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 [_____] [180 Days after commencement of the Claims Period.]

- *Medical Necessity Denial Compensation is available **only** for denials of payment for services or supplies represented by CPT® Codes or HCPCS Level II Codes that were determined by CIGNA HealthCare to be either not experimental or investigational or not Medically Necessary.*

- *No Medical Necessity Denial Compensation is available where the services or supplies were excluded from coverage under the CIGNA HealthCare Member's Plan Documents.*

- *A single Proof of Claim Form can be used to submit multiple requests ("Proofs of Claim") for Medical Necessity Denial 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.*

- ***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.

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 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 that is being requested.

2. If I have submitted internal accounting records in support of a Medical Necessity Denial 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 MEDICAL NECESSITY DENIAL PROOF OF CLAIM

For each separate Medical Necessity Denial 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 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 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 the 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) showing 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 Proof of Claim 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

Mail your completed Proof of Claim Form, with all required documentation for request for compensation, to:

Poorman-Douglas Corporation
[Address]
[Address]

Any Proof of Claim 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
MEDICAL NECESSITY DENIAL
COMPENSATION

For each separate request for Medical Necessity Denial 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 cover sheet.

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

CPT® Codes or HCPCS Level II Codes For Which Compensation (or additional compensation) is sought in this Medical Necessity Denial Proof of Claim: