HMO Re / Provider Excess Claim Form

STARLINE

Check Appropriate Box: ☐ Initial Claim ☐ Subsequent Claim

Client / MCO Name: _____ Policy Number: _____

Reinsurance Carrier: _____

Deductible: $ _____ Policy Period: _____

MEMBER / SUBSCRIBER INFORMATION:

Member / Subscriber Name: _____ ID Number: _____

Initial Effective Date of Coverage: _____ Coverage Termination Date: _____ Date of Birth: _____

Member / Subscriber Type:

☐ COMMERCIAL ☐ Group ☐ Individual ☐ Other ☐ Exchange ☐ Non-Exchange

☐ MEDICAID ☐ SSI ☐ Non SSI ☐ TANF ☐ CHIP ☐ DUAL ☐ Medi-Cal ☐ Other

☐ MEDICARE ☐ MA ☐ Pace ☐ DUAL ☐ Other

OTHER INSURANCE:

Is there any other health care coverage provided under any employer, state, federal, Medicare or Medicaid plan? ☐ Yes ☐ No

Name of Other Plan: _____ Policy Number: _____

DIAGNOSIS / ACCIDENT INFORMATION:

Primary Diagnosis: _____ ICD 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? ☐ Yes ☐ No If yes, please explain: _____

Is there third party liability? ☐ Yes ☐ No Name of Subrogation Vendor: _____

Transplant: ☐ Yes ☐ No Transplant Date: _____ Transplant Type: _____ Transplant Network: _____

Premature: ☐ Yes ☐ No Birth Weight: _____ Gestational Age: _____

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: _____ Email Address: _____

Please email this form to mcclaims@starlinegroup.com or mail it to StarLine, Claims Dept, 804 Main Street, Suite 2A, Osterville, MA 02655

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