



HMO REINSURANCE/PROVIDER EXCESS CLAIM NOTIFICATION REPORT

Check Appropriate Box	<input type="checkbox"/> 50% Notification	<input type="checkbox"/> Diagnosis Notification	<input type="checkbox"/> Initial Notification	<input type="checkbox"/> Subsequent Notification
Health Plan Name				
Health Plan Policy Number				
Health Plan Contact Person				
Contact Phone and E-mail				
Policy Period				
Deductible	\$			
Current Date				

MEMBER INFORMATION

Member Name			
Social Security Number			
Date of Birth			
Original Effective Date			
Is claimant covered by any other insurance (Auto, Worker's Compensation)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, please provide details			
Is this claim a result of an accident?			
If yes, please provide details			

CLAIM DATA

Diagnosis (include ICD-9)				
Prognosis				
Inpatient Stays:				
	<u>Dates of Service</u>	<u>Facility</u>	<u>Billed Charges</u>	<u>Paid Amount</u>
Stay 1			\$	\$
Stay 2			\$	\$
Stay 3			\$	\$
Stay 4			\$	\$
	Is claimant discharge from the hospital?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician	Billed Charges: \$	Paid Amount: \$		
Other (Outpatient, etc)	Billed Charges: \$	Paid Amount: \$		
Total Paid	Billed Charges: \$	Paid Amount: \$	Estimated Future Liability: \$	

Please e-mail this form to mclclaims@starlinegroup.com or fax it to 508-495-0708 or mail it to Star Line Group, Claims Dept, 180 Teaticket Highway, East Falmouth, MA 02536.