BEACON RISK STRATEGIES

POTENTIAL CLAIM NOTIFICATION/ CLAIMS REIMBURSEMENT REQUEST

POTENTIAL CLAIM: ☐ **SPECIFIC CLAIM FILING:** ☐

GROUP NAME: _____ POLICY #: _____

EMPLOYEE NAME: _____ CLAIMANT SS#: _____

CLAIMANT NAME: _____ CLAIMANT DOB: _____

CLAIMANT GENDER: _____ RELATIONSHIP: _____

Primary Diagnosis: _____ DATE OF ONSET: _____

Secondary Diagnosis: _____

Accident?: _____ If So, Details: _____

Attending Physician: _____ Physician Phone: _____

Other Physician (s): _____ Physician Phone: _____

Hospital: _____ Hospital Phone: _____

First Charge Date: _____ Last Charge Date: _____

Total Paid $: _____ Total Pending $: _____

Prognosis: _____

Estimated Future Expenses $: _____

Comments about Clinical Info., Pre-Screen, Audit, Bill Negotiating and /or Medical Case Management: _____

REIMBURSEMENT REQUEST

TOTAL BENEFITS PAID $: _____

LESS SPECIFIC DEDUCTIBLE $: _____

BALANCE $: _____

REIMBURSEMENT REQUESTED: _____

Please include legible copies of the following:

1. A copy of the enrollment card with Effective Date.
2. HIPPA ,COBRA and Approved LOA Documentation
3. Itemized Provider Billings Attached to each corresponding E.O.B. and Benefit Check.
4. Proof of no other Insurance Coverage, if claimant is Dependent.

SUBMITTED BY: _____ TITLE: _____

TPA NAME: _____ PHONE: _____

FULL ADDRESS _____ FAX: _____

_____ EMAIL: _____

Prepared Date: _____ Notes: _____

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