Kline v. Envision Healthcare Corp - 7057
PO BOX 44
Minneapolis MN 55440-0044

IMPORTANT LEGAL MATERIALS

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FOR OFFICIAL USE ONLY

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CLAIM FORM

Kline v. Envision Healthcare Corporation, et al., Case No. CV2019-003061
Superior Court of Arizona – Maricopa County

IF YOU DO NOT FOLLOW THESE INSTRUCTIONS, YOUR CLAIM COULD BE DELAYED OR REJECTED.

I. INSTRUCTIONS FOR MAKING A CLAIM

TO MAKE A CLAIM FOR A WRITE-OFF OR REFUND:

1. **Complete and sign this Claim Form**.
   - Make sure this form is filled out completely and accurately.
   - Sign and date the RELEASE AND SWORN VERIFICATION STATEMENT (Part V).
2. **Include supporting documentation** with your Claim Form as described in detail in Part II.
3. **Mail the completed Claim Form and supporting documentation** to the Claims Administrator at the address shown on the last page of this form, **postmarked no later than April 16, 2021**.

One claim should be submitted for each date of service for which you are seeking a write-off or refund.

If you need additional copies of the Claim Form, you may contact the Claims Administrator, by phone at 866-216-0281 or by email at info@AZanesthesiasettlement.com, or you can visit the Settlement website, AZanesthesiasettlement.com, where the Claim Form is available to download.

II. SUPPORTING DOCUMENTATION FOR WRITE-OFFS AND REFUNDS

Every claim for a write-off or refund **must include** an **Explanation of Benefits** ("EOB") from your health insurance or plan for the out-of-network anesthesia services. The EOB should show the "Allowable Charge" (also sometimes referred to as the "allowed amount," "approved charge," "maximum allowable," "eligible expense," or "payment allowance," among other terms), which is the maximum allowed reimbursement for out-of-network anesthesia services as determined by your health insurance or plan.

Your claim must also include the following **additional** documents depending on your situation:

Situation	Required Additional Documentation
You made payment(s) for the out-of-network services (this includes making or forwarding a payment after receiving reimbursement for the services directly from your health insurance or plan)**.**	**Proof of any payment(s) made** for the out-of-network anesthesia services. Proof of payment might include, for example, a copy of a credit card statement or a cleared check.
The account was sent to collections.	A copy of the **invoice(s) from the collection agency**.
After the account was sent to collections, you made payment(s).	**Proof of any payment(s) made to the collection agency**. Proof of payment might include, for example, a copy of a credit card statement or a cleared check.

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Neither you nor your health insurance or plan paid the Allowable Charge	**Payment of the Allowable Charge or any portion of the Allowable Charge not yet paid**. Before you can receive a write-off or refund of any amount billed above the Allowable Charge, payment of the Allowable Charge for the out-of-network anesthesia services is required.

FAILURE TO INCLUDE SUPPORTING DOCUMENTATION MAY RESULT IN THE REJECTION OF YOUR CLAIM. If such documents are not in your possession, you will need to obtain copies of the documents or equivalent documents. For example, you can obtain an EOB from the health insurance or plan that you had at the time you received the services.

III. YOUR INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ____

Street Address: _____

City: _____ State: ____ ____ Zip Code: ____ ____ ____ ____ ____

Telephone Number: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____

Email Address: _____

IV. CLAIM INFORMATION

Please identify in the spaces below the Arizona hospital, affiliated physician practice (if known), and date of service for the anesthesia department medical services you received between April 15, 2017 and [date of executed settlement agreement].

NOTE: Anesthesia services provided at non-Arizona hospitals or at Arizona hospitals at which physician practices affiliated with Envision Healthcare Corporation, EmCare, Inc. and Anesthesia Physicians of Arizona, P.C. (collectively "Defendants") did not provide anesthesia services, or anesthesia services provided before April 15, 2017, are not subject to write-off or refund and should not be submitted as a claim. If you do not know whether the Arizona hospital you went to was affiliated with any of the Defendants, you can call the Claims Administrator at the following toll-free number: (866) 403-6541.

