# IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

## CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

You must read the Class Notice and Claim Instructions before completing this Claim Form.

**SECTION A: CLAIMANT INFORMATION - ALL CLAIMANTS MUST COMPLETE THIS SECTION (EITHER THROUGH A MEDICAL GROUP/ORGANIZATION OR INDIVIDUALLY, BUT NOT BOTH).**

**Indicate whether the Claimant is a Medical Group/Organization or an Individual Medical Professional and complete the information below. Check one.**

| ☐ **MEDICAL GROUP/ORGANIZATION** | If Medical Group/Organization, please indicate the number of Medical Professionals for whom you are filing this claim. | |
|---|---|---|

| *Medical Group or Organization Name* | *National Provider Identifier (NPI, if applicable)* |
|---|---|
| *Name and Title of Person Filing* | *Phone Number* |
| *Email Address of Person Filing* | |

**Medical Groups/Organizations: Please see Instructions. You must complete the Rider to this Claim Form and provide the required information regarding all Medical Professionals for which you are filing a claim.**

| ☐ **INDIVIDUAL MEDICAL PROFESSIONAL** | *Please Indicate Your Medical Professional Type* |
|---|---|
| *Name of Medical Professional* | *National Provider Identifier (NPI)* |
| *Name of Representative (if Medical Professional is Deceased)* | *Phone Number* |
| *Email Address of Medical Professional (or Representative, if Medical Professional is Deceased)* | |

**Were you first licensed to practice before March 12, 2008?** ☐ **Yes** ☐ **No**

If you are the legal heir or representative of a deceased Class Member, you must attach documentation including a death certificate and letters of administration for an estate to confirm your status. The Tax I.D. requested in Section D is that of the heir or estate.

**Provide the business address for the Medical Group/Organization or Individual Medical Professional.**

| *Address 1* | | *Address 2* |
|---|---|---|
| *City* | *State* | *Zip Code* |

**SECTION B: ALL CLAIMANTS MUST COMPLETE THIS SECTION**

| | |
|---|---|
| ☐ | By checking the box to the left, I certify that I have reviewed the Class Notice and that I am a Class Member (as described in the Class Notice). |

Check **ONLY ONE** of the boxes below or on the next page to designate the range of Allowed Amounts that are the basis of this claim. **Medical Groups/Organizations must complete the Rider attached to this Claim Form** (or attach a list in substantially the same form) that designates the range of Allowed Amounts for each Medical Professional for which this Claim Form is being submitted rather than check any boxes below.

| | |
|---|---|
| ☐ | By checking this box, I certify that my total Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were less than or equal to $250,000. |
| ☐ | By checking this box, I certify that my Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were more than $250,000 but less than or equal to $500,000. |

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### SECTION B (CONTINUED)

| | |
|---|---|
| ☐ | By checking this box, I certify that my Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were more than $500,000 but less than or equal to $750,000. |
| ☐ | By checking this box, I certify that my Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were more than $750,000 but less than or equal to $1,000,000. |
| ☐ | By checking this box, I certify that my Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were more than $1,000,000. |

*Reminder: Although Claimants are not required to calculate exact Allowed Amounts, a good-faith estimate is required. Knowingly certifying Allowed Amounts without a good-faith basis may result in denial of the claim.*

### SECTION C: ALL CLAIMANTS MUST COMPLETE THIS SECTION

**If the Settlement Notice Administrator determines you are eligible for a settlement award, you may choose to receive your payment as a check mailed to the address you provided on the previous page, by electronic transfer (ACH or wire), or by digital payment (virtual Mastercard, PayPal, or Venmo). Claimants with awards greater than $10,000 must choose check, ACH, or wire, and cannot select PayPal, Venmo, or Virtual Mastercard. The Settlement Notice Administrator will issue your entire payment using the single payment method you select, and you may not split your award across multiple payment types.**

**Select your preferred method of payment and enter the required information. If you elect to receive an electronic or digital payment and the information you enter is incorrect or incomplete, the Settlement Administrator will convert your award to a check payment. Be sure to double check that the payment information you provide is up-to-date and you're the payment details you provide are correct and associated with the correct account.**

**Select one and complete the required information.**

☐ **CHECK PAYMENT**
**(For any payment amount; for payments less than $100,000, there may be a fee of up to $25 for this payment method; for payments of $100,000 or more, there may be a fee of up to $100 for this payment method.)**

The check will be made payable to the Medical Group/Organization or Medical Professional listed on the previous page.

☐ **ACH PAYMENT**
**(For any payment amount; there are no fees associated with this payment method.)**

An Automated Clearing House (ACH) payment is a type of electronic bank-to-bank payment and is a way to transfer money between bank accounts, rather than using card networks, wire transfers, or paper checks. ACH Electronic Transfers are quicker than standard checks and typically arrive within 3-5 business days after the initiation of the payment.

