Greenwich Insurance Company

Specific Claim Reimbursement Form

[ ] Initial Claim [ ] Subsequent Claim [ ] Advance Specific Funding

Employer/Group ______________________ Policy Period ___________________
Policy Type _________________________

Employee Name ______________________ Employee ID# __________________
Claimant Name ______________________ Relationship ________DOB________
Effective Date ______________________ Termination Date ________________
Last Date Worked ____________________ COBRA Effective Date ___________

Primary/ Secondary Diagnosis____
Date of Onset_____________ Prognosis_______________________________________

Total Plan Benefits Paid this Submission ____________________
Less Specific Deductible (Unless Previously Met) ____________________
Reimbursement Requested ____________________

Estimate Future Expenses ____________________

Please include the following information if applicable

[ ] Enrollment Form
[ ] Proof of Credible Coverage
[ ] COBRA Election Form/Payments
[ ] Disability/Leave of Absence/FMLA Time
[ ] Accident Details, Subrogation Documents
[ ] COB Investigation Documentation
[ ] Paid Claim Report or EOB's
[ ] Precertification/Manage Care Reports
[ ] Itemized or Electronic Bills
[ ] Voids, Refunds, Overpayment Requests
[ ] RX Invoices or Detailed RX Report
[ ] Proof of Claim Payments

Submitted by _________________________ TPA ______________________________
Phone _________________________ E Mail ______________________________
Date _________________________

Please provide above form and required documentation too: lori.farrell@ssfllc.com or mail to: Greenwich Insurance Company, Claims Department, 6443 Ridings Road, Suite 101, Syracuse, NY 13206. (315)433-5214 Ext. 207