MRM MARLTON RISK MANAGEMENT

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Please e-mail this completed document to:
claims@marltonriskmgmt.com

Specific Stop-Loss Claim / 50% or Catastrophic Diagnosis Notice

Use this form to report a Specific Stop-Loss claim to Marlton Risk Management LLC, or whenever a claimant reaches 50% of the Specific Stop-Loss deductible or has a catastrophic diagnosis.

Please answer ALL questions completely before submitting this form. Failure to answer all questions may result in a delay in claim payment.

1 Date and Type of Notice

Please print clearly

Date of this notice	Type of notice (check one): ☐ 50% notice ☐ Catastrophic notice ☐ Initial claim submission ☐ Subsequent claim submission

2 Policyholder Information

Please specify name and address of an authorized representative of the policyholder.

Name of policyholder			Stop-Loss policy number
Name of authorized representative of policyholder			Benefit year From: To:
Street address	City	State	Zip code

3 Employee/Claimant Information

Name of employee	Social Security number Date of birth | |	Gender ☐ M ☐ F
Name of claimant (If different)	Relationship to employee Date of birth	Gender ☐ M ☐ F

Employee date of hire	Employee date last worked	Date claimant insured on plan

Other insurance? ☐ Yes ☐ No	If yes, please describe	Has employee returned to work? ☐ Yes ☐ No	If yes, date of return
Is the employee retired? ☐ Yes ☐ No	If yes, retirement date	Is claimant a full-time student? ☐ Yes ☐ No If yes, provide supporting documentation	

Was this person out of work at any time during the benefit year? ☐ Yes ☐ No

If yes, indicate how the employee was covered (check all that apply): From To	Premiums paid by Employee	Employer
☐ Family Medical Leave Act (FMLA)	☐	☐
☐ Long-Term Disability (LTD)	☐	☐
☐ Short-Term Disability (STD)	☐	☐
☐ Medical Leave of Absence	☐	☐
☐ COBRA (see below)	☐	☐
☐ Other:	☐	☐

Date premiums are paid through:

FMLA	Medical Leave of Absence	COBRA*

Continued on next page

4 Claimant's Condition

Diagnosis (ICD-9 Code and Description)	First treatment date
Current prognosis	If ESRD, first date of dialysis
Is the claimant still hospitalized? ☐ Yes ☐ No	Are PPO and cost saving measures in place? ☐ Yes ☐ No
Is Medical Case Management involved? ☐ Yes ☐ No	If yes, provide Case Management provider name and phone number

5 Claim Information

Reimbursement Request:

Total TPA Paid Amount $ _____

Less Specific Deductible $ _____

Less Benefits Paid Outside Plan $ _____

Less Previous Reimbursement Amts. $ _____

Reimbursement Request Amt. $ _____

*Advance Funding Request Amt. $ _____

*Please check the Excess Loss Policy Schedule Page to determine if this benefit is elected.

6 Required Documentation

Please Attach:

1. Detail Paid Claim Report which includes:

   Claimant Name or Identifier (such as Social Security Number and relationship to the employee)
   Diagnosis Code(s)
   Dates of Service – Incurred (From-To)
   Type of Service or Procedure Codes (CPT, HCPCS & Hospital Revenue Codes)
   Provider Identification
   Payment Calculation: Charge Amount, Allowable Amount, Deductible, Co-Pay, Discount, Ineligible Amounts, & Paid Amount
   Processed and/or Paid Date

2. Eligibility Information:

   Copy of Enrollment Card or screen print for the claimant indicating Hire Date, Original Coverage Effective Date, Termination Date, Cobra Effective Date
   Copy of Cobra Election Form, if applicable
   If the claimant is also the employee: Work status of employee (Active-FMLA-Medical Leave of Absence, last date actively at work, date leave began, return to work date, dates of FMLA)
   Identify Other Insurance if applicable (Medicare, Worker's Comp., Auto Insurance, Other)
   If illness or injury is accident related, please provide date and details of accident with applicable Subrogation information

3. Copies of bills over $5,000 Physician Charges and $10,000 Facility Charges

7 Notice and Signature

I certify that the information is correct and that the claim has been paid in accordance with the Covered Person's Benefit Plan.

Third Party Administrator _____

Completed By (Print)_____

Date _____

Address_____ City_____ State _____ Zip _____

Phone No._____ Fax No. _____

Email Address_____