ONE80 INTERMEDIARIES

Medical Stop Loss

CLAIMS KIT & ADMINISTRATIVE GUIDELINES

Excess Loss Notifications and Claim Reimbursement Submissions

For more information visit:
www.**One80**.com

V042025

Administrative Guidelines

Excess Loss Notifications and Claim Reimbursement Submissions

WELCOME TO ONE80 INTERMEDIARIES

The Claims Kit emphasizes the importance of consistent and effective communication between the Claims Administrator for a Benefit Plan and One80 Intermediaries. In the kit there is information on the One80 Medical Stop Loss Claims Team and procedures for submitting a Specific or Aggregate Excess Loss Claim for reimbursement.

INTRODUCTION

The Claims Kit is provided to you as a guide. If you are uncertain about any of the information given, or have any questions, please contact our office at 610-566-1666.

✓ Corporate Office Address:

One80 Intermediaries | Medical Stop Loss
18 Campus Blvd. Suite 208,
Newtown Square, PA 19073

Contact:

Joanne McLoughlin I VP of Claims
e: jmcloughlin@one80.com
t: 484-448-6180
f: 610-566-4877

✓ Premium, Policy Issue and Compliance Office:

One80 Intermediaries | Medical Stop Loss
18 Campus Blvd. Suite 208,
Newtown Square, PA 19073

Contact:

Michelle Heffernan I VP of Operations
e: mheffernan@one80.com
t: 484-448-6078
f: 610-566-4877

CONTACT INFORMATION

✓ **Information on Claim Issues:**

Call or Email:

Joanne McLoughlin I VP of Claims
e: jmcloughlin@one80.com
t: 484-448-6180
f: 610-566-4877

✓ **Additional Claims Kits or Claim Forms Issues:**

Call or Email:

One80 Medical Stop Loss Claims Department
e: ESLClaims@one80.com
t: 610-566-1666
f: 610-566-4877

✓ **Submission of Potential Specific Excess Loss Claim Notifications and Monthly Aggregate Excess Loss Reports:**

If you are e-mailing your submission, please send to:

One80 Medical Stop Loss Claims Department
e: ESLClaims@one80.com

If you are mailing a hard copy of your submission, please send to the following:

One80 Intermediaries l Medical Stop Loss
18 Campus Blvd. Suite 208,
Newtown Square, PA 19073
ATTN: CLAIMS DEPARTMENT

✓ **Submission of Specific Excess Loss Claim and Aggregate Excess Loss Claim:**

If you are e-mailing your submission, please send to:

One80 Medical Stop Loss Claims Department
e: ESLClaims@one80.com

If you are mailing a hard copy of your submission, please send to the following:

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18 Campus Blvd. Suite 208,
Newtown Square, PA 19073
ATTN: CLAIMS DEPARTMENT

Potential Large Loss Notification

An important responsibility of the Claims Administrator for an employer sponsored Benefit Plan which includes a Specific Excess Loss contract is the timely notification to One80 of any claimant who may have a potentially large claim.

A potentially large claim is any covered individual whose total paid claims are EXPECTED to exceed 50% of the Specific Excess Loss Deductible or who has a diagnosis that is identified on the Trigger Diagnosis List following this page.

Typically, potential large claimants are identified two ways:

1. **By Diagnosis**

   Identification of a potential large claim can be made through a request for eligibility or benefit verification for a serious diagnosis, or through the process of pre-admission certification, utilization review, or large case management. Such potential claims can also be identified by review of the claim and diagnosis when the claims are submitted for adjudication.

   If pre-admission certification, utilization review, or large case management is performed by a third party, please advise the contracted medical management firm of the importance of receiving immediate notification of an admission, outpatient procedure or request for sub-acute care.

   Submission of a "POTENTIAL SPECIFIC EXCESS LOSS NOTIFICATION" form is required when the covered person is diagnosed with any of the conditions listed on page seven.

2. **By Amount Paid**

   The terms of the Excess Loss contract require that you complete the "POTENTIAL SPECIFIC EXCESS LOSS NOTIFICATION" form when the total amount paid on a claimant has reached 50% of the Specific Excess Loss Deductible, regardless of the diagnosis.

   IMPORTANT: Providing this information to One80 as early as possible enables us to advise, direct, and make available to you, the administrator, and our mutual clients, technical and financial resources to assist in the management and adjudication of large claims.

