Stop Loss Carrier: ____

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Specific Stop Loss Reimbursement Request

Mailing Address:
Stop Loss Concepts, Inc.
5854 Heritage Landing Dr.
East Syracuse, NY 13057
1-800-795-6709

Initial Claim ☐ Continuing Claim ☐

Employer's Name		Policy Number & Type
Policy Period From:	To:	Employee Name

Claimant's Name (If other than employee)	Relationship to Employee	Original Effective Date of Claimant's Coverage Under Employer's Plan
Employee Hire Date	Termination Date	COBRA Effective Date

ESTIMATE OF FUTURE POTENTIAL LIABILITY (*Must Be Completed for every Claim*) $__________________

The Following ***MUST*** be completed for every claim:

Diagnosis: ____ Date Claim Incurred: _______________

Total Benefits Paid $__________________

Less Specific Deductible $__________________

Balance $__________________

Reimbursement Request $__________________

Individual claim report is required for initial & continuing claims

Lifetime Maximum to Date______________

COMPLETE FOR CONTINUING CLAIM

Plan benefits paid this submission $__________________

Reimbursement Requested $__________________

The following items are required when submitting a claim (please check items included):

- ☐ Original signed and dated enrollment form
- ☐ Other Coverage Information
- ☐ Student status from bursar's office
- ☐ COBRA Election Form/documentation of payments
- ☐ Medicare Election Form
- ☐ FMLA/COBRA memo, if claim is for employee
- ☐ Credible Coverage, if applicable
- ☐ Home Health Care: copy of treatment plan documentation
- ☐ Plan Document/Amendments
- ☐ Verification of deductible/out of pocket
- ☐ Copies of all bills and explanations of benefits
- ☐ Pre-existing information
- ☐ Pre-certification documentation
- ☐ Letter of medical necessity for physical therapy, speech therapy, etc
- ☐ Injury Claims: history of accident and subrogation
- ☐ Operative report, if assistant surgeon used

TPA NAME:	CONTACT PERSON: EMAIL:	
ADDRESS:	PHONE NUMBER: FAX NUMBER:	DATE COMPLETED: