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 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

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 defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be subject to prosecution for insurance fraud.