Medical Excess Notification / Claim Form

STARLINE

Check Appropriate Box: ☐ 50% Notification ☐ Diagnosis Notification ☐ Initial Claim ☐ Subsequent Claim

Policyholder Name: _____ Policy Number: _____

Reinsurance Carrier: _____ Deductible: $ _____ Policy Period: _____

EMPLOYEE INFORMATION:

Employee Name: _____ Date of Birth: _____

Date of Hire: _____ Original Effective Date: _____ Coverage Termination Date: _____

Employee's Work Status: ☐ Active ☐ Retired ☐ Disabled or LOA ☐ Other Is COBRA applicable? ☐ Yes ☐ No

CLAIMANT INFORMATION:

Name: _____ Date of Birth: _____

Relationship to Employee: _____

Original Effective Date: _____ Termination Date: _____

Is COBRA applicable? ☐ Yes ☐ No

Is claimant covered by any other coverage: (Auto, Worker's Compensation, Group Plan)? ☐ Yes ☐ No

Is pre-existing condition applicable? ☐ Yes ☐ No Is HIPPA certification applicable? ☐ Yes ☐ No

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 Is there third party liability? ☐ Yes ☐ No

CLAIM SUBMISSION INFORMATION:

If Filing Initial Claim

Total Paid this Submission: $ _____

Less Deductible: $ _____

Total Reimbursement Requested: $ _____

Subsequent Claim

Reimbursement Requested: $ _____

Claims Pending Year to Date: $ _____ Estimated Future Liability: $ _____

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 plan 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: _____ Fax: _____ Email Address: _____

V2021

PLEASE SEND TO:
Please e-mail Claim Notification Reports to mcnotices@starlinegroup.com and
Claim Reimbursement Forms to mcclaims@starlinegroup.com or mail them to
StarLine, Claims Dept, 804 Main Street, Suite 2A, Osterville, MA 02655