Name			
Address			
City		State	Zip Code
Phone		Fax	
Completed by		Date	
Email Address			

Please send to:
Star Line Group Attn: Claims Department 180 Teaticket Highway East Falmouth, MA 02536

If the claim reimbursement form is not fully completed claim payment may be delayed.