Summit Reinsurance Services, Inc.

HMO REINSURANCE ADMINISTRATION

Claim Reporting Form

After a claim exceeds the Specific Retention, the Claim form should be completed and forwarded to Summit Re with the required documentation. Please note the claims must be billed/paid prior to requesting payment.

Please complete the form in its entirety by filling in the appropriate information:

1. The Reinsured's name, agreement number, agreement period, claimant type and retention have been indicated on the form in advance.

2. **Member's Name:** The full name of the subscribing member.

3. **Patient's Name:** The full name of the patient. This may be the same as the member.

4. **Patient's Member Number:** Please provide the patient's member number.

5. **Patient Eligibility Effective Date:** The date the patient became eligible under the membership service agreement.

6. **Patient's Date of Birth:** Please provide the patient's date of birth.

7. **Eligibility Termination Effective Date:** Please provide the date the patient's coverage terminated under the membership service agreement if applicable.

8. **ICD-9 Code(s):** Please provide all applicable diagnosis information for the patient in the form of ICD-9 codes.

9. **Initial Claim vs. Supplemental Claim:** Indicates that the claim is being submitted to Summit Re for adjudication and payment for the first time OR for adjudication and payment in addition to a previous claim for this member.

10. **Claim is due to:** Please indicate the cause of the claim; accident or illness. If accident, also indicate if auto and/or work related.

11. **Other Coverages:** Please indicate whether there are any other coverages applicable for this patient. If there are any complete the section entitled "Carrier".

12. **Carrier:** Please indicate the full name of the other coverage carrier if applicable for the patient.

HMO REINSURANCE ADMINISTRATION

Claim Reporting Form

HOSPITAL CLAIM CALCULATION

This form helps calculate claims submissions with up to three hospital confinements.

(A) **Total # of Days:** Please provide the number of days that services were rendered to the patient that are applicable for each hospital confinement.

(B) **Average Daily Maximum:** Maximum amount per day allowed to accumulate toward the deductible. May vary between in-network and out-of-network.

(C) **Inpatient Subtotal (A times B):** Product of Total No. of Days multiplied by the Average Daily Maximum.

(D) **Payment to Hospital**: Total amount of billed charges paid to hospital for this inpatient confinement**.**

(E) **Lesser of C or D:** Reimbursement under the reinsurance policy is based on the lesser of inpatient subtotal or payment to hospital.

(F) **Ancillary Charges:** Please provide the total other charges that have accumulated for the patient under the membership service agreement. Ancillary charges may include home health care, skilled nursing, extended care, rehabilitation facility, hospital-based physicians, pharmaceuticals, durable medical equipment and supplies, or ambulance services. This dollar amount should be reflective of the accumulation structure under the reinsurance policy.

(G) **Total:** E plus ancillary charges**.**

(H) **Total 1+2+3:** Total accumulated for up to three hospital confinements.

(I) **Retention:** Enter retention applicable for the population for which the patient is a member as shown in Claimant Type above.

(J) **Total Less Retention (H minus I):** Total accumulated less the retention (for initial claims only).

(K) **Coinsurance:** Percentage of ERC payment obligation.

(L) **Payment Requested:** Product of total accumulated (less the retention for initial claims only) times the coinsurance percentage.

The person completing the form should indicate their name, title, company and telephone number as well as sign and date the form.

PLEASE ATTACH THE FOLLOWING INFORMATION:

1. Enrollment Form or documentation indicating member is assigned to the policyholder
2. Billing/paid statements (UB 82/92 hospital bill summary, other provider bills) showing paid dates
3. If dependent is employed, state name, address and telephone number of dependent's employer.

The form and supporting documentation should be forwarded to:

Summit Reinsurance Services, Inc.
ATTN: Healthcare Claims
7030 Point Inverness Way, STE 350
Fort Wayne, IN 46804
Phone: (260) 469-3000
Fax: (260) 469-3014
E-mail: Claims@Summit-Re.com

HMO REINSURANCE ADMINISTRATION

Claim Reporting Form

PROFESSIONAL CLAIM CALCULATION

Total Accumulated Claim: Total payments for the patient's applicable dates of service.

Retention: Enter retention applicable for the population for which the patient is a member as shown in Claimant Type above.

Total Less Retention: Total payments accumulated less the retention (for initial claims only).

Coinsurance: Percentage of ERC payment obligation.

Payment Requested: Product of total accumulated (less the retention for initial claims only) times the coinsurance percentage.

The person completing the form should indicate their name, title, company and telephone number as well as sign and date the form.

PLEASE ATTACH THE FOLLOWING INFORMATION:

1. Enrollment Form or documentation indicating member is assigned to the policyholder
2. Billing/paid statements (UB 82/92 hospital bill summary, other provider bills) showing paid dates
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