UNITED HEALTHCARE CLASS ACTION LITIGATION

Group D claim chart for Providers seeking increased damages

Name of Claimant: _____

Tax ID Number: _____

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

*** Practice needs to provide**

Date of Service or Purchase of Supply	Name of Patient	Patient's Policy ID Number	Provider's UHC Claim ID Number	CPT or HCPCS Code *(if available)*	Original Bill Amount	Amount Paid by Defendant	Adjusted Bill Date * MM/DD/YYYY	Adjusted Bill Amount *	Amount Paid by Patient * *excluding copayment and deductible*	Indicate Percent of Recognized Loss Claimed * 50%/70%/90%

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