Specific Stop Loss Claim Form

Please submit this form to:
medTRANS Insurance
Frontrunner Captive Management, inc.
303 West Main St. Suite 300
Freehold, NJ 07728
Phone: 732.414.2942
rbeckie@frontrunnercaptive.com

☐ 50% notification ☐ Initial ☐ Subsequent _____ Of _____

Policyholder Information:

Plan Sponsor (Group Name): _____ Policy # _____

Policy Period: _____ Contract Type: 12/12? 12/15? Specific Deductible _____

Member Information:

Member Name: _____ Social Security # _____

Date of Birth: _____ Date of Hire: _____ Original Effective Date _____

Plan #: _____

Member's Work Status:

☐ Actively working _____ ☐ Retired - Retirement Date: _____

☐ Disabled & unable to work from: _____ to _____

☐ Not actively working _____ Date last worked: _____

Indicate how coverage is being continued (mark all that apply):

☐ Sick Leave: _____ to _____ ☐ Vacation: _____ to _____

☐ Leave of Absence: _____ to _____ ☐ FMLA _____ to _____

☐ Hour Bank?_____ Yes ***(Please Provide copy to report)*** _____ ☐ No

☐ Self Pay: _____ to _____ ***(please provide proof of premium payments)***

☐ Coverage Terminated? ☐ Yes ☐ No Date: _____

☐ COBRA applicable? ☐ Yes ☐ No COBRA Eff Date _____

☐ COBRA Premium Paid Through _____ COBRA Term Date _____

Claimant Information

Claimant Name: _____ Date of Birth: _____

Relationship to Member: ☐ Spouse ☐ Child ☐ Other _____

If Child, under 26 at incurred date? _____

Original Effective Date: _____ Termination Date: _____

Is COBRA applicable? ☐ Yes ☐ No COBRA Effective Date: _____

COBRA Premium Paid Through Date: _____ COBRA Tem Date: _____

Is Claimant covered by any other insurance plan? ☐ Yes ☐ No

If yes, type of coverage (Auto, Work Comp, Group Plan, Medicare): _____

Carrier: _____ Effective Date: _____ Term Date: _____

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Claim Information:

Diagnosis: _____ Date of Onset: _____ Prognosis: _____

Claimant Injured? ☐ Yes ☐ No Date of Injury: _____ Place injury occurred: _____

How did injury occur? _____

Subrogation applicable? ☐ Yes ☐ No If "Yes", please provide details _____

PPO? ☐ Yes ☐ No Name of PPO: _____

Case Mgmt? ☐ Yes ☐ No Vendor Name & Phone: _____

Claims Paid to Date: _____ Claims Pending: _____

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Total Eligible Benefits this Submission:	$
Less Specific Deductible	$
Less Aggregating Specific Deductible *(if Applicable)*	$
Balance	$ 0.00
Percentage to be Reimbursed (if Applicable)	$ 100%
Reimbursement Requested	$
Advanced Funding	$

Your Request Should Include Copies of the Following Information

- ☐ Enrollment Form (initial/Current)
- ☐ Member Claim Form
- ☐ COBRA Election form
- ☐ Cumulative paid claims report
- ☐ Checks/Registers
- ☐ Deductible/Coinsurance Proof of satisfaction
- ☐ Itemized Bills/Electronic Claim Data
- ☐ R&C Calculations
- ☐ Precertification Forms
- ☐ Hospital Audits/Reviews
- ☐ Hospital Records
- ☐ Large Case Mgmt Reports
- ☐ Material to support Claim
  - ☐ COB
  - ☐ Physician Statements
  - ☐ Subrogation Information
  - ☐ Work Comp Information
  - ☐ Accident details (Police report, etc)

TPA/Claims Administrator Name: _____

Address: _____

City _____ **State** _____ **Zipcode** _____

Phone _____ **Fax:** _____ **E-Mail** _____

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I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ATTACHED FRAUD NOTICE, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAIN IN ACCORDANCE WITH THE PLAN DOCUMENT.

AUTHORIZED SIGNATURE: _____ DATE: _____

Submit to:

medTRANS Insurance Ltd.
C/O Frontrunner Captive Management, inc.
303 West Main St
Suite 300
Freehold, NJ 07728 E-Mail rbeckie@frontrunnercaptive.com

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Fraud Notice to included on each claim/Application Form

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing

Georgia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive