## ADVANCE NOTICE OF EXCESS CLAIM REPORT

Please provide the following information for excess claims which have reached 50% of the Specific Deductible.

Group Name:______________________________________________________________________

Specific Deductible:____________________________ Policy Year:_____________________________

## CLAIMANT INFORMATION

Employee Name:_____________________________ DOB:_________ Effective Date: _____________

Claimant Name:______________________________ DOB:_________________________________

Effective Date:________________________________ Relationship: ME FE MSP FSP MC FC

Diagnosis:___________________________________________________________________________
(Please include ICD-9 code)

Amount paid to date: $______________________________Amount pending: $____________________

Reason pending:_______________________________________________________________________

Estimate of additional charges: $_________________________________________________________

Initial date of treatment:_________________________________________________________________

Date of last hospitalization:______________________________________________________________

Current treatment:_____________________________________________________________________

***Please contact Montgomery Management if you are unable to obtain a discount on a hospital bill. ***

Large Case Management? YES__________________ NO_______________________________

(If yes, please submit copies of LCM reports)

Please see Potential High Dollar Diagnosis page for mandatory Large Case Management assessments.

Name of LCM company: ________________________________________________________

Name of Contact: ___________________________ Phone#: __________________________

If NO, Please advise reason:_____________________________________________________

Prognosis:____________________________________________________________________________

TPA Name:___________________________________________________________________________

Address:_____________________________________________________________________________

Phone#:___________________________________ Fax#:____________________________________

Submitted by: ______________________________ Date: ___________________________________

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MONTGOMERYMANAGEMENT

# *AGGREGATE EXCESS INSURANCE MONTHLY CLAIM REPORTS*

**Contract Holder :** ______________________ **Carrier :** ______________________

**Policy Period :** ______________________ **Aggregate Basis :** ______________________

| Month/Year | # of EE | Agg Ret. Factor | Est. Att. Pt. This month | Claims Paid This Month | Claims Paid YTD | Claims Paid Outside Rein. | Specific Exc. Reim |
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**Total Claims Paid YTD :** ______________________

**Less Claims Paid Outside Reinsurance :** ______________________
**Less Specific Excess Reimbursements :** ______________________
**Less YTD Attachment Point :** ______________________
**Claims Exceed Attachment Point by :** ______________________

**Montgomery Management**
**Two Valley Square - Suite 110**
**512 Township Line Road**
**Blue Bell, PA 19422**

**ADMINISTRATOR :** ______________________

**SUBMITTED BY :** ______________________ **DATE :** ______________________

MONTGOMERYMANAGEMENT

# Directory

| Name | Title | Extension | Email |
|---|---|---|---|
| Burton, Niambi | Underwriting Coordinator Director | 104 | *nburton@montmgmt.com* |
| Cooper, Chris | Executive Vice President of Sales | 110 | *ccooper@montmgmt.com* |
| Dickinson, Donna | Senior Accountant | 115 | *ddickinson@montmgmt.com* |
| Kniffin, Carolyn | Stop-Loss Auditor | 116 | *ckniffin@montmgmt.com* |
| Landis, Becky | Claims Coordinator | 102 | *blandis@montmgmt.com* |
| Luciany, Stephanie | Underwriting Coordinator | 123 | *sluciany@montmgmt.com* |
| McCarthy, Anne Marie | President and CEO | 105 | *amccarthy@montmgmt.com* |
| McLoughlin, Joanne | Senior Stop-Loss Auditor | 129 | *jmcloughlin@montmgmt.com* |
| Mecke, Fay | Vice President of Claims | 117 | *fmecke@montmgmt.com* |
| Sardinia, Ted | Vice President of Sales | | *tsardinia@montmgmt.com* |
| Schneider, Lisa | Senior VP of Underwriting | 100 | *lschneider@montmgmt.com* |
| Staab, Carrie | Chief Underwriting Officer | 120 | *cstaab@montmgmt.com* |
| Weakland, Michelle | Senior Stop-Loss Auditor | 106 | *mweakland@montmgmt.com* |

MONTGOMERYMANAGEMENT

# CLAIM DOCUMENTATION GUIDE

## Please include the following information with ALL requests for reimbursement:

~ **Copies of EOB'S MUST be included and attached to the bills they pertain to**

~ **Enrollment Card**
**Must be signed and dated**
**(If effective date does not correspond with the plan's waiting period please have the group's authorized representative explain eligibility. This may be done by completing an eligibility form.**

~ **Proof deductible and co-insurance were met for all calendar years involved**

**This may include:**

1. **RIP report**
2. **Copies of EOB's showing the deduction**

## Please included the following information when applicable:

~ **Last day worked AND date returned to work dates. Please confirm the eligibility wording in the plan document is consistent with the way the individual is being covered as specified by employer group.**

**How coverage continued or is continuing during the absence, such as:**

1. **COBRA**
   **ALL documentation, including but not limited to:**
   1. **Certified letter offering cobra**
   2. **Signed cobra election form**
   3. **Proof Cobra premiums are paid**
2. **FMLA**
   **Copy of application**
3. **LEAVE OF ABSENCE**
   **Copy of application**

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**~ Pre-X Information including but not limited to:**

1. **Pre-X Investigation (All documentation is required for Montgomery Management's records)**
2. **Certificate of Creditable Coverage**

**~ Large Case Management**
**(All potential high dollar diagnosis' should be assessed for large case management, see Potential High Dollar Diagnosis form)**

1. **All large case management reports**

**~ Pre-Certification Information - as required by the plan**
**MUST come from pre-certification company**

**~ Other Insurance Information**
**This information may include but is not limited to the following:**

1. **Recent form signed and dated by employee showing no other insurance on claimant**
2. **Complete name, address & phone number of other employer and copy of waiver**
3. **Divorce decree or court order stating who must cover dependent in the case of a divorce, single parents or guardianship**

**~ Home Health Care/Skilled Nursing**

1. **Physician orders with length and duration**

**~ Accident/Injury Details**
**This may include but is not limited to the following:**

1. **When, where AND how accident/injury occurred (written statement signed by the insured)**
2. **Signed and dated subrogation agreement (for each accident)**
3. **Police report**
4. **Copy of Auto Policy declaration page**
5. **EOB's showing payments made by auto carrier ( we will offset by auto carrier payments)**

**~ Therapy (Speech, Occupational, and Physical)**

1. **Physician orders with length and duration**

**~ Durable Medical Equipment**

1. **Physician orders including time frame**
2. **Purchase price of each item**

MONTGOMERYMANAGEMENT

# Initial Specific Excess Claim Request for Reimbursement

Submission #1

Group Name: ______________________________

Policy Year: ______________ Contract Type: ______________

**Claimant Information**

Employee Name: ______________ Social Security #: ______________

Effective Date: ______________ Date of Birth: ______________

How is employee currently being covered: Active _____ Retired _____ COBRA ______

Leave of Absence _____ Other _____ If not active, please provide last date worked: _______

Claimant Name: ______________ Relationship: ______________

Effective Date: ______________ Date of Birth: ______________

Diagnosis: ______________ Prognosis: ______________

Large Case Management: _____ Yes ______ No Large Case Manager: ______________

Date Claim Met Specific Deductible: ______________ Estimated Amount to Reserve: __________
(Expected Future Claims)

The following information must be provided in order to consider claim for reimbursement:

1. **ELIGIBILITY**
   A. Enrollment Card
   B. Eligibility Documentation (i.e. COBRA documentation, including but not limited to, certified letter offering Cobra, signed election form with Cobra effective date and proof Cobra premiums paid)
2. **ALL CORRESPONDENCE IN RELATION TO CLAIM**
   A. Pre-Ex Information or HIPPA certificate
   B. Large Case Management Reports
   **C.** Pre-certification Information
   **D.** Medical Records (if available)
   **E.** Other insurance Information
3. **CLAIMS**
   A. Complete Itemized Bill
   (please note it is required that all bills are date stamped)
   B. Copy of EOB's and checks attached to the bills they pertain to
   **Please contact Montgomery Management if you are unable to obtain a discount on a hospital bill.**

**Amount Paid** ______________

**Specific Deductible** ______________

**Amount Requested** ______________

TPA Name: ______________________________

Address: ______________________________

______________________________

Phone: ______________ Fax: ______________

Submitted by: ______________ Date: ______________
(please print)

# Large Case Management

Below is a list of situations that may require Large Case Management. If you have a claimant that falls into one of these catagories please have their case assessed for LCM.

1. Home Uterine Monitoring/Terbutaline Infusion Therapy

2. Home IV/Infusion Therapy (i.e., Antibiotics, TPN, Chemotherapy, Narcotics, Enteral, etc…)

3. Private Duty Nursing

4. Extensive Durable Medical Equipment

5. Inpatient Rehabilitation, Psychiatric, Chemical Dependency, and Skilled Nursing Facility Confinements.

6. Home Health Care beyond 3 weeks

7. Hospitalizations beyond 2-3 weeks

8. Any situation in which the TPA feels Case Management intervention would be helpful.

The next page contains a list of potential high dollar claims. You should notify Montgomery Management when you encounter any of these diagnoses. If it is apparent claims will reach the specific deductible level; Large Case Management should be activated.

When Large Case Management is implemented please forward us all documentation on the case when you receive it.

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## Potential High Dollar Diagnoses

Montgomery Management should be contacted immediately if you receive notification of any of the diagnoses listed below. Notification includes, but is not limited to, pre-certification, benefits verification or provider bills.

