PartnerRe

Claim Reporting Form – Medical Excess Reinsurance (Period Certain)

Claim Reimbursement Request: (Select Filing Type)

Company: _____ Contract Term: _____ to _____

Contract #: _____

Claims Basis – Applicable Incurred and Paid Period: (Select Claim Basis)

Name of Subscriber: _____ Subscriber DOB: _____
(Last Name, First Name)

Subscriber Unique ID #: _____ Subscriber Effective Date: _____

Subscriber Status: (Select) Terminated or COBRA Effective Date: _____

Name of Claimant: _____ Claimant DOB: _____
(Last Name, First Name)

Relationship to Subscriber: (Select) Claimant Effective Date: _____

Claim is Due to: (Select) Work Related Claim: (Select)

Automobile Accident: (Select) Third Party Subrogation Applies: (Select)

Diagnosis: _____

Will Medical Expenses be Paid by: Auto Insurance: (Select) Workers Compensation: (Select) Other (COB etc.): Other (COB

Medicare: (Select) Reason for Medicare Eligibility: _____ Medicare Effective: _____

Prognosis: _____
(Please include expected treatment)

Total Amount Paid to Date: _____ Incurred From/Thru Date: _____ to _____

Company Retention: _____ Paid From/Thru Date: _____ to _____

Coinsurance Percentage: _____ 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

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 of insurance fraud and is subject to criminal and/or civil penalties as defined by your state statutes.

This form contains personal and Protected Health Information under HIPAA and may be transmitted only in an HIPAA compliant medium. **DO NOT SEND VIA AN UNSECURED E-MAIL TRANSMISSION.**

PartnerRe America Insurance Company
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