300 N. Meridian Street, Suite 1710
Indianapolis, IN 46204
Phone: 1-877-884-6475
Fax: 463-203-5151
stoplossclaims@valenzhealth.com

☐ Prompt Pay Discount
☐ Case Management Involved
☐ Advanced Funding

Request for Reimbursement

Group Name: _____

Contract Basis: _____

Employee Name: _____

Date Employed: _____

Full Time: ☐ Yes ☐ No

Cobra: ☐ Yes ☐ No

Effective Date: _____

Specific Deductible: _____

Effective Date: _____

Actively at Work: ☐ Yes ☐ No

Termination Date: _____

If employee is not actively at work, Valenz Health will require documentation as to how coverage is being extended.

Claimant Name: _____ Effective Date: _____ DOB: _____

Diagnosis: _____ Prognosis: _____

LCM: ☐ Yes ☐ No LCM Vendor: _____

If claimant is being followed by large case management (LCM), please provide copies of reports.

Total Paid Claims _____

Less Retention _____

Less Corridor Remaining _____

Less Previous Reimbursements _____

Amount Requested $ 0.00

Claims Request cannot be processed without the Enrollment Card and the following:

Copy of all:
- ☐ Bills
- ☐ Explanation of Benefits
- ☐ Check Reports
- ☐ Deductible & Out of Pocket Proof
- ☐ COBRA Election Form + Proof of Payment
- ☐ R & C Calculations
- ☐ Medicare Election Form
- ☐ Pre-certification Forms

Investigation Materials for:
- ☐ Coordination of Benefits
- ☐ Physicians Statements
- ☐ Workers Compensation
- ☐ Subrogation
- ☐ Large Case Management Reports
- ☐ Hospital Audits
- ☐ Divorce Decrees or Court Orders
- ☐ Cost Containment/Repricing

TPA Name: _____

Prepared By: _____ Date: _____

Phone Number: _____ Email: _____