Plaintiff understands that the Medicare Secondary Payer Act (42 U.S.C. §1395y(b))("Act") applies to any personal injury settlement involving a Medicare beneficiary and requires that Medicare be reimbursed for any of its conditional payments made on behalf of the Medicare beneficiary. As part of the Act, Plaintiff may have an obligation to verify his or her status as a Medicare beneficiary and resolve conditional payments made on his or her behalf by Medicare, if any. In the event it is determined that the Plaintiff is a Medicare beneficiary, [Defendant and/or Insurer(s)] may have an obligation to report the settlement amount and other requisite information to Medicare. The [Defendant and/or Insurers] will report this settlement as per the Act and all applicable reporting guidelines provided by the Centers for Medicare and Medicaid Services (CMS).

If Plaintiff, Defendant and/or Insurers determine that Plaintiff is medical eligible, there may be a Medicare reimbursement right or an obligation to report the settlement amount to Medicare. The parties expressly agree that payment of settlement proceeds is not conditioned upon Plaintiff providing proof that all Medicare reimbursement claims and obligations have been satisfied. Rather, Defendant and/or Insurers agree to forward the settlement proceeds to Plaintiff's attorney within the time frame set forth in Case Management Order #14 once this executed release has been provided by Plaintiff. Plaintiff's attorney shall: (1) hold all settlement proceeds in a client trust account or similar account to be used to reimburse Medicare, if necessary; (2) provide Defendant with a copy of the final demand letter, waiver letter or no-conditional payment letter issued by Medicare or the COBC; and (3) provide Defendant with proof of full payment of the final demand as defined in the Case Management Order prior to disbursing to Plaintiff any proceeds received in connection with this settlement. Subparagraphs 9(a) through 9(c) of Case Management Order 17 are incorporated herein by reference, and made a part of this release. As part of this settlement, Plaintiff agrees to indemnify, defend, and hold [Defendant and Insurers] harmless against and from any Medicare claims, actions, judgments or settlements asserted by any entity arising from the personal injuries that are the subject of this settlement, except to the extent of Defendant's active negligence, including but not limited to Defendant's failure to pay the settlement or report.

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF WAYNE

IN RE: ALL ASBESTOS PERSONAL
INJURY CASES

Case No. 03-310422-NP
Hon. Robert Colombo Jr.

_________________________________/

CASE MANAGEMENT ORDER #17

Regarding Requirements of MMSEA Sec. 111 And Medicare's Right of Recovery

At a session of this Court , in the
City of Detroit, County of Wayne,
State of Michigan on this date:

______________________ 2010

The Motion for Entry of Case Management Order # 17 having been filed, served on all Counsel in the above litigation, and heard in open court, with all interested parties having been given an opportunity to be heard, and in an effort to a) comply with the requirements of the federal Health Insurance Portability and Accountability Act, (HIPAA), b) to establish a Social Security Number (SSN) privacy policy as contemplated by Administrative Order 2006-2 of the Michigan Supreme Court, c) to facilitate the compliance of the parties to this litigation with the requirements of the Medicare, Medicaid and SCHIP Extension Act of 2007, (PL 110-173) (MMSEA) Section 111, ("Section 111"), and to facilitate Medicare's right of recovery under "Medicare

Secondary Payer" (MSP) rules and regulations, with the Court being fully advised of the premises for the pending motion:

IT IS HEREBY ORDERED that the Motion for Entry of Case Management Order # 17 is hereby GRANTED.

IT IS FURTHER ORDERED that the privacy policy adopted by entry of this Order shall be subject to the following terms and conditions:

<u>Procedures for Distribution of Query and Reporting Information For MMSEA Sec. 111 Compliance:</u>

1. **For Future Filings in Wayne County Asbestos-Related Personal Injury Actions**:

   a) **Form A – Query Information:** In cases filed after the date of entry of this Order, within 90 days of filing complaint, each Plaintiff shall complete and file electronically, on Lexis/Nexis or other service as the Court may order, Form A, attached, enabling defendants to obtain by query to CMS a determination as to whether Plaintiff is Medicare eligible at the time of the query. No signature of a Plaintiff or counsel is required on Form A;

   b) **Form B – Reporting Information:** As soon as practicable after receiving a response to the CMS query, lead defense medical counsel shall electronically inform all parties of the CMS response on Lexis/Nexis or other service as the Court may order. Where it has been determined that Plaintiff or Plaintiff's decedent is/was Medicare eligible, Plaintiff shall complete and file electronically Form B, attached, (except for information requested in boxes 12, 13 and 100 - 102 on that Form), thus providing all defense counsel with information necessary to comply with reporting requirements of MMSEA Sec. 111. No signature of a Plaintiff or counsel is required on that form;

   c) Form B Filing Deadline – Reporting Inconsistencies: On the due date of Plaintiff's Discovery Brochure, Medicare eligible Plaintiffs or decedent's representative shall complete and file Form B to the extent required in paragraph (1)(b). This filing will be made electronically, on Lexis/Nexis or other service as the Court may order. If a defendant intends to report information that is inconsistent with the information provided by Plaintiff on Form B, prior to doing so, defendant will reasonably notify Plaintiff of the information to be reported, and will agree to meet and confer prior to the filing of the report so as to resolve inconsistencies to the extent possible.

2. **For Cases Filed and Pending Further Proceedings**:

   a) **Cases with 2010 Trial Dates**: For cases filed before the date of this Order, with trial dates scheduled in 2010, each Plaintiff shall provide defendants with full social security numbers for Plaintiff or Plaintiff's decedent, by way of a spreadsheet or otherwise, filed electronically, on Lexis/Nexis or other service as the Court may order, within 30 days of entry of this Order, enabling defendants to obtain by query to CMS a determination as to whether Plaintiff is currently Medicare eligible. On or before the trial date every Medicare eligible Plaintiff or Plaintiff's decedent shall complete Form B and file same electronically on Lexis/Nexis or other service as the Court may order.

   b) **Cases With Trial Dates In And After 2011, Or Not Yet Scheduled For Trial**: In cases set for trial after January 1, 2011, and other cases pending at the time of entry of this Order, each Plaintiff or Plaintiff's decedent shall complete and file electronically, on Lexis/Nexis or other service as the Court may order, Form A, attached, on the date Plaintiff's Discovery Brochure is due. Form B shall be completed by Medicare eligible Plaintiff's or Plaintiff's decedent and filed electronically, on Lexis/Nexis or other service as the Court may order, on or before the trial date.

