



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 report 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

### COMPLETE FOR INITIAL CLAIM ONLY

Date Claim Incurred/ From: \_\_\_\_\_ To: \_\_\_\_\_

Benefits paid by plan: \$ \_\_\_\_\_

Specific Deductible: \$ \_\_\_\_\_

Amount Requested: \$ \_\_\_\_\_

Advance Amount

Requested: \$ \_\_\_\_\_

### COMPLETE FOR CONTINUING CLAIM

Total of previous requests: \$ \_\_\_\_\_

Benefits paid this submission: \$ \_\_\_\_\_

Additional 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 \_\_\_\_\_

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.