UNITED HEALTHCARE CLASS ACTION LITIGATION

Claims Information Request Authorization Form

To receive a copy of the claims information made available to the Claims Administrator by the Defendants in connection with the Covered Out-of-Network Services or Supplies that were either received or provided from January 1, 2002 until May 28, 2010, please complete this Request Form and provide the following information:

Part I ***(Subscribers and Providers)***

[ ] I am a Class Member in the United HealthCare Class Action Litigation and I authorize the Defendants to send the Claims Administrator, and the Claims Administrator to send me a copy of the information furnished by Defendants regarding the Covered Out-of-Network Services or Supplies that I received/provided from January 1, 2002 through May 28, 2010 to assist me in filing a Group B, C or D claim.

Name: _____

Address: _____

_____

Daytime Telephone Number **Email Address**

Part II ***(Subscribers Only)***

Notice Number
(The "Notice Number" can be found under the return address on the Notice mailed to you by the Claims Administrator. If you did not receive a mailed Notice from the Claims Administrator, please indicate "Not Available").

Insurance Policy ID Number **Social Security Number**

Part III ***(Providers Only)***

Notice Number
(The "Notice Number" can be found under the return address on the Notice mailed to you by the Claims Administrator. If you did not receive a mailed Notice from the Claims Administrator, please indicate "Not Available").

Tax ID Number **Billing Tax ID Number of Medical Practice**
(To properly identify information for a Provider Group, the Claims Administrator ***must*** *be provided with the Billing Tax ID of the medical practice* ***and*** *a list of names of the individual Providers with their personal Tax IDs.* ***Please use the table on the following page to provide this information.****)*

Part IV ***(Subscribers and Providers)***

I certify under penalty of perjury that to the best of my knowledge, the information above is true and correct. This authorization form is executed this _____ day of _____ 2010 in _____ (City), _____ (State).

Submit this form to the Claims Administrator at:

United Healthcare Class Action Litigation
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001
Fax: (516) 222-0271
Email: unitedhealthcare@berdonclaimsllc.com

_____
Signature

_____
Print your name

Provider Name	Provider Tax ID

Billing Tax ID: _____