

UNITED HEALTHCARE CLASS ACTION LITIGATION

Groups B & C claim chart for Subscribers who partially paid Adjusted Bill Amounts

Name of Claimant: _____

For **each** Covered Out-of-Network Service or Supply received, please provide the following information (*must be documented*):

Date of Service or Purchase of Supply <i>MM/DD/YYYY</i>	Name of Provider	Name of Patient	Original Bill Amount	Allowed Amount	Adjusted Bill Date <i>MM/DD/YYYY</i>	Adjusted Bill Amount	Paid Portion of Adjusted Bill <i>excluding copayment and deductible</i>	Unpaid Portion of Adjusted Bill <i>excluding copayment and deductible</i>	Indicate Percent of Recognized Loss Claimed <i>50%/70%/90%</i>
Totals: \$									

Paid Portion of Adjusted Bill (*excluding copayment and deductible*) represents your Group B claim
Unpaid Portion of Adjusted Bill (*excluding copayment and deductible*) represents your Group C claim