CIGNA Physician Settlement
Settlement Administrator
P.O. Box 3170
Portland, 97208-3170

For Official Use Only

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

MDL NO.: 1334

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES ONLY TO PROVIDER TRACK CASES

CIGNA HEALTHCARE PHYSICIAN SETTLEMENT PROOF OF CLAIM FORM FOR MEDICAL NECESSITY DENIAL COMPENSATION

DEADLINE FOR SUBMISSION: POSTMARKED BY FEBRUARY 18, 2005.

Medical Necessity Denial Compensation is available **only** for denials of payment for services or supplies represented by CPT® Codes or HCPCS Level II Codes determined by CIGNA HealthCare to be either experimental or investigational or not Medically Necessary. It does not include denials or reductions based on payment and benefit limitations (*e.g.,* coordination of benefit rules, violations of preauthorization requirements or referral requirements, limitations stemming from capitation or other risk-bearing agreements with the Class Member submitting the claim or with other health care providers or where the services or supplies were excluded from coverage under the CIGNA HealthCare Member's Plan Documents). To obtain a list of the types of Clinical Information to include with your Medical Necessity Denial Proof of Claim, visit www.CIGNAPhysicianSettlement.com or call the Settlement Administrator toll-free at 1-877-683-9363.

A single Proof of Claim Form may be used to submit multiple requests for Medical Necessity Denial Compensation. A separate cover sheet must precede each individual request for payment. Each individual request for payment must relate to a single episode of care, although it may seek compensation for multiple CPT® Codes or HCPCS Level II Codes. The cover sheet is attached to this Form.

Physician Groups and Physician Organizations may submit Proofs of Claim on behalf of Physicians employed by or otherwise working with them at the time that the original claims were made, without the necessity of individual signatures from the individual Physicians; provided, however, that the Class Member that submits the Proof of Claim Form must be the Physician, Physician Group or Physician Organization that originally submitted the claim and must use the same tax identification number as was used on the original claim when submitting the Proof of Claim.

PLEASE NOTE: If you file a Category A Settlement Fund Claim Form, you are not eligible for Medical Necessity Denial Compensation and may not use this Proof of Claim Form.

Capitalized terms used in this Proof of Claim Form that are not otherwise defined herein have the meaning assigned to them in the Settlement Agreement.

COMPLETE ALL SECTIONS AND SIGN THE CERTIFICATION IN SECTION II.

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SECTION I: PHYSICIAN INFORMATION

Name of Physician:

First Name MI Last Name

Name of Physician Group or Physician Organization (if applicable):

CIGNA HealthCare Provider Number (if applicable):

Tax Identification Number: EIN OR Social Security Number (if TIN unavailable)

Address:

City State Zip

Country (if not U.S.):

E-mail Address (optional):

SECTION II: CERTIFICATION

Failure to sign this Certification will result in denial of your Proof of Claim.

I hereby certify the following:

1. As to each request for Medical Necessity Denial Compensation that accompanies this Proof of Claim Form:

   (a) the CPT® or HCPCS Level II Code(s) for which payment (or additional payment) is requested describe services or supplies that were actually provided to a CIGNA HealthCare Member during the Class Period;

   (b) the payment (or additional payment) requested has not already been made by CIGNA HealthCare on resubmission of the claim or on an appeal; and

   (c) there has been no prior final judgment, arbitration ruling or settlement with respect to the payment or additional payment that is being requested.

2. If I have submitted internal accounting records in support of a Medical Necessity Denial request for payment, the CIGNA HealthCare Remittance Form and the HCFA 1500 (now CMS 1500) or other claim form originally submitted to CIGNA HealthCare cannot be located and are not available for submission.

3. I understand that if I billed the CIGNA HealthCare Member to whom services or supplies were provided for the amount not originally paid by CIGNA HealthCare, and if the CIGNA HealthCare Member reimbursed me for such amount, it is expected that I will reimburse the CIGNA HealthCare Member with any amount paid pursuant to the Settlement Agreement.