Trigger Diagnosis List

Administrators are required to notify One80 of potentially large claimants who are diagnosed with any of the following conditions or are receiving any of the listed types of care or recommended for any of the listed procedures. To assist in the identification of potential large claims, the following list is provided.

ACCIDENTS
- Head & Spinal Cord Injury
- Burns Requiring Hospitalization:
  (2nd or 3rd degree covering 10% or more of the body)
- Traumatic Head/Brain Injury/Spinal Cord Injury
- Multiple Crushing Injuries and/or Fractures

AIDS/HIV/RELATED DISORDERS

AMPUTATIONS (Major Extremities)

BLOOD DISORDERS
- Aplastic Anemia
- Hemophilia
- Thrombocytopenia

CANCER

CARDIAC
- Cardiomyopathy
- Congestive Heart Failure

CEREBRAL VASCULAR ACCIDENT

CONGENITAL DEFECTS
- Brain
- Spinal Cord
- Nervous System
- Vessels
- Kidney
- Chromosome
- Cystic Fibrosis
- Cerebral Palsey

DIABETES MELLITIS (with Complications)

HOSPITAL STAYS
- 14 days or more
- Multiple admissions in 12-month period

GENE THERAPY

GROWTH HORMONE THERAPY

INFECTIOUS DISEASES
- Tuberculosis
- Septicemia
- Bacterial Meningitis
- Osteomyelitis

I.V. THERAPY
- Enzyme Replacement
- Home I.V. Therapy
- Antibiotic Therapy
- TPN/TPA

KIDNEY FAILURE (End Stage Renal Disease)
- Dialysis

MECHANICAL ASSISTANCE DEPENDENCY
- Apnea Monitors
- Ventilators
- Any Other Conditions Requiring Mechanical Assistance to Sustain Life

NEWBORN WITH COMPLICATIONS
- Extreme Immaturity
- Birth Trauma
- Respiratory Distress or Disorders
- Congenital Anomalies

NEUROLOGICAL DISORDERS
- Amyotrophic Lateral Sclerosis (ALS)
- Muscular Dystrophy
- Stroke
- Multiple Sclerosis (MS)

OBSTETRICAL COMPLICATIONS
- High Risk Pregnancies
- Expected Multiple Birth (of 3 or More Infants)

PSYCHIATRIC (resulting in Hospital Confinement)

SEVERE RESPIRATORY CONDITIONS

SICKLE CELL ANEMIA

TRANSPLANTS
- Major Organs
- Bone Marrow
- Stem Cell
- Any Complications Thereof/Post transplant patients

OTHER
- Patients in Medical Case Management
- Patients Requiring Skilled Nursing Facilities, Home Health Care, Hospice, Daily Private Nursing
- Fibromyalgia and Other Fatigue/Stress Conditions
- Chronic Pain Management
- Interim Hospital Billings
- Intensive Levels of Home Health Care Supplies and/or Service

Instructions for filing notices for Potential Claims and requests for reimbursement of Specific Excess Loss Claims

The following guidelines and claim forms are to be used when reviewing and reporting Specific Excess Loss Claims:

1. **Trigger Diagnosis List**
   Used as a guideline to identify covered individuals who represent potential ongoing claims and/or potentially large claims.

2. **Potential Specific Excess Loss Claim Notifications Form**
   To be sent as an initial notification:
   a. When claimant diagnosis is listed on the Trigger Diagnosis List included in this Claims Kit.
   b. When claimant total paid claims exceeds 50% of the Specific Excess Loss Deductible, regardlessof the diagnosis.

   If you are e-mailing your submission, please send to:
   ESLClaims@one80.com

   If you are mailing a hard copy of your submission, please send to the following:
   One80 Intermediaries l Medical Stop Loss
   18 Campus Blvd. Suite 208,
   Newtown Square, PA 19073
   ATTN: CLAIMS DEPARTMENT

   NOTES:
   a. Do not attach any copies of incurred or paid claims including any bills or other documentation.
   b. Attach copies of Utilization Review records if applicable (confidential).

3. **Update of Potential Specific Excess Loss Claim Notification Form**
   To be sent each month, once an initial notification has been filed.

   If you are e-mailing your submission, please send to:
   ESLClaims@one80.com

   If you are mailing a hard copy of your submission, please send to the following:
   One80 Intermediaries l Medical Stop Loss
   18 Campus Blvd. Suite 208,
   Newtown Square, PA 19073
   ATTN: CLAIMS DEPARTMENT

   NOTES:
   a. Do not attach any copies of incurred or paid claims including any bills or other documentation.
   b. Attach copies of Utilization Review records if applicable (confidential).
   c. Do not continue to submit once Specific Excess Loss Claim Form is submitted.