Date of Service (MM/DD/YYYY): ____ ____ / ____ ____ / ____ ____ ____ ____

Patient Last Name: _____ First Name: _____ Middle Initial: ____

Patient Date of Birth (MM/DD/YYYY): ____ ____ / ____ ____ / ____ ____ ____ ____

Guarantor Last Name: _____ First Name: _____ Middle Initial (if different from Patient): ____

Hospital Name: _____

City: _____ State: ____ ____ Zip Code: ____ ____ ____ ____ ____

Affiliated Physician Practice Name (If Known): _____

Check the box(es) indicating the supporting documentation that you have enclosed with this Claim Form for the date of service listed above. **You must include the required supporting documentation and a completed Claim Form for each date of service for which you are seeking a write-off or refund.**

- ☐ Explanation of Benefits ("EOB")
- ☐ Payment: $ _____
- ☐ Proof of Payments Already Made:
  - ☐ Check:
  - ☐ Credit Card Statement
  - ☐ Other: _____
- ☐ Invoice from Collection Agency

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V. RELEASE AND SWORN VERIFICATION STATEMENT

PLEASE READ THE BELOW CAREFULLY AS IT WILL AFFECT YOUR LEGAL RIGHTS.

With full awareness and understanding of this release, I hereby acknowledge I have received the Notice of Settlement. I submit this Claim Form to participate in the settlement reached in this Lawsuit, and submit to the jurisdiction of the Superior Court of Arizona, Maricopa County, with respect to my claim asserted herein, and for purposes of enforcing the release of claims stated in this Claim Form and in the Settlement Agreement. I further agree and acknowledge that I am bound by the terms of the Order and Judgment that may be entered by the Court in this Lawsuit, and the terms of the Settlement Agreement, including the release of claims set forth therein.

I, _____ (**PRINT NAME**), swear under penalty of perjury of the laws of Arizona that the information I have supplied in this Claim Form is accurate, truthful, and complete in all respects. I understand that the above information will be reviewed and verified by a representative from the Claims Administrator, and that I may be contacted for more information, if needed. I understand that my claim will be reviewed by the Claims Administrator and may be approved or denied, and pursuant to the Arizona Confidentiality of Medical and Payment Records, A.R.S. Sec. 12-2292 and the Health Insurance Portability and Accountability Act ("HIPAA"), I consent to and authorize the Claims Administrator, the Defendants, and the Parties' counsel to review my billing records and any related medical information on the billing records for the purpose of determining whether or not I am entitled to a write-off or a refund.

Signature: _____ Date: ____ ____ / ____ ____ / ____ ____ ____ ____

You do NOT need to submit any medical records with this Claim Form. The only documents required to process your claims and to determine whether you are entitled to a write-off or refund under the Settlement are set out in Part II. If you do include medical information, you expressly acknowledge that it may be reviewed by the Parties' counsel and/or the Claims Administrator and consent to such review.

VI. MAILING INSTRUCTIONS

Please mail your completed claim form and supporting materials no later than April 16, 2021 to:

By U.S. Mail:

Kline v. Envision Healthcare Corp - 7057
PO BOX 44
Minneapolis MN 55440-0044

YOU ARE STRONGLY ENCOURAGED TO KEEP A COPY OF YOUR COMPLETED CLAIM FORM AND ALL ATTACHMENTS FOR YOUR RECORDS, AND TO ENSURE CONFIRMATION OF DELIVERY USING A TRACKING-ENABLED METHOD OF MAIL (E.G., CERTIFIED MAIL, OR USPS PROOF OF MAILING) OR BY CALLING THE CLAIMS ADMINISTRATOR AT 866-216-0281 .

NEITHER ENVISION HEALTHCARE CORPORATION, EMCARE, INC., ANESTHESIA PHYSICIANS OF ARIZONA, P.C. (NOR ANY OF THEIR SUBSIDIARIES OR AFFILIATES), PLAINTIFF, THEIR ATTORNEYS, NOR THE CLAIMS ADMINISTRATOR ARE RESPONSIBLE FOR LOST, MISDIRECTED, OR DELAYED MAIL SHIPMENTS.

VII. WHAT HAPPENS NEXT?

Your Claim Form, if and when received, will be reviewed and processed by the Claims Administrator to determine if you are eligible and have satisfied the requirements for a write-off or refund. If there is a curable defect in your claim, the Claims Administrator will contact you and give you a chance to fix the defect. If you are an Approved Claimant, your write-off or refund will be processed in a reasonable amount of time, as approved by the Court. Refund checks will be delivered by mail to the address you supplied.

IT IS **YOUR** RESPONSIBILITY TO SEND THE CLAIMS ADMINISTRATOR YOUR NEW CONTACT INFORMATION IF IT CHANGES TO ENSURE RECEIPT OF FURTHER NOTICES AND YOUR REFUND CHECK.