SLG
BENEFITS & INSURANCE, LLC

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TPA REPRICING REFERRAL FORM

Date________________

From____________________________________ Phone_____________ Fax______________________

Plan Sponsor Name_________________ Policy Effective Date_________ Contract Basis____________

Specific Deductible $________________________ Has this deductible been satisfied? Y ☐ N ☐

Employee Name____________________________ SS#_____________________

Claimant Name______________________________ D.O.B_________ SS#_____________________

Claimant Eligibility Date________________ Claims Paid to date for this policy period $____________

Individual Plan Deductible $______ Has this been met? Y ☐ N ☐ If No, what amount remains? $___________

Out of Pocket $_______ Has this been met? Y ☐ N ☐ If No, what amount remains? $_________

Out of Network Deductible $______ Has this been met? Y ☐ N ☐ If No, what amount remains? $___________

Quick pay turnaround ☐ Limits if any____

Plan Sponsor check generation schedule____

Reason for submission: No PPO ☐ Out of Network ☐ Questionable charges ☐ Other

Comments____

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TPA____________________________ Telephone____________________ Fax____________________

Street Address___________________________ City__________ State______ Zip Code____________

Prepared by (please print legibly)____ Date________________

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