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Specific Stop-Loss Claim / 50% or Catastrophic Diagnosis Notice

Use this form to report a Specific Stop-Loss claim to DHR Management, LLC., or whenever a claimant reaches 50% of the Specific Stop-Loss deductible or has a catastrophic diagnosis.

Please answer ALL questions completely before submitting this form. Failure to answer all questions may result in a delay in claim payment.

1 Date and Type of Notice

Please print clearly

Date of this notice	Type of notice (check one): ☐ 50% notice ☐ Catastrophic notice ☐ Initial claim submission ☐ Subsequent claim submission

2 Policyholder Information

Please specify name and address of an authorized representative of the policyholder.

Name of policyholder			Stop-Loss policy number
Name of authorized representative of policyholder			Benefit year From: To:
Street address	City	State	Zip code

3 Employee/Claimant Information

Name of employee	Social Security number | |	Date of birth	Gender ☐ M ☐ F
Name of claimant (If different)	Relationship to employee	Date of birth	Gender ☐ M ☐ F

Employee date of hire	Employee date last worked	Date claimant insured on plan

Other insurance? ☐ Yes ☐ No	If yes, please describe	Has employee returned to work? ☐ Yes ☐ No	If yes, date of return

Is the employee retired? ☐ Yes ☐ No	If yes, retirement date	Is claimant a full-time student? ☐ Yes ☐ No If yes, provide supporting documentation

Was this person out of work at any time during the benefit year? ☐ Yes ☐ No

If yes, indicate how the employee was covered (check all that apply):	From	To	Premiums paid by Employee	Premiums paid by Employer
☐ Family Medical Leave Act (FMLA)			☐	☐
☐ Long-Term Disability (LTD)			☐	☐
☐ Short-Term Disability (STD)			☐	☐
☐ Medical Leave of Absence			☐	☐
☐ COBRA (see below)				
☐ Other:				

Date premiums are paid through:

FMLA	Medical Leave of Absence	COBRA*

Continued on next page

4 Claimant's Condition

Diagnosis (ICD-9 Code and Description)		First treatment date
Current prognosis		If ESRD, first date of dialysis
Is the claimant still hospitalized? ☐ Yes ☐ No	Are PPO and cost saving measures in place? ☐ Yes ☐ No	
Is Medical Case Management involved? ☐ Yes ☐ No	If yes, provide Case Management provider name and phone number	

5 Claim Information

Reimbursement Request:

Total TPA Paid Amount $ _____

Less Specific Deductible $ _____

Less Benefits Paid Outside Plan $ _____

Less Previous Reimbursement Amts. $ _____

Reimbursement Request Amt. $ _____

*Advance Funding Request Amt. $ _____

*Please check the Excess Loss Policy Schedule Page to determine if this benefit is elected.

6 Required Documentation

Please Attach:

1. Detail Paid Claim Report which includes:
   - ☐ Claimant Name or Identifier (such as Social Security Number and relationship to the employee)
   - ☐ Diagnosis Code(s)
   - ☐ Dates of Service – Incurred (From-To)
   - ☐ Type of Service or Procedure Codes (CPT, HCPCS & Hospital Revenue Codes)
   - ☐ Provider Identification
   - ☐ Payment Calculation: Charge Amount, Allowable Amount, Deductible, Co-Pay, Discount, Ineligible Amounts, & Paid Amount
   - ☐ Processed and/or Paid Date
2. Eligibility Information:
   - ☐ Copy of Enrollment Card or screen print for the claimant indicating Hire Date, Original Coverage Effective Date, Termination Date, Cobra Effective Date
   - ☐ Copy of Cobra Election Form, if applicable
   - ☐ If the claimant is also the employee: Work status of employee (Active-FMLA-Medical Leave of Absence, last date actively at work, date leave began, return to work date, dates of FMLA)
   - ☐ Identify Other Insurance if applicable (Medicare, Worker's Comp., Auto Insurance, Other)
   - ☐ If illness or injury is accident related, please provide date and details of accident with applicable Subrogation information
3. Copies of bills over $5,000 Physician Charges and $10,000 Facility Charges

7 Notice and Signature

I certify that the information is correct and that the claim has been paid in accordance with the Covered Person's Benefit Plan.

Third Party Administrator _____

Completed By (Print)_____

Date _____

Address_____ City_____ State _____ Zip _____

Phone No._____ Fax No. _____

Email Address_____