# Notification / Reimbursement Claim Form

*Please email the completed form to: StopLossCoordinators@selecthealth.org. Please attach any additional documentation (case management reports, utilization review reports, and other applicable documentation) in the same email as this form.*

**Date of Notice:**

**Please select one or more of the following:**

- ☐ 50%/Potential Large Claim Notice
- ☐ Initial Claim
- ☐ Supplemental Claim
- ☐ Final Request

## A. Policyholder Information

**Group Name:**

**Specific Deductible:**

**Aggregate Specific Deductible:**

**Policy Period:**

**Contract Type:**

## B. Employee Information

**Employee Name:**

**Date of Birth:**

**Subscriber ID #:**

**Hire Date:**

**Original Effective Date:**

**Status:**

**COBRA Effective Date:**

**COBRA Termination Date:**

**Terminated as of:**

## C. Claimant Information

**Claimant Name:**

**Date of Birth:**

**Relationship:**

**Original Effective Date:**

**Termination Date:**

**Other Coverage:** ☐ yes ☐ no

**If YES, Type of Coverage:**

**Carrier:**

**Effective Date:**

## *D. Claim Information*

**Diagnosis:**

**ICD-10:**

**Prognosis:**

**If ESRD, First Date of Dialysis:**

**Is Claimant Still Hospitalized?** ☐ yes ☐ no

**Details of Injury:**

**Subrogation Applicable?** ☐ yes ☐ no

**Please Provide Details:**

**Total Claims Paid to Date:**

**Specific Deductible:**

**Previously Reimbursed:**

**Reimbursement Requested at This Time:**

**Are PPO and Cost Saving Measures in Place?**

**Claimant Injured?** ☐ yes ☐ no

**Date of Injury:**

**Place of Injury:**

## *E. Third Party Administrator (TPA)*

**TPA Name:**

**Phone Number:**

**Address:**

**Email:**

**Required: *** ☐ **I certify that, to the best of my knowledge, the information provided here and the reimbursement requested is correct.**

**First and Last Name: ***

**Title:**

**Date:**

**City:**

**State:**

**Zip Code:**

**Signature (type here)** **Date**