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 CATEGORY ONE COMPENSATION

DEADLINE FOR SUBMISSION: Postmarked by [_____] [180 days after commencement of the Claims Period].

- *Category One Compensation is available **only** for denials of payment based on Claim Coding or Bundling Edits for Category One Codes in the specific circumstances and within the date of service limitations (if any) identified on the Category One Code List. The Category One Code List is available on the website maintained by the Settlement Administrator and is also available through Class Counsel. The Category One List is attached as Exhibit 1 to the Settlement Agreement.*

- *A single Proof of Claim Form can be used to submit multiple requests ("Proofs of Claim") for Category One Compensation. A separate Proof of Claim cover sheet, with attached documentation, must be used for each Proof of Claim. The Proof of Claim cover sheet is attached to this Proof of Claim Form.*

- *To the extent they are authorized to do so, Physician Groups and Physician Organizations may submit Proofs of Claim on behalf of Physicians employed by or otherwise working with them without the necessity of individual signatures from the individual Physicians; provided, however, that the Class Member who or which submits the Proof of Claim Form must be the Physician, Physician Group or Physician Organization who or which originally submitted the claim and must use the same tax identification number or numbers as were used on the original claim.*

- ***PLEASE NOTE:** If you file a Category A Settlement Fund Claim Form, you are not eligible for Category One 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.

SECTION I: PHYSICIAN INFORMATION

Name of Physician: _____

Name of Physician Group, Physician Organization, Partnership, Hospital, or Corporation (if applicable): _____

CIGNA HealthCare Provider Number (if applicable): _____

Tax Identification Number: _____

Address: _____

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 Proof of Claim for Category One Compensation that accompanies this Proof of Claim Form:

   (a) the Category One Code(s) for which payment (or additional payment) is requested describe services 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 additional payment that is being requested.

2. If I have submitted internal accounting records in support of a Category One Proof of Claim, 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.

Name (Last, First, M.I.)	Signature
Date	Title (if applicable)

SECTION III: DOCUMENTATION NEEDED FOR EACH CATEGORY ONE PROOF OF CLAIM

For each separate Category One Proof of Claim that you are submitting, complete a cover sheet (attached to this Form) indicating the CPT® Code(s) for which compensation (or additional compensation) is sought. Attach the documentation that supports that Proof of Claim behind the cover sheet.

Failure to include sufficient documentation with each Proof of Claim cover sheet will result in denial of your Proof of Claim.

Checklist for Category One Claims:

- This Proof of Claim Form, with signed certification. You may use one Proof of Claim Form to submit multiple Category One Proofs of Claim.
- A cover sheet for each Proof of Claim indicating the CPT® Code(s) for which compensation (or additional compensation) is sought.
- Documentation for each Proof of Claim, attached to the cover sheet, showing that payment was denied by CIGNA HealthCare for one or more Category One Codes under the circumstances and within the date of service limitations (if any) set forth in the Category One Code List. Acceptable documents are true and correct copies of:
  - CIGNA HealthCare Remittance Form (*i.e.*, Explanation of Payments form) showing payment was denied; **or**
  - For those items not asterisked on the Category One Code List, the HCFA 1500 form (now CMS 1500) or other claim form showing that the Category One Codes were originally submitted to CIGNA HealthCare for payment and were denied; **or**
  - If the Remittance Form and HCFA 1500/CMS1500 or other claim form cannot be located, internal accounting records (*e.g.*, printouts of accounts receivable records or paid account records) showing, as to the claim at issue, that the Category One Codes were originally submitted to CIGNA HealthCare for payment under the specific combinations and within the date of service limitations set forth on the Category One Code List and that those remain unpaid.

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

Mail your completed Proof of Claim Form, with all required documentation for each Proof of Claim, to the Settlement Administrator at the following address:

Poorman-Douglas Corporation
[Address]
[Address]

Any request for Category One Compensation postmarked after [_____] is not a Valid Proof of Claim and will be denied by the Settlement Administrator.

CONTAINS PATIENT-IDENTIFIABLE
MEDICAL PRIVACY INFORMATION

CIGNA HEALTHCARE PHYSICIAN SETTLEMENT
PROOF OF CLAIM

COVER SHEET FOR REQUEST
FOR CATEGORY ONE COMPENSATION

For each separate request for Category One Compensation that you are submitting, fill out this cover sheet indicating the CPT® Code(s) for which compensation (or additional compensation) is sought. The Category One Code List is available on the website maintained by the Settlement Administrator.

Attach the documentation that supports each separate request for compensation behind the completed cover sheet.

Failure to include sufficient documentation with each Proof of Claim cover sheet will result in denial of your Proof of Claim.

CPT® Code(s) for which compensation (or additional compensation) is sought in this Category One Proof of Claim: