SummitRe

CLAIM FORM

Please complete and submit for claims exceeding your retention.

Reinsured: _____ **Subscriber's Name:** _____

Agreement# _____ **Patient's Name:** _____

Coverage Period: _____ **Patient's Member#:** _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other-Explain _____

Line of Business: **Retention:**

☐
☐
☐
☐
☐
☐
☐
☐

Patient Gender: ☐ Male ☐ Female

Patient Eligibility Effective Date: _____ **Patient Eligibility Termination Date:** _____

Patient's Date of Birth: _____

Other Coverage(COB): ☐ No
☐ Yes - what relation is subscriber? _____
DOB of subscriber _____
Which policy is primary? _____
Carrier/Policy type _____

Claim is due to:
☐ Illness
☐ Accident
If accident: ☐ Auto ☐ Work-related ☐ Other third party

Carrier name/policy: _____

☐ Initial Claim ☐ Supplemental Claim

ICD-10 diagnosis code(s): _____
(or diagnosis description) _____
_____
_____

Accident details: _____
(Date, location, etc.) _____

Paid/Submitted:	**Total Amount Eligible:**		**Retention:**		**Coinsurance**
		-		X	

Reimbursement:
$0

PLEASE SEE THE CLAIM SUBMISSION REQUIREMENTS FOR REPORTING PROCEDURES

Completed by: _____ _____
Name Date

Company: _____ Telephone: _____

Return to: claims@summit-re.com
6920 Pointe Inverness Way, Suite 140, Fort Wayne, IN 46804 • (260) 469-3000