UNITEDHEALTHCARE LIPOSUCTION FOR LIPEDEMA REIMBURSEMENT CLAIM FORM

You are receiving this Claim Form because you are a Class Member in the case captioned *Mary Caldwell v. UnitedHealthcare Insurance Company et al., Case No. 3:19-cv-02861-WHA*.

If UnitedHealthcare denied your pre-authorization or post-service request for liposuction surgery to treat lipedema between January 1, 2015 and December 31, 2019, on the grounds that the requested was "unproven," and you paid out-of-pocket for the surgery on or before December 22, 2023 and were not reimbursed by any other source (including, for example, other insurance or Medicare), then you may use this Claim Form to request reimbursement from UnitedHealthcare.

YOU HAVE UNTIL MAY 20, 2024 TO SUBMIT THE COMPLETED CLAIM FORM. If you did not pay out-of-pocket for liposuction surgery, do not submit this form.

UnitedHealthcare shall pay the claims of any Class Member who (1) provides medicals records stating that they had liposuction to treat lipedema and (2) provides evidence of out-of-pocket payment. Reimbursement will be subject to a reduction only for the cost-share (co-insurance , co-pay or deductible) that you would have paid under your contract with UnitedHealthcare if the claim originally had been covered. You will not be entitled to reimbursement for any portion of the payment that was covered by another health plan, insurer, Medicare, or any other third-party.

UnitedHealthcare will pay the claims who provide the above evidence within 60 days of receiving the claim, unless it needs additional information.

If you need assistance submitting the reimbursement request, please contact GIANELLI & MORRIS, at 550 South Hope Street, Suite 1645 Los Angeles, CA 90071, 213-489-1600 no later than April 20, 2024. Submitting this Claim Form does not guarantee that you will receive benefits.

Instructions:

Please read all of the instructions and complete the Claim Form as indicated below.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent reimbursement for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

When you have completed this Claim Form, please mail it—along with supporting documentation—directly to the Settlement Administrator at the address listed below:

United Lipedema Settlement
c/o JND Legal Administration
PO Box 91232
Seattle, WA 98111

UNITEDHEALTHCARE MEMBER (OR FORMER MEMBER) INFORMATION				
Member (or former member) Name Last	First			Middle
Home Address		Date of Birth (Mo / Day / Yr)		Primary Phone Number
City	State	Zip	Patient Sex	Is this a new address? YES ☐ NO ☐
UnitedHealthcare Member ID No.				

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OTHER COVERAGE OR BENEFITS INFORMATION	
Have you received coverage or benefits from any other health plan or health insurance company for liposuction surgery to treat lipedema? YES ☐ NO ☐	If you were enrolled in Medicare when you paid out-of-pocket for liposuction surgery to treat lipedema, indicate the parts you were enrolled in at the time of coverage: PART A ☐ PART B ☐
If the answer is "Yes" to the above, what date did you receive coverage or benefits? Date:	If you were enrolled in Medicare when you paid out-of-pocket for liposuction surgery to treat lipedema, what dates were you enrolled? Effective Date: End Date:

Name of other health plan or insurance company		Policy No. / Subscriber No.		
Health Plan or Insurance company address	City	State	Zip	
Name of policyholder		Social Security No.	Date of Birth	
Employer Name	Employer Address	City	State	Zip

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION
I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically-related facility to furnish to UnitedHealthcare, its agents, designees, or representatives, any and all information pertaining to medical treatment for purposes of reviewing, investigating, or evaluating this claim. I also authorize UnitedHealthcare, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer, or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization becomes effective immediately and will remain in effect until _____. A photocopy or scan of this authorization will be considered as effective and valid as the original. I certify that the above statements are correct.

UNITEDHEALTHCARE MEMBER, FORMER MEMBER, OR PARENT OR LEGAL GUARDIAN'S SIGNATURE (if Member is under 18 years old)

PRINT NAME

DATE

CONTINUED ON NEXT PAGE

INFORMATION RELATED TO YOUR LIPOSUCTION SURGERY

Instructions: Please complete this section to the best of your ability. In addition, please enclose (1) documentation related to proof of payment for your liposuction surgery to treat lipedema, and (2) medical records in your possession as well as reasonably available to you (e.g., your doctor's or surgeon's records available upon your request) related to your liposuction surgery.

Please submit the following documentation that demonstrates that you incurred and paid out-of-pocket for liposuction surgery to treat lipedema:

(i) a bill from the health care provider and/or medical facility (which includes the date of service and a description of the service provided); and

(ii) one of the following:

(a) cancelled checks that correspond to the bill for the liposuction surgery; or

(b) receipts from your health care provider(s) and/or medical facility(ies); or

(c) credit card receipts reflecting your payment to the health care provider(s) and/or medical facility(ies).

You can request a copy of your bill showing both your payment and the date of services received from your provider if you have not kept a copy. You must include both a copy of the bill, as well as proof that you paid the bill, with your claim form.

UnitedHealthcare cannot process your reimbursement without adequate proof of payment.

Dates Of Service	Place Of Service	Health Care Provider	Service Received	Amount You Paid For Service
Example June 17, 2015	Santa Rosa Medical Group	John Smith	Liposuction for lipedema	$3,000
1.				
2.				
3.				
4.				

I AFFIRM THAT I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ON THIS CLAIM FORM AND ACCOMPANYING CLAIM FORM DOCUMENTATION PAGE(S) TO THE BEST OF MY ABILITY. I UNDERSTAND THIS CLAIM IS SUBJECT TO REVIEW AND VERIFICATION, AND THAT UNITED HEALTHCARE MAY REQUEST THAT I SUBMIT ADDITIONAL INFORMATION TO SUPPORT MY CLAIM FOR REIMBURSEMENT,	
UNITED HEALTHCARE MEMBER, FORMER MEMBER, OR PARENT OR LEGAL GUARDIAN'S SIGNATURE (if Member is under 18 years old) _____	DATE