Underwriting Management Experts

Dear Third-Party Administrators:

Please find all forms required for filing Specific Claims and Aggregate Accommodations with Underwriting Management Experts:

- **A list of potential high dollar or catastrophic diagnosis codes**
- **A 50% Advance Notification**
- **An Initial Specific Excess Claim Reimbursement Request**
- **A Supplemental Specific Claim Reimbursement Request**
- **A Specific Claim Eligibility/Work Status Form**
- **An Aggregate Report/Tracking Form (one, two, three and four tier)**
    - **This should be submitted on a monthly basis and separated by the number of tiers, as specified in the contract terms**
- **An Advanced Funding Request Form**
- **A banking form for ACH transfers**
- **Documentation required for claim submittal**
- **Coordination of Benefits Questionnaire**

Should you have any questions regarding the completion of these forms, please call us at 855-315-5088.

Thank you,

Heather Helbe
Sr. VP. of Claims

# ICD-10 Code List

**A00–B99 Infectious Diseases**
A41-A41.9 Sepsis
B17.1–B17.11 Hepatitis C

**C00–D49 Neoplasms**
C00–C14 Malignancies of oral cavity and pharynx
C15–C26 Malignant neoplasm of digestive organs
C30–C39 Malignant neoplasm of respiratory
C43– C44 Melanoma
C50–C50 Breast Malignancies
C51–C68 Genitourinary Malignancies
C69–C72 Malignancies of Nervous System
C81–C96 Leukemias, Lymphomas and Myelomas

**D50–D89 Hematologic Disorders**
D57.1 Sickle Cell Anemia
D61.01 Aplastic Anemia
D66 Hemophilia/Hereditary Factor VIII Deficiency
D69.3 Immune thrombocytopenic purpura (ITP)
D80.0 - D80.7 Hypogammaglobulinemia
D81.0 Severe Combined Immune Deficiency (SCID)
D82.1 DiGeorge Syndrome
D83.1 Immune Deficiency T Cells (AIDS)
D83.0 - D83.9 Common Variable Immunodeficiency
D84.1 Hereditary Angioedema (HAE)

**E70–E88 Metabolic Disorders**
E74.02 Pompe Disease
E75.21 Fabry Disease
E75.22 Gaucher's Disease
E84.0 Cystic Fibrosis

**F01-F99 Mental and Behavioral Disorders**
F10-F19 Alcohol/Opioid Abuse
F20-F31 Schizophrenia/Bipolar Disorder
F32-F69 Major Depressive Disorder
F84-F89 Developmental Disorders

**G00–G99 Disease of the Nervous System**
G12.21 Lou Gehrig's disease (ALS)
G35 Multiple Sclerosis
G61.0 Guillain-Barre Syndrome
G80.0-G80.9 Cerebral Palsy
G91.1 Obstructive Hydrocephalus

**I00–I99 Disease of Circulatory System**
I27.0 Primary Pulmonary Hypertension
I42.0–I42.9 Cardiomyopathy
I46.9 Cardiac Arrest
I60.9 Subarachnoid Hemorrhage

**J00–J99 Disease of Respiratory System**
J40-J47 Chronic Lower Respiratory Diseases (COPD, Emphysema, Bronchitis, Asthma)
J96.00–J96.92 Respiratory Failure

**K00– K95 Disease of Digestive System**
K50-K51.919 Crohn's/Ulcerative Colitis
K70.0–K74.69 Chronic Liver Disease
K72.00– K72.91 Liver Failure

**M00-M99 Diseases of Musculoskeletal System**
M05.10-M06.9 Rheumatoid Arthritis
M15-M19 Osteoarthritis
M32 Systemic Lupus Erythematosus (SLE)
M50 Cervical Disc Disorders
M72.6 Necrotizing Fasciitis

**N00–N99 Disease of Genitourinary System**
N18.1–N18.9 Chronic Renal Failure

**O00–O9A Pregnancy, Childbirth & Puerperium**
O30.10–O30.109 Triplet Pregnancy
O30.20– O30.209 Quadruplet Pregnancy
O60.00–O60.14 Preterm Labor

**P00–P96 Perinatal Conditions**
P07.00–P07.36 Preterm Infant
P22.0 Respiratory Distress Syndrome of Newborn

**Q00–Q99 Congenital Malformations**
Q05.0-Q05.9 Spina Bifida
Q20–Q28 Congenital Heart Diseases
Q39.0–Q39.4 Tracheoesophageal Fistula
Q41.0-Q42.9 Congenital Absence, atresia and stenosis
Q89.7 Multiple Anomalies
Q90.0-Q90.9 Down Syndrome

**S00–T88 Injury, Poisoning and Trauma**
S06.0–S06.9 Brain Injuries
S12–S14 Spinal Cord Injuries
S88 - Amputations
T07 Multiple Trauma Injuries
T20–T32 Burns
T79 Early Complications of Trauma
T86.00– T86.09 Graft vs. Host Disease
T86.90– T86.99 Complications of Transplants

Underwriting Management Experts

# ADVANCE NOTICE OF EXCESS CLAIM REPORT

Please provide the following information for excess claims that have reached 50% of the specific deductible

Group Name:______________________Specific Deductible:________________Policy Effective Date:_______________

**Claimant Information**

Employee Name:_________________________DOB:_____________________Effective Date:____________________

Claimant Name:__________________________DOB:_____________________Effective Date:____________________

Relationship to Employee: ME ☐ FE ☐ MSP ☐ FSP ☐ MC ☐ FC ☐

Diagnosis: _____________________________(Include ICD-10 Codes) Original Diagnosis Date:___________________

Amount Paid to Date:___________________________________Amount Pending:________________________________

Reason Pending:_____________________________________________________________________________________

*****Please forward any large hospital bills, or notice of high dollar Rx and/or treatments*****

Estimate of Additional Charges:_______________________________________________________________________

Initial Date of Treatment:___________________If ongoing treatment, estimate of additional charges:_________________

Current Treatment and Prognosis:______________________________________________________________________

______________________________________________________________________________________________________

______________________________________________________________________________________________________

Please specify if LCM is currently in place: Y ☐ N ☐

If yes, list contact and phone:__________________________________________________________________

If no, specify reason:_________________________________________________________________________

TPA Name:_________________________________________________________________________________________

Address:___________________________________________________________________________________________

______________________________________________________________________________________________________

Phone:__________________________________________________________E-mail:__________________________

Submitted By:_____________________________________________________Date:____________________________

PLEASE SUBMIT TO: **claims@umexperts.com**

**WARNING:** *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits*

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# ELIGIBILITY DOCUMENTATION LIST

Please include the following information with all requests:

- Enrollment card, other insurance information, and/or documentation to show current eligibility status. This should be completed and signed by the group's authorized representative.
- A paid report in Excel reflecting amount paid and requested (if it is a supplemental request, only include the bills and back-up documentation for the requested amount)
- Proof deductible and coinsurance were met for all calendar years involved

**Please include the following information when applicable:**

- For any leave of absence, date last worked, and date returned to active status.
- How coverage is being maintained or continued during the absence from work per provisions in the SPD.
- **COBRA**
  All documentation to include:
  - Certified Letter offering COBRA
  - Signed COBRA election form
  - Proof of payment of Cobra premiums
- **FMLA**
  - Copy of group's FMLA policy
- **Leave of Absence**
  - Copy of paperwork as specified in the SPD

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**900 Forty Foot Road | Lansdale, Pa 19446 | Phone: 267-519-1900 | Toll Free: 855-315-5088 | www.umexperts.com**

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# SPECIFIC CLAIMANT WORK STATUS FORM

Please have this form completed and signed by the group's authorized representative. This should be filled out completely.

