CREATIVE RISK UNDERWRITERS

Specific Excess Loss Claim Form

Date: _____ ❑ Initial Claim Filing ❑ Immediate Reimbursement Request ❑ Subsequent Claim Filing # _____

NOTE: ***Prior to submitting a claim***, a Potential Specific Excess Loss Notification must have been completed and sent to CRU to properly reserve for this claim. If the Notification is on file, we can proceed on this claim.

ELIGIBILITY SECTION (On Subsequent Claims Only Complete * Fields)

*Contractholder: _____

	***Employee**	***Claimant**
*Name:	_____	_____
Gender/Relation:	_____	_____
DOB:	_____	_____
Effective Date:	_____	_____
Termination Date:	_____	_____
COBRA Effective:	_____	_____

EXCESS LOSS SECTION

Carrier: _____ Contract Number: _____ Contract Year: _____

Specific Deductible: $_____ Current Contract Basis: _____

CLAIM INFORMATION (On Subsequent Claims Only Complete * Fields)

Other Coverage: ❑ NO ❑ YES - If yes, include information: _____

❑ COB ❑ TPL ❑ W/C ❑ Medicare ❑ Other

If known, please provide the following information: LCM implemented ❑ NO ❑ YES

Diagnosis: _____ Prognosis: _____

Other Comments: _____

_____

*Case Mgmt Co: _____ *Contact: _____ *Phone: _____

*PPO(s): _____

*Diagnosis (use ICD-9 & Description): _____

*Status: _____

*Prognosis: _____

*Comments: _____

Continued on Page 2

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INITIAL EXCESS LOSS FILING INFORMATION

Total Amount Paid: $_____

Less Specific Deductible: $_____

Reimbursement Requested: $_____

Immediate Reimbursement Requested (included in above amount): $_____

SUBSEQUENT REIMBURSEMENT REQUEST

Total Paid to Date: $_____

Total Pended: $_____

Reimbursement requested $_____

Immediate Reimbursement requested (included in the amount above) $_____

Please include the following information with your submission to prevent delays: (On Subsequent Claims Only Complete * Fields)

- ❑ Enrollment form(s) that provides the date of hire and effective date for the employee.
- ❑ If applicable, enrollment form that provides the effective date of coverage for dependent.
- ❑ If applicable, COBRA election form and proof of all COBRA premiums paid.
- ❑ Proof of deductibles/coinsurance has been met. System screen print of accumulators is acceptable.
- ❑ Current documentation of any other medical coverage.
- ❑ *Copies of claims that exceed $25,000.
- ❑ *Copies of pre-certifications.
- ❑ *If applicable, complete details of accident and subrogation information
- ❑ *System generated report which provides, at a minimum, the employer name, claimant name, diagnosis codes, procedure/revenue codes, charge amounts, discounts, deductibles, coinsurance, provider name, dates of service, paid amounts, check numbers and check dates.
- ❑ *If a system generated report is not available, please provide all claim copies and explanation of benefits. If the EOB does not contain check numbers or check dates we will need a copy of the check register to verify payments.

Additionally, we may request other information that may be needed to complete the audit process such as work status, medical records, etc.

Signed: _____ Date: _____

Administrator Name: _____ Phone: _____

Please submit this form to:

Via Mail

Creative Risk Underwriters, LLC
1343 Canton Road, Suite B-1
Marietta, GA 30066

Via Mail

Please email to claims@creativeuw.com