Appendix I-3

Medicare Confidential Reporting Information Form

IN RE NUVARING® PRODUCTS LIABILITY LITIGATION — APPENDIX I-3

MEDICARE CONFIDENTIAL REPORTING INFORMATION FORM

Pursuant to Section 111 of the Medicare, Medicaid and SCRIP Extension Act of 2007

Case Name:			**Case Number:**	
Is the injured party presently or has he/she ever qualified for or been enrolled in Medicare Part A or B? ☐ Yes ☐ No				
Section A	**ALLEGED INJURED PARTY INFORMATION** *(if party is DECEASED, also complete Section F)*		*Please see footnote at bottom of page	
4. Medicare Claim Number (*also known as HICN*):			**5. SSN:**	
6. Injured Party Last Name: ***(Please print name exactly as it appears on Social Security card.)***	**7. Injured Party First Name:** ***(Please print name exactly as it appears on Social Security card.)***		**8. Injured Party Middle Name:** ***(Please print name exactly as it appears on Social Security card.)***	
9. Gender: ☐ Male ☐ Female	**10. Date of Birth** *(MM/DD/YYYY)*:		**Deceased?** ☐ Yes ☐ No	
Section B	**ALLEGED INCIDENT INFORMATION**			
12. CMS Date of Incident: Please state the date of accident or date of first exposure:		**13. Industry Date of Incident: Please state the date of accident or date of last exposure:**		
15. ICD-9 Alleged Cause of injury, illness or incident code*:	**17. State of Venue:**	**19. ICD-9 Diagnosis Codes**:**		
Section C	**ALLEGED INJURED PARTY'S ATTORNEY OR OTHER REPRESENTATIVE INFORMATION**			
84. Representative Type (please check one): ☐ **A = Attorney** ☐ **G = Guardian/Conservator** ☐ **P = Power of Attorney** ☐ **O = Other**				
85. Representative Last Name:	**86. Representative First Name:**		**87. Representative Firm Name:**	
88. TIN/EIN, if Firm Entity; Social Security Number if individual:		**89. Mailing Address:**		
91. City:	**92. State:**	**93. Zip Code +4:**	**95. Phone:**	**96. Ext. (if any):**
Section D	**SETTLEMENT INFORMATION**			
100. Date of Settlement:		**101. Amount of Settlement:**		
Section E	**SIGNATURE/ATTESTATION**			

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

_____ _____

Plaintiff Name (Please Print) **Claim Number**

_____

Name of Person Completing This Form if Plaintiff is Unable (Please Print)

_____ _____

Signature of Person Completing This Form **Date**

Subscribed and sworn to before me this ____ day of _____, 20___.

_____

By:

_____ _____

Attorney for Claimant **State Bar #**

_____ _____

Firm Name **Date**

*THE CURRENT LIST OF VALID CODES ACCEPTED BY CMS FOR SECTION 111 REPORTED MAY BE FOUND AT: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/06_codes.asp.

Please provide valid ICD-9 Codes for any injury or illness you allege arose from the allegations made against settling defendant. **NOTE: separate ICD-9 codes are required for each body part you assert was/is affected.

The information in this form is to be held confidential and not used in discovery or in any proceeding in evidence or otherwise, except to communicate with the U.S. Government or its designee or to defend any claim of lien or fine pursuant to Medicare statutes, rules and regulations including MMSEA Section 111.

Case Name:	**Case Number:**

ATTENTION

If Alleged Injured Party is NOT DECEASED and you have completed Page 1, you may stop here.

Please continue to Section F (Claimant Information) only if Alleged Injured Party in Section A is deceased.
At least Claimant 1 information is required if Alleged Injured Party is deceased.

Case Name:	Case Number:

Section F	**CLAIMANT INFORMATION** *(Use only if Alleged Injured Party in Section A is deceased.)* Please fill out one for each separate Claimant.

CLAIMANT 1

104. Claimant Relationship to Alleged Injured Party: ☐ **E = Estate (Individual)** ☐ **X = Estate (Entity)** ☐ **O = Other (Individual)** ☐ **F = Family (Individual)** ☐ **Y = Family (Entity)** ☐ **Z = Other (Entity)**

105. TIN/EIN, if Entity; Social Security Number, if Individual:	**106. Claimant Last Name:**
107. Claimant First Name:	**108. Claimant Middle Initial:**
109. Claimant Entity/Organization Name:	
110. Mailing Address:	

112. City:	**113. State:**	**114. Zip Code +4:**	**116. Phone:**	**117. Ext. (if any):**

119. Claimant Relationship Type: ☐ **A = Attorney** ☐ **P = Power of Attorney** ☐ **G = Guardian/Conservator** ☐ **O = Other**

120. Claimant Representative Last Name:	**121. Claimant Representative First Name:**	**122. Claimant Representative Firm Name:**
123. TIN/EIN, if Entity; Social Security Number, if Individual:	**124. Representative Mailing Address:**	

126. City:	**127. State:**	**128. Zip Code +4:**	**130. Phone:**	**131. Ext. (if any):**

_____ _____ _____

Signature(s) of Claimant 1 / Claimant 1 Representative **Date** **Printed Name**

Subscribed and sworn to before me this ____ day of _____, 20___.

_____

By:

_____ _____

Attorney for Claimant **State Bar #**

_____ _____

Firm Name **Date**