CRUM & FORSTER®
A FAIRFAX COMPANY

Email to: CrumCC@cfins.com

REQUEST FOR COST CONTAINMENT

Date Submitted: Telephone #:

REQUESTOR/TPA/MGU:

EMPLOYER GROUP NAME:

CLAIMANT INFORMATION

Claimant Name: DOB:

Diagnosis:

Facility/Provider:

CLAIMS INFORMATION

DOS – From: To: Billed Charges: $

Has the claim been paid: ☐ Yes ☐ No Total Paid: $

Is there some type of Network discount? ☐ Yes ☐ No Network:

Type of Network Discount: ☐ % of billed charges ☐ Per Diem ☐ Case Rate ☐ DRG ☐ Unknown

Discount amount: $ Discount %: Discount expires on

Comments/Special Instructions/Benefit limitations:

TYPE OF SERVICE REQUESTED

☐ Prescreen and call to discuss ☐ Sign-Off ☐ Bill Review ☐ Negotiations ☐ Transplant ☐ Dialysis ☐ Neonatal

☐ Physician Specialty Review ☐ Specialty Pharmacy ☐ Air Ambulance ☐ Implant ☐ No ☐ Other

***Please attach CLAIMS (UB and IB), Medical Records and CM report if available.**