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 TWO COMPENSATION

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

- *Category Two Compensation is available **only** for denials or reductions of payment based on Claim Coding or Bundling Edits other than the Claim Coding or Bundling Edits on the Category One Code Lists. Category Two Compensation is **not** available for denials or reductions of payment based on Claim Coding or Bundling Edits for Category One Codes unless those claims were billed outside the circumstances and 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 Code 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 Two 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 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.*

- *If Category One Compensation is available for a Proof of Claim, you may not receive Category Two Compensation for that Proof of Claim.*

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

EXHIBIT 12

- *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 Two Compensation that accompanies this Proof of Claim Form:

   (a) the CPT® Code(s) 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) being 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 Category Two 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 TWO PROOF OF CLAIM

For each separate Category Two Proof of Claim that you are submitting, complete a cover sheet (attached to this Form) indicating the CPT® Code(s) or HCPCS Level II 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 Two Claims:

- This Proof of Claim Form, with signed certification. You may use one Proof of Claim Form to submit multiple Category Two Proofs of Claim.
- A cover sheet for each Proof of Claim indicating the CPT® Code(s) or HCPCS Level II Code(s) for which compensation (or additional compensation) is sought.
- Documentation for each Proof of Claim, attached to the cover sheet, showing that (i) you were denied payment, in whole or in part; or (ii) you received reduced payment, including payment for a different billing code than the one(s) billed, for one or more CPT® Code(s) or HCPCS Level II Code(s); or (iii) you received a reduced payment based upon the application of Multiple Procedure Logic. Acceptable documents are true and correct copies of:
    - CIGNA HealthCare Remittance Form (*i.e.*, Explanation of Payments form) showing that payment was denied, in whole or in part, on the CPT® or HCPCS Level II Codes in question; **or**
    - If you cannot locate the Remittance Form, copies of internal accounting records (*e.g.*, printouts of accounts receivable records or paid account records), provided that those records show as to the claim at issue all CPT® Code(s) or HCPCS Level II Code(s) which were submitted for payment and those that remain unpaid, in whole or in part.
    - If your internal accounting records or CIGNA HealthCare Remittance Form do not show all CPT® Code(s) or HCPCS Level II Code(s) which were submitted for payment, you may supplement those records with additional documentation, such as the HCFA 1500 (now CMS 1500).

and

- A complete copy of the clinical, operative, or other medical records generated in connection with services you provided on the specific date of service concerned.

NOTE: 1. *You **DO NOT** have to include clinical, operative or other medical records for Category Two Compensation Proofs of Claim seeking compensation for denials of payment based on the contention that CIGNA HealthCare (i) failed to recognize **modifiers 50, RT, LT, FA-F9, or TA-T9**; and/or (ii) translated a **HCPCS Level II "J" Code** into an incorrect or overbroad CPT® Code. However, you must submit a copy of the HCFA 1500 or other claim form used to submit the original claim, showing exactly how all services or supplies included in the claim were originally billed to CIGNA HealthCare. You must also submit documentation showing that payment was denied in whole or in part for the codes at issue. Documentation may include a copy of the CIGNA Health Care Remittance Form or of your internal accounting records.*

2. *You **DO NOT** have to include clinical, operative or other medical records for Category Two Compensation Proofs of Claim seeking compensation for denials of payment based on the contention that CIGNA HealthCare incorrectly processed one or more **modifier 51 exempt CPT® Codes** and/or **add-on CPT® Codes** using Multiple Procedure Logic when those codes were exempt from multiple procedure reduction. However, you must submit documentation showing that payment was denied in whole or in part for the codes at issue. Documentation may include a copy of the CIGNA Health Care Remittance Form or of your internal accounting records.*

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 Two 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 TWO COMPENSATION

For each separate request for Category Two Compensation that you are submitting, fill out this cover sheet indicating the CPT® Code(s) or HCPCS Level II Code(s) for which compensation (or additional compensation) is sought.

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.

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