IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

R3000

	)	IN RE: ASBESTOS LITIGATION
MASTER FILE	)	
	)	NO. 09 L 000000

SUPPLEMENTAL CASE MANAGEMENT ORDER REGARDING COMPLIANCE WITH REPORTING REQUIREMENTS OF THE MEDICARE SECONDARY PAYER ACT

To aid in the resolution of and payment of claims in all asbestos actions filed in this Court, to manage this complex docket, to protect the interests of all parties, and in an effort to facilitate the compliance of the parties to this litigation with the requirements of "Medicare Secondary Payer Act," 42 U.S.C. Sec. 1395y, et seq (MSP) and any rules and regulations promulgated thereunder including the Medicare, Medicaid and SCHIP Extension Act of 2007 (PL 110-173), with the Court being fully advised of the premises for the pending motion **IT IS HEREBY ORDERED**, that the following procedures relating to compliance with MSP shall be followed:

Procedures for Distribution of Query, Consent to Release and Reporting Information For MSP Compliance:

1. **Form A-1 - Query Information and Form A-2 - Consent to Release:** In cases filed after the date of entry of this Order, within 90 days of filing complaint (30 days for exigent cases), each Plaintiff, with Plaintiff as referenced throughout this Order to mean all Plaintiffs in a case including but not limited to the physically injured person and/or authorized representative of the physically injured person and loss of consortium claimant(s), shall complete and file electronically on LexisNexis or other service as the Court may order, Forms A-1 and A-2, attached as Exhibits A-1 and A-2. Forms A-1 and A-2 shall also be completed to the best of Plaintiffs' ability in regard to a decedent whose injury is at issue. The related deadline for completion of said forms in cases currently pending, is within 60 days of the entry of this Order, but no later than 30 days before any scheduled trial. No trial setting will be given and/or proceeded upon prior to such proper completion and submission of Forms A-1 and A-2.

2. **Form B – Reporting Information:** Plaintiffs will complete in full and return the Reporting Form "Form B," attached Exhibit B, to Defendants as to Plaintiffs, Decedent and/or signatory to the release who are or were Medicare eligible. No settlement or judgment is final and enforceable, nor is payment due, until Form B is completed as to all signatories to the Release who are Medicare eligible and, if applicable, as to the Decedent. If a Defendant and/or its insurers intends to report ICD-9 or ICD-10 Codes that are inconsistent with the information provided 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 in an attempt to resolve inconsistencies to the extent possible. Form B is not required to be submitted to Defendant(s) for a Plaintiff, Decedent or signatory to the release where the appropriate non-eligible Medicare affidavit is provided instead (attached Exhibit C).

3. **Other Data Forms**: The Court is satisfied that these Data Forms (inclusively Forms A-1, A-2, Form B and Exhibit C) are sufficient to facilitate Defendant(s)' determination of the status of a Plaintiff or Plaintiff's decedent or signatory to the release 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 Forms attached, except upon order of the Court. Completion of these forms will not eliminate any discovery obligations that otherwise exist under the Illinois Rules of Civil Procedure.

4. **Resolution Payments:** No settlement, judgment, award or other payment is full, final and enforceable and the Court shall retain jurisdiction of a case until necessary closing documents, including Medicare reporting information contained within Form B has been received by Defendants as to all plaintiffs, decedent and signatories to the release who are or were Medicare beneficiaries.

Date: 4/25/12

Judge: William D. Maddux

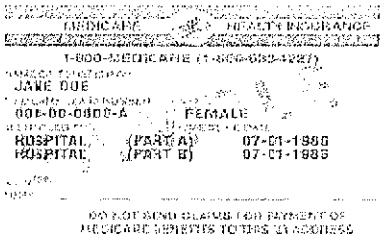
ENTERED
JUDGE WILLIAM D. MADDUX-1559
APR 25 2012
DOROTHY BROWN
CLERK OF THE CIRCUIT COURT
OF COOK COUNTY, IL
DEPUTY CLERK

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 II.		
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.

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: _____

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 10-11)

Case Name:	Case Number:	17. State of Venue: (USPS Abbreviation)
Defendant Name:		

Is the injured party presently or has he/she ever qualified for or been enrolled in Medicare Part A, B, C or D?

☐ Yes ☐ No

Section A – ALLEGED INJURED PARTY INFORMATION *(If a party is DECEASED, also complete Section D; if living, provide address in Section G)*

4. Medicare Claim Number: (also known as HICN)			
5. Social Security Number:	6. Injured Party Last Name: (Please print name 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	Date of Death: (MM/DD/YYYY):

Section B – ALLEGED INCIDENT INFORMATION

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

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 (MM/DD/YYYY):

15. Alleged Cause of Injury, Illness or Incident ("e" codes only – no "v" codes):

19. ICD-9 Diagnosis Code 1 (no decimal):

Provide valid ICD-9-CM Codes for any injury or illness you allege arose from the allegations made against settling defendant.

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:

Description of Illness/Injury (Free Form Text Description):

Section C – ALLEGED INJURED PARTY'S ATTORNEY or OTHER REPRESENTATIVE INFORMATION

84. Claimant Representative Type (please check one):

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

85. Claimant Representative Last Name:	86. Claimant Representative First Name:	87. Claimant Representative Firm Name:		
88. TIN/EIN, if Firm Entity; SSN. if Individual:	89-90. Representative Mailing Address:			
91. City:	92. State:	93-94. Zip Code +4:	95. Phone:	96. Ext. (if any):

Section D – CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased)*
If Section D Claimant has a representative other than Section C Representative, complete Section F

104. Claimant Relationship to Alleged Injured Party (please check one):

☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

105. TIN/EIN (Social Security, if individuals):	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):

Section E – SETTLEMENT INFORMATION

100. Date of Settlement:	101. Amount of Settlement:

CMO EXHIBIT B

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 10-11)

Section A-LOC	**LOSS OF CONSORTIUM PLAINTIFF INFORMATION** **THIS SECTION MUST BE COMPLETED ONLY IF THE NON-EXPOSED PLAINTIFF(S) ALLEGES LOSS OF CONSORTIUM, IS MEDICARE ELIGIBLE AND EFFECTIVELY RELEASES MEDICAL CARE/TREATMENT** **PROVIDE ESTATE INFORMATION IN SECTION D**		
4-LOC. Medicare Claim Number: (also known as HICN)			
5-LOC. Social Security Number:	6-LOC. Last Name: (Please print name exactly as it appears on Social Security card.)		
7-LOC. First Name: (Please print name exactly as it appears on Social Security card.)	8-LOC. Middle Name: (Please print name/initial exactly as it appears on Social Security card.)		
9-LOC Gender: ☐ Male ☐ Female	10-LOC. Date of Birth: (MM/DD/YYYY)	Deceased? ☐ Yes ☐ No	Date of Death: (MM/DD/YYYY):
15-LOC. Alleged Cause of Injury, Illness or Incident ("e" codes only – no "v" codes): (Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 19-LOC)			
19-LOC. ICD-9 Diagnosis: (Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 15-LOC)			

Signature of Attorney representing Plaintiff/Claimant(s) 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 herein is well grounded in fact to the best of his/her knowledge, information and belief formed after reasonably inquiry.

*Numbers reflect claim input file field numbers, as set forth in Version 3.2 of the Official MGHP User Guide by CMS.

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 10-11)

Case Name:	Case Number:
Defendant Name:	

Section F CLAIMANT'S (found in Section D) ATTORNEY OR OTHER REPRESENTATIVE INFORMATION

119. Claimant Representative Type (please check one):
☐ 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; SSN. if Individual:	124. Representative Mailing Address:	

126. City:	127. State:	128. Zip Code +4:	129. Phone:	130. Ext. (if any):

Section G ALLEGED INJURED PARTY'S ADDRESS

Representative Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

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

Claimant Relation to Alleged Injured Party (please check one):
☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ I=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

TIN/EIN (Social Security, if individuals):	Claimant Last Name:
Claimant First Name:	Claimant Middle Initial:

Claimant Entity/Organization Name:

Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Claimant Representative Type (please check one):
☐ A=Attorney ☐ P=Power of Attorney ☐ G=Guardian/Conservator ☐ O=Other

Claimant Representative Last Name:	Claimant Representative First Name:	Claimant Representative Firm Name:
TIN/EIN, if Firm Entity; SSN. if Individual:	Representative Mailing Address:	

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Section B cont. Additional ICD-9 fields, if necessary

31. ICD-9 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 Code13:	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:

<u>If additional Section D Claimants exist, use page 3 and duplicate page, if necessary.</u>

CMO EXHIBIT B

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 10-11)

Case Name:	Defendant Name:

Section D cont.: ADDITIONAL CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased)*

Claimant Relation to Alleged Injured Party (please check one):

☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

TIN/EIN (Social Security, if individuals):	Claimant Last Name:
Claimant First Name:	Claimant Middle Initial:

Claimant Entity/Organization Name:

Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Claimant Representative Type (please check one):

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

Claimant Representative Last Name:	Claimant Representative First Name:	Claimant Representative Firm Name:

TIN/EIN, if Firm Entity; SSN. if Individual:	Representative Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Section D cont.: ADDITIONAL CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased)*

Claimant Relation to Alleged Injured Party (please check one):

☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

TIN/EIN (Social Security, if individuals):	Claimant Last Name:
Claimant First Name:	Claimant Middle Initial:

Claimant Entity/Organization Name:

Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Claimant Representative Type (please check one):

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

Claimant Representative Last Name:	Claimant Representative First Name:	Claimant Representative Firm Name:

TIN/EIN, if Firm Entity; SSN. if Individual:	Representative Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Section D cont.: ADDITIONAL CLAIMANT INFORMATION *(Use only if Alleged Injured Party in Section A is deceased)*

Claimant Relation to Alleged Injured Party (please check one):

☐ E=Estate (Individual) ☐ X=Estate (Entity) ☐ F=Family (Individual) ☐ F=Family (Entity) ☐ O=Other (Individual) ☐ Z=Other (Entity)

TIN/EIN (Social Security, if individuals):	Claimant Last Name:
Claimant First Name:	Claimant Middle Initial:

Claimant Entity/Organization Name:

Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Claimant Representative Type (please check one):

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

Claimant Representative Last Name:	Claimant Representative First Name:	Claimant Representative Firm Name:

TIN/EIN, if Firm Entity; SSN. if Individual:	Representative Mailing Address:

City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 10-11)

Field#	Field Name	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 SECURITYCARD 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.
	DATE OF DEATH	Provide the date the Alleged Injured Party deceased.
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 CUASE OF INJURY, ILLNESS OR INCIDENT	Claimant must provide either: 1) both a valid Alleged Cause of Injury, Incident or Illness Code (Field 15) and at least one valid ICD-9 Diagnosis Code (Field 19) OR 2) the Description of Illness/Injury(Field 57). Claims submitted on or after 1/1/11, Claimant must provide both a valid Alleged Cause of Injury, Incident,or Illness Code (Field 15) and at least one valid ICD-9 Diagnosis Code. (See notes above for Spouse injury codes)
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.
19-55	ICD-9 DIAGNOSIS CODE 1 - 19	(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 an E or a V Code). (See notes above for Spouse injury codes)
57	RESERVED FOR FUTURE USE	Formerly used for the obsolete -- Description of 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. 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	REPRESETNATIVE FIRM NAME	Provide the Name of the Representative's Firm.
88	TIN/EIN, IF FIRM/ENTITY;SOCIAL SECURITY NUMBERIF 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. IncludeZip+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.
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 thedate of court approval. If there is no written agreement, then it is the date of payment.
101	AMOUNT OF SETTLEMENT	Provide total amount of Settlement
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.

Medicare Confidential Reporting Information* [FORM B]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 10-11)

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 representative 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 REPRESENTATIVE LAST NAME	Provide the last name of the Claimant's Representative.
121	CLAIMANT REPRESENTATIVE 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; SOCIALSECURITY 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	CLAIMANT REPRESENTATIVE MAILING ADDRESS	Provide mailing address for the claimant's representative.
126	CLAIMANT REPRESENTATIVE CITY	Provide mailing address city for the claimant's representative.
127	CLAIMANT REPRESENTATIVE STATE	Provide mailing address state for the claimant's representative.
128	CLAIMANT REPRESENTATIVE ZIP CODE +4	Provide mailing address zip code for the claimant's representative.
130	CLAIMANT REPRESENTATIVE PHONE	Provide telephone extension of claimant's representative, if extension is available.
131	CLAIMANT REPRESENTATIVE PHONE EXTENSION, IF ANY	Provide telephone extension of claimant's representative, if extension is available.

CMO EXHIBIT B

[NAME(S)], et al,	)	IN THE
	)	
Plaintiff(s),	)	[COURT]
	)	
v.	)	FOR
	)	
[NAME(S)], et al,	)	[LOCATION]
	)	
Defendant(s).	)	CASE NO.

AFFIDAVIT OF PLAINTIFF(S)

1. I(We), [PLAINTIFF(S)], am over the age of eighteen (18) and am competent to be a witness in this matter. I have personal knowledge of the facts set forth herein.

