SKYWARD SPECIALTY INSURANCE | Accident & Health

SKYWARD SPECIALTY INSURANCE
600 TOWNPARK LANE, SUITE 500, KENNESAW, GA 30144
713.935.4800 | 800.796.9165 (TOLL FREE) | CLAIMS FAX: 610.280.4299

REQUEST FOR SPECIFIC EXCESS LOSS REIMBURSEMENT

This request represents ☐ Initial Submission ☐ Subsequent Submission ☐ Specific Advance

Policy Holders Name: _____ Policy Period (for this claim): _____

Basis Coverage: ☐ 12/12 ☐ 12/15 ☐ 15/12 ☐ 24/12 ☐ Other _____

Employees Name: _____ Date of Birth: _____ SSN: _____

Date of Hire: _____ Original Effective Date of Coverage: _____

Claimant's Name (if other than EE): _____ Date of Birth: _____ Relationship: _____

Claimant's SSN: Claimant's Original Effective Date of Coverage with Employer: _____

Diagnosis: _____

Status: ☐ Active ☐ Retired Last Day Worked: _____ Returned to Work: _____

REQUIRED DATA (√ attachments)

- ☐ Complete Skyward Insurance Accident & Health Eligibility Verification Worksheet
- ☐ Copy of original enrollment card (documentation of eligibility)
- ☐ Copy of Certificate of Coverage as required by HIPAA
- ☐ Pre-existing condition investigation documentation if appropriate
- ☐ Excel file **(preferred)** or computer print-out include: date received by TPA, date of service, CPT codes to include modifiers, ICD-9 codes, date paid, date processed, amount billed, amount paid, coinsurance, deductible, co-payments; amount not covered (reason), & check number; or itemized bills & EOBs **(Submit complete claim file for all transplants)**
- ☐ Pre-certification documentation
- ☐ Copy of other insurance information/COB documentation
- ☐ Copy of hospital bills over $100,000 (UB-04 only, unless bills spans two plan years)
- ☐ All accident claims require complete details (police reports for motor vehicle accidents)
- ☐ Private duty nursing charges must include all nursing notes
- ☐ Documentation confirming claims were funded (and proof of paid for end of policy payments)
- ☐ Proof of deductible & coinsurance when met prior to current plan year

**This is not a comprehensive list. We reserve the right to request additional information as needed.*

Was Large Case Management implemented? ☐ Yes ☐ No If yes, please attach LCM Findings

Was a hospital audit/negotiation performed? ☐ Yes ☐ No If no, reasons: _____

If yes, vendor name and results: _____

Total benefits paid by the Administrator: $ _____

Specific deductible (first submission): -$ _____

Amount of reimbursement requested: $ _____

Pending claims : $ _____

Est. total cost: $ _____

Claim is: ☐ Open ☐ Closed

☐ In-network ☐ Out-of-network

Authorized Signature _____ Date _____

Claims Administrator _____

Address _____

Phone _____ Fax _____ Email _____

Send claims and required documentation to ah-specific@skywardinsurance.com or fax to 610.280.4299

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.