3. **Electronic Filing Only**: Except as provided in Paragraph 7, below, filing/distribution of all forms required by this order and all related correspondence to the parties shall be made electronically only on Lexis/Nexis or other service as the Court may order so as to limit distribution of Social Security numbers or other personal/private information to the parties and their insurers;

4. **Limited Purpose**: The Data Forms are to be completed and served on defense counsel of record for the limited purpose of facilitating compliance with MSP and MMSEA Section 111 rules and regulations and not for any other purpose;

5. **Other Data Forms Prohibited**: The Court is satisfied that these Data Forms are sufficient to facilitate the determination of the status of a Plaintiff or Plaintiff's decedent as a Medicare beneficiary, thus precluding the use of any other such

forms the Defendants might submit to Plaintiff's Counsel for this purpose. Plaintiffs will not be compelled to complete any forms submitted for this limited purpose other than the Data Form attached, except upon order of the Court;

6. **Confidentiality**: Plaintiffs, their Counsel, the Recipients of completed Data Forms, meaning Defendants, Defendant's insurers, any person or entity defined as an RRE (Responsible Reporting Entity) under Section 111, and their authorized representatives and agents), shall not file the Data Forms with this Court, or in any other state or federal judicial forum, except as provided in paragraph 7 of this Order, without an order of leave from this Court;

7. **Permissible Use/Distribution:** Defendants' Counsel are allowed to distribute completed Forms A & B to their clients and their client's insurers for their use in reporting under MMSEA Sec. 111 and for other purposes associated with facilitation of Medicare's right of recovery under Medicare Secondary Payer (MSP) laws and regulations. Attorneys for the parties, the parties themselves, and their insurers are prohibited from disclosing or disseminating the Data Forms or the information contained in these Data Forms to any other person or entity other than the Center for Medicaid/Medicare Services (CMS), or its contractors, except as is reasonably required to a) effectuate the determination of Medicare/Medicaid Beneficiary status, b) report as required under Section 111, or c) communicate with the U.S. Government or its designee or to defend any Medicare recovery claim or fine pursuant to federal statutes, rules and regulations, including but not limited to MMSEA Section 111. To the extent that

the SSN's have been used by defendants and their insurers in the past for purposes of, but not limited to, the monitoring and evaluation of new claims, to determine, for example, if they have defended a suit or claim made by or on behalf of the same claimant previously, such use of the data and such practices shall be allowed;

8. **Sanctions for Impermissible Use or Distribution:** Unauthorized use or unlawful distribution of the SSN's collected under this Order, or other violations of this Order, will be subject to penalties that fall within the Court's contempt powers, or such other penalties as may issue in further orders of this Court.

Procedures for Protection of Medicare's Right of Recovery:

9. Upon the settlement of a claim, the Court will proceed as outlined in subparagraphs 9(a) through (c) below, if the parties explicitly adopt those provisions by reference in their release and/or settlement agreement;

   a) Escrow/Trust Account: If Plaintiff, defendant and/or their insurers determine that Plaintiff is, or Plaintiff's decedent was, Medicare eligible, Plaintiff's counsel shall hold the net (after distribution of attorney's fees and costs) settlement amount pursuant to that agreement in an escrow account, client trust account or other like account. If there is a Medicare claim that puts into question the sufficiency of the escrowed or trust account proceeds to satisfy Medicare's right of recovery, then Plaintiff's counsel shall return all attorneys fees paid to it on Plaintiff's case to the escrow or trust account pending resolution of the Medicare claim;

b) **Payment of Medicare Reimbursement; Release of Funds From Escrow/Trust Account:** Once Plaintiff's counsel has received a waiver, final demand or no conditional payment letter from CMS, and Plaintiff's counsel has paid the Medicare recovery claim, if any, Plaintiff's counsel may then pay the net settlements to the client(s) upon providing to defendants a copy of the waiver, final demand, or no conditional payment letter and proof of payment of said amount. Proof of payment pursuant to terms of the release and this Order means a copy of a draft payable to Medicare or its recipient entity with an amount matching that of the final demand. Plaintiff's counsel may redact the bank name, routing number, account number and signature from the check.

c) **Motion For Partial Distribution; Exigent Circumstances:** Plaintiff's counsel may move the court for an order allowing partial distribution of the net settlement proceeds to Plaintiff(s) in exigent circumstances where Plaintiff(s) can show that the amount necessary to satisfy Medicare's right of recovery is less than the entire amount of Plaintiff's net settlement proceeds. In such circumstances, Plaintiff's counsel must produce a copy of any conditional payment, waiver, final demand or no-conditional payment letter from CMS as may exist in order to evidence the extent of Medicare's right of recovery. If this Court allows a partial distribution to Plaintiff from the escrow or trust fund, prior to the full and final satisfaction of Medicare's right of recovery, and if there arises a Medicare recovery claim that puts into question the sufficiency

of the remaining escrow or trust account proceeds to satisfy Medicare's right of recovery, then Plaintiff shall return all monies received through any order of partial distribution by this Court to the escrow or trust account pending resolution of the Medicare recovery claim.

10. **Where Plaintiff Is Not Medicare Eligible**: In cases where at the time of settlement the parties agree that Plaintiff or Plaintiff's decedent is not or was not Medicare eligible, the net settlement proceeds do not need to be held in escrow and may be distributed in accordance with other provisions of the Case Management Order and Wrongful Death Act where applicable.

11. **Untimely Settlement Payments By Defendants**: In the event a defendant fails to submit the settlement proceeds consistent with Case Management Order No. 14, in addition to the interest which shall accrue on the settlement proceeds, defendant will also be responsible to reimburse Plaintiff for any interest, costs and penalties which accrue on Plaintiff's Medicare recovery claim due to the defendant's late payment.

____

CIRCUIT JUDGE

FILED
APR 01 2010
CLERK OF CIRCUIT COURT
THIRD JUDICIAL CIRCUIT
MADISON COUNTY, ILLINOIS

IN THE CIRCUIT COURT
THIRD JUDICIAL CIRCUIT
MADISON COUNTY, ILLINOIS

IN RE: ALL ASBESTOS LITIGATION)
FILED IN MADISON COUNTY)

Order re Medicare Reporting in All Madison County Asbestos Cases

To assist all parties in compliance with MMSEA Section 111 reporting, this Court hereby orders as follows:

(a) No later than the date that plaintiff deposits answers to interrogatories in the CRD, plaintiff will complete and deposit the CMS Form ("Form A-1")(or such new or amended form as CMS may provide) and the authorization ("Form A-2") in the CRD. No trial setting will be given prior to such proper completion and deposit of this Form in the CRD.

