Evolution Risk Partners, LLC
claims@evolutionrisk.com
www.evolutionrisk.com

SPECIFIC STOP LOSS CLAIM FORM

☐ **Claim Notification (50% or trigger diagnosis)** ☐ **Initial Claim**
☐ **Supplemental Claim # (2, 3, 4, etc.)** ☐ **Final Request**

GROUP INFORMATION

Group name	Policy period MM DD YY through MM DD YY
Stop loss carrier	Policy #
Specific deductible	Contract basis

EMPLOYEE/CLAIMANT INFORMATION

Fill in all that apply	EMPLOYEE INFO	CLAIMANT INFO
Name		
Gender/Relation		
DOB	MM DD YY	MM DD YY
Original effective date	MM DD YY	MM DD YY
Date of hire	MM DD YY	
Termination date	MM DD YY	MM DD YY
Actively at work	☐ Yes ☐ No	
Retired/Retirement date	MM DD YY	
Date last worked	MM DD YY	
Disabled and unable to work	Start: MM DD YY End: MM DD YY	
COBRA effective date	MM DD YY	MM DD YY
COBRA premium paid through	MM DD YY	MM DD YY
FMLA	Start: MM DD YY End: MM DD YY	

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OTHER COVERAGE

Is claimant covered by any other coverage? ☐ Yes ☐ No	
If yes, type of coverage (Auto, Work Comp, Group Plan, Medicare, Other):	Carrier:
Effective date: MM DD YY	Termination date: MM DD YY
How and when was this verified?	

DIAGNOSIS DETAILS

Diagnosis (with applicable ICD10 codes and description):	
Status:	Prognosis:
Case management? ☐ Yes ☐ No	Vendor name & phone #:
Comments:	

ACCIDENT/SUBROGATION DETAILS

Claimant Injured? ☐ Yes ☐ No	Date of injury: MM DD YY
Place injury occurred:	
How did injury occur?	
Subrogation applicable? ☐ Yes ☐ No If "Yes," please provide details:	
Effective date: MM DD YY	Termination date: MM DD YY

Total TPA paid: $____________

Less specific deductible (or applicable laser): $____________

Less aggregating specific deductible: $____________

Balance: $____________

Total prior reimbursments: $____________

Percentage to be reimbursed: $____________

Reimbursement requested: $____________

Simultaneous (advanced) funding requested: ☐ Yes ☐ No

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

Enrollment/ Eligibility Documentation
EOB/Claim Checks/Registers
Deductible/Coinsurance Proof of Satisfaction
Complete Paid Claims Detail/History Report
Itemized Bills
Precertification Forms
Hospital Audits/Reviews/Pre-Screens

Hospital Records
Large Case Management Reports
Investigative Materials to Support Claim:
- COB (Current)
- Subrogation Information
- Work Comp Information
- Accident Details (Police Report, etc.)

Administrator Name/Contact Person	
Address	
Phone	Email

Authorized Signature

Date (MM DD YY)

Any person who knowingly and with intent to defraud any insurance company or other person files a 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

SUBMIT TO: **E-mail: claims@evolutionrisk.com**
Evolution Risk Partners, LLC
c/o Corporate Benefit Audits, Inc.
21 High Street, Suite 202
North Andover, MA 01845