300 N. Meridian Street, Suite 1710
Indianapolis, IN 46204
1-877-884-6475
463-203-5151 – Fax

stoplossclaims@valenzhealth.com

Potential Claim Notification

Name of Group: _____ Effective Date: _____

Contract Basis: _____ Name of Employee: _____

Full Name of Claimant: _____

Beginning Date of Illness/Injury: _____ Claim Amount to Date: _____

Primary and Secondary Diagnosis: _____

Prognosis: ☐ Excellent ☐ Fair ☐ Poor ☐ Terminal ☐ Deceased

Future Treatment or Surgeries:

_____

_____

CPT Surgery Codes: _____

TPA Name: _____

Submitted by: _____ Date: _____

Phone: _____ Email: _____