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Spartanburg, SC 29304

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Aggregate Request Form

Policyholder Name ____

Policy Number ______________________ Effective Date ________________

Minimum Attachment Point for the Policy Period ____________________________

A. Total Claims Year to date $________________________

B. Less Specific Claims (Paid or Payable) (-) $________________________

C. Less Ineligible or Extracontractual Claims (-) $________________________

D. Less Refunds, Recoveries, Voids (-) $________________________

E. Total Eligible Toward Aggregate $________________________

F. Attachment Point $________________________
Higher of the Year to date Attachment Point, or Minimum Attachment Point

G. Less Previous Month's Advancement/Reimbursement (-) $____________________

H. Amount Requested (E-F-G) $________________________
(If negative, amount due carrier)

ATTACHMENTS

1. Contract year to date monthly check register showing all payments, voids, reissues and refunds, identifying any non-claim payments (e.g. administration fees, etc.). The register should show check number, date of check, name of claimant, incurred date and check amount.
2. Contract year to date paid claim report by claimant (by month if monthly). Report must contain procedure and diagnosis codes and should only include those charges eligible for the Aggregate.
3. Listing of all Specific Stop Loss claims for the Aggregate period.
4. Policy year eligibility listing by month.
5. Attachment Point calculation
6. Funding transaction registers and bank statements for the first and last month of the Aggregate period. In addition, the bank statement for the month following the close of the Aggregate paid period.
7. Itemized prescription drug invoices (if applicable). The itemized invoices should include the patient name, name of the drug, NDC code, quantity dispensed, days' supply, date filled and the charge. The report should also indicate if the reimbursement was through a retail pharmacy or mail order method.
8. A report that notes all PBM or other vendor rebates for charges related to the contract period.

9. A current report for all voided payments, adjustments and refunds for the contract period.
10. A listing by claimant for any pending overpayment requests.
11. A listing by claimant of any pending or recovered subrogation claims paid during the contract period.
12. A listing by claimant of any extra-contractual payments or verification there were none.
13. A report that indicates total payments for the contract year by benefit code or type, (i.e., office visit, ambulance, medical records, etc.).

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

TPA/Company

Name____

Address ____

Phone _________________________ Ext. ___________ Fax________________________________

Signature ____

Title ____ Date _________________________