Swiss Re
Corporate Solutions

Dear Valued Partner:

Please take a few minutes to review the contents of our Administrative Services Only (ASO) Claims Kit. It provides key instructions for identifying and reporting specific and aggregate claim information to Swiss Re Corporate Solutions as well as information relative to expedited reimbursements.

General Information & Instructions:

- Filing deadlines: All requests for reimbursement for specific claims should be filed within 30 days of the known loss. Aggregate claims or accommodations should be filed within 30 days of the accommodation month or end of the policy period. In no event will Swiss Re reimburse claims submitted more than one year after the Expiration Date of the policy.
- Swiss Re recommends ACH for all claim reimbursements. This allows for the safest and fastest method of reimbursement to our mutual clients. Please see the ACH form within this kit.
- If there is a claim refund due back to Swiss Re, please forward to the attention of our Accounting Department at the following mailing address:
  Swiss Re Corporate Solutions
  2 Waterside Crossing, Suite 200
  Windsor, CT 06095
- Swiss Re has designated e-mail addresses for reporting information. PLEASE USE THE CORRECT ADDRESS as follows:
  - All notifications, trigger diagnosis, LCM reports, pre-certification reports, etc. should be sent to: RS_notifications@swissre.com
  - All requests for reimbursement for BOTH specific and aggregate coverage should be sent to: RS_Claims@swissre.com
  - Aggregate reports should be sent to: RS_aggreports@swissre.com. Aggregate reports are only required upon the following events:
    - At the end of the policy period
    - At the renewal of the policyholder's contract
    - At point of request for aggregate claim or accommodation reimbursement

Included in this Claims Kit is the following:

For Specific Coverage:

- Administrative Services Only - Claim Filing Requirements
- Administrative Services Only - Claim Request Form
- Excel Import - Format Requirements
- Notification Form
- ICD-10 Codes for Trigger Notification
- ACH - Form

For Aggregate Coverage:

- Standard requirements for Aggregate Accommodation and Aggregate claim submission
- Aggregate Claim Submission - Form
- Aggregate Report – Sample Form

Please contact us with any questions or concerns you may have. We look forward to our continued relationship with you.

Aimee Fagan
Head NA A&H Claims
1-856-446-9773
Aimee_Fagan@swissre.com

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Administrative Services Only - Claim Filing Requirements

In an effort to provide superior customer service to our mutual clients, Swiss Re Corporate Solutions has simplified our Specific Claim filing requirements for our ASO partners.

These include:

1. **ASO Claim Request Form –** this provides all employer, employee and claimant information we will need in order to determine claimant eligibility. Please be sure this is completed in its entirety to ensure prompt claims service.
2. **Paid Claim Report –** preferred report should be in Excel format, as detailed within this kit. See Excel Import - Format Requirements on subsequent page. [The Paid Report must at a minimum provide claimant name or other identifier, dates of service, paid amount and paid date.]
3. **Copies of bills** for any hospital bill over $250,000 and ancillary provider bills over $100,000 and RX drug names for drugs over $5,000. Applicable Pre-certs should be sent if available.
4. **Submit All Claim Documentation to RS_Claims@swissre.com.**

Claim Notification Procedures:

1. **ASO Notification Claim Form** – any large dollar claim (50% of the specific deductible) or key diagnosis claim should be sent to Swiss Re Corporate Solutions. Please submit the appropriate completed form to RS_notifications@swissre.com.
2. **Provide Details on key diagnoses** – see ICD-10 for Complete List. We must be notified on all cancer, hepatitis C, Dialysis, significant cardiac claims including LVAD, all transplant and large specialty drug claims.

Contact Information:

RS_Claims@swissre.com

1-816-235-3700

Swiss Re Corporate Solutions

ADMINISTRATIVE SERVICES ONLY - REQUEST FOR REIMBURSEMENT

Initial Request ☐ Subsequent Request ☐

REQUIRED INFORMATION

Employer Name:

Policy Period: Employee Name:

Claimant Name: Claimant DOB: Diagnosis (ICD-10):

Total Amount Paid Specific Deductible

Amt Requested This Claim:

ADDITIONAL INFORMATION (Optional)

Date of Hire: Original Effective Date:

Last Day Worked **Work Status** **Date**

Return to Work Active

Leave of Absence From To Retired

FMLA Date From To Leave

STD From To Terminated

LTD From To COBRA Eff. Date

Premiums PTD From To

Medicare Eff Date A/B

Dialysis 1st Date

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE UNDERLYING PLAN DOCUMENT.

