

Claim Reporting Form

Managed Care Specific Excess Loss Reinsurance Agreement

Claim Reimbursement Request: _____

Covered Entity: _____ Claim ~Basis: _____

Agreement #: _____ Policy Period: _____ to _____

Population Type: _____

Covered Plans, HMO or MCO Name: _____

Name of Covered Person: _____ Date of Birth: _____
 (Last Name, First Name)

Covered Person Unique ID #: _____ Effective Date: _____

Current Status: _____ Termination Date: _____

Claim is Due to: _____ Work Related Claim: _____

Automobile Accident: _____ Third Party Subrogation Applies: _____

Diagnosis: _____

Will Medical Expenses be Paid by:

Auto Insurance: _____ Workers Compensation: _____ Other (COB etc.): _____

Medicare: _____ Reason for Medicare Eligibility: _____ Medicare Effective: _____

Prognosis: _____
 (please include expected treatment)

Amount Reported This Claim: _____ Expenses Incurred Thru Date: _____

Less Specific Deductible: _____ Expenses Paid Thru Date: _____

Coinsurance Percentage: _____ Estimated Additional Costs: _____

REIMBURSEMENT REQUEST: _____

Signature: _____ Title: _____ Date: _____

Direct inquiries to: PartnerRe America Insurance Company, Attn: Claims Department, 6900 Wedgwood Road North, Maple Grove, MN 55311
 1 612 234 4920 claimshealth@partnerre.com

These forms contain personal and Protected Health Information under HIPAA and may be transmitted only in a HIPAA compliant medium. **DO NOT SEND VIA AN UNSECURED E-MAIL TRANSMISSION.**

INSURANCE FRAUD WARNING: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading, is guilty of insurance fraud and is subject to criminal and/or civil penalties as defined by your state statutes.