UNITEDHEALTHCARE LIPOSUCTION FOR LIPEDEMA RE-REVIEW 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 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 have not yet had the surgery, you may use this form to request re-review.

YOU HAVE UNTIL MAY 20, 2024 TO SUBMIT THE COMPLETED CLAIM FORM. If you already paid out-of-pocket for liposuction surgery, do not submit this form. Please submit the reimbursement claim form.

UnitedHealthcare shall authorize and reimburse for a future surgery for which re-review is requested through this Claim Form for any Class Member who (1) attests under penalty of perjury that they currently have no other insurance or benefit plan that provides coverage for liposuction to treat lipedema and (2) their surgeon verifies that the pre-service request is for medically necessary liposuction to treat lipedema.

UnitedHealthcare will notify you whether the request is approved within 60 days of receiving the surgeon verification or any follow-up information United Healthcare requests from the surgeon.

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) AND SURGEON 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.					

Requesting Provider/facility name:
Requesting Provider/facility NPI:
Requesting Provider/facility phone number:
Requesting Provider/facility fax number:

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OTHER COVERAGE OR BENEFITS INFORMATION					
Do you currently have coverage or benefits from any other health plan or health insurance company for liposuction surgery to treat lipedema? YES ☐ NO ☐			If you are currently enrolled in Medicare, indicate the parts you were enrolled in at the time of coverage: PART A ☐ PART B ☐		
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

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Member Affirmation	
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 RE-REVIEW REQUEST	
UNITED HEALTHCARE MEMBER, FORMER MEMBER, OR PARENT OR LEGAL GUARDIAN'S SIGNATURE (if Member is under 18 years old) __________________________________	DATE

Surgeon Affirmation	
I AFFIRM THAT I AM REQUEST PRE-AUTHORIZATION FOR MEDICALLY NECESSARY LIPOSUCTION TO TREAT LIPEDEMA	
SIGNATURE OF PROVIDER __________________________________	DATE
CONTACT NAME OF OFFICE PERSONNEL TO CALL WITH QUESTIONS: TELEPHONE NUMBER:	