

**Claim Reporting Form – Medical Excess Reinsurance (Period Certain)**

Claim Reimbursement Request: \_\_\_\_\_

Company: \_\_\_\_\_ Contract Term: \_\_\_\_\_ to \_\_\_\_\_

Contract #: \_\_\_\_\_

Claims Basis – Applicable Incurred and Paid Period: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_  
 (Last Name, First Name)

Subscriber Unique ID #: \_\_\_\_\_ Subscriber Effective Date: \_\_\_\_\_

Subscriber Status: \_\_\_\_\_ Terminated or COBRA Effective Date: \_\_\_\_\_

Name of Claimant: \_\_\_\_\_ Claimant DOB: \_\_\_\_\_  
 (Last Name, First Name)

Relationship to Subscriber: \_\_\_\_\_ Claimant Effective Date: \_\_\_\_\_

Claim is Due to: \_\_\_\_\_ Work Related Claim: \_\_\_\_\_

Automobile Accident: \_\_\_\_\_ Third Party Subrogation Applies: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Will Medical Expenses be Paid by: Auto Insurance: \_\_\_\_\_ Workers Compensation: \_\_\_\_\_ Other (COB etc.): \_\_\_\_\_

Medicare: \_\_\_\_\_ Reason for Medicare Eligibility: \_\_\_\_\_ Medicare Effective: \_\_\_\_\_

Prognosis: \_\_\_\_\_  
 (Please include expected treatment)

Total Amount Paid to Date: \_\_\_\_\_ Incurred From/Thru Date: \_\_\_\_\_ to \_\_\_\_\_

Company Retention: \_\_\_\_\_ Paid From/Thru Date: \_\_\_\_\_ to \_\_\_\_\_

Coinurance Percentage: \_\_\_\_\_ REIMBURSEMENT REQUEST: \_\_\_\_\_

Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Direct inquiries to: PartnerRe America Insurance Company, Attn: Claims Department, 6900 Wedgwood Road North, Maple Grove, MN 55311  
 1 612 234 4920 [claimshealth@PartnerRe.com](mailto:claimshealth@PartnerRe.com)

**INSURANCE FRAUD WARNING:** Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading of insurance fraud and is subject to criminal and/or civil penalties as defined by your state statutes.

This form contains personal and Protected Health Information under HIPAA and may be transmitted only in an HIPAA compliant medium.  
**DO NOT SEND VIA AN UNSECURED E-MAIL TRANSMISSION.**