RBS Re
An HM Insurance Group Company

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(617) 742-1800 ext. 224
Fax to: (617) 742-3480 fax
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# NAVIGATOR PROGRAM ACCESS FORM

*Use this form to notify RBS of your intent to access the Navigator Program. Please use the* **Notification of Potential Claim** *form to access Neonatal Case Management services*

**Company Name :** _____ **Retention$:** _____ **Agreement #:** _____ **Effective Date:** _____

**Plan Type :** **Commercial** _____ **Medicare** _____ **Medicaid** _____ **Other:** _____

**Member/Covered Person/Insured :** _____ **Member ID:** _____

**Claimant (Patient) :** _____ **D.O.B.:** _____ **SSN :** _____ **Sex:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home Phone Number:** _____ **Work Phone Number:** _____

**Relationship to Member:** _____ **Has eligibility been confirmed?** _____

**Physician:** _____ **City/State:** _____ **If OON, please provide TAX ID:** _____

**Physician Phone:** _____ **Fax:** _____ **Specialty:** _____

**Network Discount obtained (%)?** _____ **Name of Network:** _____ **Has negotiations been attempted?** _____

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

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

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

**Network Discount obtained (%)?** _____ **Name of Network:** _____ **Has negotiations been attempted?** _____

**Diagnosis(es):** _____ **ICD-9 Code(s):** _____

**Procedure(s):** _____ **CPT Code(s):** _____

**Clinical Status/Information :** _____

**Case Management (if assigned) Contact:** _____ **Phone:** _____ **Fax:** _____

## PLEASE INDICATE PROGRAMS OF INTEREST

Check [x] appropriate box(es)

☐ **Claims repricing** Bill Amount $: _____

☐ **Bill Audit** Bill Amount $: _____ Prescreen Bill? Yes _____ No _____
*Please provide UB-92 or HCFA 1500, itemized bill, patient authorization*

☐ **Bill Negotiations** Bill Amount $: _____
Claim is payable at %: _____ Deductible/Out-of-Pocket (Owed): _____
Has any payment been made on this bill? _____ How frequently are claim checks issued? _____

☐ **Catastrophic Case Management** (except Neonatal Case Management)
Prescreen for Case Management and make recommendations? _____
Open direct Case Management? _____ Specialty: _____
High Risk Maternity Case? _____ Specific High Risk Maternity Condition: _____
Expected Date of Delivery: _____ Planned Delivery Site: _____
*For Neonatal Case Management, please submit a Notification of Potential Reinsurance Claim Form*

☐ **Specialized Physician Review** **Transplant:**_____ **Other:**_____

☐ **Pharmaceutical Network**
Primary Therapy: _____ Dosage: _____
Secondary Therapy: _____ Dosage: _____
Access Device: _____ Allergies: _____

Additional Comments/Instructions: _____

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

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