



Dear Third Party Administrators:

Enclosed please find all the forms necessary for filing specific and aggregate claims with Montgomery Management.

- A List of Potential High Dollar Diagnoses.
- An Advance Notice of Excess Claim Report.
- An Initial Specific Excess Claim Request for Reimbursement.
- A Supplemental Specific Excess Claim Request for Reimbursement.
- A Specific Claim Eligibility Form.
- An Aggregate Excess Insurance Monthly Claims Report (This report should be submitted monthly for all groups with aggregate coverage).

** Please use photocopies of these forms for claim submissions. **

We also have attached our phone directory for your convenience. Should you have any questions regarding the completion of these forms, please call us at 1-800-883-1500.

Thank you,

Fay Mecke
Vice President of Claims



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: _____



Company Directory

Name	Title	Extension	Email
Burton, Niambi	Claims Coordinator	104	<i>nburton@montmgmt.com</i>
Clark, Amy	Underwriting Coordinator	131	<i>aclark@montmgmt.com</i>
Cooper, Chris	Executive Vice President of Sales	110	<i>ccooper@montmgmt.com</i>
Derstine, Christine	Contracts Coordinator	101	<i>cderstine@montmgmt.com</i>
Dickinson, Donna	Senior Accountant	115	<i>ddickinson@montmgmt.com</i>
Gallagher, Samantha	Underwriting Manager	111	<i>sgallagher@montmgmt.com</i>
Landis, Becky	Stop-Loss Auditor	102	<i>blandis@montmgmt.com</i>
Luciany, Stephanie	Underwriter	123	<i>sluciany@montmgmt.com</i>
McCarthy, Anne Marie	President	105	<i>amccarthy@montmgmt.com</i>
McLoughlin, Joanne	Senior Stop-Loss Auditor	129	<i>jmcloughlin@montmgmt.com</i>
Mecke, Fay	Vice President of Claims	117	<i>fmecke@montmgmt.com</i>
Murphy, Irene	Underwriting Coordinator	113	<i>imurphy@montmgmt.com</i>
Sardinia, Ted	Vice President of Sales	130	<i>tsardinia@montmgmt.com</i>
Schneider, Lisa	Senior VP of Underwriting	100	<i>lschneider@montmgmt.com</i>
Staab, Carrie	Chief Underwriting Officer	120	<i>cstaab@montmgmt.com</i>
Weakland, Michelle	Senior Stop-Loss Auditor	106	<i>mweakland@montmgmt.com</i>

137 S. Main Street | North Wales, PA 19454
Phone: (215) 793-0313 | Toll-free: (800) 883-1500 | Fax: (215) 793-0535
info@montmgmt.com | www.montmgmt.com



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 include 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

- ~ 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 diagnoses 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



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

Amount Paid: _____

Specific Deductible: _____

Amount Requested: _____

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.

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 categories, 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.



