



SPECIFIC CLAIM REIMBURSEMENT FORM

To: Kismet Risk Management Associates
Email: claims@kismetrisk.com

From:

Date:
Phone #:
Email:
Effective Date:
Expiration Date:

Policyholder:

Policy #: Specific Deductible: \$

Employee: DOB: SS#:

What is employee's work status?

Actively working the required number of hours per week to be considered full-time

Retired on:

Disabled and has been out of work from: to

Coverage is being continued under the following means (complete as applicable):

Sick Time: to Vacation Time: to

FMLA: to Leave of Absence: to

Terminated coverage on: Is COBRA applicable?

COBRA effective date: COBRA termination date:

Claimant: Sex: Relationship: DOB:

Total Benefits Paid:

Less Specific Deductible:

Balance:

Reimbursement Requested: Estimated Future Expenses:

Check if Simultaneous Specific Reimbursement Request

Please include legible copies of the following:

- 1. A copy of the Enrollment Card including documentation of the employee's original effective date and date of hire
2. Documentation that the employee/dependent meets the eligibility requirements at time of claim (i.e., hours worked, Actively-at-Work)
3. Itemized provider billings
4. Explanation of Benefits and/or checks indicating that the claims have been paid (match with itemized bill copies - do not staple)
5. If the deductible and co-insurance were previously met, please submit documentation
6. Documentation that no other insurance was available at the time of claim (COB)
7. Operative reports and the calculation of the reasonable and customary fees
8. Accident details and Subrogation Agreements, when appropriate
9. Summary report of all claims paid in this contract period
10. COBRA election and proof of COBRA payment, when appropriate
11. Precertification documentation and LCM reports

Prepared by: Print Name:

Title: