PROVIDER EXCESS REIMBURSEMENT REQUEST – HOSPITAL

☐ Initial Submission ☐ Subsequent Submission

Policyholder: _____

Policy Number: _____ Insurance Carrier: _____

Policy Holder Federal Tax ID Number _____

Policy Period: _____ Claims Basis: _____

Member's Name: _____ Member ID# _____

Managed Care Affiliation: _____

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 the member's & 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.

Submitted by: _____ Date: _____

Company: _____

Address: _____

Phone: _____ FAX: _____ E-mail: _____

Please Submit to:

IOA Re, LLC
Cathy Washburn
MCClaims@ioare.com
190 West Germantown Pike, Suite 200
East Norriton, PA 19401