Settlement Administrator
PO Box 3240
Portland, OR 97208-3240

The Shane Group, Inc. v. Blue Cross Blue Shield of Michigan
No. 2:10-cv-14360
U.S. District Court for the Eastern District of Michigan

CLAIM FORM FOR INSURERS OR SELF-INSURED ENTITIES

If you are an insurer that paid a general acute care hospital in Michigan for your insureds' healthcare services or a self-insured entity whose health plan participants received healthcare services at a general acute care hospital in Michigan between January 1, 2006 and June 23, 2014, you are a member of the Settlement Class in a lawsuit against Blue Cross Blue Shield of Michigan ("BCBSM") and are entitled to submit a claim to share in the Settlement money. A list of the relevant hospitals is attached to this form.

If you wish to submit a claim, complete this form and mail it, postmarked on or before **November 16, 2014**, to the address below. You may also complete the Claim Form electronically at www.MichiganHospitalPaymentsLitigation.com on or before **November 16, 2014**.

Your claim will be reviewed to determine whether or not you are entitled to payment and the amount of any payment. More information, including details on how payments are determined, is available at www.MichiganHospitalPaymentsLitigation.com or by writing, emailing, or calling the Settlement Administrator. Inquiries regarding your claim can be made by contacting the Settlement Administrator by writing to the address below, emailing info@MichiganHospitalPaymentsLitigation.com, or calling (877) 846-0588.

You may not share in the Settlement Fund if you exclude yourself from the Settlement. BCBSM, related corporate entities, and BCBSM's officers, directors, employees, agents, and attorneys are not eligible to share in the Settlement money and are excluded from the Settlement Class.

Please mail your claim to: **Settlement Administrator**
PO Box 3240
Portland, OR 97208-3240

SECTION A: CLAIMANT INFORMATION

Claimant's Business Name:

(Please write the Business Name as you would like it to appear on the check, if eligible for payment.)

Claimant's Contact Person:

Street Address:

City: State: ZIP Code:

Telephone Number: – – Claimant's Tax Identification Number: –

Email Address:

(By providing an email address, you are authorizing the Settlement Administrator to provide you with information relevant to your claim via email.)

The Settlement Administrator will use this information for all communications relevant to this claim (including the check, if eligible for payment). If your contact information changes, you **MUST** notify the Settlement Administrator in writing at the mailing or email address above.

SECTION B: AUTHORIZED AGENT CONTACT INFORMATION

Please indicate whether you are filing on your own behalf as a Class Member or as the authorized agent of a Class Member:

☐ I am the Class Member named in Section A above.
(If so, you may skip the rest of this section.)

☐ I am filing on behalf of the Class Member named in Section A above.

If you are filing on behalf of a Class Member, state your relationship to the Class Member (e.g., third party administrator, attorney, etc.):

Agent's Business Name:

Agent's Contact Person:

Street Address:

City: State: ZIP Code:

Telephone Number:

			–				–				

Agent's Tax Identification Number:

		–							

Email Address:

(By providing an email address, you are authorizing the Settlement Administrator to provide you with information relevant to your claim via email.)

SECTION C: YOUR HOSPITAL HEALTHCARE PAYMENTS

To make a claim, you must provide two things: (1) a completed and signed copy of this form, stating all eligible hospital healthcare payments that you wish to be included in your claim; and (2) a copy of records documenting the hospital charges that you paid. YOU ARE NOT ELIGIBLE TO FILE A CLAIM FOR CHARGES PAID BY YOUR INSURED; YOU MAY ONLY FILE A CLAIM FOR CHARGES YOU ACTUALLY PAID.

C-1: Claim Table

On the Claim Table, please list each hospital from the attached list that you paid for healthcare services, the date(s) the hospital provided the services, and the amount(s) you paid to the hospital. You may include only payments for hospital healthcare services provided between January 1, 2006 and June 23, 2014. Purchases from a hospital pharmacy are **not** included in the Settlement, and may not be included in your claim.

If you are a self-insured entity, you may include amounts paid to the hospital for services received by your health plan participants, even if your health plan participants reimbursed you. You may **not** include amounts paid to the hospital by the plan participants themselves, even if you reimbursed the participant.

