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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 TWO COMPENSATION

DEADLINE FOR SUBMISSION: POSTMARKED BY FEBRUARY 18, 2005.

Category Two Compensation is available **only** for denials or reductions in payment with respect to claims submitted to CIGNA HealthCare resulting from the application of Claim Coding and Bundling Edits that are not eligible for Category One Compensation. Category Two Compensation is not limited to specific codes or code combinations. 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). To assist you in identifying eligible claims, CIGNA HealthCare has created a Facilitation List specific to each Class Member. For further information and to request a Facilitation List, 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 Category Two 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.

If Category One Compensation is available for a request for payment, you are not eligible to receive Category Two Compensation for that request for payment.

PLEASE NOTE: If you file a Category A Settlement Fund Claim Form, you are not eligible to receive Category Two 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 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) 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 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)

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SECTION III: DOCUMENTATION NEEDED FOR EACH CATEGORY TWO REQUEST FOR PAYMENT

For each separate Category Two 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 Two Claims:

- This Proof of Claim Form, with signed certification. You may use one Proof of Claim Form to submit multiple Category Two 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 (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 as submitted, in whole or in part, for 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), if 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) that 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 Information (including but not limited to clinical notes and/or operative reports, as appropriate) generated in connection with services you provided on the specific date of service concerned.

EXCEPTIONS TO CLINICAL INFORMATION REQUIREMENT:

1. You **DO NOT** have to include clinical, operative or other medical records for Category Two requests for payment that are 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.

   NOTE: If you are unable to show, through the above documentation, how the services or supplies were originally billed to CIGNA HealthCare (inclusive of the modifiers submitted with each CPT® Code or HCPCS Level II Code billed), then you may not submit the request for payment under these special documentation exceptions, but instead must submit the request for payment in accordance with the general requirements above.

2. You **DO NOT** have to include clinical, operative or other medical records for Category Two requests for payment that are 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. Such documentation may include a copy of the CIGNA Health Care Remittance Form or 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

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 Two 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 CATEGORY TWO COMPENSATION

For each separate request for Category Two 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 Category Two 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

1. Code — Modifier
2. Code — Modifier
3. Code — Modifier
4. Code — Modifier
5. Code — Modifier
6. Code — Modifier
7. Code — Modifier
8. Code — Modifier
9. Code — Modifier
10. Code — Modifier
11. Code — Modifier
12. Code — Modifier
13. Code — Modifier
14. Code — Modifier
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18. Code — Modifier
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