(b) For all cases in which plaintiff has already deposited answers to interrogatories in the CRD and has a trial setting prior to June 30, plaintiff will within 30 days from the date of this Order or 7 days before trial, whichever is earlier, complete and deposit the Form A-1 and Form A-2 in the CRD. For all other cases in which plaintiff has already deposited answers to interrogatories in the CRD and has a trial setting, plaintiff will within 90 days from the date of this Order complete and deposit the Form A-1 and Form A-2 in the CRD. This paragraph (b) is subject to Illinois Supreme Court Rule 201(k).

(c) As a condition of any settlement, plaintiff will promptly complete in full and return the Reporting Form ("Form B") to settling defendant along with the release or settlement agreement. No settlement is final and enforceable until this Form B is completed. Except to defend against a claim of lien or fine, alleged, potential or otherwise, relating to Medicare reporting or Medicare payments or liens, any completed Form B will be held confidential by plaintiff(s) and defendant(s), its insurers and re-insurers and their attorneys and will not be used or admissible in evidence in any proceeding or discovery. Form B will be signed by at least one counsel for plaintiff and will state that the signature of the attorney constitutes a certificate by him that he has read the information supplied in this Form and that all information stated therein is well grounded in fact to the best of his knowledge, information and belief formed after reasonable inquiry. If defendant intends to report information that is inconsistent with the information on Form B, prior to doing so, defendant will reasonably notify plaintiff of that information to be reported. This paragraph will apply only to settlements after the federal government/CMS requires reporting under MMSEA Section 111.

(d) Plaintiff(s) need not provide any written answers to any interrogatories or requests for admission or, unless otherwise agreed by the parties, complete additional forms to provide information to comply with or assist in

compliance with reporting requirements under MMSEA Section 111. This paragraph (d) of this Order does not preclude any discovery that is relevant, material or discoverable for any reason unrelated to the reporting requirements of MMSEA Section 111 and does not preclude any contracts or agreements including but not limited to those intended to protect or provide for the satisfaction, discharge or release of any Medicare lien.

(e) As soon as practically possible after first learning the amount of any Medicare lien, plaintiff will deposit in the CRD a document showing the initial amount of the lien as claimed for Medicare benefits. Plaintiff will deposit in the CRD verification showing satisfaction, discharge or release of the Medicare lien within a reasonable time after such occurs.

(f) Although this Court is not requiring use of the agreements which are the subject of this paragraph (f), this Court encourages the parties to use agreements such as Forms C-1 and C-2 to protect Medicare liens and regards such agreements as an acceptable way for the parties to settle cases and provide for the protection of Medicare liens. This Court also regards it as best practice that the release or settlement agreement should state in some manner that settlement funds may need to be held by plaintiff's counsel.

(g) This Order is subject to revision as the statutes, rules, regulations and practices of the federal government and CMS may change or become more defined.

(h) The term "lien" will also include the term "claim."

Entered this first day of April, 2010.

Judge

APR 01 2010

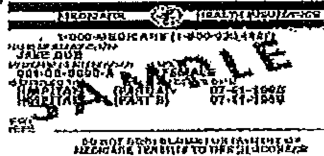
FORM A-1

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?		☐Yes	☐No
If yes, please complete the following. If no, proceed to Section III.			
Full Name *(Please print the name exactly as it appears on your SSN or Medicare card if available)*			
Medicare Claim Number:		Date of Birth (Mo/Day/Year)	
Social Security Number: *(If Medicare Claim Number is Unavailable)*	Sex	☐Female	☐Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) Claim Number

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form Date

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

FORM A-1

Section III

______________________________ ______________________________

Claimant Name (Please Print) Claim Number

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

____

____

____

____

______________________________ ______________________________

Signature of Person Completing This Form Date

Form A-2

Authorization to Release Information

NAME: ______________________________

(if applicable, exactly as shown on your Medicare card)

SOCIAL SECURITY NUMBER: ________________

MEDICARE NUMBER (HICN): ________________

(if applicable, the number on your Medicare card)

DATE OF BIRTH: ________________________

DATE OF INJURY/ILLNESS: ________________

In compliance with the Federal Privacy Act of 1974 and the HIPAA Privacy Rule, the undersigned authorizes the Centers for Medicare & Medicaid Services (CMS), and their contractors, to release to

____

or its/their designee(s), agent(s) and representative(s) (collectively "the Company") any and all information concerning conditional payments made by Medicare resulting from the personal injury/illness, which occurred/was diagnosed on or about the date listed above.

The undersigned also hereby authorizes the Company to disclose my personal information (including but not limited to my Social Security number) and information related to my injury/illness and any settlement for the specified injury/illness to CMS and its contractors.

The undersigned also hereby authorizes the Company to disclose my Social Security number to the Social Security Administration to determine social security benefits (for the purposes of determining Medicare eligibility).

This form expires in three years from the date of execution; however, I understand that I may revoke this "Authorization to Release Information" at any time.

SIGNED: ______________________________ **DATE:** ______________

FORM B

MEDICARE CONFIDENTIAL REPORTING INFORMATION FORM

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007

Case Name:	Case Number:

Is the injured party presently or has he/she ever qualified for or been enrolled in Medicare Part A or B? ☐ Yes ☐ No

Section A **ALLEGED INJURED PARTY INFORMATION** *(If party is DECEASED, also complete Section F)* *Please see footnote at bottom of page

4. Medicare Claim Number *(also known as HICN)*

5. Social Security Number:

6. Injured Party Last Name: *(Please print name exactly as it appears on Social Security card.)*

7. Injured Party First Name: *(Please print name exactly as it appears on Social Security card.)*

8. Injured Party Middle Name: *(Please print name exactly as it appears on Social Security card.)*

9. Gender: ☐ Male ☐ Female

10. Date of Birth: *(MM/DD/YYYY)*

Deceased? ☐ Yes ☐ No

Section B **ALLEGED INCIDENT INFORMATION**

12. CMS Date of Incident: Please state the date of accident or date of first exposure, ingestion, implantation with respect to settling defendant's product and/or premises.

13. Industry Date of Incident: Please state the date of accident or date of last exposure, ingestion, or implantation with respect to settling defendant's product and/or premises.

15. Alleged Cause of Injury, Illness or Incident: Please state the alleged cause of injury, incident or illness and the ICD-9-CM (InternationalClassification of Diseases, Ninth Revision, Clinical Modification code(s)) with respect to the same.****

17. State of Venue

19. ICD-9 Diagnosis Code 1: Please provide valid ICD-9 Codes for any injury or illness you allege arose from the allegations made against settling defendant. NOTE: separate ICD-9 codes are required for each body part you assert was/is affected. **

21. ICD-9 Diagnosis Code 2:	23. ICD-9 Diagnosis Code 3:	25. ICD-9 Diagnosis Code 4:	27. ICD-9 Diagnosis Code 5:	29. ICD-9 Diagnosis Code 6:
31. ICD Diagnosis Code 7:	33. ICD-9 Diagnosis Code 8:	35. ICD-9 Diagnosis Code 9:	37. ICD-9 Diagnosis Code 10:	39. ICD-9 Diagnosis Code 11:
41. ICD-9 Diagnosis Code 12:	43. ICD-9 Diagnosis Code 13:	45. ICD-9 Diagnosis Code 14:	47. ICD-9 Diagnosis Code 15:	49. ICD-9 Diagnosis Code 16:

51. ICD-9 Diagnosis Code 17:	53. ICD-9 Diagnosis Code 18:	55. ICD-9 Diagnosis Code 19:

57. Description of Illness/Injury (Free Form Text Description): ***

*NUMBERS REFLECT CLAIM INPUT FILE FIELD NUMBERS AS SET FORTH IN VERSION 2 OF THE OFFICIAL NGHP USER GUIDE

** CLAIMS SUBMITTED PRIOR TO 1/1/11 **MUST** PROVIDE EITHER: (1) BOTH A VALID ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) AND AT LEAST ONE VALID DIAGNOSIS CODE IN THE ICD-9 DIAGNOSTIC CODE 1 (FIELD 19) OR THE DESCRIPTION OF INJURY ILLNESS (FIELD 57)
CLAIMS SUBMITTED ON OR AFTER 1/1/11 **MUST** CONTAIN **BOTH** THE ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) AND THE ICD-9 DIAGNOSTIC CODE 1 (FIELD 19).

***FIELD 57 IS REQUIRED THROUGH 12/31/10 IF NO ALLEGED CAUSE OF INJURY, INCIDENT OR ILLNESS CODE (FIELD 15) OR NO ICD-9 DIAGNOSTIC CODE 1 (FIELD 19) IS PROVIDED.

****THE CURRENT LIST OF VALID CODES ACCEPTED BY CMS FOR SECTION 111 REPORTED MAY BE FOUND AT: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp.

The information in this form is to be held confidential and not used in discovery or in any proceeding in evidence or otherwise, except to communicate with the U.S. Government or its designee or to defend any claim of lien or fine pursuant to Medicare statutes, rules and regulations including MMSEA Section 111.

FORM B

Case Name:	Case Number:

Section C	ALLEGED INJURED PARTY'S ATTORNEY OR OTHER REPRESENTATIVE INFORMATION

84. Representative Type (please check one):

☐ A=Attorney ☐ G=Guardian/Conservator ☐ P=Power of Attorney ☐ O=Other

85. Representative Last Name:	86. Representative First Name:	87. Representative Firm Name:

88. TIN/EIN, if Firm Entity; Social Security Number if Individual:	89. Mailing Address:

91. City:	92. State:	93. Zip Code +4:	95. Phone:	96. Ext. (If any):

Section D	SETTLEMENT INFORMATION

Name of Settling Defendant:	100. Date of Settlement:	101. Amount of Settlement:

102. Funding Delayed Beyond TPOC (actual or estimated date of funding):

Section E	SIGNATURE

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Name of Attorney representing Plaintiff/Claimant	Date	Printed Name

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)

If you have completed this page in its entirety and Alleged Injured Party in Section A is not deceased, stop here.

FORM B

Case Name:	Case Number:

ATTENTION

If Alleged Injured Party is NOT DECEASED and you have completed Page 1 & 2, you may stop here.

Please continue to Section E (Claimant Information) only if Alleged Injured Party in Section A is deceased.
At least Claimant 1 information is required if Alleged Injured Party is deceased.

FORM B

Case Name:	Case Number:

Section F CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased.)*

CLAIMANT 1

104. Claimant Relationship to Alleged Injured Party:
- [ ] E=Estate (Individual)
- [ ] X=Estate (Entity)
- [ ] O= Other (Individual)
- [ ] F=Family (Individual)
- [ ] Y=Family (Entity)
- [ ] Z=Other (Entity)

105. TIN/EIN, If Entity; Social Security Number, If Individual:	106. Claimant Last Name:

107. Claimant First Name:	108. Claimant Middle Initial:

109. Claimant Entity/Organization Name:

110. Mailing Address:

112. City:	113. State:	114. Zip Code+4	116. Phone:	117. Ext: (If any):

119. Claimant Representative Type:
- [ ] A=Attorney
- [ ] P=Power of Attorney
- [ ] G=Guardian/Conservator
- [ ] O=Other

120. Claimant Representative Last Name:	121. Claimant Representative First Name:	122. Claimant Representative Firm Name:

123. TIN/EIN, If Firm/Entity; Social Security #, If Individual:	124. Representative Mailing Address:

126. City:	127. State:	128. Zip Code+4	130. Phone:	131. Ext. (If any):

Counsel for Claimant 1   Date   Printed Name

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)

FORM B

Case Name:	Case Number:

Section F continued CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased.)*

CLAIMANT 2 (Auxiliary Record)

A7. Claimant Relationship to Alleged Injured Party:
- ☐ E=Estate (Individual)
- ☐ X=Estate (Entity)
- ☐ O= Other (Individual)
- ☐ F=Family (Individual)
- ☐ Y=Family (Entity)
- ☐ Z=Other (Entity)

A8. TIN/EIN, if Entity; Social Security Number, if Individual:	A9. Claimant Last Name:

A10. Claimant First Name:	A11. Claimant Middle Initial:

A12. Claimant Entity/Organization Name:

A13. Mailing Address:

A15. City:	A16. State:	A17. Zip Code+4	A19. Phone:	A20. Ext. (if any):

A22. Claimant Representative Type:
- ☐ A=Attorney
- ☐ P=Power of Attorney
- ☐ G=Guardian/Conservator
- ☐ O=Other

A23. Claimant Representative Last Name:	A24. Claimant Representative First Name:	A25. Claimant Representative Firm Name:

A26. TIN/EIN, if Firm/Entity; Social Security #, if Individual:	A27. Representative Mailing Address:

A29. City:	A30. State:	A31. Zip Code+4	A33. Phone:	A34. Ext. (if any):

Counsel for Claimant 2   Date   Printed Name

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)

FORM B

Case Name:	Case Number:

Section F continued CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased.)*

CLAIMANT 3 (Auxiliary Record)

A36. Claimant Relationship to Alleged Injured Party:
☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ O= Other (Individual)
☐ F=Family (Individual) ☐ Y=Family (Entity) ☐ Z=Other (Entity)

A37. TIN/EIN, if Entity; Social Security Number, if Individual:	38. Claimant Last Name:

A39. Claimant First Name:	A40. Claimant Middle Initial:

A41. Claimant Entity/Organization Name:

A42. Mailing Address:

A44. City:	A45. State:	A46. Zip Code +4	A48. Phone:	A49. Ext. (if any):

A51. Claimant Representative Type:
☐ A=Attorney ☐ P=Power of Attorney
☐ G=Guardian/Conservator ☐ O=Other

A52. Claimant Representative Last Name:	A53. Claimant Representative First Name:	A54. Claimant Representative Firm Name:

A55. TIN/EIN, if Firm/Entity; Social Security #, if Individual:	A56. Representative Mailing Address:

A58. City:	A59. State:	A60. Zip Code +4	A62. Phone:	A63. Ext. (if any):

Counsel for Claimant 3 ____ Date ____ Printed Name ____

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)

FORM B

Case Name:	Case Number:

Section F continued CLAIMANT INFORMATION (*Use only if Alleged Injured Party in Section A is deceased.*)

CLAIMANT 4 (Auxiliary Record)

A65. Claimant Relationship to Alleged Injured Party:
- [ ] E=Estate (Individual)
- [ ] X=Estate (Entity)
- [ ] O= Other (Individual)
- [ ] F=Family (Individual)
- [ ] Y=Family (Entity)
- [ ] Z=Other (Entity)

A66. TIN/EIN, if Entity; Social Security Number, if Individual:	67. Claimant Last Name:

A68. Claimant First Name:	A69. Claimant Middle Initial:

A70. Claimant Entity/Organization Name:

A71. Mailing Address:

A73. City:	A74. State:	A75. Zip Code +4	A77. Phone:	A78. Ext. (If any):

A80. Claimant Representative Type:
- [ ] A=Attorney
- [ ] P=Power of Attorney
- [ ] G=Guardian/Conservator
- [ ] O=Other

A81. Claimant Representative Last Name:	A82. Claimant Representative First Name:	A83. Claimant Representative Firm Name:

A84. TIN/EIN, if Firm/Entity; Social Security #, if Individual:	A85. Representative Mailing Address:

A87. City:	A88. State:	A89. Zip Code +4	A91. Phone:	A92. Ext. (If any):

Counsel for Claimant 4   Date   Printed Name

(The signature of the attorney hereto constitutes a certificate by him/her that he/she has read the information supplied in this Form and that all information stated therein is well grounded in fact to the the best of his/her knowledge, information and belief formed after reasonable inquiry.)

FORM B - DEFINITIONS

*The following definitions are provided to assist in the completion of the **MEDICARE MANDATORY REPORTING INFORMATION FORM.***

#	Field Name / Question:	Definition:
4	MEDICARE CLAIM NUMBER (HICN)	Provide Alleged Injured Party's Medicare Health Insurance Claim Number (if one has been issued). This number can be found on Medicare Card if available.
5	SOCIAL SECURITY NUMBER	Provide Alleged Injured Party's Social Security Number if Medicare Claim Number (HICN) is not available.
6	LAST NAME	Provide last name of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD** or Medicare Card if available.
7	FIRST NAME	Provide first name of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD** or Medicare Card if available.
8	MIDDLE INITIAL	Provide middle initial of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD** or Medicare Card if available.
9	GENDER	Indicate Alleged Injured Party's gender by selecting MALE or FEMALE.
10	DATE OF BIRTH	Provide Alleged Injured Party's Date of Birth.
	DECEASED?	Indicate if the Alleged Injured Party is deceased by selecting YES or NO.
12	CMS DATE OF INCIDENT	Provide Date of Incident (DOI). DOI as defined by CMS: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of FIRST exposure. For claims involving ingestion (for example, a recalled drug), it is the date of FIRST ingestion. For claims involving implants it is the date of the implant (or date of the first implant if there are multiple implants).
13	INDUSTRY DATE OF INCIDENT	Provide Industry Date of Incident (DOI) routinely used by the insurance/workers' compensation industry: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure, or implantation, the date of incident is the date of LAST exposure, ingestion, or implantation.
15	ALLEGED CAUSE OF INJURY, ILLNESS OR INCIDENT	**Claims submitted prior to 1/1/11,** Claimant must provide either: 1) <u>both</u> a valid Alleged Cause of Injury, Incident or Illness Code (Field 15) <u>and</u> at least one valid ICD-9 Diagnosis Code (Field 19) <u>OR</u> 2) the Description of Illness/Injury (Field 57). **Claims submitted on or after 1/1/11,** Claimant must provide <u>both</u> a valid Alleged Cause of Injury, Incident, or Illness Code (Field 15) <u>and</u> at least one valid ICD-9 Diagnosis Code. **A description of Illness/Injury (Field 57) will not be accepted on or after 1/1/11.**
17	STATE OF VENUE	Provide the US postal abbreviation corresponding to the US State whose state law controls resolution of the claim. Use "US" where the claim is a Federal Tor Claims Act liability insurance matter or a Federal workers' compensation claim.
19	ICD-9 DIAGNOSIS CODE 1	(International Classification of Diseases, Ninth Revision, Clinical Modification) - Must be on the current list of valid codes accepted by CMS found at www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp. At least one valid diagnostic code must NOT be on the list of insufficient codes (found in Appendix H to the NGHP User Guide, V. 2.0, and NOT and E or a V Code).
21	ICD-9 DIAGNOSIS CODE 2	See explanation for Field 19.
23	ICD-9 DIAGNOSIS CODE 3	See explanation for Field 19.
25	ICD-9 DIAGNOSIS CODE 4	See explanation for Field 19.
27	ICD-9 DIAGNOSIS CODE 5	See explanation for Field 19.
29	ICD-9 DIAGNOSIS CODE 6	See explanation for Field 19.
31	ICD-9 DIAGNOSIS CODE 7	See explanation for Field 19.
33	ICD-9 DIAGNOSIS CODE 8	See explanation for Field 19.
35	ICD-9 DIAGNOSIS CODE 9	See explanation for Field 19.
37	ICD-9 DIAGNOSIS CODE 10	See explanation for Field 19.

