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: _____

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) 67-1862
claims@orienrisk.com

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