Evolution Risk Partners, LLC
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SPECIFIC STOP LOSS CLAIM FORM

☐ **Notification (50% or Trigger)** ☐ **Initial Request** ☐ **Supplemental** ☐ **Final** ☐ **Advance Funding** ☐ **Expedited**

Policyholder:			
Policy #		**Policy Year**	
Employee Name:		Claimant Name:	
Gender:	Date of Birth:	Gender:	Date of Birth:
EE's Hire Date:		Relationship to EE:	
Original Eff Date:		Original Eff Date:	
EE's last date of work:		EE's Date return to work:	

What is the employment status of this employee? Please check all that apply:

☐ Active	# of hours work/week:		as of		☐ Retired	Date of retirement:	
☐ Terminated	Termination Date:		Term Reason:				
☐ FMLA	From Date:		To Date:		RTW Date:		
☐ Other LOA	Specify type of leave:						
	From Date:		To Date:		RTW Date:		
☐ COBRA	Effective Date:		Term Date:		Premium paid through:		

Is claimant covered by any other coverage?	☐ No ☐ Yes	If yes, type of coverage:	
Effective date:	Termination date:	Medicare A ☐ B ☐	1st date of Dialysis:

Diagnosis:		Prognosis:	
Comments:			
Total TPA Paid for this submission:	$		
Total "Unpaid/Advance" for this submission:	$		
Subtotal:	$		
Less Specific Stop Loss Deductible/Laser:	$		
Less Aggregating Specific Deductible:	$		
Current Reimbursement Request:	$		

Were the claims related to injury: ☐ No ☐ Yes	Date of Injury:		If MVA, Auto Med Amount:	
Nature of Injury:				
Subrogation Applicable:	☐ No ☐ Yes Provide Details:			
(Accident details, signed subrogation form, attorney letter/contact information, copy of auto insurance policy, if applicable)				

YOUR REQUEST SHOULD INCLUDE COPIES OF THE FOLLOWING INFORMATION (IF APPLICABLE):

Enrollment/ Eligibility Documentation	Hospital Records
EOB/Claim Checks/Registers	Large Case Management Reports
Deductible/Coinsurance Proof of Satisfaction	Investigative Materials to Support Claim
Complete Paid Claims Detail/History Report	• COB (Current)
Itemized Bills	• Subrogation information
Precertification Forms	• Work Comp information
Hospital Audits/Reviews/Pre-Screens	• Accident Details (Police Report, etc.)

Claims Administrator:			
Completed by Authorized Name/Contact:			
Address:			
Phone:		**Email:**	

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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

SUBMIT TO: E-mail: claims@evolutionrisk.com
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