SPECIFIC CLAIM

Request for Reimbursement / Advance Proof of Loss

Please check one of the following:

☐ **Initial Request** ☐ **Request for Advance** ☐ **Supplemental Request** ☐ **Final Request**

Date: _____

1. Name of Contract holder / Plan Sponsor: _____ **2. Contract No.:** _____

3. Agreement Year (For this Request): From _____ **To** _____

4. Employee's Name _____ **Date of Birth:** _____ **Original Eff Date:** _____

5. Claimant: _____ **Date of Birth:** _____ **Original Eff Date:** _____

6. Relation to Employee: _____ **7. Nature of Illness / Prognosis:** _____

8. Eligibility Status: ☐ **Active** ☐ **On Leave / FMLA** ☐ **Disabled / Last Day Worked**
☐ **COBRA / Eff Date** _____ ☐ **Termination Date** _____

9. Total Amount of Eligible Claims Expense of Plan (This Request) **$** _____
10. Less Specific Attachment Point - (actually Paid by Plan) 1st Request Only **$** _____
11. Total Reimbursement and/or Advance Requested by Plan (Subtract 10 from 9) **$** _____

Additional Information: _____

The plan warrants that all monies necessary to pay for services and supplies, except amounts eligible for **Specific Advance** funding as evidenced by the attached list of checks, has been paid to the respective providers of medical services or supplies to which this claim relates, and that the proceeds of any Specific Advance shall only be used to pay for those services of providers or supplies to which this claim relates. The Plan agrees to release the above checks listed as ready for payment immediately upon receipt of an advance under this Proof of Loss.

Authorized Signature: _____

Title: _____

TPA: _____

Address: _____

Telephone: _____

E-mail Address: _____

Send Complete with Necessary Attachments to:

ORIEN RISK ANALYSTS
3279 Veterans Memorial Hwy
Suite D-9
Ronkonkoma, NY 11779
T: (631) 467-3901
F: (631) 467-1862
claims@orienrisk.com

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