



Preliminary Claim Unit Repricing
Cost Containment Referral Form

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

Group Name: \_\_\_\_\_ Policy Effective Date: \_\_\_\_\_ Contract Type: \_\_\_\_\_

Group's Specific Deductible \$ \_\_\_\_\_ Has the deductible been satisfied? Y  N

Employee Name: \_\_\_\_\_ Social Security Number ----- \_\_\_\_\_

Claimant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Claimant Effective Date \_\_\_\_\_ Claims Paid to date for this policy year \$ \_\_\_\_\_

Quick pay turnaround  Okay/Limits if any \_\_\_\_\_

Previous re-pricing attempt? \_\_\_\_\_

Reason for repricing: Minimal PPO Discount  Out of Network  Questionable charges  Other

Comments: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

From: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ x \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_
Contact Name Phone No. Fax No.

Third Party Administrators Name: \_\_\_\_\_

Street Address City State Zip Code

Please submit when claimant has reached or is above 75% of the Specific Deductible.

The Plan Administrator is obligated to adjudicate Plan claims subject to the applicable terms, conditions of the Plan Document, including but not limited to, member co-payments, deductibles, exclusions and other limitations. Consideration of reimbursement under the Stop Loss policy is subject eligibility, contract terms and disclosure.

Please email completed referral form to: Repricing Coordinator at
StopLossPCU@tmhcc.com
Please attach UB-04 and/or CMS 1500 form for prompt response

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