



Dear Business Partner:

Please take a few minutes to review the contents of our Claims Kit. It provides key instructions for identifying and reporting specific and aggregate claim information to IHC Risk Solutions. Included in this Claims Kit is information about Cost Containment initiatives, Advanced Funding as well as the following:

For Specific Coverage:

- Notification Form
- ICD-9 Codes for Trigger Notification
- Request for Reimbursement - Requirements for Claim Submission
- Request for Reimbursement - Form

All notifications, trigger diagnosis, LCM reports, pre-certification reports, etc. should be sent to:
notifications@ihcrisksolutions.com

All requests for reimbursement should be sent to:
claims@ihcrisksolutions.com

For Aggregate Coverage:

- Aggregate Claim Submission - Requirements
- Aggregate Claim Submission - Form
- Monthly Aggregate Stop Loss Report

Monthly aggregate reports should be sent to:
aggreports@ihcrisksolutions.com

All requests for aggregate reimbursement should be sent to:
claims@ihcrisksolutions.com

Please contact us with any questions or concerns you may have. We look forward to our continuing partnership with you.

Anne Beltramello
Manager, Oversight CM
IHC Risk Solutions
251 Sullivan Ave.
South Windsor, CT. 06074
860-289-1844 ext. 307
Fax: 860-290-4817
abeltramello@ihcrisksolutions.com

Rick Shifrin
Vice President Claims
IHC Risk Solutions
901 Lincoln Drive West, 100
Marlton, NJ 08053
877-392-3770 ext. 306
Fax: 856-396-0370
rshifrin@ihcrisksolutions.com

IHC Risk Solutions Notification Form

Policyholder:

Specific Deductible:

Contract:

Policy Year:

Insured:

Insured D.O.B:

Insured SS#:

Claimant:

Relationship to insured:

Claimant D.O.B:

Active: Yes No

If "No" termination date:

COBRA: Yes No

If "Yes" effective date:

Retiree: Yes No

If "Yes" effective date:

Medicare: Yes No

If "Yes" effective date:

Is the claimant covered under any other Insurance? Yes No

If yes, please describe:

Date claim incurred:

Subrogation applicable? Yes No

If injury, please describe:

Has Large Case Management been initiated?: Yes No

Name of LCM Firm:

Primary Diagnosis Code:

Secondary Diagnosis Code:

Prognosis:

Total Claims Paid to Date:

Estimated Future Claims:

Is the provider in a Network? Yes No

Network:

Additional Comments:

TPA/Company Name:

Address:

Telephone:

Ext:

Email address:

Fax:

Signature:

Date:

Title:

This form may be used for trigger diagnosis, early/potential notices, or 50% notices.

Any questions regarding the use of this form should be addressed to:

Diane Poirier - phone (860) 289-1844 ext. 309

Please send to: notifications@ihcrisksolutions.com or

Fax to: 860-290-4817

ICD-9 Codes for Trigger Notification

This list should be referred to for completion of trigger notifications. Please send notice for all plan participants who have been diagnosed or treated for any of the code ranges listed under the following categories:

001-139 Infectious and Parasitic Diseases

038-038.9 Septicemia
042 AIDS / HIV
070-070.9 Viral Hepatitis

140-239 Neoplasms

140-149.9 Malignant Neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx
150-150.9 Malignant Neoplasm of Esophagus
151-151.9 Malignant Neoplasm of Stomach
153-153.9 Malignant Neoplasm of Colon
154-154.8 Malignant Neoplasm of Rectum
155-155.2 Malignant Neoplasm of Liver
157-157.9 Malignant Neoplasm of Pancreas
161-161.9 Malignant Neoplasm of Larynx
162-162.9 Malignant Neoplasm of Lung
170-170.9 Malignant Neoplasm of Bone
174-174.9 Malignant Neoplasm of Female Breast
179-182.8 Malignant Neoplasm of Uterus or Cervix
183-183.9 Malignant Neoplasm of Ovary
185 Malignant Neoplasm of Prostate
186-186.9 Malignant Neoplasm of Testis
188-189.9 Malignant Neoplasm of Bladder, Kidney, Urinary
191-191.9 Malignant Neoplasm of Brain
192-192.9 Malignant Neoplasm of Nervous System
194-194.9 Malignant Neoplasm of Endocrine Glands
195-195.8 Malignant Neoplasm of Other Ill-Defined Sites
196-196.9 Secondary Malignant Neo. Lymph Nodes
197-197.8 Secondary Malignant Neo. Resp. and Digestive Systems
198-198.89 Secondary Malignant Neo. Other Specified Sites
200-208.9 Lymphoma and/or Leukemia
235 Neoplasm Uncertain Behavior
239.2 Neoplasm Unspecified Nature – Bone, Skin

240-279 Endocrine, Nutritional, Metabolic, Immunity

250-250.9 Diabetes
277.0 Cystic Fibrosis
278.0 Obesity/Hyperalimant

280-289 Diseases of the Blood and Blood-Forming Organs

282.6 Sickle-Cell Anemia
284.9 Aplastic Anemia NOS
286-286.9 Coagulation Defects and/or Hemophilia

320-389 Diseases of the Nervous System and Sense Organs

330 Cerebral degenerations
340 Multiple Sclerosis
344.0-344.09 Quadriplegia and Quadriparesis
331.0-331.9 Reye's Syndrome
344.1 Paraplegia
348.0-348.9 Encephalopathy
357, 358 Neuropathy / Myasthenia Gravis

390-459 Diseases of the Circulatory System

410-410.9 Acute Myocardial Infarction
411-411.89 Acute and Subacute Ischemic Heart Disease
414-414.05 Coronary Atherosclerosis (ASHD)
415-415.19 Acute Pulmonary Heart Disease
416-416.9 Chronic Pulmonary Heart Disease
417.1 Aneurysm of Pulmonary Artery
421-421.9 Acute and Subacute Endocarditis
424-424.9 Valve Disorders
425-425.9 Cardiomyopathy
426-426.9 Conduction Disorders
427-427.9 Cardiac Dysrhythmias
428-428.9 Heart Failure
430, 431 Subarachnoid / Intracerebral Hemorrhage
434.9 Occlusion of Cerebral Arteries
436 Acute Cerebrovascular Accident (CVA)
440-441.9 Atherosclerosis / Aortic Aneurysm

460-519 Diseases of the Respiratory System

480-486 Pneumonia
490-496 Chronic Obstructive Pulmonary Disease (COPD), etc.
515 Postinflammatory Pulmonary Fibrosis
518-518.89 Pulmonary Collapse and/or Respiratory Failure

520-579 Diseases of the Digestive System

555-555.9 Regional Enteritis (Crohn's Disease)
560.0-560.9 Intestinal Obstruction
562.1 Diverticulitis of Colon
567-567.9 Peritonitis
569.0-569.9 Other Disorders of Intestine
570-571.9 Liver Diseases and Cirrhosis
572.8 Other Sequela of Chronic Liver Disease
573-573.9 Other Liver Disorders
577-577.9 Pancreas Diseases
578-578.9 Gastrointestinal Hemorrhage

580-629 Diseases of the Genitourinary System

584-584.9 Acute Renal Failure
585 Chronic Renal Failure
586 Renal Failure, Unspecified
588 Disorders resulting from impaired renal function
592 Calculus of Kidney & Ureter

630-677 Complications of Pregnancy, Childbirth

641.1 Placenta Previa
642.5-642.7 Eclampsia, pre-eclampsia
644.0-644.2 Pre-mature Labor
648.0 Gestational Diabetes
651 Multiple Gestation
654.5 Cervical Incompetence

710-739 Diseases of the Musculoskeletal System and Connective Tissue

715.0-715.9 Osteoarthritis
721.3 Lumbosacral Spondylosis
722.0-722.9 Intervertebral Disc Disorders
730-730.9 Osteomyelitis and/or Periostitis
737.3 Kyphoscoliosis and scoliosis

740-759 Congenital Anomalies

747.2 Aortic Atresia / Stenosis
751.6 Biliary Atresia
759-759.9 Other and Unspecified Congenital Anomalies

760-779 Conditions Originating in the Perinatal Period

765-765.1 Prematurity
769 Respiratory Distress Syndrome
770.0-770.9 Other Respiratory Conditions of Newborn

780-799 Symptoms, Signs, and Ill-Defined Conditions

785-785.9 Symptoms Involving Cardiovascular System
786.5-786.59 Chest Pain

800-999 Injury and Poisoning

800-804.9 Fracture of Skull
805-805.9 Fracture of Vertebral Column
806-806.9 Fracture of Vertebral Column with Spinal Cord Injury
828-828.1 Multiple Fractures
853-854.1 Intracranial Injury
869-869.1 Internal Injury
887-887.7 Traumatic Amputation of Arm and Hand
897-897.7 Traumatic Amputation of Leg
949-949.5 Burns
952-952.9 Spinal Cord Injury
996-997.0 Complications peculiar to certain specified conditions
V23 Supervision of High Risk Pregnancy
V42 – V58.9 Transplants, etc



Requirements for Claim Submission

Eligibility:

- Employee's dated enrollment form which must include original effective date of coverage, date of hire, employee's signature
- COBRA Election Form which must also include date of the qualifying event, date of election, effective date, proof of COBRA premium payments in the form of copies of checks
- If the claim is for a dependent, provide documentation as to whether the spouse is employed and covered by any health insurance and verification of student status if the dependent is a child.