Contact Name: Company:

Email/Phone:

Signature: Date:

Phone: 1-816-235-3700

RS_Claims@swissre.com

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Excel Import - Format Requirements

Below is a list of the required fields, required field names, a description of the fields and the format of the field. By receiving claims in this format, Swiss Re Corporate Solutions will be able to directly import your paid claims report into our system. This allows for maximum efficiency in the reimbursement process.

Column Name	Description	Format
ClaimantFirstName	Claimant 1st Name	Alpha
ClaimantLastName	Claimant Last Name	Alpha
EmployeeCode	Employee Code	Numeric
ProviderNumber	Provider Tax ID Number	Numeric
ClaimNumber	Claim Number	Numeric
Provider	Name of Provider	Alpha
ServiceDateFrom	Date of Service From	xx/xx/xxxx
ServiceDateTo	Date of Service To	xx/xx/xxxx
ClaimReceiptDate	Date Claim Received	xx/xx/xxxx
PaidDate	Date Claim was Paid	xx/xx/xxxx
ICD9	Diagnosis Code	xxx.xx
BilledAmount	Amount Provider Billed	Currency; 2 decimal
PPO Discount	Amount of PPO Discount	Currency; 2 decimal
Negotiated Discount	Amount of Negotiated Disc.	Currency; 2 decimal
CoPayment	CoPay Amount this Claim	Currency; 2 decimal
Other	Other Deductions this Claim	Currency; 2 decimal
Deductible	Deductible Applied this Claim	Currency; 2 decimal
Coinsurance	Coinsurance Applied this Claim	Currency; 2 decimal
Paid Amount	Amount Paid this Claim	Currency; 2 decimal
Service Type	Type of Service Provided	2 Letter Alpha
CPTCode	CPT Code	5 Digit Numeric
CheckNo	Check Number or ACH Number	Numeric

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ADMINISTRATIVE SERVICES ONLY - NOTIFICATION FORM

50 % Notice ☐ LCM Info/Pre-Cert ☐

REQUIRED INFORMATION

Employer Name:

Policy Period: Employee Name:

Claimant Name: Claimant DOB: Diagnosis (ICD-10):

Total Amount Paid Specific Deductible

Additional Claim Detail:

Optional for Notifications

Date of Hire: Original Effective Date:

Last Day Worked **Work Status** **Date**

Return to Work Active

Leave of Absence From To Retired

FMLA Date From To Leave

STD From To Terminated

LTD From To COBRA Eff. Date

Premiums PTD From To

Medicare Eff Date A/B

Dialysis 1st Date

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE UNDERLYING PLAN DOCUMENT.

Contact Name: Company:

Email/Phone:

Signature: Date:

Phone: 1-816-235-3700

RS_Claims@swissre.com

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ADMINISTRATIVE SERVICES ONLY **REQUEST FOR REIMBURSEMENT**

EXPEDITED REIMBURSEMENT

Initial Request: _____
Subsequent Request: _____

rs_Claims@swissre.com

REQUIRED INFORMATION

Employer Name: _____

Policy Period: _____ Claims Paid Through Date: _____

Employee Name: _____

Claimant Name: _____

Claimant DOB: _____ Diagnosis: _____

Total Amount Paid: _____ Specific Deductible: _____

Amt Requested This Claim: _____

ADDITIONAL INFORMATION (Required)

Date of Hire: _____ Original Effective Date: _____

Last Day Worked: _____ **Work Status:** **Date:**

Return to Work: _____ Active _____

Leave of Absence From _____ To _____ Retired _____

FMLA Date From _____ To _____ Leave _____

STD From _____ To _____ Terminated _____

LTD From _____ To _____ COBRA Eff. Date _____

Premiums PD From _____ To _____ COBRA Event: _____

Medicare Eff Date _____ A/B _____ COBRA Premiums PD _____

Dialysis 1st Date _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE UNDERLYING PLAN DOCUMENT.

