UNITED HEALTHCARE CLASS ACTION LITIGATION

Group C claim chart for Subscribers who did not fully pay 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 *MM/DD/YYYY*	**Name of Provider**	**Name of Patient**	**Original Bill Amount**	**Allowed Amount**	**Adjusted Bill Date** *MM/DD/YYYY*	**Adjusted Bill Amount**	**Unpaid Portion of Adjusted Bill** *excluding copayment and deductible*	**Indicate Percent of Recognized Loss Claimed** 50%/70%/90%
						Total:	**$**	

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