

# Summit Reinsurance Services, Inc.

7030 Pointe Inverness Way, Suite 350 ~ Fort Wayne, IN 46804 ~ (260) 469-3000 / Facsimile: (260) 469-3014

## HMO HOSPITAL CLAIM FORM

Please complete and submit on claims exceeding your Retention.

Reinsured: \_\_\_\_\_ Members' Name: \_\_\_\_\_

Agreement #: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

Period: \_\_\_\_\_ Patient's Member#: \_\_\_\_\_

<b>Claimant Type:</b>	<b>Retention:</b>	<b>Patient Eligibility Effective Date:</b>
<input type="checkbox"/> Commercial HMO	\$	_____
<input type="checkbox"/> Commercial POS	\$	<b>Patient's Date of Birth:</b>
<input type="checkbox"/> Medicare	\$	_____
<input type="checkbox"/> Medicaid	\$	<b>Eligibility Termination Date</b>
<input type="checkbox"/> Medicaid AFDC	\$	_____
<input type="checkbox"/> Medicaid SSI	\$	
<input type="checkbox"/> Other _____	\$	

ICD-9 code(s): \_\_\_\_\_

Initial Claim     Supplemental Claim

Inpatient Confinement	#1	#2	#3	
(A) Total # of Inpatient Days:				
(B) Average Daily Maximum:				
(C) Inpatient Subtotal (A + B):				
(D) Payment to Hospital				
(E) Lesser of C or D:				
(F) Ancillary Charges:				
(G) Total:				(H) Total 1 + 2 = 3

**Claim is due to:**

- Illness  
 Accident  
      Auto  
      Work Related

(I) Retention (initial claim only):	
(J) Total Less Retention (H minus I)	
(K) Coinsurance:	
(L) Payment Requested: (multiply J times K)	

Other Coverages:     COB \_\_\_\_\_     Workers Comp. \_\_\_\_\_  
                            Carrier \_\_\_\_\_                     Other \_\_\_\_\_

**PLEASE SEE THE ENCLOSED CLAIM SUBMISSION REQUIREMENTS FOR REPORTING PROCEDURES**

Completed by: \_\_\_\_\_ Name \_\_\_\_\_ Date: \_\_\_\_\_

Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.



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 Summit Reinsurance Services, Inc.  
 www.Summit-Re.com