



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

SPECIFIC EXCESS LOSS CLAIM FILING

WHEN TO FILE A SPECIFIC EXCESS LOSS CLAIM

- Whenever a Specific Excess Loss claim exceeds the Policyholders Specific Stop Loss Deductible by a minimum of \$500, it should be submitted to Summit Re for reimbursement. All subsequent claims expected payment should be \$500.

WHAT TO INCLUDE IN A SPECIFIC EXCESS LOSS CLAIM FILING

- Summit Re has an extensive SPECIFIC STOP LOSS CLAIM FORM that will need to accompany any claim filing to Summit Re. The two (2)-page claim form, listed below, asks for complete and thorough information in an effort to reduce additional questions or delays in reimbursement.

WHERE TO SEND A SPECIFIC EXCESS LOSS CLAIM FILING

- Specific Excess Loss Claims should be sent to:
Peggy Richardson, Claims Management
Summit Reinsurance Services, Inc.
7030 Pointe Inverness Way, Suite 350
Fort Wayne, IN 46804

Phone: 1-260-469-3013
Fax: 1-260-469-3014
Email: eslclaims@summit-re.com



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SPECIFIC STOP LOSS CLAIM FORM

(1 of 2)

Date: _____ Initial Claim Filing Subsequent Claim – Filing # _____

Excess Reinsurance Section

Carrier: _____ Treaty #: _____ Treaty Year: _____

Policyholder Stop Loss Section

Policyholder: _____ Policy #: _____

Policy Effective Date: _____ Stop Loss Ded: \$ _____ Policy Basis: _____

Eligibility Section

COVERED PERSON

DEPENDENT

*Name:	_____	_____
Gender/Relation:	_____ / _____	_____ / _____
Social Security/ID	_____	_____
DOB:	_____	_____
Effective Date:	_____	_____
Last day worked:	_____	_____
Date returned	_____	_____
Extension type:	_____	_____
Termination Date:	_____	_____
COBRA Effective:	_____	_____
Actively at Work:	_____	_____
Full time Student:	_____	_____

Claim Information

Dates: First DOS: _____ First Received: _____ First Admit: _____

Other Coverage: NO YES - If yes, include information:

COB TPL W/C Medicare Other _____

Large Case Mgr: _____ (*attach reports*) PPO(s): _____

Diagnosis (use ICD-9 & Description): _____

Status: _____

Prognosis: _____

Comments: _____

Date: _____ Policyholder: _____

COVERED PERSON: _____ CLAIMANT: _____

Specific Stop Loss Claim Information

Total Benefits Paid: \$ _____

Less Specific Deductible: \$ _____

Less Aggregating Specific: \$ _____

Deductions

MGU deductions: Denials - \$ _____

Pending - \$ _____

Total Prior Reimbursements: \$ _____

Reimbursement Requested: \$ _____

Please include LEGIBLE copies of the following:

- The Enrollment Form, including documentation of the covered person and claimant's effective date.
- Document the covered person and claimant met eligibility requirements of the Plan at the time of claim (i.e. Payroll records, COBRA election form, HIPAA Certificates, FMLA, etc).
- A Detailed Claim Summary showing check numbers and the date all claims have been paid. (NOTE: Summit Re reserves the right to request and review EOB's, Billings and the verification of funding on any and all claims listed)
- Copies of the itemized provider billings (on bills greater than \$25,000).
- Utilization Review and Large Case Management Reports
- Cost Containment Data (Re-pricing, Rate Negotiation, Network Savings, Hospital Audits)
- Investigative Reports (Disclosure, Pre-existing Condition, Police reports, Third Party Liability, Subrogation, other insurance).
- If the deductible and co-insurance were previously met, please document.

*Signed: _____ *Date: _____

*Administrator Name: _____ *Phone #: _____

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