UME
Underwriting Management Experts

Dear Third-Party Administrators:

Please find all forms required for filing Specific Claims and Aggregate Accommodations with Underwriting Management Experts:

- A list of potential high dollar or catastrophic diagnosis codes
- A 50% Advance Notification
- An Initial Specific Excess Claim Reimbursement Request
- A Supplemental Specific Claim Reimbursement Request
- A Specific Claim Eligibility/Work Status Form
- An Aggregate Report/Tracking Form *(one, two, three and four tier)*
  - This should be submitted on a monthly basis separated by the number of tiers, as specified in the contract terms
- An Advanced Funding Request Form
- A banking form for ACH transfers
- Documentation required for claim submittal
- Coordination of Benefits Questionnaire

Should you have any questions or concerns regarding the completion of these forms, please call us at 855-315-5088.

Thank you,

Diana Remer
Sr. V.P. of Claims

TRADITIONAL CLAIMS KIT

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ICD-10 Code List

A00-B99 INFECTIOUS DISEASES

A41-A41.9 Sepsis
B17.1-B17.11 Hepatitis C

C00-D49 NEOPLASMS

C00-C14 Malignancies of Oral Cavity and Pharynx
C15-C26 Malignant Neoplasms of Digestive Organs
C30-C39 Malignant Neoplasms of Respiratory
C43-C44 Melanoma
C50-C50 Breast Malignancies
C51-C68 Genitourinary Malignancies
C69-C72 Malignancies of Nervous System
C81-C96 Leukemias, Lymphomas and Myelomas

D50-D89 HEMATOLOGIC DISORDERS

D57.1 Sickle Cell Anemia
D61.01 Aplastic Anemia
D66 Hemophilia/Hereditary Factor VIII Deficiency
D69.3 Immune Thrombocytopenic Purpura (ITP)
D80.0-D80.7 Hypogammaglobulinemia
D81.0 Severe Combined Immune Deficiency (SCID)
D82.1 DiGeorge Syndrome
D83.1 Immune Deficiency T Cells (AIDS)
D83.0-D83.9 Common Variable Immunodeficiency
D84.1 Hereditary Angioedema (HAE)

E70-E88 METABOLIC DISORDERS

E74.02 Pompe Disease
E75.21 Fabry Disease
E75.22 Gaucher's Disease
E84.0 Cystic Fibrosis

F01-F99 MENTAL AND BEHAVIORAL DISORDERS

F10-F19 Alcohol/Opioid Abuse
F20-F31 Schizophrenia/Bipolar Disorder
F32-F69 Major Depressive Disorder
F84-F89 Developmental Disorders

G00-G99 DISEASE OF THE NERVOUS SYSTEM

G12.21 Lou Gehrig's Disease (ALS)
G35 Multiple Sclerosis
G61.0 Guillain-Barre Syndrome
G80.0-G80.9 Cerebral Palsy
G91.1 Obstructive Hydrocephalus

I00-I99 DISEASE OF THE CIRCULATORY SYSTEM

I27.0 Primary Pulmonary Hypertension
I42.0-I42.9 Cardiomyopathy
I46.9 Cardiac Arrest
I60.9 Subarachnoid Hemorrhage

J00-J99 DISEASE OF THE RESPIRATORY SYSTEM

J40-J47 Chronic Lower Respiratory Diseases (COPD, Emphysema, Bronchitis, Asthma)
J96.00-J96.92 Respiratory Failure

K00-K95 DISEASE OF THE DIGESTIVE SYSTEM

K50-K51.919 Crohn's/Ulcerative Colitis
K70.0-K74.69 Chronic Liver Disease
K72.00-K72.91 Liver Failure

M00-M99 DISEASES OF THE MUSCULOSKELETAL SYSTEM

M05.10-M06.9 Rheumatoid Arthritis
M15-M19 Osteoarthritis
M32 Systemic Lupus Erythematosus (SLE)
M50 Cervical Disc Disorders
M72.6 Necrotizing Fasciitis

N00-N99 DISEASE OF THE GENITOURINARY SYSTEM

N18.1-N18.9 Chronic Renal Failure

O00-O9A PREGNANCY, CHILDBIRTH AND PUERPERIUM

O30.10-O30.109 Triplet Pregnancy
O30.20-O30.209 Quadruplet Pregnancy
O60.00-O60.14 Preterm Labor

P00-P96 PERINATAL CONDITIONS

P07.00-P07.36 Preterm Infant
P22.0 Respiratory Distress Syndrome of Newborn

Q00-Q99 CONGENITAL MALFORMATIONS

Q05.0-Q05.9 Spina Bifida
Q20-Q28 Congenital Heart Diseases
Q39.0-Q39.4 Tracheoesophageal Fistula
Q41.0-Q42.9 Congenital Absence, Atresia and Stenosis
Q89.7 Multiple Anomalies
Q90.0-Q90.9 Down Syndrome

S00-T88 INJURY, POISONING AND TRAUMA

S06.0-S06.9 Brain Injuries
S12-S14 Spinal Cord Injuries
S88 Amputations
T07 Multiple Trauma Injuries
T20-T32 Burns
T79 Early Complications of Trauma
T86.00-T86.09 Graft vs. Host Disease
T86.90-T86.99 Complications of Transplants

ADVANCED NOTICE OF EXCESS CLAIM REPORT

PLEASE SUBMIT TO: CLAIMS@UMEXPERTS.COM

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Please provide the following information for excess claims that have reached 50% of the specific deductible

Group Name:	Specific Deductible:	Policy Effective Date:

CLAIMANT INFORMATION

Employee Name:	DOB:	Effective Date:
Claimant Name:	DOB:	Effective Date:

Relationship to Employee: ☐ ME ☐ FE ☐ MSP ☐ FSP ☐ MC ☐ FC

Diagnosis *(Include ICD-10 Codes)*:	Original Diagnosis Date:
Initial Date of Treatment:	If Ongoing Treatment:

Current Treatment and Prognosis:

Amount Paid to Date:

Amount Pending:	Reason Pending:

Estimate of Additional Charges:

Please Specify if LCM is Currently in Place: ☐ Yes ☐ No

If Yes, List Contact and Phone:

If No, Specify Reason:

TPA Name:

Address:

Phone:	Email:
Submitted by:	Date:

PLEASE FORWARD ANY LARGE HOSPITAL BILLS, OR NOTICE OF HIGH DOLLAR RX AND/OR TREATMENTS

WARNING: *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.*

ELIGIBILITY DOCUMENTATION LIST

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Please include the following information with all requests:

- Enrollment card, other insurance information, and/or documentation to show current eligibility status. This should be completed and signed by the group's authorized representative.
- Proof deductible and coinsurance were met for all calendar years involved.

Please include the following information when applicable:

- For any leave of absence, date last worked and date returned to active status.
- How coverage is being maintained or continued during the absence from work per provisions in the SPD.
- **COBRA –** all documentation to include:
  - Certified letter offering COBRA
  - Signed COBRA election form
  - Proof of payment of COBRA premiums
- **LEAVE OF ABSENCE**
  - Copy of documentation as specified in the SPD

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SPECIFIC CLAIMANT WORK STATUS FORM

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Please have this form completed and signed by the group's authorized representative. This should be filled out completely.

Group Name:_____ Policy Effective Date:_____

Employee Name:_____ Hire Date:_____

Claimant Name:_____

Original Effective Date of Employee:_____

(Month/Day/Year)

In order to process the specific claim submitted to Underwriting Management Experts, we will need the following information:

1. Time taken off work by the employee for this accident or illness. Please be specific with dates.

_____

_____

2. Explain how the employee-maintained coverage under the plan for the dates listed above.

_____

_____

3. List the date the employee returned to work with a full-time status as defined by the plan document.

_____

_____

4. If the employee has not returned to work, specify how coverage is being maintained. Be sure to include any pertinent documentation to support leave (i.e. signed COBRA election form along with proof of premiums paid, etc.)

_____

If the specific claimant is a dependent, provide the following information:
Other Insurance:_____ Date of Enrollment:_____
Effective Date:_____

_____ Date:_____
(Authorized Employer Representative Signature/Title)

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COORDINATION OF BENEFITS QUESTIONNAIRE

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Member Name: _____

Section A – Basic Information

1. Are you, your spouse, and/or dependents covered under another health, dental, and/or vision plan?
   ☐ Yes ☐ No
2. Is your spouse employed? ☐ Yes ☐ No
   Is your spouse eligible for other coverage through his/her employer? ☐ Yes ☐ No

Employer Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Section B – Policy Information — Only complete Section B if you answered "Yes" to Number 1 in Section A

1. Name of Other Insurance Carrier: _____ Type of Plan: ☐ Group ☐ Individual ☐ Retiree ☐ COBRA
2. Name of Policy Holder: _____ Date of Birth of Policy Holder: _____
3. Coverage Effective Date: _____ Coverage Termination Date: _____
4. Please list names of those covered under other plan:

_____	☐ Medical	☐ Dental	☐ Vision
_____	☐ Medical	☐ Dental	☐ Vision
_____	☐ Medical	☐ Dental	☐ Vision

Section C – Dependent Child(ren) Information

1. Are you or your spouse legally divorced or separated from the parent of any dependent child(ren) on this policy?
   ☐ Yes ☐ No
2. Does one parent/guardian have full custody of the child(ren)?
   ☐ Yes ☐ No

   If "Yes", which parent/guardian? _____ Which child(ren)? _____
3. Is one parent required by a court decree to provide health insurance coverage for the child(ren)?
   ☐ Yes ☐ No

   If "Yes", which parent/guardian? _____ Which child(ren)? _____

If other coverage is in place due to a court order, please include the court ordered policy information in Section B above

Section D – Medicare — Attach a copy of your Medicare card

1. Policy Holder's Name	Medicare Coverage				Reason for eligibility under Medicare *(Check all that apply)*		
_____	☐ A	☐ B	☐ C	☐ D	☐ Age *(65 or over)*	☐ Disability	☐ End Stage Renal
_____	☐ A	☐ B	☐ C	☐ D	☐ Age *(65 or over)*	☐ Disability	☐ End Stage Renal

2. If you checked Disability and/or End Stage Renal, attach a copy of the Medicare documentation.

Section E - Signature

I hereby certify that the above statements are true and correct to the best of my knowledge.

Member Signature _____ Date _____

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INITIAL SPECIFIC EXCESS CLAIM SUBMISSION FORM

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Group Name:_____ Terms:_____ Policy Effective Date:_____

Employee Name:_____ DOB:_____ Effective Date:_____

Is Employee Currently Active at Work: Y N If no, how is coverage being maintained:_____

Claimant Name:_____ DOB:_____ Effective Date:_____

Diagnosis Code(s):_____ Original Date of Diagnosis:_____

TPA Paid to Date Amount: $_____

Less Specific Deductible: $_____

Less Aggregate Specific: $_____

Requested Amount: $_____

Please include the following with the initial submission (additional information may be requested):

- Enrollment, eligibility information - Enrollment card or any correlating documentation, other insurance information if applicable
- Current work status (attach additional form) including dates claimant missed work
- If applicable, COBRA documentation and COBRA premiums paid to date, FMLA documentation
- If applicable, accident details including police reports and signed subrogation forms
- Precertification(s), operative reports, LCM reports, UR Notes, medical records
- Paid reports in Excel reflecting the following:
  - Provider information
  - Diagnosis codes and procedure codes
  - Billed amounts, PPO discounts, amounts paid
  - Any deductible, co-pay, or OOP processed for the claim

*****Please contact UME if you are unable to acquire a discount*****

TPA Name:_____

Address for Reimbursement:_____

_____

Phone:_____ E-mail:_____

Submitted By:_____ Date:_____

PLEASE SUBMIT CLAIMS TO: **claims@umexperts.com**

WARNING: *It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.*

SUPPLEMENTAL SPECIFIC EXCESS SUBMISSION FORM

PLEASE SUBMIT TO: CLAIMS@UMEXPERTS.COM

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Underwriting Management Experts

	Submission #:	
Group Name:	Policy Effective Date:	Terms:
Employee Name:		DOB:
Claimant Name:		DOB:
Current Work Status: ☐ Active ☐ Leave of Absence/Disability ☐ FMLA ☐ COBRA ☐ Retired ☐ Deceased, *Date:*		
Diagnosis:		
Discount Claim: ☐ **Yes** ☐ **No**		If **Yes**, date payment required:
LCM: ☐ **Yes** ☐ **No**		If **Yes**, include most recent reports.
TPA Paid to Date Amount:	$	
Current Requested Amount:	$	

PLEASE NOTE: All Supplemental requests must meet or exceed $1,000, apart from the final submission.

Please include all pertinent documentation. This may include but is not limited to:

- Precertification(s)
- Provider Information
- Claim Reports in Excel
- Savings Fee Invoices
- LCM Notes
- Updated Work Status

Additional Information may be requested. ***Please contact UME if you are unable to acquire a discount.***

TPA Name:	
Address for Reimbursement:	
Phone:	Email:
Submitted By:	Date:

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ADVANCED FUNDING CLAIM SUBMISSION FORM

PLEASE SUBMIT TO: CLAIMS@UMEXPERTS.COM

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Underwriting Management Experts

	Submission #:	
Group Name:	Policy Effective Date:	Terms:
Employee Name:		DOB:
Claimant Name:		DOB:
Current Work Status: ☐ Active ☐ Leave of Absence/Disability ☐ FMLA ☐ COBRA ☐ Retired ☐ Deceased, *Date:*		
Diagnosis:		
Discount Claim: ☐ **Yes** ☐ **No**	If **Yes**, date payment required:	
LCM: ☐ **Yes** ☐ **No**	If **Yes**, include most recent reports.	
TPA Paid to Date Amount: $		
Reimbursement Requested Amount: $		
Advanced Funding Requested Amount: $		
Total Requested Amount: $		

