



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

COMPLETE FOR CONTINUING CLAIM

Date Claim Incurred/From _____ To: _____

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 _____

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.