Group Name:______________________________Policy Effective Date:________
Employee Name:______________________________Hire Date:__________________
Claimant Name:______________________________
Original Effective Date of Employee:______________________________
(Month/Day/Year)

In order to process the specific claim submitted to Underwriting Management Experts, we will need the following information:

1. Time taken off work by the employee for this accident or illness. Please be specific with dates.

______________________________

______________________________

2. Explain how the employee-maintained coverage under the plan for the dates listed above.

______________________________

______________________________

3. List the date the employee returned to work with a full-time status as defined by the plan document.

______________________________

______________________________

4. If the employee has not returned to work, specify how coverage is being maintained. Be sure to include any pertinent documentation to support leave (i.e. signed COBRA election form along with proof of premiums paid, etc.)

______________________________

If the specific claimant is a dependent, provide the following information:
Other Insurance:______________________________Date of Enrollment:________________
Effective Date:______________________________

______________________________Date:______________________
(Authorized Employer Representative Signature/Title)

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# COORDINATION OF BENEFITS QUESTIONNAIRE

**Member Name:**____________________________________________

**Section A: Basic Information**

1. Are you, your spouse, and/or dependents covered under another health, dental, and/or vision plan? Yes ☐ No ☐
2. Is your spouse employed? Yes ☐ No ☐ Is your spouse eligible for other coverage through his/her employer? Yes ☐ No ☐

   Employer Name:____________________________ Phone Number:________________

   Address:____________________ City:__________ State:__________ Zip:________

**Section B: Policy Information – Only complete Section B if you answered "Yes" to Number 1 in Section A**

1. Name of Other Insurance Carrier:________________ Type of Plan: Group ☐ Individual ☐ Retiree ☐ COBRA ☐
2. Name of Policy Holder:________________ Date of Birth of Policy Holder:________________
3. Coverage Effective Date:________________ Coverage Termination Date:________________
4. Please list names of those covered under other plan: ________________ Medical ☐ Dental ☐ Vision ☐

   ________________ Medical ☐ Dental ☐ Vision ☐

   ________________ Medical ☐ Dental ☐ Vision ☐

**Section C: Dependent Child(ren) Information**

1. Are you or your spouse legally divorced or separated from the parent of any dependent child(ren) on this policy? Yes ☐ No ☐
2. Does one parent/guardian have full custody of the child(ren)? Yes ☐ No ☐

   If "Yes", which parent/guardian?________________ Which child(ren)?________________
3. Is one parent required by a court decree to provide health insurance coverage for the child(ren)? Yes ☐ No ☐

   If "Yes", which parent/guardian?________________ Which child(ren)?________________

   **If other coverage is in place due to a court order, please include the court ordered policy information in Section B above**

**Section D: Medicare (Attach a copy of your Medicare card)**

1. <u>Policy Holder's Name</u> — <u>Medicare Coverage</u> — <u>Reason for eligibility under Medicare (Check all that apply)</u>

   ________________ A ☐ B ☐ C ☐ D ☐ Age (65 or over) ☐ Disability ☐ End Stage Renal ☐

   ________________ A ☐ B ☐ C ☐ D ☐ Age (65 or over) ☐ Disability ☐ End Stage Renal ☐
2. If you checked Disability and/or End Stage Renal, attach a copy of the Medicare documentation.

**Section E: Signature**

I hereby certify that the above statements are true and correct to the best of my knowledge.

