Claim Form

If additional space is needed to complete any section of this form, please attach additional pages and include the patient's name at the top of each additional page.

1 Section 1: Background

1(a): Patient Information

Please note that some fields may be inapplicable if the patient is deceased.

Patient First Name | MI | Last Name

Address

City | State | ZIP Code

Patient Date of Birth (MM/DD/YYYY) / / | Patient Social Security Number – –

Email Address

Primary Phone – –

1(b): Contact Information for Patient's Authorized Representative or Representative of Patient's Estate (Supporting Documentation of Representation Required)

Complete this section ONLY if you are completing the form for an incapacitated or minor patient, or for the estate of a deceased patient.

Representative First Name | MI | Last Name

Relationship to Patient or Patient's Estate

Representative Address

City | State | ZIP Code

Address where restitution, if awarded, should be sent

City | State | ZIP Code

Tax Identification Information

For authorized representative of incapacitated or minor patient, please provide representative's Social Security Number. – –

For estate of deceased patient, please provide estate's Tax Identification Number.

☐☐ – ☐☐☐☐☐☐☐

Representative Email Address

Representative Primary Phone

☐☐☐ – ☐☐☐ – ☐☐☐☐

☐ I have included supporting documentation of representation (examples include Power of Attorney or guardianship documents for minor or incapacitated patient, or, for a deceased patient, court papers establishing representation of estate).

1(c): Basis for Filing a Claim

I am requesting restitution because (check all that apply):

Money Paid to Farid Fata (hereinafter "the defendant") or to Others for Treatments/Services/Prescriptions Ordered by the Defendant

1. ☐ I incurred out-of-pocket medical costs while I was a patient of the defendant.
2. ☐ I am the authorized representative of a minor or incapacitated patient of the defendant, or I am the representative of the estate of a deceased former patient of the defendant. The patient I am authorized to represent incurred out-of-pocket medical costs while he/she was a patient of the defendant.

Money Paid for Remedial Medical and/or Dental Treatment

3. ☐ I was a patient of the defendant and incurred out-of-pocket medical costs to remediate unnecessary or inappropriate treatments ordered by the defendant.
4. ☐ I am the authorized representative of a minor or incapacitated patient of the defendant, or I am the representative of the estate of a deceased former patient of the defendant. The patient I am authorized to represent incurred out-of-pocket medical and/or dental costs to remediate unnecessary or inappropriate treatments ordered by the defendant.

Money Paid for Remedial Mental Health Treatment

5. ☐ I was a patient of the defendant, and I incurred out-of-pocket costs when I sought mental health treatment and/or needed prescription mental health medications to address the treatment I received from the defendant.
6. ☐ I am the authorized representative of a minor or incapacitated patient of the defendant, or I am the representative of the estate of a deceased former patient of the defendant. The patient I am authorized to represent incurred out-of-pocket costs when he/she received mental health treatment and/or needed prescription mental health medications to address treatment received from the defendant.

Money Paid for Funeral Costs

7. ☐ I incurred out-of-pocket costs to pay for the funeral of a family member who was a patient of the defendant.

2 Section 2: Claims for Money Paid

2(a): Claims for Money Paid to the Defendant, Michigan Hematology Oncology (MHO), to Other Providers at the Defendant's Direction, and/or for Medications Prescribed by the Defendant

This section is for claiming restitution for unreimbursed out-of-pocket costs for treatment provided by the defendant and/or MHO and/or provided at the defendant's direction between April 11, 2005 and August 6, 2013 (including purchases of medications prescribed by the defendant between April 11, 2005 and August 6, 2013).

In this section, we are asking you to do three things:

1. **Insurance.** Tell us about the health insurance that may have covered some of the patient's costs.
2. **Costs.** List the patient's costs.
3. **Payments.** Provide proof of payment of the costs.

2(a.1): Tell Us About the Patient's Insurance

If the patient had insurance coverage at the time of treatment with the defendant, please check all that apply:

☐ Private Health Insurance
(Please provide name of company: _____)

☐ Medicare

☐ Medicaid

☐ Veterans Administration

☐ Other Public Assistance
(Please indicate type: _____)

2(a.2): List the Patient's Medical Costs

Please list all of the out-of-pocket medical costs the patient incurred between April 11, 2005 and August 6, 2013. This includes costs that were paid for treatment by the defendant, the costs of treatments and/or services he ordered, and the purchase of medications prescribed by the defendant.

If the cost was covered by insurance, please list patient costs (amounts paid within deductible or co-pays). If the cost was not covered by insurance, please list the amount paid for each visit, service, or medication. Please provide this list by filling out Table #1 on page 5.

If you are requesting compensation for a treatment or service that the defendant ordered **but did not provide himself or through MHO**, please provide documentation that the defendant ordered the treatment/service. (Examples might include invoices from the provider or Medicare Summary Notice (MSN) showing that the defendant was the referring or ordering physician.)

I am requesting compensation for at least one treatment/service that the defendant requested **but did not provide himself or through MHO**: ☐ Yes ☐ No

If yes, I am providing documentation to show that the defendant ordered the outside treatment/service(s) for which I am requesting compensation: ☐ Yes ☐ No

2(a.3): Provide Proof of Costs

In addition to listing these costs, we are asking the patient to provide proof that the patient paid the costs. It is necessary to submit supporting documentation for each claimed out-of-pocket cost. You may submit original documents or photocopies.

How to Mark the Documents That You Submit. Each document that you provide as proof should correspond to one of the rows in Table #1 on page 5. Please mark each document in the upper right-hand corner with:

1. "Table #1" and

2. The row number to which the document corresponds.

What Kinds of Documents Count as Proof? For each cost, there are two alternative ways to provide proof.

Provide Receipts. The easiest way to provide proof is to provide receipts showing that the patient paid the listed costs. The receipt should indicate the patient's name, the date of service, the type of service, and the amount of money paid. You can submit original documents or photocopies.

Show Amounts Owed, and Swear That the Patient Paid Them. If you do not have receipts showing payment, please provide proof that the amounts were owed (for example, by providing bills, Medicare Summary Notices [MSN], or Explanation of Benefits [EOB] forms). In addition, check the box below to indicate that you understand that by signing this claim, you are swearing that you, as the patient, paid all of the listed patient costs in full. Or, if you are the authorized representative of a minor or incapacitated patient or of the estate of a deceased patient, you are swearing that you have personal knowledge that the patient paid all of the listed patient costs in full.

If you have proof of payment for some listed patient costs but not for others, please submit the proof you do have and check the box below to swear that you paid the costs for which you do not have receipts.

☐ By checking this box and signing this Claim Form, I am swearing under oath and under penalty of perjury that I, as the patient, paid all of the listed patient costs in full. Or, if I am the authorized representative of a minor or incapacitated patient or of the estate of a deceased patient, I am swearing that I have personal knowledge that the patient paid all of the listed patient costs in full.

If additional pages of the table below are needed, please copy and provide as many completed pages as necessary.
NOTE: You need to fill out column #9 only if you have checked "declaration under oath" in column #8.

Table #1:
Medical out-of-pocket costs incurred between April 11, 2005 and August 6, 2013 for treatment provided by or ordered by the defendant

1. Row #	**2. Date of Service or Date Rx Filled** (MM/DD/YYYY)	**3. Type of Service**	**4. Cost**	**5. Was this cost covered by insurance? (Y/N)**	**6. If yes, what is the name of the insurance provider?**	**7. How much did the patient pay?**	**8. Supporting Documentation of Payment** (check all that apply)	**9. Supporting Documentation of Treatment and Cost** (check all that apply in this column <u>ONLY</u> if you checked "Declaration under oath" in column 8)
							☐ Cancelled check ☐ Receipt from provider ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Bill from provider ☐ Other insurance company information
							☐ Cancelled check ☐ Receipt from provider ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Bill from provider ☐ Other insurance company information
							☐ Cancelled check ