

**ASG Risk Management, Inc.**  
 Two Monument Sq., Ste. 520  
 Portland, ME 04101

Please fax completed form to: (207) 773-0044  
 Telephone No: 207-775-2332

**SPECIFIC EXCESS INSURANCE CLAIM  
 REIMBURSEMENT REQUEST**

Please check one: <input type="checkbox"/> Initial <input type="checkbox"/> Continuing
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Plan Sponsor: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Dependent Name: \_\_\_\_\_  
(if applicable)

**NOTE: This claim request cannot be processed without the following materials:**

- Copy of employee enrollment card, COB and Cobra (proof of payment) status
- All itemized bills, receipts, and statements, with copies of corresponding checks attached
- Claim summary/EOB
- Case Management notes and pre-certifications
- 50% Notification Form (if not already submitted)
- If available: Hospital discharge summary, medical records, Attending Physician's Statement, Hospital audit report

COMPLETE THIS SECTION FOR INTIAL CLAIMS ONLY	COMPLETE FOR CONTINUING CLAIMS
Incurral Dates: From _____ To _____	Total Previous of Requests: \$ _____
Benefits paid by Plan: \$ _____	Benefits Paid This Submission: \$ _____
Specific Deductible: \$ _____	Additional Amount Requested: \$ _____
Amount Requested: \$ _____	Advance Amount Requested: \$ _____
Advance Amount Requested: \$ _____	

I CERTIFY, TO THE BEST OF KNOWLEDGE AFTER REASONABLE INQUIRY, THAT THE INFORMATION I HAVE PROVIDED ON THIS FORM IS CORRECT, AND THAT THE CLAIM HAS BEEN PAID IN ACCORDANCE WITH THE PLAN SPONSOR'S PLAN DOCUMENT.

TPA: \_\_\_\_\_ Date: \_\_\_\_\_

Contact: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**FOR MANAGER USE ONLY:**

Details: \_\_\_\_\_ Amount Reimbursed: \_\_\_\_\_

Date: \_\_\_\_\_

Approved by: \_\_\_\_\_