Specific Reimbursement Request

Bardon Insurance Group, Inc.
8326 E. Hartford Drive, Suite 100
Scottsdale, AZ 85255
480.682.1400 (Main) **480.682.1450 (Fax)** **888.550.4961 (Toll Free)**

Group Name:	
Third Party Admin:	
Contract Period:	

Employee Name	ID/Social Security #	Date of Birth	Prem Pd Thru Date	Contract Basis

Claimant Name	Relationship	Date of Birth	Medical UW Laser / Separate Specific Deductible

Date of Hire:		**Original Eff. Date of Coverage (include enrollment documentation):**						
Employee Currently Actively Working FT:		**Yes**	**No**	**Retired:**	**Yes**	**No**	**Retirement Date:**	

Please complete a separate Actively-at-Work Status/Eligibility questionnaire if employee has not been AAW on regular FT basis.

COB or Creditable Cov:	**Yes**	**No**	**Include the necessary documentation (annual insurance questionnaire, COCC, etc.)**
COBRA Elected:	**Yes**	**No**	**If yes, include COBRA election form and proof of COBRA premium payment.**
SUBRO/TPL Potential:	**Yes**	**No**	**If yes, include all documentation (accident details, signed subrogation letter, etc.)**

Total Paid This Contract Period	Specific DED / Agg-Spec DED	Amount of Initial Request	Amount of Subsequent Request

All Diagnoses: (*Include all current diagnoses below using ICD-9 codes or attach a separate claim report.)*

Large Case Management:	**Yes**	**No**	**Provide LCM vendor name and contact information below.**

PLEASE ANSWER THE FOLLOWING FUNDING QUESTIONS:

All claims for this request have been funded.	Yes	No	
All claims up to the specific deductible have been funded.	Yes	No	
This is a request for a simultaneous reimbursement.*	Yes	No	Checks are issued and are awaiting funding.
This is a request for specific advance*	Yes	No	Claims are fully adjudicated without check # or paid date.

* Specific advance is not available in the last 30 days of the contract period.
* Simultaneous reimbursement is not available in the last 30 days of the contract period without prior approval.
* All requests must be received by Bardon within 7 days of the check/claim, while the contract period is in effect.
* Fax or email a copy of this form to Bardon and submit the back-up documentation within 7 days.
*** Each request for specific advance or simultaneous reimbursement must exceed 10% of the specific deductible.**
* Stop loss premium must be current for the month(s) in which the claims are paid or the advance request is received.

EXCEPTIONS TO THE FUNDING GUIDELINES LISTED ABOVE REQUIRE PRIOR WRITTEN APPROVAL FROM BARDON

Filed By: Date:

Plan Administrator: Phone:

Street Address: Email:

City/State/ZipCode:

Claims may be submitted via email to claims@bardon.net.