A DIVISION OF COMPANION LIFE INSURANCE COMPANY

Potential Large Claim Alert

Contractholder Information

☐ 50% Notification ☐ Large Case Alert ☐ Trigger Diagnosis ☐ Update to Prior Notification

Contractholder Information

Contractholder: _____ Contract Period: _____

Contract Type: _____ Specific Deductible: _____

Aggregating Specific Deductible: _____

Employee Information

Employee Name: _____ Employee ID: _____

Date of Birth: _____ Effective Date: _____

Claimant Information

Claimant Name: _____ Relationship to EE: _____

Date of Birth: _____ Effective Date: _____

Paid: $ _____ Pending: $ _____

Date(s) services were incurred: From: _____ To: _____

Date(s) benefits paid by administrator: From: _____ To: _____

ICD-10-CM Diagnosis Code: _____ Diagnosis: _____

Prognosis: _____

If hospitalized: Name of Facility: _____

Admit Date: _____ Discharge Date: _____

Case management active on claimant? ☐ Yes* ☐ No Notes attached? ☐ Yes ☐ No

*Case mgmt contact: Name: _____ Phone: _____

Estimated additional cost (this contract period): $ _____

TPA: _____

Contact Name: _____ Phone Number: _____

Email Address: _____ Date: _____

Please submit completed forms to: **claims@iisinet.com**

FRAUD NOTICE: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.