PROVIDER EXCESS 50% LOSS NOTIFICATION - HOSPITAL

Policyholder: ______________________________
Policy Number: ______________ Insurance Carrier: ______________________________
Policy Period: ______________ Claims Basis: 12/18/19 or other: ______________

Member's Name: ______________________________ SS#: ______________
Managed Care Affiliation: ______________________________

Claimant: ______________ DOB: __________ Relationship: ______________

Effective Date: ______________ Termination Date: ______________

Type of Plan: ☐ Medicare ☐ Medicaid ☐ Commercial

Type of Coverage: ☐ HMO ☐ PPO ☐ POS ☐ Other

Date of First Claim: ______________ Accident? ☐ Yes ☐ No

Specific Deductible: $ ______________ COB/TPL: ______________

Coinsurance Percentage: ______________________________

Contractual Arrangements: (i.e. Maximum Per Diem, % discount off of billed charges, Case Rates, etc.)

____

Diagnosis: Primary Code ______________ Description: ______________________________
Secondary Code ______________ Description: ______________________________

Hospital: ______________________________ ☐ In Network ☐ Out of Network

Number of Days (at each facility): ______________________________

Total Claim Paid to: (Date) ______________ $ ______________

Prognosis: ______________________________

____

____

Estimate of Total Cost: $ ______________________________

Submitted by: ______________________________ Date: ______________
Company: ______________________________
Address: ______________________________
Phone: ______________ FAX: ______________ E-mail: ______________

Case Manager: ______________________________
Phone: ______________ FAX: ______________ E-mail: ______________

Please Submit to:

IOA Re, Inc.
Attn: Claims Dept.
190 W. Germantown Pike, Suite 200
East Norriton, PA 19401
Phone: 610-940-9000 FAX 610-940-9022

PROVIDER EXCESS 50% LOSS NOTIFICATION - PHYSICIAN

Policyholder: ____________________
Policy Number: ____________ Insurance Carrier: ____________
Policy Period: ____________ Claims Basis: 12/18/19 or other: ____________

Member's Name: ____________________ SS#: ____________

Managed Care Affiliation: ____________________

Claimant: ____________ DOB: ________ Relationship: ____________

Effective Date: ____________ Termination Date: ____________

Type of Plan: ☐ Medicare ☐ Medicaid ☐ Commercial

Type of Coverage: ☐ HMO ☐ PPO ☐ POS ☐ Other

Date of First Claim: ____________ Accident? ☐ Yes ☐ No

Specific Deductible: $ ____________ COB/TPL: ____________

Diagnosis: Primary Code ____________ Description: ____________
Secondary Code ____________ Description: ____________

Total Claim Paid to: (Date) ____________ $ ____________

Prognosis: ____________________

Estimate of Total Claim Cost: $ ____________

Submitted by: ____________________ Date: ____________
Company: ____________________
Address: ____________________
Phone: ____________ FAX: ____________ E-mail: ____________

Case Manager: ____________________
Phone: ____________ FAX: ____________ E-mail: ____________

Please Submit to:

IOA Re, Inc.
Attn: Claims Dept.
190 W. Germantown Pike, Suite 200
East Norriton, PA 19401
Phone: 610-940-9000 FAX 610-940-9022

HMO Excess 50% Loss Notification – HOSPITAL

Plan: ______________________________

Reinsurance Carrier: ______________ Agreement Year: ______________

Claims Basis: 12/18/19 or other: ______________

Member's Name: ______________ SS #: ______________

Claimant: ______________ DOB: ________ Relationship: ______________

Effective Date: ______________ Termination Date: ______________

Type of Plan: ☐ Medicare ☐ Medicaid ☐ Commercial

Date of First Claim: ______________ Accident? ☐ Yes ☐ No

Coinsurance Percentage: ______________ COB/TPL: ______________

Specific Deductible: $ ______________

Contractual Arrangements: (i.e., Maximum Per Diem, % discount off of billed charges, Case Rates, etc.)

____

____

Diagnosis: Primary Code: ______________ Description: ______________

Secondary Code: ______________ Description: ______________

Hospital: ______________ ☐ In Network ☐ Out of Network

Number of Days: (at each facility) ______________

Total Claim Paid to: ______________ (date) $ ______________

Prognosis: ______________________________

____

Estimate of Total Cost: $ ______________

Submitted by: ______________ Date: ______________

Company: ______________________________

Address: ______________________________

Phone: ______________ FAX: ______________ E-mail: ______________

Case Manager: ______________________________

Phone: ______________ FAX: ______________ E-mail: ______________

Please Submit to:
IOA Re
Attn: Claims Department
190 W. Germantown Pike, Suite 200
East Norriton, PA 19401
Phone: (610) 940-9000 Fax: (610) 940-9022

HMO Excess 50% Loss Notification – PHYSICIAN

Plan: ______________________________

Reinsurance Carrier: ______________ Agreement Year: ______________

Claims Basis: 12/18/19 or other:______________

Member's Name: ______________________ SS #: ______________

Claimant: ______________ DOB: ________ Relationship: ______________

Effective Date: ______________ Termination Date: ______________

Type of Plan: ☐ Medicare ☐ Medicaid ☐ Commercial

Date of First Claim: ______________ Accident? ☐ Yes ☐ No

Specific Deductible: $ ______________ COB/TPL: ______________

Diagnosis: Primary Code: ______________ Description: ______________

Secondary Code: ______________ Description: ______________

Total Claim Paid to: ______________ (Date) $ ______________

Prognosis: ______________________________

____

____

Estimate of Total Cost: $ ______________________________

Submitted by: ______________________ Date: ______________

Company: ______________________________

Address: ______________________________

Phone: ______________ FAX: ______________ E-mail: ______________

Case Manager: ______________________________

Phone: ______________ FAX: ______________ E-mail: ______________

Please Submit to:
IOA Re
Attn: Claims Department
190 West Germantown Pike, Suite 200
East Norriton, PA 19401
Phone: (610) 940-9000 Fax: (610) 940-9022