Member Signature____________________________ Date____________

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# INITIAL SPECIFIC EXCESS CLAIM SUBMISSION FORM

Group Name:____________________ Terms:____________ Policy Effective Date:________

Employee Name:____________________ DOB:____________ Effective Date:________

Is Employee Currently Active at Work: Y N If no, how is coverage being maintained:____________

Claimant Name:____________________ DOB:____________ Effective Date:________

Diagnosis Code(s):____________________ Original Date of Diagnosis:____________

TPA Paid to Date Amount: $____________________

Less Specific Deductible: $____________________

Less Aggregate Specific: $____________________

Requested Amount: $____________________

**Please include the following with the initial submission (additional information may be requested):**

- Enrollment, eligibility information - Enrollment card or any correlating documentation, other insurance information if applicable
- Current work status (attach additional form) including dates claimant missed work
- If applicable, COBRA documentation and COBRA premiums paid to date, FMLA documentation
- If applicable, accident details including police reports and signed subrogation forms
- Precertification(s), operative reports, LCM reports, UR Notes, medical records
- Paid reports in Excel reflecting the following:
  - Diagnosis codes and procedure codes
  - Billed amounts showing PPO discounts
  - Any deductible, co-pay, or OOP processed for the claim

*****Please contact UME if you are unable to acquire a discount*****

TPA Name:____________________________________________

Address for Reimbursement:____________________________________________

____________________________________________

Phone:____________________ E-mail:____________________

Submitted By:____________________ Date:____________________

PLEASE SUBMIT CLAIMS TO: **claims@umexperts.com**

**WARNING:** *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.*

# SUPPLEMENTAL SPECIFIC EXCESS CLAIM SUBMISSION FORM

Submission #____________________________

Group Name:________________ Policy Effective Date:____________________ Terms:________________________

Employee Name:____________________________________________ DOB:________________________

Claimant Name:____________________________________________ DOB:________________________

Current Work Status: Active ☐ Leave of Absence/Disability ☐ FMLA ☐ COBRA ☐ Retired ☐

Diagnosis:________________________________________________________________________

Discount Claim: Y ☐ N ☐ If yes, date payment required:________________________

LCM: Y ☐ N ☐ If yes, include most recent reports.

TPA Paid to Date Amount: $__________________________

Current Requested Amount: $__________________________

**PLEASE NOTE: all supplemental requests must meet or exceed $1,000, apart from the final submission**

Please include all pertinent documentation for this submission. This may include, but is not limited to:

*Precertification(s) *Claim reports in Excel *Savings Fee Invoices *LCM Notes *Updated Work Status

***Additional information may be requested***

*****Please contact UME if you are unable to acquire a discount****

TPA Name:_______________________________________________________________________

Address for Reimbursement:__________________________________________________________

________________________________________________________________________________

Phone:______________________________________ E-mail:__________________________________

Submitted By:______________________________________________________ Date:________________

PLEASE SUBMIT CLAIMS TO: **claims@umexperts.com**

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# ADVANCED FUNDING CLAIM SUBMISSION FORM

Submission # ______________________________

Group Name: ______________________________ Policy Effective Date: ________________ Terms: ______________________

Employee Name: ____________________________________________________________ DOB: ______________________

Claimant Name: ____________________________________________________________ DOB: ______________________

Current Work Status: Active ☐ Leave of Absence/Disability ☐ FMLA ☐ COBRA ☐ Retired ☐

Diagnosis: ______________________________________________________________________________________________

Discount Claim: Y ☐ N ☐ If yes, date payment required: ____________________________

LCM: Y ☐ N ☐ If yes, include most recent reports.

TPA Paid to Date Amount: $__________________________________

Reimbursement Requested Amount: $__________________________________

Advanced Funding Requested Amount: $__________________________________

Total Requested Amount: $__________________________________

**PLEASE NOTE: All Advanced Funding requests must meet or exceed $1,000. Advanced Funding may be requested up to 30 days from the end of the policy terms.**

Please include all pertinent documentation. This may include but is not limited to:
*Precertification(s) *Claim reports in Excel *Savings Fee Invoices *LCM notes *Updated Work Status

***Additional information may be requested***
*****Please contact UME if you are unable to acquire a discount*****

TPA Name: ______________________________________________________________________________________________

Address for Reimbursement: __________________________________________________________________________

________________________________________________________________________________________________________

Phone: ________________________________________________ E-mail: __________________________________________

