Specific Excess Claim Reimbursement Request

❑ Initial Submission ❑ Subsequent Submission ❑ Specific Advance ❑ Discount

When claim payments have exceeded the deductible, this form should be completed and submitted to IOA Re, along with all required documentation. See Instructions in your IOA Re Claim Notification and Submission Guidelines.

Administrator: _____

Policyholder: _____

Policy Number: _____ Policy Period: _____

Insurance Carrier: _____ Claim Basis:

Employee's Name: _____ SSN: _____

Date of Hire: _____ Original Effective Date: _____

COBRA Eff. Date: (if Applicable) _____ Termination Date: _____

Claimant(s) Name: _____ DOB: _____ Relationship: _____

Primary Diagnosis: _____ ICD-9: _____

Date Incurred: _____ COB/TPL: _____

Plan Type: ❑ CMM ❑ MM ❑ PPO ❑ Other

FOR INITIAL CLAIMS, COMPLETE THE FOLLOWING:

TOTAL BENEFITS PAID BY PLAN	$_____
LESS SPECIFIC DEDUCTIBLE	$_____
BALANCE	$_____
CO-INSURANCE PERCENT	_____
REIMBURSEMENT REQUESTED	$_____

FOR A CONTINUED CLAIM, COMPLETE THE FOLLOWING:

BENEFITS PAID COVERED BY THIS SUBMISSION	$_____
CO-INSURANCE PERCENT	100%
REIMBURSEMENT REQUESTED	$_____

I certify that, to the best of my knowledge, the above information is correct and the claim has been paid in accordance with the Policyholder's Plan Document.

Submitted by:_____ Title:_____ Date:_____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

Please submit to:

IOA Re
Attn: Claims Department
190 West Germantown Pike, Suite 200, East Norriton, PA 19401

Phone: 610-940-9000 Fax: 610-940-9022