Swiss Re
Corporate Solutions

Phone: 1-913-676-5200
RS_Claims@swissre.com

Request for Reimbursement

Initial Claim   Supplemental Claim #   Advanced Claim   Other

Employer name:

Policy number: Policy period: Plan type:

Employee name: Employee ID: Employee D.O.B.:

Employee effective date: Hire date: Termination date:

Last day worked: COBRA date: Premium paid to:

Current status: Lifetime maximum paid to date:

Claimant name: Claimant D.O.B.:   Relationship:

Claimant effective date:

Diagnosis/ICD-10:

Prognosis:

Case Management   Yes   No   Vendor:

Total amount paid last year
Total eligible benefits this submission
Less specific deductible
Balance
Percent to be reimbursed
Reimbursement requested
Estimated future liability

Your reimbursement request should include the following information (if applicable)*:

Enrollment form (initial/current)	Precertification forms	Pre-Existing
COBRA election form/payments	Hospital bills over $250,000	LCM reports
EOBs/claim detail report	Ancillary bills over $100,000	Subrogation
Deductible/coinsurance proof	Worker compensation	Accident details/police reports
Continued eligibility	Coordination of benefits	

* Additional information may be required depending upon the nature of the claim request.

TPA/Company name:

Address:

Contact: Title:

Phone: Ext.:

Email: Fax:

Authorized signature   Date:

I certify that the above information is correct and that the claims have been paid in accordance with the plan document.