# National Underwriting Services, Inc.

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## 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: ___________________________________________

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Completed By: ______________________________  Phone Number: ___________________  Date: ____________

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**Failure to complete this form could delay claim payments.**