HMO Excess Reimbursement Request

☐ Initial Submission ☐ Subsequent Submission

Plan: _____

Reinsurance Carrier: _____ Agreement Year: _____

Claims Basis: _____

HMO Federal Tax ID number: _____

Member's Name: _____ SS #: _____

Claimant: _____ DOB: _____ Relationship: _____

Effective Date: _____ Termination Date: _____

Type of Plan: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other_____

Type of Coverage: ☐ HMO ☐ PPO ☐ POS ☐ Other _____

Diagnosis: Primary Code: _____ Description: _____

Secondary Code: _____ Description: _____

COB/TPL: _____ Accident? ☐ Yes ☐ No

COMPLETE THE FOLLOWING:

A) Dates of Service: From: _____ To: _____

B) Total Eligible Charges: $ _____

C) Specific Deductible: $ _____

D) Coinsurance Percentage: _____ %

E) Reimbursement $ _____

NOTE: CLAIM REQUEST CANNOT BE PROCESSED WITHOUT THE FOLLOWING REQUIRED ITEMS: **PLEASE BE SURE ALL COPIES ARE LEGIBLE.**

1) Documentation of both the member's and claimant's eligibility.
2) When needed, copies of bills and/or medical records may be requested.

I certify that, to the best of my knowledge, the above information is correct and that there have been no other reimbursements made by any other entity for these expenses.

By: _____ Title: _____ Date: _____

Company: _____

Address: _____

Phone: _____ FAX: _____ E-mail: _____

Please submit to:

IOA Re, LLC
Cathy Washburn
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East Norriton, PA 19401