UNITED HEALTHCARE CLASS ACTION LITIGATION

Group B claim chart for Subscribers who paid out-of-pocket

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 *MM/DD/YYYY*	**Name of Provider**	**Name of Patient**	**Original Bill Amount**	**Allowed Amount**	**Adjusted Bill Date** *MM/DD/YYYY*	**Adjusted Bill Amount**	**Paid Portion of Adjusted Bill** *excluding copayment and deductible*
						Total:	**$**

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