PROVIDER EXCESS REIMBURSEMENT REQUEST - HOSPITAL

Policyholder:_____
Policy Number: _____ Insurance Carrier:_____
Policyholder Federal Tax ID Number:_____
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

Diagnosis: Primary Code _____ Description:_____
Secondary Code_____ Description:_____
COB/TPL:_____ Accident? ☐Yes ☐ No

COMPLETE THE FOLLOWING:
A) Dates of Service: From:_____ To:_____ B) Length of Stay (Days)_____
C) Maximum Per Diem (if applicable) $_____ D) Total Charges $_____
E) Reimbursement Percentage (if applicable)_____ F) Specific Deductible $_____
G) Coinsurance Percentage _____ H) Eligible Charges $_____
**I) Reimbursement Requested $_____
* Eligible Charges shall equal the lesser of (B x C) or (D x E).
** Reimbursement Requested shall equal (H - F) x G.

NOTE: CLAIM REQUEST CANNOT BE PROCESSED WITHOUT THE FOLLOWING REQUIRED ITEMS: **(BE SURE ALL COPIES ARE LEGIBLE)**

1) Copy of ID Card from patient's Managed Care Affiliation OR other enrollment/eligibility information.
2) Copy of all bills.
3) When appropriate, medical records may be requested.

I certify that, to the best of my knowledge, the above information is correct and that there has been no other reimbursements made by any other entity for these expenses.

Submitted by:_____ Date:_____
Company:_____
Address:_____
Phone:_____ FAX:_____ E-mail:_____

Please Submit to:

IOA 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:_____
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

Diagnosis: Primary Code _____ Description:_____
Secondary Code_____ Description:_____

COB/TPL:_____ Accident? ☐Yes ☐ No

COMPLETE THE FOLLOWING:

A) Dates of Service: From:_____ To:_____
B) Total Eligible Charges: $_____
C) Specific Deductible: $_____
D) Coinsurance Percentage: _____ %
E) Reimbursement Requested: $_____

NOTE: CLAIM REQUEST CANNOT BE PROCESSED WITHOUT THE FOLLOWING REQUIRED ITEMS: **(BE SURE ALL COPIES ARE LEGIBLE)**

1) Copy of ID Card from patient's Managed Care Affiliation OR other enrollment/eligibility information.
2) Copy of all bills.
3) When appropriate, medical records may be requested.

I certify that, to the best of my knowledge, the above information is correct and that there has been no other reimbursements made by any other entity for these expenses.

Submitted by:_____ Date:_____
Company:_____
Address:_____
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 Reimbursement Request – HOSPITAL

Plan: _____

Reinsurance Carrier: _____ Agreement Year: _____

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

HMO Federal Tax ID number: _____

Member's Name: _____ SS #: _____

Claimant: _____ DOB: _____ Relationship: _____

Effective Date: _____ Termination Date: _____

Type of Plan: ☐ Medicare ☐ Medicaid ☐ Commercial

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

Diagnosis: Primary Code: _____ Description: _____

Secondary Code: _____ Description: _____

COB/TPL: _____ Accident? ☐ Yes ☐ No

COMPLETE THE FOLLOWING:

A) Date of Service: From_____To_____ B) Length of Stay (Days): _____

C) Max. Avg. Per Diem (if applicable): _____ D) Total Charges: _____

E) Reimbursement Percentage (if applicable):_____ F) Specific Deductible: $_____

G) Coinsurance Percentage: _____% *H) Eligible Charges: _____

**I) Reimbursement Requested: _____

* Eligible Charges shall equal the lesser of (B x C) OR (D x E) OR Paid/Negotiated Charges.

** Reimbursement Requested shall equal (H - F) x G.

***NOTE*: CLAIM REQUEST CANNOT BE PROCESSED WITHOUT THE FOLLOWING REQUESTED ITEMS:** (BE SURE ALL COPIES ARE LEGIBLE.)

1) Copy of Member's HMO ID card
2) Copy of all bills
3) When appropriate, medical records may be requested

I certify that, to the best of my knowledge, the above information is correct and that there have been no other reimbursements made by any other entity for these expenses.

By: _____ Title: _____ Date: _____

Company: _____

Address: _____

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

HMO Excess Reimbursement Request - PHYSICIAN

Plan: _____

Reinsurance Carrier: _____ Agreement Year: _____

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

HMO Federal Tax ID number: _____

Member's Name: _____ SS #: _____

Claimant: _____ DOB: _____ Relationship: _____

Effective Date: _____ Termination Date: _____

Type of Coverage: ☐ Medicare ☐ Medicaid ☐ Commercial

Diagnosis: Primary Code: _____ Description: _____

Secondary Code: _____ Description: _____

COB/TPL: _____ Accident? ☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING:

A) Date of Service: From: _____ To: _____

B) Total charges: $ _____

C) Specific Deductible: _____

D) Coinsurance Percentage: _____

E) Reimbursement Requested: $ _____

NOTE: CLAIM REQUEST CANNOT BE PROCESSED WITHOUT THE FOLLOWING REQUIRED ITEMS: (BE SURE ALL COPIES ARE LEGIBLE)

1) Copy of Member's HMO ID Card
2) Copy of all bills
3) When appropriate, medical records may be requested

I certify that, to the best of my knowledge, the above information is correct and that there has been no other reimbursements made by any other entity for these expenses.

By: _____ Title: _____ Date: _____

Company: _____

Address: _____

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