Provide the information below to receive an ACH payment.

**Account Name:** ____________________________________________

**Account Type (Checking/Savings):** ______________________________

**Bank ACH Routing Number (9 Digits):** ____________________________

**Account Number (Up to 16 Digits):** ______________________________

☐ **WIRE TRANSFER**
**(For payment amounts of $250,000 or more; there may be a fee of up to $100 for this payment method.)**

A wire transfer is a common way to electronically move money from one bank account to another. Wire transfers are quicker than standard checks, but depending on your bank or financial institution, may arrive within 1-3 business days after the initiation of the payment. *If you choose to receive payment by wire transfer, the Settlement Notice Administrator will deduct from your payment any costs associated with issuing the wire transfer. In addition, your financial institution may charge fees to receive incoming wire transfers.*

(CONTINUED ON NEXT PAGE)

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## CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

### SECTION C (CONTINUED): ALL CLAIMANTS MUST COMPLETE THIS SECTION

(**WIRE TRANSFER**: CONTINUED FROM PREVIOUS PAGE)

Provide the information below to receive a wire transfer.

**Account Name:** ______________________________________________

**Bank Name:** ________________________________________________

**Bank ABA Fedwire Routing Number (9 Digits):** ______________________________

**Account Number (Up to 16 Digits):** _________________________________

If your wire instructions include an intermediary bank, provide the intermediary bank information below.

**Intermediary Bank Name:** ________________________________________________

**Intermediary Bank ABA Fedwire Routing Number (9 Digits):** ______________________________

If your wire instructions include additional references in order to apply funds, indicate that information below.

**Instructions 1:** ______________________________________________________

**Instructions 2:** ______________________________________________________

**Instructions 3:** ______________________________________________________

☐ **PAYPAL**
**(For payment amounts $10,000 or less; there are <u>no</u> fees associated with this payment method.)**

The PayPal payment will be issued to the Medical Group/Organization or Medical Professional identified on the first page. Be sure that the email address below is for the PayPal account to which funds are to be paid. There is no charge to receive a PayPal payment and no fees will be deducted from your award.

**Email Address Associated with PayPal Account:** __________________________________________________

☐ **VENMO**
**(For payment amounts $10,000 or less; there are <u>no</u> fees associated with this payment method.)**

The Venmo payment will be issued to Medical Group/Organization or Medical Professional identified on the first page. Be sure that the email address and phone number below is for the Venmo account to which funds are to be paid. There is no charge to receive a Venmo payment and no fees will be deducted from your award.

**Email Address Associated with Venmo Account:** __________________________________________________

**Phone Number Associated with Venmo Account:** __________________________________________________

☐ **VIRTUAL MASTERCARD**
**(For payment amounts $10,000 or less; there are <u>no</u> fees associated with this payment method.)**

The Virtual Mastercard will be issued to the Medical Group/Organization or Medical Professional identified on the first page. Be sure that the email address below is for the Medical Group/Organization or Medical Professional. There is no charge to receive a Virtual Mastercard payment and no fees will be deducted from your award.

**Email Address:** __________________________________________________________

**(CLAIM FORM CONTINUES ON NEXT PAGE)**

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## CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

### SECTION D: SUBSTITUTE FORM W-9 - ALL CLAIMANTS MUST COMPLETE THIS SECTION

Enter the Social Security Number or Employer Identification Number of the Claimant whose name will appear on any check and related Form-1099. For individuals, this is your Social Security Number (SSN). For Medical Groups/ Organizations, this is your Employer Identification Number (EIN).

| *Social Security Number (SSN, Format XXX-XX-XXXX)* | *Employer Identification Number (EIN, Format XX-XXXXXXX)* |
| --- | --- |
| | |

By signing this Claim Form, I certify that:

1. The number shown on this form above is the correct Social Security Number or Employer Identification Number for this Claimant; and

2. The Claimant is not subject to backup withholding because the Claimant: (a) is exempt from backup withholding, or (b) has not been notified by the Internal Revenue Service (IRS) that the Claimant is subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the Claimant that the Claimant is no longer subject to backup withholding.

NOTE: Backup withholding is extra tax withholding that occurs when a taxpayer has underreported interest or dividends in a previous year. The IRS notifies taxpayers who are subject to backup withholding. If you (the Claimant) have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return, you must cross out item 2 above by placing a line through the section.

### SECTION E: ALL CLAIMANTS MUST COMPLETE THIS SECTION

I do declare and certify as follows:

- I am an authorized representative of the Class Member identified above;
- I am not submitting a claim on behalf of any Class Members who have submitted a request to opt out of the Class and Settlement;
- I am not submitting claims on behalf of any Class Members who are submitting separate claims on their own behalf based on the same Covered Services; and
- All of the statements and information provided in this Claim Form are true, correct and complete, to the best of my knowledge.

