Specific Excess Loss Notification of Potential Large Claim

☐ High Cost DX ☐ High paid or pending ☐ IP stay of 5+ days ☐ Potential transplant ☐ Dialysis

Policyholder:____ Policy Period:____________________________

Specific Deductible: $____________________________________ Contract Basis:___________________________

Employee Name:__________________________________ ID:________________ Date of Birth: ______________

Hire Date:___________________ Effective Date:_______________ Termination Date (if applicable):______________

Claimant Name:___________________________________ Date of Birth:_______________Relationship:__________

Effective Date:_____________________________ Termination Date (if applicable): ____________________________

COBRA Effective Date (if applicable):__________________ Eligible for Medicare? ☐ Yes ☐ No

Claimant "Actively-at-Work" on Effective Date? ☐ Yes ☐ No

Is Claimant Covered by any other Group Insurance? ☐ Yes ☐ No

If Yes, Name of Carrier and Policyholder: ____

Total Claims **Reported** To Date: $_____________________ Total Claims **Paid** To Date: $_________________________

Amounts **Pending**: $_________________________ Estimate of Future / Total Liability: $____________________

Primary Diagnosis:___________________________________Secondary Diagnosis:________________________________

Date of Onset:______________________________________ On-Going Condition? ☐ Yes ☐ No

Current Physician:___________________________________ Surgical Procedures:______________________________

Date(s) of Hospitalization:____________________________ Facility Name:_____________________________________

Is Facility In-Network? ☐ Yes ☐ No Contracted Discount:___________________________

Subrogation Involved? ☐ Yes ☐ No **If the diagnosis is related to an accident, please provide accident details.**

Case Management? ☐ Yes ☐ No CM Vendor:___________________________ **Please provide current CM report.**

Prognosis and Expected Treatment:____

____

TPA ____ Contact Name_______________________________________

Telephone____ Email ____

Signature____ Date____

Email to riskmgmt@truservices.com
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