Specific Notification / Claim Form

STARLINE

Check Appropriate Box:

☐ 50% Notification ☐ Trigger Dx Notification ☐ Initial Claim Request ☐ Supplemental Claim Request ☐ Final Claim

Employer / Group Name: _____ Specific Deductible: $ _____

Reinsurance Carrier: _____ Contract Basis: _____

Policy Period: _____ Policy Number: _____

Claims Administrator: _____

EMPLOYEE INFORMATION:

Employee Name: _____ Date of Birth: _____

Original Effective Date: _____ Date of Hire: _____

Employee's Work Status: ☐ Actively working the required number of hours per week to be considered covered

☐ Retired Date Retired: _____

☐ Disabled or Other Status Last Day of Active Work: _____

Coverage is being continued by the following: ☐ Sick time ☐ Vacation ☐ Family Medical Leave Act ☐ Leave of Absence

Coverage Termination Date: _____ Is COBRA applicable? ☐ Yes ☐ No

COBRA Effective Date: _____ COBRA Termination Date: _____

CLAIMANT INFORMATION:

Name: _____ Gender: _____

Relationship to Employee: _____ Date of Birth: _____

Original Effective Date: _____ Termination Date: _____

Is COBRA applicable? ☐ Yes ☐ No Occupation: _____

COBRA Effective Date: _____ COBRA Termination Date: _____

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

If yes, provide details:

_____

_____

If the claim involves an accident, please advise: Date: _____ Place: _____

Description of accident:

_____

_____

_____

Is Subrogation available? ☐ Yes ☐ No Is this a work related accident? ☐ Yes ☐ No

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CLAIM DATA:

Diagnosis (include ICD):

Prognosis:

UTILIZATION REVIEW / CASE MANAGEMENT (UR / CM) INFORMATION:

Has Case Management been implemented? ☐ Yes ☐ No Are CM reports included? ☐ Yes ☐ No

UR / LCM Vendor name, address, contact name and phone number:

If filing initial claim:

Total Paid this Submission: $ _____

Less Specific Deductible: $ _____

Less Aggregate Specific Deductible: $ _____

Total Reimbursement Requested: $ _____

Important: *Of the Initial Reimbursement Request, please advise:*

Paid and Funded Amount: $ _____

Processed and Not Disbursed Amount: $ _____

Supplemental Claim:

Reimbursement Requested: $ _____

Important: *Of the Initial Reimbursement Request, please advise:*

Paid and Funded Amount: $ _____

Processed and Not Disbursed Amount: $ _____

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: _____

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

PLEASE SEND TO:
StarLine Attn: Claims Department 804 Main Street, Suite 2A Osterville, MA 02655
Or Email to Notices: *slnotices@starlinegroup.com*, Claims: *slclaims@starlinegroup.com*