If you are an insurer, you may include amounts you paid to the hospital for services received by your insureds, even if your health plan participants reimbursed you. You may **not** include amounts paid to the hospital by your insureds, even if you reimbursed the insured.

If you are submitting your claim online, you can either fill out the Claim Table on the website or attach a spreadsheet or other file containing the information required by the Claim Table.

If you are submitting your claim by mail and need additional room, you may attach additional pages or recreate the Claim Table in a spreadsheet. Please number all additional pages to ensure review.

C-2: Copy of Purchase Records

You must also submit a copy of hospital bill(s) or other record(s) for all of your payments to the hospital that you wish to include in your claim. The records must show (a) the hospital providing the services, (b) the amount charged, and (c) the date(s) the services were provided. If you did not pay the hospital the full amount of the charges (because somebody else, such as your insured, paid part or for any other reason), the record must show the portion you paid. If you do not have these records, you may be able to obtain them from the relevant hospital.

If you submit by mail, please submit copies of your records, not the original records. If you are claiming a large number of payments, you can submit your supporting documentation and Claim Table on a CD or flash drive containing electronic or scanned copies of your records. If you submit online, you can submit electronic or scanned copies of your records as attachments to your claim.

If you are unable to locate or obtain your complete records, you should still submit the records that you do have. Even small payments for healthcare services at Michigan hospitals may entitle you to a minimum payment of up to $40.

CLAIM TABLE

(Please list separate visits on separate rows.)

Hospital (use code from list)	**Date(s) of Hospital Services** (mm/dd/yyyy)	**Amount You Paid to the Hospital** (in dollars)	**Insurance Provider** (use code from list)
	Total:		

When completing the above table, please use corresponding code from the below chart for the hospital and insurance company affiliated with each claimed purchase.

Code	Hospital Name
01-25	Allegan General Hospital
02-18	Allegiance Health
03-31	Alpena Regional Medical Center
04-40	Ascension Borgess-Lee Memorial Hospital
05-33	Ascension Borgess Medical Center
06-32	Ascension Borgess-Pipp Hospital
07-42	Ascension Genesys Regional Medical Center
08-50	Ascension Providence Hospital and Medical Centers
09-40	Ascension Providence Park Hospital–Novi
10-47	Ascension St. John Hospital and Medical Center
11-59	Ascension St. John Macomb-Oakland Hospital–Macomb Center
12-41	Ascension St. John North Shores Hospital
13-43	Ascension St. John River District Hospital
14-58	Ascension St. Mary's of Michigan Medical Center–Saginaw
15-59	Ascension St. Mary's of Michigan Medical Center–Standish
16-36	Ascension St. Joseph Hospital–Tawas
17-28	Aspirus Grand View Hospital
18-26	Aspirus Keweenaw Hospital
19-27	Aspirus Ontonagon Hospital
20-32	Baraga County Memorial Hospital
21-23	Bell Memorial Hospital
22-18	Botsford Hospital
145-20	Bronson Battle Creek
23-26	Bronson LakeView Hospital
75-26	Bronson Methodist Hospital
24-27	Bronson Vicksburg Hospital
25-24	Caro Community Hospital
26-25	Charlevoix Area Hospital
27-28	Cheboygan Memorial Hospital
76-37	Chippewa County War Memorial Hospital
28-41	Community Health Center of Branch County
29-32	Community Hospital–Watervliet
30-24	Covenant Medical Center
77-19	Crittenton Hospital
31-31	Deckerville Community Hospital
32-35	Dickinson County Memorial Hospital
78-38	DMC–Children's Hospital of Michigan
79-62	DMC–Detroit Receiving Hospital and University Health Center
80-59	DMC–Harper University Hospital & Hutzel Women's Hospital
81-34	DMC–Huron Valley Sinai Hospital
82-27	DMC–Sinai-Grace Hospital

Code	Insurance Provider
A-1	Aetna PPO
B-2	BCBSM Non-HMO (inpatient claims only)
C-3	HAP HMO (inpatient claims only)
D-4	HAP PPO
E-5	Priority PPO
F-6	Priority HMO
G-7	None of the Above

Code	Hospital Name
83-29	Doctors' Hospital of Michigan
33-28	Eaton Rapids Medical Center
84-28	Forest Health Medical Center
85-20	Garden City Hospital
34-32	Harbor Beach Community Hospital
35-36	Hayes Green Beach Memorial Hospital
36-28	Helen Newberry Joy Hospital
86-27	Henry Ford Cottage Hospital
87-19	Henry Ford Hospital
88-26	Henry Ford Macomb Hospital
89-40	Henry Ford Macomb Hospital–Warren Campus
90-35	Henry Ford West Bloomfield Hospital
91-29	Henry Ford Wyandotte Hospital
37-31	Hills & Dales General Hospital
92-33	Hillsdale Community Health Center
93-16	Holland Hospital
94-21	Hurley Medical Center
38-21	Huron Medical Center
39-41	Kalkaska Memorial Health Center (Munson)
95-22	Karmanos Cancer Center
96-42	Lakeland Hospitals at Niles and St. Joseph
40-44	Mackinac Straits Hospital and Health Center
41-27	Marlette Regional Hospital
42-32	Marquette General Health System
43-27	McKenzie Memorial Hospital
97-35	McLaren Bay Regional Medical Center
98-43	McLaren Central Michigan Community Hospital
99-56	McLaren Ingham Regional Medical Center (Greater Lansing)
100-38	McLaren Lapeer Regional Medical Center
101-45	McLaren Mount Clemens Regional Medical Center
102-43	McLaren Northern Michigan Regional Hospital
103-35	McLaren POH Regional Medical Center
104-31	McLaren Regional Medical Center
105-29	Mecosta County Medical Center

106-28	Memorial Healthcare (Owosso)
44-41	Memorial Medical Center of West Michigan
107-30	Mercy Memorial Hospital System
45-22	Metro Health Hospital
46-35	MidMichigan Medical Center–Clare
47-37	MidMichigan Medical Center–Gladwin
48-37	MidMichigan Medical Center–Gratiot
50-37	MidMichigan Medical Center–Midland
51-27	Munising Memorial Hospital
52-22	Munson Medical Center
108-31	North Ottawa Community Hospital
53-24	Northstar Health System
109-25	Oakland Regional Hospital
110-16	Oaklawn Hospital
111-26	Oakwood Annapolis Hospital
112-25	Oakwood Heritage Hospital
113-42	Oakwood Hospital & Medical Center–Dearborn
114-33	Oakwood Southshore Medical Center
115-24	OSF St. Francis Hospital
54-25	Otsego Memorial Hospital
55-39	Paul Oliver Memorial Hospital (Munson)
56-17	Pennock Hospital
116-19	Port Huron Hospital
57-24	Portage Health Hospital
117-33	ProMedica–Bixby Medical Center
58-36	ProMedica–Herrick Medical Center
59-18	Scheurer Hospital
60-30	Schoolcraft Memorial Hospital
61-28	Sheridan Community Hospital
62-31	South Haven Community Hospital
118-36	Southeast Michigan Surgical Hospital
119-28	Sparrow Carson City Hospital
63-25	Sparrow Clinton Hospital
64-17	Sparrow Hospital
65-23	Sparrow Ionia Hospital
120-27	Spectrum Health–Butterworth
121-31	Spectrum Health Gerber Memorial
66-32	Spectrum Health Kelsey Hospital
67-35	Spectrum Health Reed City Hospital
122-31	Spectrum Health United Hospital
123-35	Spectrum Zeeland Community Hospital
124-36	Straith Hospital for Special Surgery
125-16	Sturgis Hospital
68-20	Three Rivers Health
126-34	Trinity Chelsea Community Hospital
127-33	Trinity Mercy Hospital–Cadillac
128-33	Trinity Mercy Hospital–Grayling
129-26	Trinity MHP–Hackley Campus
130-24	Trinity MHP–Mercy Campus
69-35	Trinity MHP Mercy–Lakeshore Campus
131-34	Trinity St. Joseph Mercy–Ann Arbor
132-35	Trinity St. Joseph Mercy–Livingston
133-32	Trinity St. Joseph Mercy–Oakland
134-35	Trinity St. Joseph Mercy–Port Huron
135-31	Trinity St. Joseph Mercy–Saline
136-30	Trinity St. Mary Mercy–Livonia
137-43	Trinity St. Mary's Health Care–Grand Rapids
138-36	University of Michigan Health System
139-33	VA–Aleda E Lutz Medical Center
140-33	VA–Ann Arbor Healthcare System
141-33	VA–Battle Creek Medical Center
142-34	VA–Iron Mountain Medical Center
143-35	VA–John D. Dingell Medical Center
144-35	West Branch Regional Medical Center
70-26	West Shore Medical Center
71-40	William Beaumont Hospital–Grosse Pointe
72-36	William Beaumont Hospital–Royal Oak
73-31	William Beaumont Hospital–Troy
74-17	None of the Above