Submitted By: ____________________________________________________________________ Date: ________________

PLEASE SUBMIT CLAIMS TO: **claims@umexperts.com**

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Dear Valued Clients,

We would like to take a moment to inform you of our policies and procedures regarding year-end audits of aggregate claims. UME's procedures and the necessary documentation needed to ensure a streamlined audit process are as follows:

- The year-end aggregate claim must be submitted within 15 days of the end of the aggregate benefit period. This requirement is for any group that received reimbursement during the plan year, regardless if funds are being requested at year-end.
- If an outside vendor is contracted to perform the audit, UME will provide the vendor information.
- All documentation required to complete the year-end audit must be received within 90 days of the end of the aggregate benefit period. The below information is required to begin the year-end audit. Please note: Additional information may be requested on a case-by-case basis.
    - Gross paid claims report encompassing the entirety of the policy period, inclusive of the following:
        - Claimant names
        - Incurred dates
        - Paid dates and/or funding dates*
        - Provider information
        - CPT codes
        - DX codes
        - In-network and OON status of the claim
        - Billed charges, PPO discount (if applicable), patient responsibility, etc.
    - Pending claims report
    - Final aggregate report
    - Specific claimant report inclusive of paid and/or pending amounts
    - A complete check registers
    - Year-end census for the entire policy period, inclusive of effective and termination dates
    - A void and refund report
    - RX invoices
    - A complete detailed RX report, inclusive of the following:
        - Claimant names
        - Fill dates
        - Drug names
        - Billed charges, patient responsibility, taxes, dispensing fees, etc.
    - RX rebates
        - These amounts will be reduced from all aggregate reimbursements, regardless of how the plan appropriates them
        - If no rebate information is available, UME will apply an estimation until documentation is received
    - A copy of the PBM contract

- Out-of-contract and/or ineligible report
- Itemized case management invoices
- Patient responsibility reports
- Savings fees invoices and supporting documentation
    - Invoices must include billed charges, applicable PPO discount, savings achieved beyond the PPO discount, and the applicable fee for services rendered
    - Copies of original bills and EOBs for each claim that was reviewed for additional savings
- Bank statements for the entire policy period
    - *If the claims reporting does not include the true funding date (the date funds were dispersed to the applicable payee), please provide detailed bank reconciliations for each month of the policy

Upon completion of the audit, a report of findings will be sent. Any discrepancies or disagreements with the findings are to be reported to Heather Helbe. UME strives to have the audit completed within 6-8 weeks upon receipt of all required documentation.

Should you have any questions or concerns regarding this process, feel free to contact me at hhelbe@umexperts.com.

Sincerely,

Heather Helbe
Sr. V.P. of Claims

# Year-End Audit Documentation Checklist

The below list is a summation of the documentation required to complete the year-end audit. Please note additional information may be requested on a case-by-case basis.

- ☐ **Gross paid claims report**
- ☐ **Pending claims report**
- ☐ **Final aggregate report**
- ☐ **Specific claimant report**
- ☐ **Complete check register**
- ☐ **Complete census**
- ☐ **Void and Refund Report**
- ☐ **RX Invoices**
- ☐ **Detailed RX report**
- ☐ **RX rebates**
- ☐ **Out-of-contract and/or ineligible report**
- ☐ **Patient responsibility reports**
- ☐ **Itemized case management invoices**
- ☐ **Savings fees invoices and supporting documentation**
- ☐ **Bank statements and/or detailed bank reconciliations**
- ☐ **PBM contract**

## BANK ACCOUNT INFORMATION FOR ACH TRANSFERS

Please complete the following information for ACH funds transfers.

**Group Name:** ____________________________________________

**Effective Date:**____________________________________________

**Bank Account Number:** ______________________________________

**Bank Account Name:**_________________________________________

**ABA Number:**_______________________________________________

**Bank Name:**________________________________________________

**Bank Address:**______________________________________________

Please submit to: **claims@umexperts.com**