SKYWARD SPECIALTY INSURANCE | Accident & Health

SKYWARD SPECIALTY INSURANCE
600 TOWNPARK LANE, SUITE 500, KENNESAW, GA 30144
713.935.4800 | 800.796.9165 (TOLL FREE) | CLAIMS FAX: 610.280.4299

AGGREGATE MONTHLY ACCOMMODATION REIMBURSMENT REQUEST

Policyholder: _____ Policy Period: _____

Carrier: _____ Contract Basis: ☐ 12/12 ☐ 12/15 ☐ Other _____
☐ 12/18 ☐ Paid

Accommodation: ☐ Monthly ☐ Weekly

A.	Total Claims Paid:	$ _____
B.	**LESS** Aggregate Deductible: (The greater of: the Calculated or Minimum Aggregate Deductible)	-$ _____
C.	**LESS** Amounts Excess of Per Person Limit:	-$ _____
D.	**LESS** Exceptions, Admin Fees and other ineligible claims:	-$ _____
	SUBTOTAL:	$ _____
E.	**LESS** Previous Accommodation reimbursements:	-$ _____
	REQUESTED AMOUNT:	$ _____

NOTE: Monthly Accommodations MUST be submitted by the 15th of the month to be eligible for reimbursement. Accommodations are NOT eligible during the last month of the policy.

Send claims and required documentation to ah-aggregate@skywardinsurance.com or fax to 713.935.4801

The following information is required when filing an accommodation reimbursement request. Please submit reports in an Excel format when possible.

1. Medical Paid Claims Detail report
2. Aggregate report
3. RX Paid Claims Detail report
4. Check Register

_____ _____
Preparer Date

_____
Claims Administrator

_____
Address

_____ _____ _____
Phone Fax Email