2. I(We) understand that in reaching a settlement, the parties have considered Medicare's interest in recovering conditional payments made for medical treatment rendered as a result of the claim that is the subject of my(our) above captioned lawsuit.

3. I(We) have provided my(our) Social Security Number. I understand that if I(We) am(are) a Medicare beneficiary(ies) and I(We) do not provide the requested information, including a Health Insurance Claim Number, I(We) may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my(our) claim(s) correctly and promptly.

4. I(We) hereby make the following representations and warranties:

   (a) I(We) have not applied for Medicare benefits.

   (b) Medicare has made no conditional payments for any medical expense or prescription expense related to the claimed injury.

   (c) I(We) am(are) not, nor have I(we) ever been Medicare beneficiaries.

   (d) I(We) am(are) have not received Social Security Disability Benefits for more than 18 months, if at all.

   (e) I(We) are not in End Stage Renal Failure.

   (f) I (We) have not been diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease.

5. I(We) assume all responsibility for all liens related to the treatment of the claimed injury, including those asserted by Medicare or any other entity pursuant to the Medicare, Medicaid and SCHIP Extension Act and/or the Medicare Secondary Payer Act.

I(We) solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____

Date [PLAINTIFF]

Sworn and subscribed before me this _____ day of_____, 20__

_____

Notary Public

My Commission expires: _____

2703378_2

[NAME(S)], et al,	)	IN THE
	)	
Plaintiff(s),	)	[COURT]
	)	
v.	)	FOR
	)	
[NAME(S)], et al,	)	[LOCATION]
	)	
Defendant(s).	)	CASE NO.

AFFIDAVIT OF PLAINTIFF / ESTATE ADMINISTRATOR

1. I, [PLAINTIFF], am over the age of eighteen (18) and am competent to be a witness in this matter. I have personal knowledge of the facts set forth herein.

2. I understand that in reaching a settlement, the parties have considered Medicare's interest in recovering conditional payments made for medical treatment rendered as a result of the claim that is the subject of my(our) above captioned lawsuit.

3. I have brought the above captioned lawsuit in my capacity as the personal representative of the Estate of [PLAINTIFF'S DECEDENT], Deceased. I have provided the Social Security Number of [PLAINTIFF'S DECEDENT]. I understand that if [PLAINTIFF'S DECEDENT] was a Medicare beneficiary and I do not provide the requested information, including a Health Insurance Claim Number, I may be violating obligations that [PLAINTIFF'S DECEDENT] would have as a beneficiary to assist Medicare in coordinating benefits to pay claims of [PLAINTIFF'S DECEDENT] correctly and promptly.

4. I hereby make the following representations and warranties:

   (a) An application for Medicare benefits was not made by or on behalf of [PLAINTIFF'S DECEDENT] prior to his/her death.

   (b) Medicare has made no conditional payments for any medical or prescription expense related to the claimed injury of [PLAINTIFF'S DECEDENT].

   (c) [PLAINTIFF'S DECEDENT] was not a Medicare beneficiary.

   (d) [PLAINTIFF'S DECEDENT] did not receive Social Security Disability Benefits for more than 18 months, if at all, prior to his death nor have I received Social Security Disability Benefits on behalf of [PLAINTIFF'S DECEDENT].

   (e) [PLAINTIFF'S DECEDENT] was not in End Stage Renal Failure.

   (f) [PLAINTIFF'S DECEDENT] was not diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease.

5. In my capacity as the personal representative of the Estate of [PLAINTIFF'S DECEDENT], Deceased, I assume all responsibility for all liens related to the treatment of the claimed injury of [PLAINTIFF'S DECEDENT], including those asserted by Medicare or any other entity pursuant to the Medicare, Medicaid and SCHIP Extension Act and/or the Medicare Secondary Payer Act.

6. I have had no bodily or psychological personal injury and received no medical treatment related to the injury of [PLAINTIFF'S DECEDENT]. More specifically, I did not seek any professional counseling nor did I receive any medication as a result of psychological distress brought on by the illness of [PLAINTIFF'S DECEDENT]. I waive any and all past, present and future claims for any such injury. I am not waiving any claims that may exist from my personal exposure to asbestos.

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of this affidavit are true.

_____ _____

Date [PLAINTIFF]

Sworn and subscribed before me this _____ day of_____, 20__

_____

Notary Public

My Commission expires: _____

CMO Exhibit C