SummitRe

PROVIDER EXCESS CLAIM FORM

Please complete and submit on claims exceeding your Retention.

Insured Provider: _____

Policy #: _____

Policy Period: _____

Health Plan: _____

Line of Business:
- ☐ Commercial
- ☐ Medicaid
- ☐ Medicare
- ☐
- ☐
- ☐
- ☐
- ☐

Retention:

Subscriber's Name: _____

Patient's Name: _____

Patient's ID #: _____

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

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: _____

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

☐ Initial Claim ☐ Supplemental Claim

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

Total Amount		**Total Amount Eligible:**		**Retention:**		**Coinsurance**
			-		X	

Expected 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

For your protection California law requires the following information 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.