Instructions for filing notices for Potential Claims and requests for reimbursement of Specific Excess Loss Claims

(CONTINUED)

4. **Specific Excess Loss Claim Form (Note: Form is 2 pages)**

To be sent:

a. When a claim has exceeded the specific deductible.
b. When submitting a subsequent claim for additional expenses on same claimant.
   i. Attach legible copies of any bills paid.
   ii. Include proof of check being issued as payment.
   iii. Include incurred and paid ranges for the claims listed.
   iv. Calculate expected Excess Loss reimbursement.
   v. Attach copies of Utilization Review records if applicable (confidential).
   vi. Be sure to include the 12 items listed at the bottom of the Claim Form.

If you are e-mailing your submission, please send to:

ESLClaims@one80.com

If you are mailing a hard copy of your submission, please send to the following:

One80 Intermediaries l Medical Stop Loss
18 Campus Blvd. Suite 208,
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Potential Specific Excess Loss Notification Form

☐ Notice filed based on Diagnosis ☐ Notice filed as 50% of the Specific Deductible

Elegibility Section

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

Case Mgmt Co: _____ Contract: _____ Phone: _____

PPO(s): _____

Diagnosis (use ICD-9 & Description): _____

Status: _____

Prognosis: _____

Comments: _____

Payment Information

Charges RECEIVED to Date: $_____ Charges PAID to Date: $_____

Charges UNPROCESSED to Date: $_____

Completed by (signature): _____ Date: _____

Administrator Name: _____ Phone: _____

***** THIS NOTIFICATION DOES NOT CONSTITUTE A CLAIM FILING *****

If you are e-mailing this form, please send to: ESLClaims@one80.com

If you are mailing a hard copy of this form, please send to the following:

One80 Intermediaries l Medical Stop Loss

18 Campus Blvd. Suite 208, Newtown Square, PA 19073, ATTN: Claims Department

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." Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.* ******NOTICE – See State-Specific Fraud Notices included.******

*"**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*
If you are a California resident, you have certain rights under California privacy laws regarding your personal information. To view your rights, please review our California Privacy Notice and Notice at Collection located at www.fslins.com

Update of Potential Specific Excess Loss Notification Form

☐ Based on Diagnosis ☐ Based on Amount Paid ☐ No Activity to Report

Contractholder Name: _____

Covered Person: _____

Claimant Name: _____

Social Security #: _____

Prior Notification Date: _____

Charges RECEIVED to Date: $_____

Charges PAID to Date: $_____

Charges UNPROCESSED to Date: $_____

Diagnosis: _____

Current Status: _____

Prognosis: _____

Comments: _____

Completed by (signature): _____ Date: _____

Administrator Name: _____ Phone: _____

***** THIS NOTIFICATION DOES NOT CONSTITUTE A CLAIM FILING *****

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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 One80 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)

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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: ESLClaims@one80.com

If you are mailing a hard copy of this form, please send to the following:

One80 Intermediaries l Medical Stop Loss

18 Campus Blvd. Suite 208, Newtown Square, PA 19073, ATTN: Claims Department

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." Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.* ******NOTICE – See State-Specific Fraud Notices included.******

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Aggregate Excess Loss Claims Reporting

If you purchase Aggregate Stop loss Insurance, an AGGREGATE EXCESS LOSS MONTHLY CLAIMS REPORT must be completed and submitted each month. One80 utilizes this report to monitor your claims activity for any potential aggregate losses.

The initial month shown on the report (see below) should match the first month covered by the Contract (i.e., If the Contract became effective May 1, the first report would reflect activity for May).

Aggregate Excess Loss Monthly Claims Report

One80 requires Aggregate Excess Loss Reporting on a monthly basis. To identify the data to be reported we have developed a template in Excel titled "Aggregate Excess Loss Monthly Reporting" which is included in the email sent to you. Once saved on your computer the Aggregate Excess Loss Monthly Reporting template can be accessed and/or updated regularly for each client, and submissions can be e-mailed to One80.

Please note that if you have a format you currently use that captures the same data required by One80, you may submit your report in that format.

