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

A Liberty Mutual Company

☐ 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 9 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

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 files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.