PLEASE NOTE: All Advanced Funding requests must meet or exceed $1,000. Advanced Funding may be requested up to 30 days from the end of the policy terms. Please include all pertinent documentation. This may include but is not limited to:

- Precertification(s)
- Provider Information
- Claim Reports in Excel
- Savings Fee Invoices
- LCM Notes
- Updated Work Status

Additional Information may be requested. ***Please contact UME if you are unable to acquire a discount.***

TPA Name:	
Address for Reimbursement:	
Phone:	Email:
Submitted By:	Date:

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TRADITIONAL CLAIMS KIT

UME
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Dear Valued Clients,

We would like to take a moment to inform you of our policies and procedures regarding year-end audits of aggregate claims. UME's procedures and the necessary documentation needed to ensure a streamlined audit process are as follows:

- The year-end aggregate claim must be submitted within 15 days of the end of the aggregate benefit period. This requirement is for any group that received reimbursement during the plan year, regardless if funds are being requested at year-end.
- If an outside vendor is contracted to perform the audit, UME will provide the vendor information.
- All documentation required to complete the year-end audit must be received within 90 days of the end of the aggregate benefit period. The below information is required to begin the year-end audit. ***PLEASE NOTE:*** *Additional information may be requested on a case-by-case basis.*

- Gross paid claims report encompassing the entirety of the policy period, inclusive of the following:
  - ✔ Claimant names
  - ✔ Incurred dates
  - ✔ Paid dates and/or funding dates*
  - ✔ Provider information
  - ✔ CPT codes
  - ✔ DX codes
  - ✔ In-network and OON status of the claim
  - ✔ Billed charges, PPO discount *(if applicable)*, patient responsibility, etc.
- Pending claims report
- Final aggregate report
- Specific claimant report inclusive of paid and/or pending amounts
- A complete check register
- Year-end census for the entire policy period, inclusive of effective and termination dates
- A void and refund report
- RX invoices
- A complete detailed RX report, inclusive of the following:
  - ✔ Claimant names
  - ✔ Fill dates
  - ✔ Drug names
  - ✔ Billed charges, patient responsibility, taxes, dispensing fees, etc.
- RX rebates
  - These amounts will be reduced from all aggregate reimbursements, regardless of how the plan appropriates them
  - If no rebate information is available, UME will apply an estimation until documentation is received
- A copy of the PBM contract
- Out-of-contract and/or ineligible report
- Itemized case management invoices
- Patient responsibility reports
- Savings fee invoices and supporting documentation
  - Invoices must include billed charges, applicable PPO discount, savings achieved beyond the PPO discount, and the applicable fee for services rendered
  - Copies of original bills and EOBs for each claim that was reviewed for additional savings
- Bank statements for the entire policy period
  - *If the claims reporting does not include the true funding date *(the date funds were dispersed to the applicable payee)*, please provide detailed bank reconciliations for each month of the policy

Upon completion of the audit, a report of findings will be sent. Any discrepancies or disagreements with the findings are to be reported to Heather Helbe. UME strives to have the audit completed within 6-8 weeks upon receipt of all required documentation.
Should you have any questions or concerns regarding the process, feel free to contact me at **dremer@umexperts.com.**

Sincerely,

Diana Remer
Sr. V.P. of Claims

TRADITIONAL CLAIMS KIT

PLEASE SUBMIT TO: CLAIMS@UMEXPERTS.COM

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Year-End Audit Documentation Checklist

The below list is a summation of the documentation required to complete the year-end audit. Please note additional information may be requested on a case-by-case basis.

- ☐ Gross Paid Claims Report
- ☐ Pending Claims Report
- ☐ Final Aggregate Report
- ☐ Specific Claimant Report
- ☐ Complete Check Register
- ☐ Complete Census
- ☐ Void and Refund Report
- ☐ RX Invoices
- ☐ Detailed RX Report
- ☐ RX Rebates
- ☐ Out-of-Contract and/or Ineligible Report
- ☐ Patient Responsibility Reports
- ☐ Itemized Case Management Invoices
- ☐ Savings Fee Invoices and Supporting Documentation
- ☐ Bank Statements and/or Detailed Bank Reconciliations
- ☐ PBM Contract

BANK ACCOUNT INFORMATION FOR ACH TRANSFERS

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PLEASE SUBMIT TO: **CLAIMS@UMEXPERTS.COM**

Please complete the following information for ACH fund transfers.

Group Name:

Effective Date:

Bank Account Number:

Bank Account Name:

ABA Number:

Bank Name:

Bank Address: