



INTERNATIONAL SPECIALTY UNDERWRITERS

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SPECIFIC STOP-LOSS NOTICE OF POTENTIAL CLAIM

Group Policyholder: _____

Contract Period: _____ Contract Basis: _____

Employee Name: _____ EE DOB: _____

Social Security #: _____

Employee' Original effective date: _____

Employee status: Active Retired Disability COBRA Deceased

Claimant Name: _____ DOB: _____

Claimant's effective date: _____

Other coverage: COB Medicare W/C Third Party Liability

Date of first claim: _____

Admission & discharges dates of hospitalizations: _____

Are hospital charges subject to any negotiated or pre-arranged discounts? _____

If yes, please indicate type of arrangement and anticipated discounts: _____

Diagnosis: _____

If dx is ESRD provide the Effective date of Medicare: _____

Prognosis and anticipated treatment plan: _____

Has Large Case Management been implemented? _____ Vendor Name: _____

Total Paid to Date for this Claim: \$ _____ Paid through: _____

Estimated future costs: \$ _____

Administrator's Name: _____

Address: _____

Telephone Number: _____ **Fax Number:** _____

Print Contact Name: _____ **Date:** _____