NorthWind, LLC

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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

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: ______________