If you are e-mailing your submission, please send to:

ESLClaims@one80.com

If you are mailing a hard copy of your submission, please send to the following:

One80 Intermediaries l Medical Stop Loss
18 Campus Blvd. Suite 208,
Newtown Square, PA 19073
ATTN: CLAIMS DEPARTMENT

Aggregate Excess Loss Claim Filing

The following information is required to file an Aggregate Claim:

1. AGGREGATE EXCESS LOSS CLAIM FORM
2. An AGGREGATE PAID CLAIM REPORT completed in its entirety (See the separate EXCEL template used to track claims monthly).
3. Enrollment/eligibility records for all covered employees, dependents, and COBRA participants. (Note: For COBRA participants, documentation of premium payments must also be included in this submission.)
4. Monthly Excess loss premium billing statements beginning on the effective date of the contract through the present, to verify reported census and adjustments.
5. Financial records documenting the funding of claims during the Contract period, including a reconciled bank statement for each month of the Contract period.
6. Monthly check registers for each month of the Contract period through present.
7. A paid benefit analysis report to confirm payments for out-of-contract approvals, medical records fees, and administration fees; also a detailed Claims Paid History Report.
8. Documentation regarding voids and refunds processed during and after the Contract period, but relating to payments made during the Contract period.
9. A copy of the procedures utilized for handling claims with potential subrogation or third party liability and a listing of any such claims currently in progress.
10. Details of identified overpayments for this Contract period that are still outstanding.
11. Monthly prescription drug card statements, if applicable.

Additional information may be identified and required. One80 will advise you of these requests as they arise.

If you are e-mailing your submission, please send to:

ESLClaims@one80.com

If you are mailing a hard copy of your submission, please send to the following:

One80 Intermediaries | Medical Stop Loss
18 Campus Blvd. Suite 208,
Newtown Square, PA 19073
ATTN: CLAIMS DEPARTMENT

Aggregate Excess Loss Claim Form

Date: _____ ☐ Aggregate Accommodation # _____ ☐ Year End Filing

Contractholder: _____ Contract Period: _____

Carrier Name: _____ Contract No.: _____

Aggregate Basis: _____ Min Attach. Point: _____

Aggregate Factors: ◦ Single: $ _____ ◦ Family: $ _____ ◦ Composite: $ _____

Total Claims Paid in Contract period:		$ _____
Claims in Excess of the Specific:	-	$ _____
Claims NOT Eligible to the Aggregate:	-	$ _____
Net Eligible Claims Paid YTD:	=	$ _____

Less Attachment Point:

Attachment point is greater of:

a) YTD amount based on Census

b) Minimum Attachment Point - $ _____

Claims Exceed Attachment Point: = $ _____

Less Previously Filed Amounts: - $ _____

Amount Requested: **$** _____

Completed by (signature): _____ Date: _____

Administrator Name: _____ Phone: _____

SEND AGGREGATE EXCESS LOSS CLAIM FORM to:

If you are e-mailing this form, please send to: ESLClaims@one80.com

If you are mailing a hard copy of this form, please send to the following:

One80 Intermediaries l Medical Stop Loss

18 Campus Blvd. Suite 208, Newtown Square, PA 19073, ATTN: Claims Department

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If you are a California resident, you have certain rights under California privacy laws regarding your personal information. To view your rights, please review our California Privacy Notice and Notice at Collection located at www.fslins.com

Required Notification

ONE80 MUST BE NOTIFIED, if you receive notice of representation from an attorney, a lawsuit, or an appeal for the denial of a claim that was filed as part of a Specific or Aggregate Excess loss Claim with One80, you must immediately notify the Medical Stop Loss Claims Department at One80.

Please have all related information and documentation available when contacting One80.

If you are e-mailing, please send to:

ESLClaims@one80.com

If you are mailing a hard copy, please send to the following:

One80 Intermediaries l Medical Stop Loss
18 Campus Blvd. Suite 208,
Newtown Square, PA 19073
ATTN: CLAIMS DEPARTMENT

Help Us Help You

Enrollment Information should include:

- ✓ Employee name, date of hire, and effective date;
- ✓ Employee birth date;
- ✓ Claimant's effective date;
- ✓ Claimant's birth date;
- ✓ Current COB information pertaining to the spouse and any eligible dependent 18 years or older;
- ✓ If the claim is for an employee who missed work due to an illness, we must have documentation of the time off to confirm continued eligibility under the Plan (see One80 Eligibility Form attached).
- ✓ Complete COBRA information including verification of the event that triggered continuation of coverage, as well as, proof of timely application and continued payment under the plan.