4. I have not submitted a Category A Settlement Fund Claim Form.

First Name MI Last Name

Signature

Date (MM DD YYYY)

SECTION III: DOCUMENTATION NEEDED FOR EACH MEDICAL NECESSITY DENIAL REQUEST FOR PAYMENT

For each separate Medical Necessity Denial request for payment that you are submitting, complete a cover sheet (attached to this Form). Documentation that supports that request for payment should follow the cover sheet.

Failure to include sufficient documentation with each cover sheet will result in denial of your request for payment.

Checklist for Medical Necessity Denial Claims:

- This Proof of Claim Form, with signed certification. You may use one Proof of Claim Form to submit multiple Medical Necessity Denial requests for payment.
- A cover sheet for each request for payment. In order for your request for payment to be processed, you must include on the cover sheet: 1) the subscriber Social Security Number; 2) the patient name; 3) the date of service; 4) the provider TIN (or Social Security Number if TIN unavailable); and 5) the CPT® Code(s) or HCPCS Level II Codes for which payment was denied or reduced.
- Documentation for each request for payment, preceded by the cover sheet, showing that a claim for services or supplies was submitted to CIGNA HealthCare and payment was denied for one or more CPT® Codes or HCPCS Level II Codes due to CIGNA HealthCare's determination that the services, procedures or supplies corresponding to such codes were either not Medically Necessary or were experimental or investigational. Acceptable documents are true and correct copies of:
  - ⇒ CIGNA HealthCare Remittance Form (i.e., Explanation of Payments form) showing that payment was denied for one or more CPT® or HCPCS Level II Codes; **or**
  - ⇒ If you cannot locate the Remittance Form, internal accounting records (e.g., printouts of accounts receivable records or paid account records) if those records show that the CPT® Codes or HCPCS Level II Codes at issue were submitted to CIGNA HealthCare for payment and remain unpaid.

and

- A complete copy of the clinical, operative, or other medical records generated in connection with the services you provided. Clinical, operative or other medical records that relate to dates of service occurring more than ninety (90) days before the date of service at issue in the request for payment do not need to be submitted.

SECTION IV: AGREEMENT TO SUBMIT TO THE JURISDICTION OF THE COURT

By submitting a Proof of Claim, you are agreeing to be subject to the jurisdiction of the United States District Court for the Southern District of Florida for any proceedings relating to that Proof of Claim.

SECTION V: SUBMISSION OF PROOF OF CLAIM TO SETTLEMENT ADMINISTRATOR

Your completed Proof of Claim Form, with all required documentation, must be mailed to the Settlement Administrator at the following address:

CIGNA Physician Settlement
Settlement Administrator
P.O. Box 3170
Portland, OR 97208-3170

Any request for Medical Necessity Denial Compensation postmarked after February 18, 2005 is not a Valid Proof of Claim and will be denied by the Settlement Administrator.

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CONTAINS PATIENT IDENTIFIABLE MEDICAL PRIVACY INFORMATION

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CIGNA HEALTHCARE PHYSICIAN SETTLEMENT

COVER SHEET FOR REQUEST FOR MEDICAL NECESSITY DENIAL COMPENSATION

For each separate request for Medical Necessity Denial Compensation that you are submitting, complete this cover sheet including the CPT® Code(s) or HCPCS Level II Code(s) for which payment (or additional payment) is sought. You may attach additional pages as necessary.

Documentation that supports each separate request for payment should follow the completed cover sheet.

Failure to include sufficient documentation with each cover sheet will result in denial of your request for payment.

Episode of care for which compensation (or additional compensation) is sought in this Medical Necessity Denial request for payment:

Subscriber Social Security Number

Provider TIN

Date of Service (MM DD YYYY)

Provider SSN (if TIN unavailable)

Patient First Name

MI

Patient Last Name

	Code	Modifier		Code	Modifier
1.			11.		
2.			12.		
3.			13.		
4.			14.		
5.			15.		
6.			16.		
7.			17.		
8.			18.		
9.			19.		
10.			20.		