National Underwriting Services, Inc.

14893 S. H. 16 North, Suite #1 Helotes, Texas 78023 (210) 695-2381 Fax (210) 695-2387

50% NOTIFICATION/SPECIFIC EXCESS LOSS CLAIM FORM

__ 50% Notification ___ Initial Claim ___ Supplemental Claim ___ Final Request

Employer/Group Name: ____

Current Policy Period: ______________________ Specific Deductible: ______________

Employee Information

Employee: __________________________ Social Security Number: ____________

Date of Birth: __________ Date of Hire: __________ Original Effective Date: __________

What is the employee's work status?

_____ Actively working the required number of hours per week to be considered full-time

_____ Retired (date retired: _____________) ___ Disabled

Coverage is being continued through the following:

_____ Leave of Absence _____ FMLA _____ Sick Time _____ Vacation Coverage Termination Date: __________

Is COBRA applicable? _____ Yes _____ No COBRA eff. date: _________ COBRA term. date: _________

Claimant Information

Name: ______________________________ Original effective date: __________

Date of Birth: ____________ Relationship to Employee: __________ Gender: _______

Is claimant covered by any other insurance (i.e., Worker's Compensation, Auto, and Group Plan)? _____ Yes _____ No

Effective Date: ________________ Carrier: __________________________

Claim Data

Requested Amount $__________________ TPA Paid to Date $____________________

Incurred Dates for this request: ____/____/____ To ____/____/____ Paid Dates: ____/____/____ To ____/____/____

Diagnosis Code: __________ Description: ______________________________

Was claimant listed on NUS Disclosure Statement? _____Yes _____ No If No, Why?____________________

Was patient I/P confined? _____Yes _____ No If Yes, list DOS and procedures: ____________________

Pre-Certification needed? _____Yes _____No If Yes, Enclosed? _____

Hospital Audit performed? _____Yes _____No If Yes, Enclosed? _____

Will this claim be Subrogated? _____Yes _____ No If Yes, Enclosed? If accident, please provide the complete accident details and a police report.

Is Pre-existing Condition applicable? _____ Yes _____ No If Yes, is HIPPA certification enclosed? ______

UR/LCM Information

Are Case Management services active? _____ Yes _____ No If Yes, Enclosed? _______

UR/LCM vendor name, address, contact name and phone number: ______________________________

Completed By: __________________ Phone Number: ______________ Date: __________

Failure to complete this form could delay claim payments.