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



Corresponding ICD-9 Codes List

<u>001-139</u>	<u>Infectious and Parasitic Diseases</u>	480-486	Pneumonia
038-038.9	Septicemia	490-496	Chronic Obstructive Pulmonary Disease (COPD), etc.
042	AIDS / HIV	515	Postinflammatory Pulmonary Fibrosis
070-070.9	Viral Hepatitis	518-518.89	Pulmonary Collapse and/or Respiratory Failure
<u>140-239</u>	<u>Neoplasms</u>	<u>520-579</u>	<u>Diseases of the Digestive System</u>
140-149.9	Malignant Neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx	555-555.9	Regional Enteritis (Crohn's Disease)
150-150.9	Malignant Neoplasm of Esophagus	560.0-560.9	Intestinal Obstruction
151-151.9	Malignant Neoplasm of Stomach	562.1	Diverticulitis of Colon
153-153.9	Malignant Neoplasm of Colon	567-567.9	Peritonitis
154-154.8	Malignant Neoplasm of Rectum	569.0-569.9	Other Disorders of Intestine
155-155.2	Malignant Neoplasm of Liver	570-571.9	Liver Diseases and Cirrhosis
157-157.9	Malignant Neoplasm of Pancreas	572.8	Other Sequela of Chronic Liver Disease
161-161.9	Malignant Neoplasm of Larynx	573-573.9	Other Liver Disorders
162-162.9	Malignant Neoplasm of Lung	577-577.9	Pancreas Diseases
170-170.9	Malignant Neoplasm of Bone	578-578.9	Gastrointestinal Hemorrhage
174-174.9	Malignant Neoplasm of Female Breast	<u>580-629</u>	<u>Diseases of the Genitourinary System</u>
179-182.8	Malignant Neoplasm of Uterus or Cervix	584-584.9	Acute Renal Failure
183-183.9	Malignant Neoplasm of Ovary	585	Chronic Renal Failure
185	Malignant Neoplasm of Prostate	586	Renal Failure, Unspecified
186-186.9	Malignant Neoplasm of Testis	588	Disorders resulting from impaired renal function
188-189.9	Malignant Neoplasm of Bladder, Kidney, Urinary	592	Calculus of Kidney & Ureter
191-191.9	Malignant Neoplasm of Brain	<u>630-677</u>	<u>Complications of Pregnancy, Childbirth</u>
192-192.9	Malignant Neoplasm of Nervous System	641.1	Placenta Previa
194-194.9	Malignant Neoplasm of Endocrine Glands	642.5-642.7	Eclampsia, pre-eclampsia
195-195.8	Malignant Neoplasm of Other Ill-Defined Sites	644.0-644.2	Premature Labor
196-196.9	Secondary Malignant Neo. Lymph Nodes	648.0	Gestational Diabetes
197-197.8	Secondary Malignant Neo. Respiratory and Digestive Systems	651	Multiple Gestation
198-198.89	Secondary Malignant Neo. Other Specified Sites	654.5	Cervical Incompetence
200-208.9	Lymphoma and/or Leukemia	<u>710- 739</u>	<u>Diseases of the Musculoskeletal System and Connective Tissue</u>
235	Neoplasm Uncertain Behavior	715.0-715.9	Osteoarthritis
239.2	Neoplasm Unspecified Nature – Bone, Skin	721.3	Lumbosacral Spondylosis
<u>240-279</u>	<u>Endocrine, Nutritional, Metabolic, Immunity</u>	722.0-722.9	Intervertebral Disc Disorders
250-250.9	Diabetes	730-730.9	Osteomyelitis and/or Periostitis
277.0	Cystic Fibrosis	737.3	Kyphoscoliosis and scoliosis
278.0	Obesity/Hyperalimant	<u>740-759</u>	<u>Congenital Anomalies</u>
<u>280-289</u>	<u>Diseases of the Blood and Blood-Forming Organs</u>	747.2	Aortic Atresia / Stenosis
282.6	Sickle-Cell Anemia	751.6	Biliary Atresia
284.9	Aplastic Anemia NOS	759-759.9	Other and Unspecified Congenital Anomalies
286-286.9	Coagulation Defects and/or Hemophilia	<u>760-779</u>	<u>Conditions Originating in the Perinatal Period</u>
<u>320-389</u>	<u>Diseases of the Nervous System and Sense Organs</u>	765-765.1	Prematurity
330	Cerebral degenerations	769	Respiratory Distress Syndrome
344.0-344.09	Quadriplegia and Quadripareisis	770.0-770.9	Other Respiratory Conditions of Newborn
331.0-331.9	Reye's Syndrome	<u>780-799</u>	<u>Symptoms, Signs, and Ill-Defined Conditions</u>
344.1	Paraplegia	785-785.9	Symptoms Involving Cardiovascular System
348.0-348.9	Encephalopathy	786.5-786.59	Chest Pain
357, 358	Neuropathy / Myasthenia Gravis	<u>800-999</u>	<u>Injury and Poisoning</u>
<u>390-459</u>	<u>Diseases of the Circulatory System</u>	800-804.9	Fracture of Skull
410-410.9	Acute Myocardial Infarction	805-805.9	Fracture of Vertebral Column
411-411.89	Acute and Subacute Ischemic Heart Disease	806-806.9	Fracture of Vertebral Column with Spinal Cord Injury
414-414.05	Coronary Atherosclerosis (ASHD)	828-828.1	Multiple Fractures
415-415.19	Acute Pulmonary Heart Disease	853-854.1	Intracranial Injury
416-416.9	Chronic Pulmonary Heart Disease	869-869.1	Internal Injury
417.1	Aneurysm of Pulmonary Artery	887-887.7	Traumatic Amputation of Arm and Hand
421-421.9	Acute and Subacute Endocarditis	897-897.7	Traumatic Amputation of Leg
424-424.9	Valve Disorders	949-949.5	Burns
425-425.9	Cardiomyopathy	952-952.9	Spinal Cord Injury
426-426.9	Conduction Disorders	996-997.0	Complications peculiar to certain specified conditions
427-427.9	Cardiac Dysrhythmias	V23	Supervision of High Risk Pregnancy
428-428.9	Heart Failure	V42 – V58.9	Transplants, etc
430, 431	Subarachnoid / Intracerebral Hemorrhage		
434.9	Occlusion of Cerebral Arteries		
436	Acute Cerebrovascular Accident (CVA)		
440-441.9	Atherosclerosis / Aortic Aneurysm		
<u>460-519</u>	<u>Diseases of the Respiratory System</u>		



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: _____

(Authorized Employer Signature/Title)

Date: _____



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)