Send to claims@iatmgu.com
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INTERNATIONAL ASSURANCE OF TN
A JENCAP® COMPANY

SPECIFIC STOP-LOSS CLAIMS

_____ Initial Claim _____ Supplemental Claim

Case:	
Policy Terms:	Policy Period:
Claimant Name:	DOB:
EE Name:	EE SSN:
Relationship:	Original Effective Date on the Plan:
Date Coverage Terminated or Last Date that EE Worked:	
Diagnosis/ICD9:	Prognosis:
Case Management? ☐ Yes ☐ No	
Case Manager's Name:	Case Manager's Phone:

Total Eligible Benefits This Submission: $ _____

Less Specific Deductible: $ _____

Reimbursement Requested: $ 0.00

IMPORTANT: OMISSION OF ANY OF THE FOLLOWING DOCUMENTATION, IF APPLICABLE, WILL DELAY REIMBURSEMENT.

COPIES OF: All charges that are part of this claim; enrollment form; COBRA election forms/payments; EOBs/ check copies or registers; itemized hospital bills if PAID amount is $350,000 or more; deductible/coinsurance proof; in-patient certifications; student status; pre-existing investigation; large case management reports; subrogation/accident details/police report; Medicare card.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

Submitted by: _____

TPA Company Name: _____

Address: _____

Phone: _____ Ext.: _____ Email: _____

Authorized Signature: _____ Date: _____

