# Year-End Aggregate Reimbursement Notice Claim Form

Tokio Marine HCC – A&H Group
225 Town Park Drive, Suite 350
Kennesaw, Georgia 30144
800-447-0460

**Stop Loss Carrier (Please check one):**

☐ HCC Life Insurance Company ☐ Lasso Healthcare Insurance Company

| | | | | | |
|---|---|---|---|---|---|
| Policyholder: | | | | | |
| Contract Basis: | | Effective Date: | | Expiration Date: | |

## Attachment Point

| | |
|---|---|
| A. Minimum Attachment Point: | $ |
| B. Annual Attachment Point (calculated): | $ |

| | |
|---|---|
| Total Paid Claims: | $ |
| Less Attachment Point (greater of A or B): | $ |
| Less claims exceeding Specific Deductible/Loss Limit: | $ |
| Less previous Monthly Accommodations: | $ |
| Less ineligible claims: | $ |
| Total amount of accommodation requested: | $ |
| Reimbursement request: | $ |
| Refund due Stop Loss Carrier: | $ |

## Include the following information/documentation with your request:

1. Paid Claims Report showing the member name, incurred date, charge amount, payment date, payment amount with check numbers.
2. Eligibility listing which identifies birth date, effective date, termination date and coverage type.
3. Proof of Funding (i.e. bank statement, or funding statement). Monthly statements should include one month following the policy expiration date.
4. Void/Refund report/RX Rebates
5. Benefit/Service Code report
6. Year-End Aggregate Report
7. Specific Report showing claimants that have exceeded the Specific Deductible/Loss Limit.
8. Payments made outside the Aggregate Contract (i.e. Dental, Weekly Income, Vision, PPO Fees, Medical Record Fees and Prescription Administration)
9. Check Register for the policy period.
10. Outstanding overpayment and Subrogation log
11. If RX is covered under the Aggregate Contract, provide RX detailed report from pharmacy vendor with supporting invoices.
12. Email **ALL** claim requests and documents to: stoplossaggregate@tmhcc.com

## Please read the following before signing:

I hereby certify that, to the best of my knowledge, after reasonable inquiry (1) that the information stated herein is correct; (2) that the claims have been processed and is eligible in accordance with the Medical Benefit Plan; (3) that all the indicated expenses have actually been unconditionally paid on behalf of the Plan as required by the Stop Loss Policy.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material 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.

A notice of a claim must be submitted within 90 days after the last date for which Plan Benefits can be reimbursed under the terms of the Policy. The failure to submit a completed claim to TMHCC within 180 days, will be denied, weather or not the delay has prejudiced TMHCC.*

*Claims Filing provisions may vary by state. See policy for applicable requirements.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Claims Administrator: | | | | | | | |
| Email: | | Phone #: | | | | | |
| Address: | | City: | | State: | | Zip: | |
| Name: | | Title: | | Date: | | | |