



SPECIFIC CLAIM FORM

Initial Claim Supplemental Claim 50% Notification Specific Advancement*

Employer Name
Policy Number
EE Name
Eff Date of Birth
Paid to Date
Claimant Name
Claimant Effective Date
Diagnosis/ICD 9
Prognosis

Policy Period
SSN
EE Effective Date Hire Date
EE Termination Date
Last Day Worked Current Status
Relationship DOB
COBRA Eff. Date Prm. Paid To
Case Management Reviewed No Yes
Vendor
Telephone No.

Total Eligible Benefits this Submission \$
Less Specific Deductible \$
Balance \$
Percent to be Reimbursed %
Reimbursement Requested \$

Estimated Future Liability \$

YOUR REIMBURSEMENT REQUEST SHOULD INCLUDE THE FOLLOWING INFORMATION (IF APPLICABLE):

Copies Of:

Investigation Materials For:

- Enrollment form/Creditable Coverage Certificate
Employee Claim Form (current)
COBRA Election Form/Payments
EOBs/Claim Checks/Registers
Itemized Bills
Deductible/Coinsurance Proof
Precertification Form
Hospital Repricing Sheets
Divorce or Separation Decrees or Court Orders

- COB
Full-Time Student Status
Pre-existing
Large Case Management Reports
Subrogation (Accident Detail/Police Report)
Workers' Compensation

*ADVANCE FUNDING REQUEST FORM AND SPECIFIC CLAIM FORM MUST BE COMPLETED WHEN REQUESTING SPECIFIC ADVANCEMENT

PLEASE READ BEFORE SIGNING

I hereby certify that, to the best of my knowledge, after reasonable inquiry: (1) All applicable premiums for this group have been paid through the current period; (2) A prospective claim notification for this claim has been provided to Perico Life; (3) The specific deductible has been processed and funded, and checks have been released to all respective providers; (4) The employer is current in funding of all other claims for this group.

Signed:

Date:

TPA Name:

Address:

Phone: Ext.

Fax No.