Documentation regarding investigation results:

- Usual, reasonable and customary
- Most common semi-private room rates, when charges are billed for private room and board
- Coordination of benefits, which includes evidence of spouse's employment status and effect on order of benefit determination
- Subrogation, which includes details of accident, police report if applicable, signed subrogation agreement, all attorney correspondence, Worker's Compensation

Forms and more:

Include the following with your claim submission:

- Request for reimbursement form, fully completed, signed and dated
- Detailed itemized bills and statements related to claims such as physician's orders for home care services, operative reports
- Copies of explanations of benefits
- Proof of claim payments
- Hospital bills should include proof of hospital audit prescreening, results of hospital bill audits, pre-certification documentation, copy of the UB92 and the detailed itemization of the charges
- Large Case Management reports

Please send all claim submissions to:
IHC Risk Solutions / 901 Lincoln Drive West, Suite 100 /Marlton, NJ 08053
1-877-392-3770/claims@ihcrisksolutions.com

Request for Reimbursement

Initial Claim Supplemental Claim # _____ Advanced Claim Other - _____

Employer Name -		
Policy Number -	Policy Period -	Plan Type -
EE Name -		Social Security Number -
EE Date Of Birth -	EE Effective Date -	Hire Date -
Lifetime Maximum Paid To Date -		EE Termination Date -
Claimant Name -		Relationship -
Claimant Eff. Date -		Current Status -
Claimant Last Day Worked -		DOB -
Diagnosis / ICD9 -	COBRA Date -	Premium Paid To -
Prognosis -		Case Management - <input type="checkbox"/> Yes <input type="checkbox"/> No
Vendor -		

Total Amount Paid Last Year	
Total Eligible Benefits This Submission	
Less Specific Deductible	
Balance	
Percent To Be Reimbursed	
Reimbursement Requested	
Estimated Future Liability	

YOUR REIMBURSEMENT REQUEST SHOULD INCLUDE THE FOLLOWING INFORMATION (IF APPLICABLE):

Copies Of;		Investigation Materials For;
<input type="checkbox"/> Enrollment Form (Initial/Current)	<input type="checkbox"/> Itemized Bills	<input type="checkbox"/> COB
<input type="checkbox"/> Employee Claim Form (Current)	<input type="checkbox"/> R & C Calculations	<input type="checkbox"/> Full Time Student Status
<input type="checkbox"/> COBRA Election Form / Payments	<input type="checkbox"/> Precertification Forms	<input type="checkbox"/> Pre-Existing
<input type="checkbox"/> Medicare Election Form	<input type="checkbox"/> Hospital Audits / Rev.	<input type="checkbox"/> LCM Reports
<input type="checkbox"/> EOB's / Claim Checks / Registers	<input type="checkbox"/> Hospital Records	<input type="checkbox"/> Physician's Statement
<input type="checkbox"/> Deductible / Coinsurance Proof		<input type="checkbox"/> Subrogation
<input type="checkbox"/> Divorce or Separation Decrees, Or Court Orders		<input type="checkbox"/> Worker Compensation
		<input type="checkbox"/> Accident Details/Police Reports

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

TPA/Company Name -		
Address -		
Phone () -	Extension #	Fax Number () -
Authorized Signature -		Email:
Title -	Date -	



Aggregate Claim Submission Requirements

To submit an aggregate claim, complete the Aggregate Claim Form and the Aggregate Stop Loss Report. Please include copies of all the information requested on the forms. If you have your own program which prints out the information requested in the Aggregate Stop Loss Report, please include it with your submission.