Generally, this information is included with many initial claim submissions, and we sincerely appreciate receiving this information timely.

Accidents:

- ✓ Complete details to include: the date, where and how the accident occurred;
- ✓ If a third party may be liable, complete information relative to the Insurance policy including a copy of the policy, or details of coverage.
- ✓ A copy of the police report, if applicable; and,
- ✓ A copy of the signed Subrogation Agreement.

Medical Issues pertaining to experimental/investigational services or products:

- ✓ Case Management Reports; and/or,
- ✓ Complete copies of the research/investigation performed by the Claims Administrator in accordance with the parameters of the plan.
- ✓ For off-label chemotherapy treatment, if the plan allows treatment that is not FDA approved, a copy of the pertinent NCCN guideline, or other compendia used.

Streamlining Data Entry

One80 uses the David Young MGU System for processing claims. If the paid claims report is forwarded in Excel, the data will be able to be imported; thus, accurately re-creating the submission detail. If the paid claims report is not furnished in excel, enclosed is a listing of the items needed. We will forward a blank excel worksheet to initiate a data dump from your claims processing system to ours.

The items include:

- ✓ Social Security Number/ID number of the Claimant;
- ✓ Claimant First Name;
- ✓ Claimant Last Name;
- ✓ Employee Code;
- ✓ Claim Number;
- ✓ Provider;
- ✓ Service Date;
- ✓ Claim Receipt Date;
- ✓ Paid Date;
- ✓ ICD 9 Code;
- ✓ Billed Amount;
- ✓ Paid Amount;
- ✓ Service Type (lab, xray, out patient)
- ✓ CPT Code, Hospital Revenue Code, and/or HCPCS code;
- ✓ Check Number.

Please note changing your system generated paid claims report from Adobe to Excel may not be sufficient if the report does not list the data in columns. Also, it is not necessary that the columns appear in the order outlined above.

As you may notice the data listed above does not include all of the data items listed on a Detailed Total Paid Claims Report. With the varied plan types the import process captures only that data which is common to all plans.

Please contact Joanne McLoughlin if you should have any questions regarding this process. Her direct number is 484-448-6180 or feel free to email her at jmcloughlin@one80.com

Eligibility Verification Form

In order to provide the best possible service please complete all information in detail.
*This form is to be completed by the EMPLOYER.

Section A.

Employee Name: _____ ID #: _____

Employee Date of Birth: _____ Employee Date of Hire: _____

Original Date of Insurance: _____ Work Status: _____

Section B.

Please provide the last day the employee was actively-at-work (AAW) on a regular basis as defined by the Plan: _____

Return to work date: _____

Section C.

Has employement been terminated? ☐ Yes* ☐ No *If Yes, please give date and reason:

Is COBRA applicable? ☐ Yes* ☐ No *If Yes, please provide effective date: _____

(*If yes, please attach the election form and supporting documentation of paid premiums. Verification of other insurance may be needed for COBRA recipients.)

Section D.

Please indicate any dates the employee was absent during this claim period.
Specify the dates fo each absence and how elegibility was maintained:

	From	To	Total Time Used
Sick Leave Used:			
Vacation Time Used:			
FMLA:			
Other:			

IF the leave/absence was intermittent, please provide all start and end dates.
Please attach any and all documentation (e.g. time sheets).

Start date:	End date:
Start date:	End date:
Start date:	End date:

Section E.

If the employee had no absences during the reported claim period, please check here: ☐

Section F.

I confirm that to the best of my knowledge the above information is accurate and current.

Authorized Signature: _____ Title: _____

Name of Group: _____ Date: _____

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FRAUD WARNING NOTICE TO APPLICANT - PLEASE CAREFULLY READ THE FOLLOWING:

Rev 02/23

GENERAL FRAUD NOTICE: NOTE TO ALL PARTIES COMPLETING THIS FORM:
Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

CALIFORNIA FRAUD NOTICE:
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.

STATE FRAUD NOTICE: For the states of AL, AZ, AR, CO, DE, DC, FL, GA, IN, KS, KY, LA, MD, ME, NC, NE, NH, NJ, NM, OK, OR, PA, RI, TN, TX, VA, VT, WA and WV, please refer to the following fraud notices:	
Alabama	Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.
Arizona	For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana, Rhode Island, West Virginia	Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado	It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Delaware	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
District of Columbia	WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Georgia, Oregon, Vermont	Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
Indiana	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
Kansas	Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Maryland	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD WARNING NOTICE TO APPLICANT - PLEASE CAREFULLY READ THE FOLLOWING:

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STATE FRAUD NOTICE (CONTINUED):	
Maine, Tennessee, Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Nebraska	Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false, incomplete or misleading information is guilty of insurance fraud.
New Hampshire	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.
New Jersey	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New Mexico	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.
North Carolina	Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Texas	Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Virginia	Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Coordination of Benefits for Insurance Coverage Form

Primary Insurance Company Name: _____

NOTE: If you have other insurance in addition to your primary coverage, we will need your other insurance information to send to your primary insurance company. By coordinating benefits among all insurance carriers, you will receive the maximum benefits available. (*Required Fields)

PATIENT

*Name of Patient: _____ *Date of Birth: _____

INSURED

*Name of Insured: _____ *Phone #: _____

*Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Group or Claim #: _____

***Does the Patient have other insurance or Medicare Coverage?**

☐ YES » Continue with form ☐ NO » Go to *Signature section*

OTHER INSURANCE CARRIER

*Name of the Subscriber for the Other Insurance policy: _____

*Name of the Employer: _____

*Name of Other Insurance Carrier: _____

*Insurance Carrier Claim address: _____ Carrier Phone #: _____

*Policy #: _____ *Group #: _____

Beginning date of Coverage: _____ *End date of Coverage (if applicable): _____

*Other insurance covers? ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

PHARMACY

Pharmacy name: _____ Pharmacy phone #: _____

If the Patient has other coverage and is a child or dependent whose natural parents are divorced or not married and not living together, please complete the following. If there are multiple Patients, please complete a separate form for each Patient.

Name of Dependent(s): _____

Relationship of other insurance member to child: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other: _____

Child resides with: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other: _____

Person(s) with legal custody: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other: _____

(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." Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

*"**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 If you are a California resident, you have certain rights under California privacy laws regarding your personal information. To view your rights, please review our California Privacy Notice and Notice at Collection located at www.fslins.com*

Coordination of Benefits for Insurance Coverage Form

Is there a court decree that has assigned primary responsibility for health care coverage? ☐ Yes* ☐ No

- Relationship of party with decreed responsibility: ☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Other: _____
- Name of responsible party: _____
- Address: _____

Name and date of birth of both parents	
◦ Mother's name: _____	◦ Father's name: _____
◦ Date of Birth: _____	◦ Date of Birth: _____

MEDICARE

*Name of Individual Covered by Medicare: _____

*Medicare ID#: _____

Date of Birth: _____ Date of Retirement (if applicable): _____

*Medicare Part A effective date (if applicable): _____

*Medicare Part B effective date (if applicable): _____

*Medicare Part D Prescription Drug Coverage effective date (if applicable): _____

*Entitlement Reason:

- ☐ Age
- ☐ Disability Date disability began: _____
- ☐ End Stage Renal Disease: _____
- ☐ First date of dialysis: _____
- ☐ Kidney transplant date: _____

SIGNATURE: _____

*Insured or Patient Name (print): _____

*Signature of Insured or Patient: _____

*Date: _____

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ACH Form for Claim Reimbursement(s)

General Information

Date	
Policyholder Name	
Policy Number	
Financial Contact for Policyholder: Name	
Financial Contact for Policyholder: Phone # *(A verification call will be made to authenticate banking information)*	
Financial Contact for Policyholder: E-mail	
Contact Name to Receive ACH EOR Detail	
Contact Email to Receive ACH EOR Detail	
Contact Phone # to Receive ACH EOR Detail	

☐ Check box if the administrator holds the account on behalf of the policyholder

Bank Details

Bank Name	
Bank Address	
Bank Contact Name	
Bank Contact Phone Number	

Bank Account Name	
Bank Account Number	
Bank ABA Number	
Account Type:	

POLICYHOLDER APPROVAL:

_____

Officer Signature

_____

Printed Name/Title

_____

Date

Internal Use Only

Bank Approval/Date: _____

DYS Approval/Date: _____

System Update/Date: _____

Please return completed form to ESLFinance@one80.com

One80 Intermediaries l Medical Stop Loss, 18 Campus Blvd. Suite 208, Newtown Square, PA 19073
p: 610-566-1666 f: 610-566-4877

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