NOTE: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications in Section D required to avoid backup withholding.

| *Signature of Claimant* | *Date* |
| --- | --- |
| | |

**Any Claim Form submitted online or postmarked after July 29, 2025 is not a Valid Claim Form and will be denied by the Settlement Notice Administrator.**

**Before submitting your Claim Form, please be sure to:**

- **Complete Section A – Claimant Information**
- **Complete Section B and the attached Rider listing the Health Care Facilities for which you are submitting this Claim Form and listing the required key information.**
- **Complete Section C.**
- **Complete Section D.**

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- **Sign the Certification in Section E.**

**WE STRONGLY RECOMMEND SUBMITTING YOUR CLAIM FORM ONLINE. IF THAT IS NOT FEASIBLE, PLEASE SUBMIT YOUR CLAIM FORM VIA REGISTERED OR CERTIFIED MAIL AND RETAIN YOUR RECEIPT AND A COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.**

**Claim Forms must be sent to the Settlement Notice Administrator at P.O. Box 26443, Richmond, VA 23261.**

**If you have any questions, please contact the Settlement Notice Administrator by telephone at (888) 452-3095 or by email at Administrator@BCBSProviderSettlement.com.**

**Medical Groups/Organizations: You must complete the Rider on the next page and provide the required information regarding all Medical Professionals for which you are filing a claim.**

## RIDER FOR MEDICAL GROUPS/ORGANIZATIONS THAT ARE FILING CLAIMS ON BEHALF OF MEDICAL PROFESSIONALS

| *Medical Group or Organization Name* | |
|---|---|
| *Name and Title of Person Filing* | *Phone Number* |
| *Email Address of Person Filing* | |

**List of Individual Medical Professionals and Key Information, For EACH Medical Professional for Whom You Are Submitting Claims (Please attach additional pages of this form, if necessary)**

**Medical Professional Name:**

| *Medical Professional Type* | | |
|---|---|---|
| *Business Address 1 (Address at which Medical Professional Practices/Practiced)* | *Business Address 2* | |
| *Business City* | *Business State* | *Business Zip Code* |

**Was Medical Professional Licensed Prior to March 12, 2008?** ☐ **Yes** ☐ **No**

| *National Provider Identifier (NPI, if applicable)* | *Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)* |
|---|---|
| *Time Period for Which Claimant is Submitting Claim on behalf of Medical Professional (Format: MM/DD/YYYY to MM/DD/YYYY)* | *Points Based on Range of Allowed Amounts (1, 2, 3, 4, or 5)* |

**Medical Professional Name:**

| *Medical Professional Type* | | |
|---|---|---|
| *Business Address 1 (Address at which Medical Professional Practices/Practiced)* | *Business Address 2* | |
| *Business City* | *Business State* | *Business Zip Code* |

**Was Medical Professional Licensed Prior to March 12, 2008?** ☐ **Yes** ☐ **No**

| *National Provider Identifier (NPI, if applicable)* | *Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)* |
|---|---|
| *Time Period for Which Claimant is Submitting Claim on behalf of Medical Professional (Format: MM/DD/YYYY to MM/DD/YYYY)* | *Points Based on Range of Allowed Amounts (1, 2, 3, 4, or 5)* |

**To add information for more Medical Professionals, use the next page. You may print and use extra copies of the next page as many times as needed to submit information for each Medical Professional. Remember to include all pages with your Claim Form submission. You may also provide the information requested in an Excel spreadsheet by upload through the Settlement Website or by mailing a thumb drive with your Claim Form.**

**List of Individual Medical Professionals and Key Information, For EACH Medical Professional for Whom You Are Submitting Claims**
**(Please attach additional pages of this form, if necessary)**

**Medical Professional Name:**

*Medical Professional Type*

| *Business Address 1 (Address at which Medical Professional Practices/Practiced)* | | *Business Address 2* |
|---|---|---|
| *Business City* | *Business State* | *Business Zip Code* |

**Was Medical Professional Licensed Prior to March 12, 2008?** ☐ **Yes** ☐ **No**

| *National Provider Identifier (NPI, if applicable)* | *Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)* |
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| *Time Period for Which Claimant is Submitting Claim on behalf of Medical Professional (Format: MM/DD/YYYY to MM/DD/YYYY)* | *Points Based on Range of Allowed Amounts (1, 2, 3, 4, or 5)* |

**Medical Professional Name:**

*Medical Professional Type*

| *Business Address 1 (Address at which Medical Professional Practices/Practiced)* | | *Business Address 2* |
|---|---|---|
| *Business City* | *Business State* | *Business Zip Code* |

**Was Medical Professional Licensed Prior to March 12, 2008?** ☐ **Yes** ☐ **No**

| *National Provider Identifier (NPI, if applicable)* | *Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)* |
|---|---|
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