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**Potential Specific Benefit Claim Notification**

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| --- | --- | --- | --- | --- |
| **POLICYHOLDER** |  | | | |
| **Policy #** |  | | **Policy Year** |  | |
| **Specific Ded.** |  | | **Contract Basis** |  | |
|  |  | |  |  | |
| Employee: | |  | Covered Person: |  |
| Date of Birth: | |  | Date of Birth: |  |
| Hire Date: | |  | Relationship to EE: |  |
| Effective Date: | |  | Effective Date: |  |
| Termination Date: | |  | Termination Date: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Other Coverage: | Medicaid | | | Spouse’s Plan | | Eff Date | |  | | | Carrier | | |  | |
|  | Medicare | | | Parts Elected | |  | | | | | Eff Date | |  | | |
| Present EE Status | Active | | | FMLA/LOA/STD/LTD | | | Retired | | Retirement Date | | | | | |  |
| Last Date Worked | |  | FMLA Date | |  | | | | | to | |  | | | |
| LOA/STD/LTD Date | |  | | To |  | | | COBRA Eff Date | | | |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLAIM INFORMATION** | | | | | | | | | | | | | | | |
| Diagnosis (ICD 10) | |  | | | | | | | | | | | | | |
| Onset Date | |  | | | | | | Prognosis | | |  | | | | |
| Accidental Injury? | Yes  No | | | Date of Injury | |  | | | | Place of Injury | | | | |  |
| How did injury occurred? | | |  | | | | | | | | | | | | |
| Attending Physician | | |  | | | | Phone # | | | | | |  | | |
| Hospital | | |  | | | | Phone # | | | | | |  | | |
| Claimant is hospitalized | | | | | | | Claimant is continuing treatment | | | | | | | | |
| ESRD | | | 1st Date of Dialysis | | | |  | | | | | | | | |
| Has Large Case Management been implemented | | | | | | | Yes  No | | | | | | | | |
| Case Mgmt Co |  | | | | | | Phone # | | |  | | | | | |
| Claims Paid YTD |  | | | | | | Claims Pending YTD | | | | |  | | | |
| Estimates of future expenses: | | | | | | | | | | | | | | | |
| Less than $50K | $50K-$100K | | | | $100K-$150K | | | | $150K-$200K | | | | | Other $ | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Claims Administrator | |  | | | | |
| Address |  | | | | | |
| City |  | | State |  | Zip |  |
| Phone |  | | Email |  | | |
| Completed By |  | | Date |  | | |

BHSI Potential Specific Benefit Claim Notification Form 08/2016 \*\*\*\* CONFIDENTIAL \*\*\*\*