HMO Re / Provider Excess Notice Form

STARLINE

Client / MCO Name: _____ Reinsurance Policy Number: _____ Effective Date: _____

Deductible: _____ Check Appropriate Box: ☐ 50% Notification ☐ Diagnosis Notification

Member Name: _____ Member ID #: _____ D.O.B.: _____ Gender: _____

Original Effective Date: _____ Coverage Termination Date: _____

Member / Subscriber Type: ☐ COMMERCIAL ☐ Group ☐ Individual ☐ Other ☐ Exchange ☐ Non-Exchange

☐ MEDICAID ☐ SSI ☐ Non SSI ☐ TANF ☐ CHIP ☐ DUAL ☐ Other

☐ MEDICARE ☐ MA ☐ Other

Diagnosis: _____ ICD Code: _____

Prognosis: _____

Clinical Status: _____

PREMATURE / NEONATAL: Birth Weight: _____ Gestational Age: _____

TRANSPLANTS: Transplant Center: _____ Transplant Type: _____

Transplant Network Request: ☐ Yes ☐ No ☐ Direct Contract Transplant Network: _____

Evaluation Date: _____ Transplant Date: _____

INPATIENT STAYS:

Admitted	Discharged	Facility	In-Network / OON	Billed	Paid	Plan Payment Type (%DRG)
			☐ In ☐ OON			
			☐ In ☐ OON			
			☐ In ☐ OON			

Total Billed Charges: _____ Total Paid Charges: _____ Estimated Future Liability: _____

Completed By: _____ Date: _____

Email: _____ Phone: _____

Case Management Contact: _____

Email: _____ Phone: _____

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

V2021