Contact Name: _____ Company: _____
Email/Phone: _____
Signature: _____ Date: _____

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ICD-10-CM Diagnosis Codes for Disclosure Notification

This list should be referred to for completion of trigger notifications. Please send notice for all plan participants who have been diagnosed or treated for any of the code ranges listed under the following categories:

A00-B99 Certain infectious and parasitic disease

A40	Streptococcal sepsis
A41	Other Sepsis
B15-B19	Viral hepatitis
B20	Human immunodeficiency virus [HIV] disease

C00-D49 Neoplasms

C00-C96	Malignant neoplasms
D46	Myelodysplastic syndromes

D50-D89 Diseases of the blood and blood-forming organs & disorders involving the immune mechanism

D57	Sickle-cell disorders
D59	Acquired hemolytic anemia
D60-D64	Aplastic and other anemias
D65-D69	Coagulation defects, purpura and other hemorrhagic conditions
D70-D77	Other diseases of blood and blood-forming organs
D80-D89	Certain disorders involving the immune mechanism

E00-E89 Endocrine, nutritional and metabolic diseases

E10-E13	Diabetes mellitus
E15-E16	Other disorders of glucose regulation and pancreatic internal secretion
E65-E68	Obesity and other hyper alimentation
E70-E89	Metabolic disorders

F01-F99 Mental, Behavioral and Neurodevelopmental disorders

F10.1	Alcohol Abuse
F11.1	Opioid Abuse
F20	Schizophrenia
F31	Bipolar Disorder
F32.3	Major depressive disorder, single episode, severe with psychotic feature
F33.1-F33.3	Major Depressive Disorder, recurrent
F84.0	Autistic Disorder
F84.2	Rett's Syndrome
F84.5	Asperger's syndrome

G00-99 Diseases of the nervous system

G00	Bacterial Meningitis
G04	Encephalitis Myelitis and Encephalomyelitis.
G06-G07	Intracranial and intraspinal abscess and granuloma
G12.21	Amyotrophic Lateral Sclerosis
G35	Multiple Sclerosis
G36	Other Acute Disseminated Demyelination
G37	Other Demyelinating disease of central nervous system
G82.5	Quadraplegia
G83.4	Cauda Equina Syndrome
G92	Toxic Encephalopathy
G93.1	Anoxic Brain Injury

I00-I99 Diseases of Circulatory System

I20	Angina Pectoris
I21.09-I22	Acute myocardial infarction
I24	Acute and Subacute Ischemic Heart Disease
I25	Chronic ischemic heart disease
I26	Pulmonary embolism
I27	Other pulmonary heart disease
I28	Other diseases of pulmonary vessels
I33	Acute & Subacute Endocarditis
I34-I38	Heart Valve Disorders
I42-I43	Cardiomyopathy
I44-I45	Conduction Disorders
I46	Cardiac Arrest
I47-I49	Cardiac Dysrhythmias
I50	Heart Failure
I60-161	Subarachnoid Hemorrhage / Intercerebral Hemorrhage
I63	Cerebral infarction
I65.8-I66	Occlusion of Precerebral /Cerebral Arteries
I67	Other cerebrovascular disease
I70	Atherosclerosis / Aortic Aneurysm

J00-J99	**Diseases of Respiratory System**
J40-J44	Chronic Obstructive Pulmonary Disease (COPD)
J84.10-J84.89	Postinflammatory Pulmonary Fibrosis
J98.11-J98.4	Pulmonary Collapse / Respiratory Failure

K00-K95	**Diseases of Digestive System**
K22	Esophageal obstruction
K25-K28	Ulcers
K31	Other diseases of stomach & duodenum
K50	Crohn's disease
K51	Ulcerative colitis
K55-K64	Diseases of intestine
K65-K68	Diseases of peritoneum & retroperitoneum
K70-K77	Diseases of liver
K83	Diseases of biliary tract
K85-K86	Diseases of pancreatitis
K90-K95	Other diseases of digestive system/Complications of bariatric procedures

M00-M99	**Diseases of Musculoskeletal System & Connective Tissue**
M15-M19	Osteoarthritis
M32	Systemic lupus erythematosus
M34	Systemic sclerosis
M41	Scoliosis
M43	Spondylolysis
M50	Cervical disc disorders
M51	Thoracic, thoracolumbar & lumbosacral intervertebral disc disorders
M72.6	Necrotizing Fasciitis
M86	Osteomyelitis