Section D: YOUR SHARE OF THE SETTLEMENT MONEY, IF ANY

Your share of the Settlement money, if any, will depend on the hospital(s) you paid, the date(s) the hospital provided the services, the amount of your payment(s), and the number of others who submit a valid Claim Form and the amount of their hospital payments. For more information, please review the Plan of Allocation, which is located on the website www.MichiganHospitalPaymentsLitigation.com as an exhibit to the Settlement Agreement, or contact the Settlement Administrator at:

Settlement Administrator
PO Box 3240
Portland, OR 97208-3240

Email Address: info@MichiganHospitalPaymentsLitigation.com
Toll-Free Number: (877) 846-0588

Section E: HIPAA SAFE HARBOR

The records you submit may contain information identifying the recipients of services or other personal health information. If so, you will fall within the safe harbor of the Health Insurance Portability and Accountability Act ("HIPAA") for court-ordered production of personal health information, 45 C.F.R. § 164.512(e)(1)(i), and have no liability under HIPAA or any state confidentiality statute, regulation, or other requirement, for supplying such member information to the Claims Administrator.

Section F: CONFIDENTIALITY

All information you submit will be kept confidential by the Settlement Administrator and Class Counsel. It will not be used for any purpose other than administering your claim and determining the amount, if any, of your payment. It will not be disclosed to BCBSM, the Plaintiffs, or any entity other than the Settlement Administrator and Class Counsel, and potentially the Court, under seal, if the Court needs to resolve a dispute concerning your claim. All documents you provide will be destroyed after all claims are finally resolved.

Section G: RELEASE

If you are a Settlement Class Member and do not timely and validly request to be excluded from the Settlement, and the Settlement receives Final Approval, you will release and discharge forever all Released Claims against BCBSM and related entities and individuals, whether or not you submit a Claim Form. For more information, see Paragraphs 58-59 of the Settlement Agreement, available at www.MichiganHospitalPaymentsLitigation.com.

Section H: CLAIMANT CERTIFICATION AND SIGNATURE

I hereby certify under penalty of perjury that:

1. I have been authorized by the Claimant to file a claim on their behalf and to receive on behalf of the Claimant any and all amounts that may be allocated to it from the Settlement Fund.
2. The information in this Claim Form is true and accurate to the best of my knowledge, information, and belief.
3. The Claimant is a member of the Settlement Class and did not request to be excluded from the Settlement.
4. I have read and agree to the Release in Paragraphs 58-59 of the Settlement Agreement.
5. I understand that I may be asked to provide additional information to validate this claim, and that the claim may be denied if I am unable to provide the requested information.
6. Neither I nor the Claimant have assigned or transferred (or purported to assign or transfer) or submitted any other claim for the same hospital payments and have not authorized any other person or entity to do so and know of no other person or entity having done so on the Claimant's behalf.
7. In the event that the Claimant later claims that I did not have the authority to claim or receive payments from the Settlement Fund on its behalf, I and/or my employer will indemnify and hold the parties, their counsel, and the Settlement Administrator harmless with respect to such claims.

Signature | **Dated** MM – DD – YY

Print Name:

Company Name:

Title of Signatory:

Claimant Name (if different than above):

ACCURATE PROCESSING OF CLAIMS MAY TAKE SIGNIFICANT TIME.
THANK YOU IN ADVANCE FOR YOUR PATIENCE.