TRU Services, A Liberty Mutual Company
152 Conant Street, 2nd Floor
Beverly, MA 01915
Phone: (978)564-0200
Fax: (978)564-0201

☐ Initial
☐ Subsequent

Specific Excess Insurance Claim

Reimbursement Request

This form must be completed for all reimbursements
Plan Sponsor ______________________ Policy # ___________________________________
Employee Name ____
If applicable:
Dependent Name ____

This Claim Request cannot be processed without the following:

- Copy of Employees Enrollment Data and Continued Eligibility Form completed
- Detailed paid claims report to include: provider name, date of service, CPT/ICD 10 code, charge amount, discount amount, coinsurance, deductible/co-pay, paid amount and paid date or explanation of benefits (EOB)
- All itemized billing statements corresponding to detailed paid claims repot or EOB
- Case management reports
- Any other document that may be needed to satisfy the reimbursement of this claim, such as but not limited to; subrogation, pre-certifications and medical reports

Date Claim Incurred/To: From: Total of previous requests: $______________
Benefits paid by plan: $___________________ Benefits paid this submission: $______________
Specific Deductible: $___________________ Additional amount requested: $______________
Amount Requested: $___________________ Advance amount requested: $______________
Advance Amount
Requested: $___________________

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIM HAS BEEN PAID IN ACCORDANCE WITH THE PLAN SPONSOR'S PLAN DOCUMENT.

TPA: ____ Date: ____________________________
Contact: ____ Tel #: ____________________________

FOR HOME OFFICE USE ONLY:
Date:____ Amount Reimbursed: $_______________
Approved by:___________________________________ Details______________________________

A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.