

Large Case Management

☐ No

☐ Yes

P.O. Box 535057 Pittsburgh, PA 15253-5057 Tel: 800-328-5433 Fax: 412-544-1246 hmig.com

HM Stop Loss Specific Stop Loss Claim Form

| Please complete the form and save as PD | F, or prin | t in blue or black ink. | | | | | | | |
|---|------------|-------------------------|----------------------------|---|--------------------------|----------------|-----------|------|--|
| Check appropriate type of claim: ☐ Initial Claim ☐ Subsequent Reimbursement | | | ☐ Potential Large Case | | | Other_ | | | |
| EMPLOYER INFORMATION | | | | | | | | | |
| Group Name | | | | | | | | | |
| Group Number | | | Plan Ty | |]15/12 | □Paid | | | |
| Coverage Period / / through / / | | | ☐ ☐12/1 ☐12/1 | | <u>]</u> 24/12 | Other | | | |
| | | | | | | | | | |
| EMPLOYEE INFORMATION | | | | | | | | | |
| Last Name | | | | First Name | | | | M.I. | |
| ☐ Male ☐ Female | | Date of Birth | | | Social Sec | curity Number | | | |
| Date of Hire | Effective | e Date of Insurance | | [| Current Employ Full Time | /ment Status: | Part Time | e | |
| ast Day Worked Termination Date | | | | ☐ Laid Off ☐ Retired ☐ Military Duty ☐ Terminate ☐ Family Medical Leave | | | | ted | |
| | | | | | | | | | |
| CLAIMANT INFORMATION I (If the claim | nant is of | | | nplete this se | ection) | | | | |
| Last Name | | | First Name M.I. | | | | | | |
| Date of Birth | | | ffective Date of Insurance | | | | | | |
| Relationship to Insured | | | | | | | | | |
| Spouse Child | | | | | | | | | |
| Is the Dependent employed? Yes No If yes, name, address and telephone number of Employer: | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| CLAIMANT INFORMATION II (Must be | complete | ed) | | | | | | | |
| Date of Accident/Illness | | | Diagno | Diagnosis ICD Code | | | | | |
| Prognosis | | | | Does Claimant have any other insurance? Yes No | | | | | |
| Does the individual have coverage COBRA Effection through COBRA? Yes No | | | ate | | COBRA Pr | remium Paid to | | | |

Vendor for Large Case Management (if applicable)

| Reimbursement requested | \$ | | | | | |
|---|---|--|--|--|--|--|
| Estimated future liability | \$ | | | | | |
| Your reimbursement request should inclu | ide the following inform | ation: | | | | |
| Copies of: Enrollment form (initial/current) COBRA election form and proof of payment EOBs/claim checks/registers Itemized bills Deductible/coinsurance proof Pre-certification forms | | Investigation Materials for (if applicable): | | | | |
| | | COB (include divorce, separation, and/or court orders) Full-time student status Pre-existing conditions Large case management reports Subrogation (include reimbursement agreement and accident details) Workers' Compensation | | | | |
| TPA INFORMATION | | | | | | |
| TPA Name | | | | | | |
| Addross (Street City State 7in) | | | | | | |
| Address (Street, City, State, Zip) | | | | | | |
| Contact Name | | | Telephone Number | | | |
| | | | () | | | |
| Medical Management Contact Name | | | Telephone Number | | | |
| | | | () | | | |
| | atement of claim containing to the commits a fraudulent | g any materially false informat insurance act, which is a crime | to defraud any insurance company or other ion, or conceals for the purpose of misleading, , and shall also be subject to a civil penalty not | | | |
| We certify that the above info | ormation is correct and | that the claims have been pa | id in accordance with the plan. | | | |
| Authorized Signature | | | Date | | | |
| Title | | | | | | |
| | Send Claims to: | stoplossmail@hmig.com | | | | |
| | | Or mail to: HM Life Insurance Company P.O. Box 535057 Pittsburgh, PA 15253-5057 | of New York | | | |

Total eligible benefits for this submission

Less specific deductible

Balance

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Fax: 412-544-1246