Mail to : **RBS Re**
160 State Street, 7th Floor
Boston, Massachusetts 02109
Attn: Medical Management Dept.
(617) 742-1800 ext. 224
Fax to: (617) 742-3480 fax
Email to: MedicalManagement@RBSRe.com

RBS Re
An HM Insurance Group Company

EMPLOYER STOP-LOSS NOTIFICATION FORM

Please use this form to notify RBS of any potential claims >50% specific deductible, inpatient stays > 30 days, and any suggested diagnosis on Trigger List

Group Name : _____ **Deductible:** _____ **Policy #:** _____ **Effective Date:** _____

Employee's Name: _____ **SSN :** _____ **DOB :** _____

Claimant's Name: _____ **Relationship :** _____ **DOB :** _____

Effective Date: _____ **Termination Date :** _____

Actively At Work: _____ **Cobra Effective Date:** _____ **Full Time Student :** _____

Other Insurance : _____

Date of Accident / Illness : _____ **Diagnosis/ ICD-9 Code :** _____

Prognosis : _____

Total Paid : _____ **Total Pended :** _____ **Est of Future Expenses :** _____

Case Manager : _____ **Tel # :** _____ **Fax # :** _____

Admitted : _____ **Discharged:** _____ **Facility :** _____ **NET or OON :** _____

Admitted : _____ **Discharged:** _____ **Facility :** _____ **NET or OON :** _____

Discharged to : _____ **Expired (Y/N) :** _____ **Date Expired :** _____

Clinical Status/Information : _____

ORGAN TRANSPLANT

Medical Center: _____ **Transplant Type:** _____

Has Network Been Notified ? _____ **If Yes, which network ?** _____

Evaluation Date : _____ **Transplanation Date:** _____

RBS NAVIGATOR PROGRAM (Please check [x] any programs of interest. A RBS representative will contact you)

Repricing / Negotiation	_____	Hospital Bill Audit	_____	Pharmaceutical Network	_____
Hi Risk Obstetrical CM	_____	Neonatal CM	_____	Organ Transplants	_____

Submitted by: _____ **Title:** _____ **Date:** _____

Address: _____ **Tel #:** _____ **Fax #:** _____