

BEACON RISK STRATEGIES

POTENTIAL CLAIM NOTIFICATION/ CLAIMS REIMBURSEMENT REQUEST

POTENTIAL CLAIM: SPECIFIC CLAIM FILING:

GROUP NAME: _____ POLICY #: _____
EMPLOYEE NAME: _____ CLAIMANT SS#: _____
CLAIMANT NAME: _____ CLAIMANT DOB: _____
CLAIMANT GENDER: _____ RELATIONSHIP: _____

Primary Diagnosis: _____ DATE OF ONSET: _____
Secondary Diagnosis: _____
Accident?: _____ If So, Details: _____

Attending Physician: _____ Physician Phone: _____
Other Physician (s): _____ Physician Phone: _____
Hospital: _____ Hospital Phone: _____
First Charge Date: _____ Last Charge Date: _____
Total Paid \$: _____ Total Pending \$: _____
Prognosis: _____
Estimated Future Expenses \$: _____

Comments about Clinical Info., Pre-Screen, Audit, Bill Negotiating and /or Medical Case Management: _____

REIMBURSEMENT REQUEST

TOTAL BENEFITS PAID \$: _____
LESS SPECIFIC DEDUCTIBLE \$: _____
BALANCE \$: _____
REIMBURSEMENT REQUESTED: _____

Please include legible copies of the following:

1. A copy of the enrollment card with Effective Date.
2. HIPPA ,COBRA and Approved LOA Documentation
3. Itemized Provider Billings Attached to each corresponding E.O.B. and Benefit Check.
4. Proof of no other Insurance Coverage, if claimant is Dependent.

SUBMITTED BY: _____ TITLE: _____
TPA NAME: _____ PHONE: _____
FULL ADDRESS: _____ FAX: _____
EMAIL: _____

Prepared Date: _____ Notes: _____