ORION NAVIGATOR

STARLINE

Orion Navigator Request For Assistance

Submit to: orion@starlinegroup.com

Referral Date: _____ Submitted by (print): _____

Email Address: _____ Phone: _____

POLICY INFORMATION:

Account Name/Policyholder Name: _____

Policy Type: ☐ Employer Stop Loss ☐ Medical Excess ☐ HMO Reinsurance ☐ Provider Excess

Population Type: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Other (describe): _____

PATIENT INFORMATION:

Patient Name: _____ Patient Date of Birth: _____

Patient Gender: _____ Primary Diagnosis (ICD-10 code): _____

Diagnosis Description: _____

CLAIM(S) INFORMATION:

Dates of Service: *from* _____ *to* _____ Billed Charges: $ _____

Has the claim been paid? ☐ No ☐ Yes Total Paid $ _____

Is there some type of Network discount? ☐ No ☐ Yes Network Name: _____

Type of Network Discount: _____ % of billed charges ☐ Per Diem ☐ Case Rate ☐ DRG ☐ Unknown

Discount amount: $ _____ Discount % _____ Discount Expires On: _____

CASE MANAGEMENT INFORMATION:

Contact Name: _____ Company Name: _____

Contact Email: _____ Contact Phone: _____

ASSISTANCE REQUESTED *Please attach claims (UB and IB) and CM report if available:*

☐ Air Ambulance Negotiation
☐ Bill Review/Audit/Negotiation
☐ Kidney Dialysis Contract
☐ Physician/Peer Review
☐ Cancer Care Review
☐ Congenital Heart Disease Resources
☐ Mental/Substance Abuse
☐ Transplant
☐ Out of Network
☐ Ventricular Assist Device Contract
☐ Specialty Pharmacy/High Cost Drug Review
☐ Less than 25% discount
☐ Other (please describe below)

ADDITIONAL COMMENTS *Special instructions / benefit limitations / clinical information:*

_____

_____

_____

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