ORIEN
RISK ANALYSTS

SPECIFIC CLAIM PRELIMINARY NOTIFICATION

To Be Completed When Claims Exceed 50% Of the Specific Attachment Point

Date: _____

1. Name of Plan: _____ 2. Effective Date: _____

3. Claimant: _____ 4. Relationship to EE: _____

5. Name of Employee: _____ 6. EE ID No.: _____

7. Original Effective Date of Group Plan Coverage – Employee: _____ Claimant: _____

8. Effective Date of Stop Loss Policy: _____ 9. Specific Attachment Point: _____

10. Claimant has Incurred Expenses in the Amount of: $ _____

Total Claim Estimated to Reach: $ _____

11. Date of Loss: _____ 12. Claimant's Date of Birth: _____

13. Diagnosis: _____

14. Prognosis: _____

Other Pertinent Info: _____

15. Managed Care Involved? Yes ☐ No ☐

If Yes, Contact Name & Number: _____

16. Hospital Confinement? Yes ☐ No ☐ In Network? Yes ☐ No ☐

If Yes, Name of Hospital: _____

Completed by: _____

TPA: _____

Address: _____

Address: _____

Telephone: _____

Fax: _____

E-Mail: _____

Send Complete with Necessary Attachments to:

Orien Risk Analysts
3279 Veterans Memorial Highway
Suite D-9
Ronkonkoma, NY 11779
T: (631) 467-3901
F: (631) 467-1862
claims@orienrisk.com

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Ed. 2019