



### 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 \_\_\_\_\_

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