G2771CA1

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 CATEGORY ONE COMPENSATION

DEADLINE FOR SUBMISSION: POSTMARKED BY FEBRUARY 18, 2005.

Category One Compensation is available **only** for denials of or reductions in payment based on Claim Coding and 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 at www.CIGNAPhysicianSettlement.com, www.hmosettlements.com, www.hmocrisis.com, www.milbergweiss.com, www.archielamb.com, www.kttlaw.com and www.whatleydrake.com or by calling the Settlement Administrator toll-free at 1-877-683-9363. The Category One Code List is attached as Exhibit 1 to the Settlement Agreement. Category One Compensation does not include denials or reductions based on payment and benefit limitations (*e.g.*, coordination of benefit rules, violations of preauthorization requirements, violations of referral requirements, limitations stemming from capitation or other risk-bearing agreements with the Class Member submitting the claim or with other health care providers).

A single Proof of Claim Form may be used to submit multiple requests for Category One 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 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 IN SECTION II.

G2772CA1

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 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 payment or additional payment that is being requested.
2. If I have submitted internal accounting records in support of a Category One 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 CATEGORY ONE REQUEST FOR PAYMENT

For each separate Category One 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 Category One Claims:

- This Proof of Claim Form, with signed certification. You may use one Proof of Claim Form to submit multiple Category One 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 date of service; 2) the provider TIN (or Social Security Number, if TIN unavailable); and 3) the CPT® Code(s) or HCPCS Level II Codes for which payment was denied or reduced. If you are submitting accounting records, you must also include 4) the subscriber Social Security Number and 5) the patient name.
- For those items **without an asterisk on the Category One Code List,** documentation for each request for payment showing that codes on the Category One Code List were submitted under the circumstances and within the date of service limitations (if any) set forth in the Category One Code List. Acceptable documents include:
  - ⇒ 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; **or**
  - ⇒ CIGNA HealthCare Remittance Form (*i.e.,* Explanation of Payments form) showing that the Category One Codes were submitted; or
  - ⇒ If the Remittance Form and HCFA 1500/CMS1500 or other claim form cannot be located, you may submit internal accounting records (*e.g.,* printouts of accounts receivable records or paid account records) showing, as to the claim at issue, the Category One Codes originally submitted to CIGNA HealthCare for payment under the specific circumstances and within the date of service limitations set forth on the Category One Code List.
- For those items **with an asterisk on the Category One Code List,** documentation for each request for payment showing both that codes were submitted and payment was denied or reduced 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 documentation includes any combination of the following, so long as it demonstrates the relevant codes that were both submitted and denied or reduced:**
  - ⇒ A copy of the relevant CIGNA HealthCare Remittance Form (*i.e*., Explanation of Payments form);
  - ⇒ A copy of your HCFA 1500 form (now known as the CMS 1500) or other claim form;
  - ⇒ If the Remittance Form and HCFA 1500/CMS1500 or other claim form cannot be located, or if those documents are insufficient to establish that the Category One Codes were submitted and denied or reduced, you may submit internal accounting records (*e.g.,* printouts of accounts receivable records or paid account records) showing, as to the claim at issue, the Category One Codes originally submitted to CIGNA HealthCare for payment under the specific circumstances and within the date of service limitations set forth on the Category One Code List and those that 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

Your completed Proof of Claim Form, with all required documentation for each request for payment, 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 Category One Compensation postmarked after February 18, 2005 is not a Valid Proof of Claim and will be denied by the Settlement Administrator.

G2774CA1

CONTAINS PATIENT IDENTIFIABLE MEDICAL PRIVACY INFORMATION

For Official Use Only

CIGNA HEALTHCARE PHYSICIAN SETTLEMENT

COVER SHEET FOR REQUEST FOR CATEGORY ONE COMPENSATION

For each separate request for Category One Compensation that you are submitting, complete this cover sheet indicating 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 Category One request for payment:

Subscriber Social Security Number **(Required only if submitting accounting records.)**

Provider TIN

Date of Service (MM DD YYYY)

Provider SSN (if TIN unavailable)

Patient First Name

MI

Patient Last Name **(Required only if submitting accounting records.)**

Specific CPT code pairs (dropped/paid codes) as listed on the Exhibit 1 - Category One Code List:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.