NorthWind, LLC

1595 Paoli Pike, Suite 103
West Chester, PA 19380
P: 610.840.0401 / F: 610.840.0402
www.northwindllc.com

SPECIFIC STOP-LOSS NOTICE OF POTENTIAL CLAIM

Group: _____

Policyholder: _____

Contract Period: _____ Contract Basis: _____

Employee Name: _____ EE DOB: _____

Social Security #: _____

Employee's Original effective date: _____

Employee status: ☐ Active ☐ Retired ☐ Disability ☐ COBRA ☐ Deceased

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Claimant Name: _____ DOB: _____

Claimant's effective date: _____

Other coverage: ☐ COB ☐ Medicare ☐ W/C ☐ Third Party Liability

Date of first claim: _____

Admission & discharges dates of hospitalizations: _____

_____

Are hospital charges subject to any negotiated or pre-arranged discounts? _____

If yes, please indicate type of arrangement and anticipated discounts: _____

_____

Diagnosis: _____

_____

Prognosis and anticipated treatment plan: _____

_____

Has Large Case Management been implemented? _____ Vendor Name: _____

Total Paid to Date for this Claim: $_____ Pending: $_____

Administrator's Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Print Contact Name: _____ Date: _____

E-mail address: _____