



Mail to : **RBS Re**  
 160 State Street, 7th Floor  
 Boston, Massachusetts 02109  
 Attn: Medical Management Dept.  
 (617) 742-1800 ext. 224  
 Fax to: (617) 742-3480 fax  
 Email to: [MedicalManagement@RBSRe.com](mailto:MedicalManagement@RBSRe.com)

**NOTIFICATION OF POTENTIAL REINSURANCE CLAIM**

*Please use this form to notify RBS of potential claims >75% retention (deductible), inpatient stays > 30 days, neonates, transplants through direct arrangement.*

Company Name : \_\_\_\_\_ Retention\$: \_\_\_\_\_ Agreement #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Plan Type : Commercial \_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Other: \_\_\_\_\_  
 Claimant (Patient) : \_\_\_\_\_ D.O.B.: \_\_\_\_\_ SSN : \_\_\_\_\_  
 Covered Person (Insured) : \_\_\_\_\_ Relationship: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Admitted : \_\_\_\_\_ Discharged: \_\_\_\_\_ Facility : \_\_\_\_\_ NET or OON : \_\_\_\_\_ TAX ID: \_\_\_\_\_  
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 Admitted : \_\_\_\_\_ Discharged: \_\_\_\_\_ Facility : \_\_\_\_\_ NET or OON : \_\_\_\_\_ TAX ID: \_\_\_\_\_  
 Discharged to : \_\_\_\_\_ Other : \_\_\_\_\_ Expired : \_\_\_\_\_ Date Expired : \_\_\_\_\_  
 Diagnosis(es): \_\_\_\_\_ ICD-9: \_\_\_\_\_  
 Clinical Status/Information : \_\_\_\_\_

**NEONATAL** (Sick full term babies on vent, premies 32 wks gestation or earlier, complex congenital anomalies, <1500 gms with Failure to Thrive, etc)

Date of Birth: \_\_\_\_\_ A: Sex: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Apgars: \_\_\_\_\_  
 Gestational Age: \_\_\_\_\_ B: Sex: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Apgars: \_\_\_\_\_  
 Facility at Birth: \_\_\_\_\_ C: Sex: \_\_\_\_\_ Birth Weight: \_\_\_\_\_ Apgars: \_\_\_\_\_  
 NICU Facility: \_\_\_\_\_ City/State: \_\_\_\_\_ NET or OON : \_\_\_\_\_

**ORGAN TRANSPLANT**

Medical Center: \_\_\_\_\_ Transplant Type: \_\_\_\_\_  
 Has Network Been Notified ? \_\_\_\_\_ If Yes, which network ? \_\_\_\_\_ Client's Direct? \_\_\_\_\_  
 Evaluation : \_\_\_\_\_ Transplant Performed? \_\_\_\_\_

Estimated Total Length of Stay : (REQUIRED) \_\_\_\_\_ Prognosis (REQUIRED) : \_\_\_\_\_  
 Negotiated Arrangements : Fixed Fee/ % : \$ \_\_\_\_\_ Negotiated SNF rate: \$ \_\_\_\_\_  
 Estimated Total Payment (for the plan year, past, present and future) : (REQUIRED) \$ \_\_\_\_\_  
 COB: \_\_\_\_\_ Has Subrogation been secured? \_\_\_\_\_ (If Yes please provide copy of the signed subrogation)  
 Accident: \_\_\_\_\_ If Yes, state How, Where and When occurred : \_\_\_\_\_

**RBS NAVIGATOR PROGRAM** (Please check [x] any programs of interest. A RBS representative will contact you)

Claims Repricing/ Bill Negotiations \_\_\_\_\_ Hospital Bill Audit \_\_\_\_\_ Pharmaceutical Network \_\_\_\_\_  
 Catastrophic/Hi Risk Obstetrical Case Management \_\_\_\_\_ Neonatal Case Management \_\_\_\_\_ Organ Transplants \_\_\_\_\_

Submitted by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Tel #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Case Manager : \_\_\_\_\_ Tel # : \_\_\_\_\_ Fax # : \_\_\_\_\_