Catastrophic Inmate Medical Insurance Claim Procedures

The Insurance Carriers provide claims review and monitoring services. As part of this process, it is requested that the procedure outlined below be followed closely.

1) Please notify Alliant Insurance Services,Inc within 48 hours of any potential claim by sending a completed **48 Hour Notification Form** to Mariana Salyer at MSALYER@ALLIANT.COM or Fax the completed form to (619)699-0901.

2) Before a claim can be considered for reimbursement, the following "Proof of Loss" information must be submitted:

   A) A complete **Specific Claim Proof of Loss Notification Form** detailing the request for benefit payments.

   B) A **copy of all itemized medical and hospital bills** for the requested reimbursement.

   C) A **copy of all checks issued in payment** for each claimant.

   D) A **statement from the jail facility** providing incarceration dates.

After the company receives the above information, the claim is reviewed. Claims are usually paid within 60 days. Claim forms are included in this packet and may be duplicated as needed.

IMPORTANT:

Eligible expenses incurred after a policy is cancelled or non-renewed are not eligible for reimbursement.

CIMI 48 Hour Notification Form - Hospital Admittance

Jail Information

Name of Jail Facility: _____

Address of Jail Facility: _____

_____

Current Policy # (REQUIRED): _____ Policy Eff. Date: _____

Jail/Sheriff's Office Contact (THIS MUST BE THE PERSON IN CHARGE OF MAKING INMATE MEDICAL DECISIONS)

Name: _____ Title: _____

Email: _____ Phone: _____

Inmate Information

Name: _____ DOB: _____

Jail ID # (REQUIRED): _____

Incarcreation Date: _____

Hospital Information

Name of Hospital Admitted To: _____

Hospital Contact Name: _____

Contact's Title: _____ Contact's Phone #: _____

Date Admitted: _____ Hospital Discount Agreement %: _____

Type of Injury: _____

Expected Hospital Release Date: _____ Expected Claim? ☐ Yes ☐ No

Prognosis _____

CIMI—Specific Claim Proof of Loss Notification Form

INSURED INFORMATION	
Facility Name:	
Effective Date:	Expiration Date:
Supervisor/Administrator:	Policy Number:
CLAIMANT INFORMATION	
Claimant:	Date of Birth:
Incarceration Date:	Date Released:
CLAIM INFORMATION	
If Accident, Date:	Location:
Describe Accident:	
Nature of Injury:	
If Illness, Diagnosis:	Date First Consulted Physician:
Attending Physician Name:	Attending Physician Phone:
Attending Physician Address:	Attending Physician City, State, Zip:
Hospital Name:	Hospital Phone:
Hospital Address:	Hospital City, State, Zip:
Is claimant still hospitalized?	Is large case management involved?
Is claimant receiving continuing treatment?	Is subrogation available?
Prognosis:	
Is there any other collectible insurance for this claim?	
Total benefits submitted:	Less specific dedubtible:
	Reimbursable claim:

DOCUMENTATION

If this is an Initial Proof of Loss, please include copies of the following documentation:

1. Itemized Hospital Bills
2. Copy of checks paid to providers
3. Completed Claim Form

If this is a continuing claim, please provide claim number:

I hereby represent that to the best of our knowledge, the information provided is complete and correct.

Submitted By:_____ Title:_____ Date:_____

CIMI—Specific Claim Proof of Loss Supplemental Claim Form

Inmate Name: _____

DOB: _____

Primary Diagnosis: _____

Current Lloyd's of London Policy Number: _____

Insured Check Date	Insured Check Amount	Incurred Date Range
MM/DD/YY	$X,XXX.XX	From (MM/DD/YY): To (MM/DD/YY):
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	
	$	

Authorized Signature: _____ Date: _____

TOTAL Insured Check Amount: $_____

Less Specific Deductible: $_____

Reimbursement Amount: $_____