PartnerRe

Claim Reporting Form
Employer Excess of Loss Insurance

Claim Reimbursement Request: ______________________ Simultaneous Funding: ____________

Policyholder: ______________________ Claims Basis: ____________

Policy #: ______________________ Policy Period: ____________ to ____________

Subscriber Benefit Plan Name: ______________________

Name of Subscriber: ______________________ (Last Name, First Name) Subscriber DOB: ____________

Subscriber Unique ID #: ______________________ Subscriber Effective Date: ____________

Current Status: Terminated or COBRA Effective Date: ____________

Name of Claimant: ______________________ (Last Name, First Name) Claimant DOB: ____________

Relationship to Subscriber: ______________________ Claimant Effective 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, Suite 120, Maple Grove, MN 55311
1 612 234 4920 claimshealth@partnerre.com

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.

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.

PartnerRe America Insurance Company
6900 Wedgwood Road North, Suite 120 • Maple Grove, MN 55311 • Tel. 1 612 234 4920 • www.partnerre.com/health

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