1. TRANSPLANT/DIALYSIS PATIENTS
   - -Heart Transplant
   - -Liver Transplant
   - -Bone Marrow Transplant
   - -Organ Rejection
   - -Cardiomyopathy
   - -Biliary Aresia
   - -Renal Failure
2. NEONATAL PATIENTS
   - -Premature Birth
   - -Hydrocephalus
   - -Respiratory Distress and in ICU for over one week
   - -Meningiomyelocele
   - -Bronchopulmonary Dysplasia
   - -Major or Multiple Congenital Anomaly
3. OBSTERICAL PATIENTS
   - -Expected Multiple Births of 3 or more Infants
   - -Previous History of Neonatal ICU confined Infant
   - -Toxemia (Hypertension) requiring hospitalization
4. NEUROLOGICAL PATIENTS
   - -Brain Tumor
   - -TIA (Transient Ischemic Attack)
   - -Closed Head Injury
   - -Unconsciousness (any cause)
   - -Cerebral Aneurysm or AV Malformation
   - -Meningitis or Encephalitis
   - -Reye's Syndrome
   - -Anoxic Encephalopathy
   - -Guillain-Barre
   - -Quadriplegia
   - -Paraplegia
   - -Chronic Stroke
   - -M.S., A.L.S
   - -Alzheimer's Disease
5. TRAUMATICALLY INJURED PATIENTS
   - -Thermal Burns or Frostbite (child over 10%; adult over 20%)
   - -Crush Injuries
   - -Amputations
   - -Multiple Trauma or Fractures
6. PSYCHO-NEUROTIC IMPAIRMENTS
   - -Anorexia Nervosa
   - -Adolescent Adjustment
   - -Manic depression; (bipolar disorder)
   - -Schizophrenia
   - -Sexual Abuse
   - -Depression with or without suicide attempt
7. CARDIOVASCULAR CONDITION
   - -Ruptured Abdominal Aortic Aneurysm
   - -MI (Heart Attack)
   - -Cardiac Bypass
   - -Intractable Angina
   - -Peripheral Vascular Disease with pending amputation
8. RESPIRATORY CONDITION
   - -Respirator Dependency
   - -Emphysema
   - -Chronic Bronchitis or Asthma
9. MALIGNANCY PATIENTS
   - -Multiple Surgeries
   - -Radiation Treatments
   - -Cancer in Children
   - -Chemotherapy
   - -Acute Leukemia
   - -Aplastic Anemia
   - -Kaposi's Sarcoma
10. OTHER DIAGNOSIS
    - -AIDS
    - -Cystic Fibrosis
    - -Muscular Dystrophy
    - -Cerebral Palsy
    - -Lupus
    - -Loss of Sight or Hearing
    - -Diabetes with Complications
    - -Chronic Gastro-Intestinal

MONTGOMERYMANAGEMENT

# SPECIFIC CLAIM ELIGIBILITY FORM

Please have this form completed in full by an authorized representative of the employer group. This form should be submitted when the claimant's original effective date differs from the effective date listed on the enrollment card.

Today's Date: ____________________________________________

Employer Group: ____________________________________________

Employee Name: ____________________________________________

Date of Employment: ________________________________________

Original Effective Date of Employee:_____________________________________
(Day/Month/Year)

A specific claim was submitted to Montgomery Management. In order to process this claim we will need the following information:

1. Time taken off work by employee for this accident/illness. (Please be specific.)
   ____________________________________________________________________
   ____________________________________________________________________

2. How was the employee covered by your plan for the above dates:
   ____________________________________________________________________
   ____________________________________________________________________

3. When did the employee return to a full-time active employment?
   ____________________________________________________________________

4. If the employee did not return to full-time status please provide continuation of coverage documentation.

If the Specific Claim is on a dependent, please provide the following information:

Claimant Name: ___________________________________________________________

Date of Enrollment: ___________________ Effective Date: _____________________

________________________________________ Date: _______________________
(Authorized Employer Signature/Title)

MONTGOMERYMANAGEMENT

# Supplemental Specific Excess Claim Request for Reimbursement

Submission # _______________
Specific Advancement _________
Final _______

**NOTE**: Specific advances must exceed $1,000.00 unless it is the final submission.

Group Name: ______________________________________________

Policy Year: ________________ Contract Type: ____________________

**Claimant Information**

Employee Name: ____________________ Date of Birth: ______________

Claimant Name: ____________________ Date of Birth: ______________

Diagnosis: ____________________ Prognosis: ______________
Large Case Management: _____ Yes ______ No Large Case Manager: __________

Estimated Amount to Reserve: ___________
(Expected Future Claims)

Amount Requested: ___________

The following information must be provided in order to consider claim for reimbursement:

1. Complete Itemized Bill
(please note it is required that all bills are date stamped)
2. Copy of EOB's and checks attached to the bills they pertain to

**Please contact Montgomery Management if unable to obtain discount on the hospital bill.**

TPA Name: ______________________________________________

Address: ______________________________________________

______________________________________________

Phone: ____________________ Fax: ____________________

Submitted by: ______________________________ Date: __________
(please print)