CLEAR FORM

ONE80 INTERMEDIARIES
Vista Underwriting

Specific Excess Loss Notification Form

Date: _____ ☐ Initial Claim Filing ☐ Subsequent Claim – Filing # _____

☐ Specific Advanced Payment

NOTE: Prior to submitting a claim, a Potential Specific Excess Loss Notification must have been completed and sent to Vista to properly reserve for this claim. If the Notification is on file, we can proceed on this claim.

Elegibility Section (On Subsequent Claims Only Complete * Items)

*Contractholder: _____

	*Covered Person	*Claimant
○ *Name:		
○ Gender/Relation:	/	/
○ DOB:		
○ Effective Date:		
○ Termination Date:		
○ COBRA Effective:		
○ Actively at Work:		
○ Full time Student:		

Excess Loss Section

Carrier: _____ Contract Number: _____ Contract Year: _____

Specific Deductible: $ _____ Current Contract Basis: _____

Claim Information (On Subsequent Claims Only Complete * Items)

Dates: ○ First DOS: _____ ○ First Received: _____ ○ First Admit: _____

Other Coverage: ☐ Yes* ☐ No

*If Yes, include information: ☐ COB ☐ TPL ☐ W/C ☐ Medicare ☐ Other: _____

*Case Mgmt Co: _____ *Contract: _____ *Phone: _____

PPO(s): _____

*Diagnosis (use ICD-9 & Description): _____

*Status: _____

*Prognosis: _____

*Comments: _____

*Date: _____ *Contractholder: _____

*COVERED PERSON: _____ *CLAIMANT: _____

(Continue on Page 2)

Fraud Compliance Notice: "Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

"California Residents: for your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison." Per California Insurance Code Section 1871.2

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Specific Excess Loss Notification Form

Excess Loss Claim Information (On Subsequent Claims Only Complete * Items)

*Total Benefits Paid: $ _____

*Less Specific Deductible: $ _____

*Balance: $ _____

Deductions (On Subsequent Claims Only Complete * Items)

*Benefit %: $ _____

*Total Prior Reimbursements: $ _____

*Reimbursement Requested: $ _____

*Est. Future Expenses: $ _____

Please include LEGIBLE copies of the following (12) items:

- ☐ Enrollment information sufficient to document the covered person and claimant's effective date.
- ☐ Document the covered person and claimant met eligibility requirements of the Plan at the time of claim. (i.e. Payroll records indicating hours worked, COBRA election form & premium payment records, etc.).
- ☐ *Copies of the itemized provider billings (on bills greater than $10,000 or $100,00 for hospital billings).
- ☐ *Copies of the Explanation of Benefits on all claims paid.
- ☐ *Copies of the check registers or other reporting showing check numbers and the date claims have been paid.
- ☐ If the deductible and co-insurance were previously met, please document.
- ☐ Document there was no other insurance available to the claimant at the time of the claim (COB).
- ☐ All medical records obtained through pre-existing investigations, when appropriate.
- ☐ *Operative reports and the calculation of the reasonable and customary fees.
- ☐ Document accident details and subrogation agreements, when appropriate.
- ☐ *Prognosis and an estimation of outstanding liabilities and/or future expenses.

*Completed by (signature): _____ *Date: _____

*Administrator Name: _____ *Phone: _____

If you are e-mailing this form, please send to: claims@vistaunderwriting.com

If you are mailing a hard copy of this form, please send to the following:
One80 Intermediaries l Vista Underwriting, Rose Tree Corporate Center, Building II, Suite 4050,
1400 N. Providence Road, Media, PA 19063, ATTN: Claims Department

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