



REINSURANCE CLAIM FORM

Forward to:
 RBS Re
 7301 SW 57th Court, Suite 450
 South Miami, Florida 33143
 Attn: Claims Department.
 (305) 262-2662
 (305) 262-9909 fax

Initial Request for Reimbursement

Subsequent Request for Reimbursement

Reins. Agreement #: _____ Agreement Year: _____ through _____

Company: _____

Covered Person: _____

Claimant: _____ Sex: () M () F

Date of Birth: ___/___/___ Plan Type: () HMO () PPO () POS () Medicare () Medicaid () Other

Relationship of Claimant to Covered Person: _____

Diagnosis/Code: _____ Claimant Effective Date: _____

Health Care Provider	Contracted Facility	Billed Charges	Amount Paid	RBS Eligible Amt
_____	() Yes () No	\$ _____	\$ _____	\$ _____
_____	() Yes () No	\$ _____	\$ _____	\$ _____
_____	() Yes () No	\$ _____	\$ _____	\$ _____
_____	() Yes () No	\$ _____	\$ _____	\$ _____
Total Claim				\$ _____
Company Retention				\$ _____
Subtotal				\$ _____
Reimbursement Percentage				_____ %
Total Reimbursement				
being Requested				\$ _____

COB: () Yes () No If Yes, please indicate name of other Carrier: _____

Accident: () Yes () No If Yes, please indicate How, Where and When accident occurred:

Subrogation/Right of Recovery: () Yes () No If Yes, please provide us with a copy of the signed subrogation letter.

Comments: _____

Submitted by: _____ Title: _____ Date: _____

Address: _____ Tel #: _____ Fax #: _____

- The following items are required before reimbursement request can be processed:
- Eligibility-Copy of the original enrollment application with initial claim submission
 - UB - 92 Hospital Bill Summary
 - Copy of Physician, drug and DME bills (if applicable)
 - Proof of Claim Payment (explanation of benefits or worksheet)