

## Kismet Risk Management Associates

Aggregate Claim Request Form
6500 Byron Center Ave, Ste 200, Byron Center, MI 49315
Phone: Claims' Direct: (317) 288-3385 x106 Email: claims@kismetrisk.com

Insured:											
Policy Period: Basis:			Specific Deductible: \$								
Administrato	or:										
Coverage(s): Medical: X Dental:			Vision:		Rx Card:		Other:				
Minimum A	ggregate Rete	ntion: \$									
Aggregate R	etention Facto	ors: Single <sup>1</sup> : \$		Family <sup>2</sup> : <u>\$</u>		Composite <sup>3</sup> : \$		Other: \$			
Ce			Census X	Factors				Loss Fund To		Paid Claims	
Month	Single Census	Single <sup>1</sup>	Family Census	Family <sup>2</sup>	Total Census	Composite <sup>3</sup>	Month	Accumulative <sup>B</sup>	Month	Accumulative <sup>A</sup>	
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Aggregate Claim Calculation  Paid Claims Year-to-Date: \$  Less Specific Excess Claims: \$  Less Claims Paid Outside  Aggregate Contract: \$  Less Aggregate Deductible: \$  Less Refunds/Voids: \$  Less Previous Monthly  Accommodations: \$  Reimbursement Due Group: \$  Refund Due Carrier: \$  Signed:						<ol> <li>PLEASE PROVIDE THE FOLLOWING TO AVOID DELAY:         <ol> <li>Paid Claims Analysis Report showing name of claimant, incurred date, charge, payment amount and date, claim #, ICD9/ICD10, CPT code</li> <li>Eligibility listing which identifies birth date, effective date, termination date and coverage type</li> <li>Proof of Funding. This must include monthly bank statements and/or deposit slips</li> <li>Void/Refund report</li> <li>Benefit/Service Code report</li> <li>Aggregate Report – Monthly Loss Summary Report</li> <li>Specific Report showing claimants have exceeded the Specific Deductible/Loss Limit</li> <li>Payments made outside the Aggregate Contract (i.e. Dental, Weekly Income, Vision, PPO Fees, Medical Records Fees, Rx Admin.)</li> </ol> </li> <li>Year to Date Check Register</li> </ol>					
Title:						<ol> <li>Outstanding overpayments and subrogation issues</li> <li>Detailed Rx Itemizations and Invoices (if covered under Aggregate)</li> </ol>					
	Date: Phone #: Fa										