N00-N99	**Diseases of the Genitourinary System**
N00-N01	Acute and Rapidly Progressive Nephritic Syndrome
N03	Chronic Nephritic Syndrome
N04	Nephrotic Syndrome
N05-N07	Nephritis and Nephropathy
N08	Glomerular Disorders classified elsewhere
N17	Acute Kidney Failure
N18	Chronic Kidney Disease (CKD)
N19	Renal Failure, Unspecified

O00-O9A	**Pregnancy, childbirth and the puerperium**
O09	High Risk Pregnancy
O11	Pre-Existing Hypertension with Pre-Eclampsia
O14-O15	Pre-Eclampsia and Eclampsia
O30	Multiple Gestation
O31	Other complications specific to Multiple Gestations

P00-P96	**Certain conditions originating in the perinatal period**
P07	Disorders of newborn related to short gestation and low birth weight
P10- P15	Birth Trauma
P19	Fetal distress
P23-P28	Other respiratory conditions of newborn
P29	Cardiovascular disorders originating in the perinatal period
P36	Bacterial sepsis of newborn
P52-P53	Intracranial hemorrhage of newborn
P77	Necrotizing enterocolitis of newborn
P91	Other disturbances of cerebral status newborn

Q00-Q99	**Congenital malformations, deformations and chromosomal abnormalities**
Q00-Q07	Congenital malformations of the nervous system
Q20- Q26	Congenital Cardiac malformations
Q41-Q45	Congenital Anomalies of Digestive system
Q85	Phakomatoses, not classified elsewhere
Q87	Congenital malformation syndromes affecting multiple systems
Q89	Other Congenital malformations

R00-R99	**Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified**
R07.1-R07.9	Chest Pain
R40-R40.236	Coma
R57-R58	Shock, Hemorrhage
R65.2-R65.21	Severe sepsis

S00-T88	Injury, Poisoning and Certain Other Consequences of External Causes
S02	Fracture of skull and facial bones
S06	Intracranial injury
S07	Crush injury to head
S08	Avulsion and traumatic amputation of part of head
S12-S13	Fracture and injuries of cervical vertebra and other parts of neck
S14.0-S14.15	Injury of nerves and spinal cord at neck level
S22.0	Fracture of thoracic vertebra
S24	Injury of nerves and spinal cord at thorax level
S25	Injury of blood vessels of thorax
S26	Injury of heart
S32.0-S32.2	Fracture of lumbar vertebra
S34	Injury of lumbar and sacral spinal cord and nerves
S35	Injury of blood vessels at abdomen, lower back and pelvis
S36-S37	Injury of intra-abdominal organs
S48	Traumatic amputation of shoulder and upper arm
S58	Traumatic amputation of elbow and forearm
S68.4-S68.7	Traumatic amputation of hand at wrist level
S78	Traumatic amputation of hip and thigh
S88	Traumatic amputation of lower leg
S98	Traumatic amputation of ankle and foot
T30-T32	Burns and corrosions of multiple body regions
T81.11-T81.12	Postprocedural cardiogenic and septic shock
T82	Complications of cardiac and vascular prosthetic devices, implants and grafts
T83-T85	Complications of prosthetic devices, implants and grafts
T86	Complications of transplanted organs and tissue
T87	Complications to reattachment and amputation

Z00-Z99	Factors Influencing Health Status and Contact with Health Services
Z37.5-Z37.6	Multiple births
Z38.3-Z38.8	Multiple births
Z48-Z48.298	Encounter for aftercare following organ transplant
Z49	Encounter for care involving renal dialysis
Z94	Transplanted organ and tissue status
Z95	Presence of cardiac and vascular implants and grafts
Z98.85	Transplanted organ removal status
Z99.1	Dependence on respirator
Z99.2	Dependence on dialysis

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ACH Claim Payment Authorization

Policyholder name, *as it appears on the W9*:

Name of authorized policyholder representative:

The ACH payment will be sent to the following account:

Bank name: Savings Checking

Bank Address:

Account holder name:

9 Digit Routing number: Account number:

Claim payment details will be provided to the entity or individual submitting the claims to Swiss Re Corporate Solutions America Insurance Corporation (AIC). Additionally, I authorize the following to receive such details, including Personal Health Information (PHI). *Please complete an additional form if other recipients are to be included.*

Producer contact(s) authorized to receive Personal Health Information (PHI):

Name: Name:

Title: Title:

Email: Email:

TPA name:

Policyholder contact(s) authorized to received Personal Health Information (PHI):

Name: Name:

Title: Title:

Email: Email:

As an authorized representative for the above-listed Policyholder, I give express permission for Swiss Re Corporate Solutions America Insurance Corporation (AIC) to utilize ACH wire transfers for the reimbursement of claims. By signing and submitting this form, the Policyholder agrees it is obligated to timely provide AIC with any changes to its account information or other designations above. *Please note, signature must be completed by a Policyholder contact, Administrator representative signatures will not be accepted.*

Authorized Policyholder Contact Signature: Date:

For any questions contact our Technical Accounting team via AH_Accounting@swissre.com or your assigned Account Manager.

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Standard Requirements for Aggregate Claim Submission

The following listing is required for all Aggregate claims. Requirements for Aggregate Accommodations are identified with a designated (A). Some aggregate claims will be audited by a contracted outside auditor. You will be notified of those situations, and additional information may be requested for those audits. The standard information is as follows:

1. A completed Aggregate Claim Submission Form (A)
2. Final or Monthly Aggregate Report (A)
3. **Please reduce the requested amount by 25% of the Rx Spend from your monthly accommodation calculation for RX Rebates (A)**
4. Attachment point calculation (A)
5. Check register
6. Paid Claim Detail Report (A) – Should include the following information:
    a. Claimant name
    b. Claim number
    c. Billed Amount
    d. PPO Discounts
    e. Employee Responsibility (coinsurance, co-pay, or deductibles)
    f. Any Other Deductions
    g. Paid Amount
    h. Provider name
    i. Incurred dates of service
    j. Paid date
7. Rx Detail Report by Claimant with drug name listed, ingredient cost, dispensing fee, co-pays, and any administrative fees (A)
8. Rx Invoices that support the amount submitted under the aggregate
9. Schedule of Rx Rebates – even if the group isn't the ultimate recipient. Rebates are refunds and not reimbursed per the policy. An estimate of 25% of Paid Rx Claims can be used in lieu of actual rebates if not yet known. (A)
10. Benefit Code Analysis (A)
11. Policy year eligibility listing with effective dates, term dates and COBRA status
12. Bank Statements – to show proof of adequate claim funding throughout the policy period
13. Calculation of specific claims (A)
14. Voids/Refunds/Reissued Claims
15. Outstanding over-payments
16. Description of the funding process and any vendors used to issue payment
17. Listing of any subrogation cases pertaining to the policy period

(A) = Required for aggregate accommodation. At the end of the policy period, all accommodations are subject to a complete audit.

Please send to: RS_Claims@swissre.com

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Aggregate Claim Submission Form

Carrier:

Employer Name:

Policy Period:

Total Paid Claims Under the Policy:	
Less: Specific Claims Paid or Payable:	
Less: Ineligible or Extra-Contractual Claims:	
Less: Refunds, Recoveries, and Voids:	
Less: Outstanding Overpayments:	
Less: Any Other deductions:	
Less: Attachment Point (will be the higher of the Minimum Attachment Point* or the Year-to-date attachment point):	
Less: Any previous advancement/accommodations:	
Amount Requested:	

*Refer to policy for definition of Minimum Attachment Point

Completed by: Completed Date:

Phone: Email:

Please send to: RS_Claims@swissre.com

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Swiss Re Corporate Solutions SAMPLE MONTHLY AGGREGATE REPORT

TPA:

MINIMUM ATTACHMENT POINT:

CARRIER:

MONTHLY AGGREGATE FACTOR: Single Family Composite

POLICYHOLDER:

AGGREGATE CONTRACT BASIS:

AGGREGATE PERIOD:

COVERAGES: Med Rx Dental Other

Month & Year	# Single	# Family	Monthly Aggregate Attachment Point	Year to Date Aggregate Attachment Point	Gross Monthly Paid Claims	Gross Year To Date Paid Claims	Out of Contract Payments	Adjustments: Void or Returned Checks	Specific Excess Claim Payments	Net Adjusted Monthly Paid Claims	Year to Date % Over / Under Agg. Att. Pt.

*Please indicate the % of Claims vs. the Aggregate Attachment Point in the last column

Please submit all monthly aggregate reports to: RS_aggreports@swissre.com (*aggregate reports only)*