FORM B - DEFINITIONS

#	Field Name / Question:	Definition:
39	ICD-9 DIAGNOSIS CODE 11	See explanation for Field 19.
41	ICD-9 DIAGNOSIS CODE 12	See explanation for Field 19.
43	ICD-9 DIAGNOSIS CODE 13	See explanation for Field 19.
45	ICD-9 DIAGNOSIS CODE 14	See explanation for Field 19.
47	ICD-9 DIAGNOSIS CODE 15	See explanation for Field 19.
49	ICD-9 DIAGNOSIS CODE 16	See explanation for Field 19.
51	ICD-9 DIAGNOSIS CODE 17	See explanation for Field 19.
53	ICD-9 DIAGNOSIS CODE 18	See explanation for Field 19.
55	ICD-9 DIAGNOSIS CODE 19	See explanation for Field 19.
57	DESCRIPTION OF ALLEGED ILLNESS OR INJURY	Enter a free-form text description of alleged illness or injury. Include description of major body part allegedly injured (e.g. head, arm, leg, etc.) and cause of alleged illness/injury.
84	REPRESENTATIVE TYPE	Indicate the type of representative that the Alleged Injured Party has. Select from the options provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O= Other Blank = None If Alleged Injured Party has more than one representative, provide attorney information if available.
85	REPRESENTATIVE LAST NAME	Provide Last Name of Representative.
86	REPRESENTATIVE FIRST NAME	Provide First Name of Representative.
87	REPRESENTATIVE FIRM NAME	Provide the Name of the Representative's Firm.
88	TIN/EIN, IF FIRM/ENTITY; SOCIAL SECURITY NUMBER IF INDIVIDUAL	Provide Alleged Injury Party's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
89	MAILING ADDRESS	Provide mailing address for the alleged injured party's representative named above.
91	CITY	Provide mailing address city for the alleged injured party's representative named above.
92	STATE	Provide mailing address state for the alleged injured party's representative named above.
93	ZIP CODE +4	Provide mailing address zip code for the alleged injured party's representative named above. Include Zip+4 code if known; if not known enter 0000.
95	PHONE	Provide telephone number of alleged injured party's representative.
96	PHONE EXTENSION, IF ANY	Provide telephone extension of alleged injured party's representative, if extension is available.
	NAME OF SETTLING DEFENDANT	Refer to Section D.
100	DATE OF SETTLEMENT	Date the Release is signed unless court approval is required - then it is the later of the date the Release is signed or the date of court approval. If there is no written agreement, then it is the date of payment.
101	AMOUNT OF SETTLEMENT	Refer to Section D.
102	FUNDING DELAYED BEYOND TPOC (ACUTAL OR ESTIMATED DATE OF FUNDING)	If funding for the TPOC is delayec, provide actual or estimated date of funding.

FORM B - DEFINITIONS

#	Field Name / Question:	Definition:
The following Claimant Fields are only required if the Alleged Injured Party is deceased.		
104	CLAIMANT'S RELATIONSHIP TO ALLEGED INJURED PARTY	Indicate relationship of the claimant to the alleged injured party/Medicare beneficiary by selecting from the options provided: E = Estate, Individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Blank = Not applicable (rest of the section will be ignored)
105	TIN/EIN, IF ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Provide Claimant's Social Security Number (SSN) if individual or Federal Tax Identification Number (TIN)/Employer Identification Number (EIN) if claimant is an entity.
106	CLAIMANT LAST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide last name.
107	CLAIMANT FIRST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide first name.
108	CLAIMANT MIDDLE INITIAL	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide middle initial.
109	CLAIMANT ENTITY/ORGANIZATION NAME	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The Estate of John Doe", "The Family of John Doe", "The Trust of John Doe", etc.
110	MAILING ADDRESS	Provide mailing address for claimant.
112	CITY	Provide mailing address city of the claimant.
113	STATE	Provide mailing address state of the claimant.
114	ZIP CODE +4	Provide mailing address zip code for the claimant. Include Zip+4 code if available.
116	PHONE	Provide telephone number of the claimant.
117	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant, if extension is available.
119	CLAIMANT REPRESENTATIVE TYPE	Indicate the type of represntative the claimant has by selecting from the option types provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Blank = Not applicable (rest of the section will be ignored)
120	CLAIMANT REPRESNTATIVE LAST NAME	Provide the last name of the Claimant's Representative.
121	CLAIMANT REPRESNTATIVE FIRST NAME	Provide the first name of the Claimant's Representative.
122	CLAIMANT REPRESENTATIVE FIRM NAME	Provide the Name of the Claimant's Representative's Firm or Entity.
123	TIN/EIN, IF FIRM/ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Claimant's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
124	REPRESENTATIVE MAILING ADDRESS	Provide mailing address for the claimant's representative.
126	CITY	Provide mailing address city for the claimant's representative.
127	STATE	Provide mailing address state for the claimant's representative.
128	ZIP CODE +4	Provide mailing address zip code for the claimant's representative.
130	PHONE	Provide telephone number of the claimant's representative.
131	PHONE EXTENSION, IF ANY	

FORM B - DEFINITIONS

#	Field Name / Question:	Definition:
A7	CLAIMANT'S RELATIONSHIP TO ALLEGED INJURED PARTY	Indicate relationship of the claimant to the alleged injured party/Medicare beneficiary by selecting from the options provided: E = Estate, Individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Blank = Not applicable (rest of the section will be ignored)
A8	TIN/EIN, IF ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Provide Claimant's Social Security Number (SSN) if individual or Federal Tax Identification Number (TIN)/Employer Identification Number (EIN) if claimant is an entity.
A9	CLAIMANT LAST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide last name.
A10	CLAIMANT FIRST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide first name.
A11	CLAIMANT MIDDLE INITIAL	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide middle initial.
A12	CLAIMANT ENTITY/ORGANIZATION NAME	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The Estate of John Doe", "The Family of John Doe", "The Trust of John Doe", etc.
A13	MAILING ADDRESS	Provide mailing address for claimant.
A15	CITY	Provide mailing address city of the claimant.
A16	STATE	Provide mailing address state of the claimant.
A17	ZIP CODE +4	Provide mailing address zip code for the claimant. Include Zip +4 code if available.
A19	PHONE	Provide telephone number of the claimant.
A20	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant, if extension is available.
A22	CLAIMANT REPRESENTATIVE TYPE	Indicate the type of represntative the claimant has by selecting from the option types provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Blank = Not applicable (rest of the section will be ignored)
A23	CLAIMANT REPRESNTATIVE LAST NAME	Provide the last name of the Claimant's Representative.
A24	CLAIMANT REPRESNTATIVE FIRST NAME	Provide the first name of the Claimant's Representative.
A25	CLAIMANT REPRESENTATIVE FIRM NAME	Provide the Name of the Claimant's Representative's Firm or Entity.
A26	TIN/EIN, IF FIRM/ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Claimant's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
A27	REPRESENTATIVE MAILING ADDRESS	Provide mailing address for the claimant's representative.
A29	CITY	Provide mailing address city for the claimant's representative.
A30	STATE	Provide mailing address state for the claimant's representative.
A31	ZIP CODE+4	Provide mailing address zip code for the claimant's representative.
A33	PHONE	Provide telephone number of the claimant's representative.
A34	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant's representative, if extension is available.

FORM B - DEFINITIONS

#	Field Name / Question:	Definition:
A36	CLAIMANT'S RELATIONSHIP TO ALLEGED INJURED PARTY	Indicate relationship of the claimant to the alleged injured party/Medicare beneficiary by selecting from the options provided: E = Estate, Individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Blank = Not applicable (rest of the section will be ignored)
A37	TIN/EIN, IF ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Provide Claimant's Social Security Number (SSN) if individual or Federal Tax Identification Number (TIN)/Employer Identification Number (EIN) if claimant is an entity.
A38	CLAIMANT LAST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide last name.
A39	CLAIMANT FIRST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide first name.
A40	CLAIMANT MIDDLE INITIAL	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide middle initial.
A41	CLAIMANT ENTITY/ORGANIZATION NAME	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The Estate of John Doe", "The Family of John Doe", "The Trust of John Doe", etc.
A42	MAILING ADDRESS	Provide mailing address for claimant.
A44	CITY	Provide mailing address city of the claimant.
A45	STATE	Provide mailing address state of the claimant.
A46	ZIP CODE +4	Provide mailing address zip code for the claimant. Include Zip +4 code if available.
A48	PHONE	Provide telephone number of the claimant.
A49	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant, if extension is available.
A51	CLAIMANT REPRESENTATIVE TYPE	Indicate the type of represntative the claimant has by selecting from the option types provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Blank = Not applicable (rest of the section will be ignored)
A52	CLAIMANT REPRESNTATIVE LAST NAME	Provide the last name of the Claimant's Representative.
A53	CLAIMANT REPRESNTATIVE FIRST NAME	Provide the first name of the Claimant's Representative.
A54	CLAIMANT REPRESENTATIVE FIRM NAME	Provide the Name of the Claimant's Representative's Firm or Entity.
A55	TIN/EIN, IF FIRM/ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Claimant's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
A56	REPRESENTATIVE MAILING ADDRESS	Provide mailing address for the claimant's representative.
A58	CITY	Provide mailing address city for the claimant's representative.
A59	STATE	Provide mailing address state for the claimant's representative.
A60	ZIP CODE +4	Provide mailing address zip code for the claimant's representative.
A62	PHONE	Provide telephone number of the claimant's representative.
A63	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant's representative, if extension is available.

FORM B - DEFINITIONS

#	Field Name / Question:	Definition:
A65	CLAIMANT'S RELATIONSHIP TO ALLEGED INJURED PARTY	Indicate relationship of the claimant to the alleged injured party/Medicare beneficiary by selecting from the options provided: E = Estate, Individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe") Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Blank = Not applicable (rest of the section will be ignored)
A66	TIN/EIN, IF ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Provide Claimant's Social Security Number (SSN) if individual or Federal Tax Identification Number (TIN)/Employer Identification Number (EIN) if claimant is an entity.
A67	CLAIMANT LAST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide last name.
A68	CLAIMANT FIRST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide first name.
A69	CLAIMANT MIDDLE INITIAL	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide middle initial.
A70	CLAIMANT ENTITY/ORGANIZATION NAME	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The Estate of John Doe", "The Family of John Doe", "The Trust of John Doe", etc.
A71	MAILING ADDRESS	Provide mailing address for claimant.
A73	CITY	Provide mailing address city of the claimant.
A74	STATE	Provide mailing address state of the claimant.
A75	ZIP CODE +4	Provide mailing address zip code for the claimant. Include Zip +4 code if available.
A77	PHONE	Provide telephone number of the claimant.
A78	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant, if extension is available.
A80	CLAIMANT REPRESENTATIVE TYPE	Indicate the type of represntative the claimant has by selecting from the option types provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Blank = Not applicable (rest of the section will be ignored)
A81	CLAIMANT REPRESNTATIVE LAST NAME	Provide the last name of the Claimant's Representative.
A82	CLAIMANT REPRESNTATIVE FIRST NAME	Provide the first name of the Claimant's Representative.
A83	CLAIMANT REPRESENTATIVE FIRM NAME	Provide the Name of the Claimant's Representative's Firm or Entity.
A84	TIN/EIN, IF FIRM/ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Claimant's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
A85	REPRESENTATIVE MAILING ADDRESS	Provide mailing address for the claimant's representative.
A87	CITY	Provide mailing address city for the claimant's representative.
A88	STATE	Provide mailing address state for the claimant's representative.
A89	ZIP CODE +4	Provide mailing address zip code for the claimant's representative.
A91	PHONE	Provide telephone number of the claimant's representative.
A92	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant's representative, if extension is available.

Form C-1

AGREEMENT

This Agreement is entered into this __ day of ________, 2010 between [NAME OF PLAINTIFF'S FIRM] (hereinafter "PLAINTIFF'S FIRM") and [NAME OF DEFENDANT] (hereinafter "defendant"), as a matter of convenience to resolve certain on-going issues involving possible Medicare liens. It applies to all pending and future asbestos personal injury cases resolved by defendant and the clients of PLAINTIFF'S FIRM by settlement, but is not an agreement to settle such cases or a commitment by either party to do so.

Whereas, defendant by this Agreement endeavors to protect any relevant Medicare lien; and

Whereas, defendant with PLAINTIFF'S FIRM and other parties has been involved in efforts, by Court order or otherwise, to arrange for the protection of Medicare liens and compliance with Medicare reporting requirements;

Therefore, in consideration of the mutual covenants contained herein and other good and valuable consideration, including such settlements as may be reached, in any case wherein defendant settles with a client of PLAINTIFF'S FIRM:

(1) Defendant will not include any agency of the U.S. Government or its designee as a payee on the settlement check.

(2) PLAINTIFF'S FIRM agrees to hold in its trust account sufficient funds to pay all Medicare liens relating to such settlement, claim and legal action or has in fact satisfied all Medicare liens in full. PLAINTIFF'S FIRM will notify the U.S. Government or its designee, including CMS, of any settlement which this Agreement governs and will work to satisfy or otherwise obtain discharge or release of any Medicare lien including "set asides," if any.

(3) If defendant receives a claim for any unsatisfied Medicare lien by lawsuit or otherwise, relating to the above-described settlements, claims and legal actions, defendant will notify PLAINTIFF'S FIRM by regular mail and request from them any evidence that the lien has been satisfied in full which defendant will provide to the governmental authority or its designee. If such evidence is not forthcoming or fails to resolve the claim in full without payment by defendant, defendant may by regular mail notify PLAINTIFF'S FIRM to undertake the principal response to the matter or to arrange payment or other resolution. If the U.S. government or its designee including CMS brings suit, PLAINTIFF'S FIRM will undertake the principal defense of such matter whether joined by the U.S. government or its designee including CMS or joined by defendant through third party claim or otherwise. PLAINTIFF'S FIRM will not undertake to

represent defendant as its client. PLAINTIFF'S FIRM will be liable to defendant for the amount owed or paid by such defendant to the United States Government or its designee including CMS for the allegedly unsatisfied Medicare lien plus all attorney fees and out of pocket expenses reasonably necessary and incurred to obtain judgment or settlement from PLAINTIFF'S FIRM for the amount due hereunder. By consenting to entry of judgment for any amounts due to defendant pursuant to this agreement, PLAINTIFF'S FIRM may cut off liability to defendant for any attorney fees and out of pocket expenses incurred after the date of such judgment. PLAINTIFF'S FIRM will not be liable to defendant for any attorney fees and out of pocket expenses to defend the claim brought by the U.S. government or its designee including CMS.

(4) This Agreement does not waive any rights of indemnity or hold harmless from the PLAINTIFF'S FIRM'S client pursuant to any indemnity or hold harmless in the Release or Settlement Agreement.

(5) This Agreement will apply severally to each described settled asbestos personal injury case, and all remedies and waivers set forth herein shall likewise severally apply.

(6) Either party may terminate this Agreement upon 60 days written notice, but such termination will not affect the obligations of this Agreement for any settlement entered prior to the effective date of such termination.

(7) The undersigned warrant and represent that they are authorized to execute this agreement on behalf of PLAINTIFF'S FIRM and defendant respectively.

(8) "Including" means including but not limited to. The singular means the plural and vice versa when appropriate. The masculine terms include the feminine version of the same terms.

[NAME OF PLAINTIFF'S FIRM]

By: ______________________________

Name: ____________________________

Defendant, _________________________

By: ______________________________
Its Attorney

Form C-2

AGREEMENT

WHEREAS, ________________ (individually or collectively referred to as "Releasor") and ________________ (individually or collectively referred to as "Releasee") have reached a settlement of Releasor's claim(s) against Releasee relating to the action described as __________________________ Plaintiff(s) versus ________________ et al Defendants in the Circuit Court for the Third Judicial Circuit, Madison County, Illinois, Cause No. _________________; and

WHEREAS, Releasee by this Agreement endeavors to protect any relevant Medicare lien; and

WHEREAS, Releasee with other parties has been involved in efforts, by Court order or otherwise, to arrange for the protection of Medicare liens and compliance with Medicare reporting requirements;

On this ____ day of _______________, 20____, in consideration of a payment from Releasee to Releasor in the amount of _________________________, and further in consideration that Releasee will not include any governmental agency of the United States, or its designee, as a co-payee on the settlement payment check, [Plaintiff's law firm name] ("Plaintiff's Counsel") agrees to hold in its trust account sufficient funds with which to pay all Medicare liens relating to the aforementioned settlement, claim and legal action to the extent that all Medicare liens have not otherwise been satisfied in full. Plaintiff's Counsel will notify the U.S. Government or its designee, including CMS, of

any settlement which this Agreement governs and will work to satisfy or otherwise obtain discharge or release of any Medicare lien including "set asides," if any.

If Releasee receives a claim for any unsatisfied Medicare lien by lawsuit or otherwise, relating to the above-described settlements, claims and legal actions, Releasee will notify Plaintiff's Counsel by regular mail and request from them any evidence that the lien has been satisfied in full which Releasee will provide to the governmental authority or its designee. If such evidence is not forthcoming or fails to resolve the claim in full without payment by Releasee, Releasee may by regular mail notify Plaintiff's Counsel to undertake the principal response to the matter or to arrange payment or other resolution. If the U.S. government or its designee including CMS brings suit, Plaintiff's Counsel will undertake the principal defense of such matter whether joined by the U.S. government or its designee including CMS or joined by Releasee through third party claim or otherwise. Plaintiff's Counsel will not undertake to represent Releasee as its client. Plaintiff's Counsel will be liable to Releasee for the amount owed or paid by such Releasee to the United States Government or its designee including CMS for the allegedly unsatisfied Medicare lien plus all attorney fees and out of pocket expenses reasonably necessary and incurred to obtain judgment or settlement from Plaintiff's Counsel for the amount due hereunder. By consenting to entry of judgment for any amounts due to Releasee pursuant to this agreement, Plaintiff's Counsel may cut off liability to Releasee for any attorney fees and out of pocket expenses incurred after the date of such judgment. Plaintiff's Counsel will not be liable to Releasee for any attorney fees and out of pocket expenses to defend the claim brought by the U.S. government or its designee including CMS.

The undersigned warrants and represents that he/she is authorized to execute this agreement on behalf of Plaintiff's Counsel. This Agreement does not waive any rights of indemnity or hold harmless from Releasor pursuant to any indemnity or hold harmless in the Release or Settlement Agreement. "Including" means including but not limited to. The singular means the plural and vice versa when appropriate. The masculine terms include the feminine version of the same terms.

[Name of Plaintiff's Law Firm]

By:__________________________

[Name of attorney]

[Name of Defendant]

By:__________________________

[Title]