- Contract year-to-date check register showing all payments, voids, reissues and refunds; identifying any non-claim payments (e.g. administration fees, etc.). The register should show check number, date of check, name of claimant, incurred date, and check amount.
- Contract year-to-date claim listing by coverage and claimant. *Only include the coverage eligible for the Aggregate.*
- A listing of all Specific Stop Loss claims for the Aggregate period
- Policy year eligibility listing
- Attachment point calculation
- Benefit Code Analysis Report
- Funding

Please send to:

IHC Risk Solutions / 901 Lincoln Drive West, Suite 100 / Marlton, NJ/08053

1-877-392-3770/claims@ihcrisksolutions.com



Aggregate Claim Submission Form

CARRIER:

Employer Name:

Policy Number:

Policy Period:

Minimum Attachment Point for the Policy Period:

1. Total Claims Year-to-Date
2. Less Specific Claims (Paid or Payable) ()
3. Less Ineligible or Extra-contractual Claims ()
4. Less Refunds/Recoveries/Voids ()
5. Total Eligible toward Aggregate
6. Attachment Point
Higher of the Year-to-Date Attachment Point, or Minimum Attachment Point.
7. Less Previous Month's Advancement/Reimbursement ()
8. Amount Requested (5-6-7)
If negative, amount due Carrier

REQUIRED ATTACHMENTS

- A. Contract year-to-date check register showing all payments, voids, reissues, and refunds; identifying any non-claim payments (e.g. administration fees, etc.). The register should show check number, date of check, name of claimant, incurred date, and check amount.
- B. Contract year-to-date claim listing by coverages and claimant. Only include those coverages eligible for the Aggregate.
- C. Listing of all Specific Stop Loss claims for the Aggregate Period.
- D. Policy year eligibility listing.
- E. Attachment-Point-Calculation.
- F. Benefit Code Analysis Report
- G. Funding

TPA/Company Name:

Address:

Phone () - Ext Fax:() -

Signature:

Date:

Email:

Cost Containment

Managing high dollar claims continues to be an extremely important and evolving process for many clients. In an effort to assist our TPA partners, IHC Risk Solutions has developed the “Compass Solutions” program and devoted an Oversight Case Management team for the sole purpose of containing high dollar claims. As one of our TPA partners, you have full access to the following resources:

Compass Solutions:

IHC Risk Solutions offers a cost-effective suite of services and vendors to manage catastrophic and complex claim situations. We can assist in connecting you with industry experts who provide cost effective services that support quality outcomes. Included in our Compass Solutions suite of vendors are those experts in the field for:

- Medical Case Management
- Large Claims Review
- National Transplant Networks
- Dialysis Cost Solutions
- Specialty Pharmacy
- Prospective Extra-Contractual Negotiations

To learn more about these vendors and what they offer, you may find them on our web site at www.ihcrisksolutions.com (click on Compass Solutions) or by contacting one of our OCM members as listed below.

Oversight Case Management:

The goal of our Oversight Case Management (OCM) unit is to become an extension of your large claims management team. We work to identify possible large claims at the earliest point of intervention. We can help suggest alternatives and provide access to our team of Compass Solutions vendors. To assist you with these needs, our OCM staff includes the following:

Diane Poirier, Notification Administrator
dpoirier@ihcrisksolutions.com
1-860-289-1844 ext. 309

Kristen Komedja, OCM Nurse
kkomedja@ihcrisksolutions.com
1-860-289-1844 ext. 312

Rose Pagani, OCM Analyst
rpagani@ihcrisksolutions.com
1-860-289-1844 ext. 300

Anne Beltramello, OCM Manager
abeltramello@ihcrisksolutions.com
1-860-289-1844 ext. 307

You are welcome to contact any of our team members to find out more information.



Specific Advanced Funding

The “Specific Advanced Funding” product is standard in all cases for IHC Risk Solutions clients. Under Advanced Funding, specific reimbursement is available to the policyholder for eligible expenses upon meeting the following requirements:

- The specific deductible must be paid in full by the policyholder prior to any claims being considered for Advanced Funding. Payment of the Specific Deductible must be made at least ten (10) business days prior to the end of the Specific Benefit Period.
- The claim amount must be equal to or greater than \$1,000.
- Claims submitted for Advanced Funding must have been fully processed according to the terms of the Plan by the Administrator and must be ready for payment.
- Normal Specific claim audit procedures will be implemented prior to any checks being issued by IHC Risk solutions.
- The employer’s payment for Eligible Expenses must be released to the provider within five (5) days of receiving the reimbursement check from IHC Risk Solutions. If these payments are not made within five (5) business days, the reimbursement check must be returned to IHC Risk Solutions.
- Any portion of the reimbursement check not used to reimburse Eligible Expenses, due to additional discounts or any other reason, must be returned to IHC Risk Solutions within five (5) business days.
- All initial or subsequent Advance Funding claim requests must be received by the Company ten (10) business days prior to the end of the Specific Benefit Period. Any requests received after that date are not eligible for Advance Funding and therefore, must be fully Paid by the Plan in order to be eligible for reimbursement under this policy.

Subject in all other respects to the policy terms, conditions and limitations.