## PROVIDER EXCESS REIMBURSEMENT REQUEST - HOSPITAL

Policyholder:_	
Policy Number	: Insurance Carrier:
Policyholder Fe	ederal Tax ID Number:
Policy Period:	Claims Basis: 12/18/19 or other:
Member's Nam	ne: SS#:
Managed Care	Affiliation:
Claimant:	DOB: Relationship:
Effective Date:	Termination Date:
Type of Plan:	Medicare Medicaid Commercial
Type of Covera	age: HMO PPO POS Other
Diagnosis: Prin	nary Code Description:
Sec	ondary Code Description:
COB/TPL:	Accident? Yes No
COMPLETE T	THE FOLLOWING:
C) Maximum	ervice: From: To: B) Length of Stay (Days) Per Diem (if applicable) D) Total Charges   D) Total Charges
E) Reimburse	ment Percentage (if applicable) F) Specific Deductible \$
G) Coinsuran	ce Percentage H) Eligible Charges \$
**I) Reimburse	ement Requested \$
	arges shall equal the lesser of (B x C) or (D x E).
	rsement Requested shall equal (H - F) x G.
NOTE OF A	DA DEOLUCIA CANDIOT DE DOCCEGGED MUNICIPAL TUE FOI LOMIDAG
	IM REQUEST CANNOT BE PROCESSED WITHOUT THE FOLLOWING UIRED ITEMS: (BE SURE ALL COPIES ARE LEGIBLE)
1)	Copy of ID Card from patient's Managed Care Affiliation <u>OR</u> other enrollment/eligibility information.
2)	Copy of all bills.
	When appropriate, medical records may be requested.
-,	,,
	to the best of my knowledge, the above information is correct and that there has been no other and by any other entity for these expenses.
Submitted by:_	Date:
Company:	
Address:	
Phone:	FAX:E-mail:
Please Submit	to: IOA Re. Inc.

10A Re, Inc.
Attn: Claims Dept.
P. O. Box 975
190 W. Germantown Pike, Suite 200
East Norriton, PA 19401
Phone: 610-940-9000 FAX 610-940-9022

## PROVIDER EXCESS REIMBURSEMENT REQUEST - PHYSICIAN

Policyholder:						
Policyholder: Policy Number:	Insurance Carrier:					
Policy Period:	Claims Basis: 12/1	8/19 or other:				
Member's Name:		SS#:				
Wiemoer's Ivame.		33π				
Managed Care Affiliation:						
Claimant:	DOB:	Relationship:				
Effective Date:	ite:Termination Date:					
Type of Plan: Medicare	Medicaid Commerc	cial				
Type of Coverage: HMO	□ PPO □ POS □ Oth	ner				
Diagnosis: Primary Code	Dagam	iption:				
		iption:				
Soverium y co.						
COB/TPL:		Accident? Tyes				
	NG.					
COMPLETE THE FOLLOWI		Tr.				
<ul><li>A) Dates of Service:</li><li>B) Total Eligible Charge</li></ul>		To:				
C) Specific Deductible:	\$ \$					
D) Coinsurance Percenta	age:					
E) Reimbursement Requ						
E) Kelmoursement Kequ	esied. <u>\$</u>					
-	CANNOT BE PROCESSE : (BE SURE ALL COPI	ED WITHOUT THE FOLLOWING ES ARE LEGIBLE)				
1) Copy of ID Ca	ard from nationt's Managed	Care Affiliation OR other enrollment/eligibility information.				
	_	Care Arrination <u>OK</u> other enformendengionity information.				
,	us. iate, medical records may b	an requested				
3) When appropr	iate, medicai records may c	e requested.				
Legrify that to the best of my	knowledge, the above info	rmation is correct and that there has been no other				
reimbursements made by any o						
Submitted by:		Date:				
Company:						
Address:						
Phone:	FAX:	E-mail:				
Please Submit to:	IO	A 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 Reimbursement Request – HOSPITAL**

Plan:					
Rein	surance Carrier:	Ag	Agreement Year:		
Clair	ns Basis: 12/18/19 or other:				
HMO	Federal Tax ID number:				
Member's Name:			SS #:		
Claimant: DOB		3:	Relationship:		
		ation Dat	e: _		
Туре	of Plan: Medicare Medicaid Comme	ercial			
Туре	of Coverage: HMO PPO POS Of	ther			
Diag	nosis: Primary Code:	Descrip	tion:		
	Secondary Code:	Descrip	tion: _		
COB	/TPL:			Accident? Yes No	
CO	MPLETE THE FOLLOWING:				
A)	Date of Service: FromTo	B)	Lengt	h of Stay (Days):	
C)	Max. Avg. Per Diem (if applicable):	D)	Total	Charges:	
E)	Reimbursement Percentage (if applicable):	F)	Speci	fic Deductible: _\$	
G)	Coinsurance Percentage:	*H)	Eligit	ole Charges:	
**I)	Reimbursement Requested:  * Eligible Charges shall equal the lesser of (B x * Reimbursement Requested shall equal (H - F)		x E) C	PR Paid/Negotiated Charges.	
	TE: CLAIM REQUEST CANNOT BE PROCESSED MS:(BE SURE ALL COPIES ARE LEGIBLE.)	WITHOU	J <b>T THE</b>	FOLLOWING REQUESTED	
	<ol> <li>Copy of Member's HMO ID card</li> <li>Copy of all bills</li> <li>When appropriate, medical records may be</li> </ol>	requested			
I cer	rtify that, to the best of my knowledge, the above interreimbursements made by any other entity for these	formation e expense	is corres.	ect and that there have been no	
Ву:	Title:			Date:	
Com	pany:				
Add	ress:				
Phor	ne: FAX:		E-mai	il:	

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

## **HMO Excess Reimbursement Request - PHYSICIAN**

<u> </u>		
Agreeme	Agreement Year:	
	SS #:	
DOB:	Relationship:	
Termination Date:		
id Commercial		
Description:	·	
Description:		
	Accident? Yes No	
<b>3</b> :		
	To:	
\$	_	
	_	
	_	
\$	_	
E PROCESSED WITHOUT OPIES ARE LEGIBLE) and ards may be requested		
the above information is contity for these expenses.	rect and that there has been no	
Title:	Date:	
E-ma	il:	
	DOB: Termination Date: id Commercial Description: Description:  \$  E PROCESSED WITHOUTOPIES ARE LEGIBLE) rd rds may be requested the above information is contity for these expenses.  Title:	

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