



LARGE CLAIM ALERT

To: Perico Life Claims Department

Referral Date: _____

From: _____

UR/UM Vendor: _____

Company

Contact

Telephone No.

Employer: _____

Specific Deductible: _____

Policy Number: _____

Policy Period: _____

Case Mgmt.: _____

Company

Contact

Telephone No.

COVERED PERSON/PATIENT DEMOGRAPHICS – PROVIDER INFORMATION

Covered Person: _____

Social Security No.: _____

Patient: _____

Date of Birth: _____

Relationship to Covered Person: _____

Patient Eligibility Date: _____

Covered Person Address: _____

Insured Eligibility Date: _____

Insured Telephone Number: _____

Attending Physician: _____

Telephone Number: _____

Physician Address: _____

Patient Diagnosis: _____

Date of Loss: _____

Planned Procedure (if known): _____

Prognosis: _____

Hospital: _____

Telephone Number: _____

Address: _____

Contact: _____

Does this facility participate in a local PPO? Yes [] No []

Are Case Management services active at this time? Yes [] No []

Claims Paid During this Policy Period: \$ _____

Reason for Referral to Perico Life: _____