CLINICAL NOTICE SUBMISSION PROCESS

1. The attached clinical notification form should be used by the medical management staff to notify Summit Re of potential cases in which high dollar claims may be incurred or where Summit ReSources may be of assistance to you.
2. Complete the Clinical Notification Form *(all sections that apply to your case).*
    a. Demographic information
        i. Member name
        ii. Patient name
        iii. Member number
        iv. Patient date of birth
    b. Amount of eligible expenses paid to date *(check with claims/finance)*
        i. Professional
        ii. Hospital
        iii. Other
    c. Total amount of claim expected
    d. Dates of services
    e. Billed received – if you have received a claim for services rendered, are there questionable charges or charges that appear to exceed reasonable and customary? If yes, please explain.
    f. Diagnosis – you may use either ICD-10 codes or disease descriptions. Please include all pertinent diagnoses
    g. Prognosis and current treatment plan – please be as specific as possible.
    h. Inpatient facility
        i. Name
        ii. In-network?
        iii. If out-of-network, has a rate been negotiated and if so, what is it?
        iv. Expected length of stay (LOS)
    i. High cost drugs
        i. Name of drug
        ii. Frequency
        iii. Expected cost per month
        iv. Drug distributor used
    j. Is the member receiving dialysis
        i. In-network provider?
        ii. If out-of-network, has a rate been negotiated and what is it?
        iii. Dialysis costs per month
        iv. Referral for transplant? If not, why?
        v. Dialysis start date
    k. Out-of-network services
        i. Is the member receiving any services out-of-network other that those services listed on this form that are covered by the reinsurance agreement?
        ii. Has a rate been negotiated? If so, what is it?
        iii. Type of service
    l. Is an outside vendor performing case management? If so, name of company.
    m. Is the member in a NICU?
        i. Is the facility in-network?
        ii. If out-of-network, has a rate been negotiated? If so, what is it?
        iii. Expected length of stay (LOS)

n. Form completed by
    i. Name
    ii. Title
    iii. Phone
    iv. Email address

3. Completed forms may be faxed to 260-469-3014, emailed via encrypted software to eslclaims@summit-re.com or mailed to Summit Reinsurance Services, 7030 Pointe Inverness Way, Suite 350, Fort Wayne, IN 46804.
4. In lieu of the clinical notification form, you may submit a report containing similar information.

Please contact us with questions or concerns:

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