CRUM & FORSTER
A FAIRFAX COMPANY

Email to: ReClaim@cfins.com

REQUEST FOR COST CONTAINMENT

Date Submitted: Requested by:

EMPLOYER GROUP NAME:

PROGRAM: Direct ESL Program ESL INO Other

CLAIMANT INFORMATION

Claimant Name: DOB:

Diagnoses:

Facility/Provider:

CLAIMS INFORMATION

DOS: – Billed Charges: $

NETWORK DISCOUNT: Network: Discount amount: $

Discount % Allowable amount: $

HAS THE CLAIM BEEN PAID? Yes No Total/Partial Payment: $

TYPE OF DISCOUNT: % of Billed Charges Per Diem Case Rate DRG PBM RBP Unknown

DOMESTIC REDUCTION: % POLICY HAS COST CONTAINMENT LANGUAGE: Yes No

Comments/Special Instructions/Benefit limitations:

TYPE OF SERVICE REQUESTED

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

Physician Specialty Review Specialty Pharmacy Neonatal Air Ambulance Implant Other

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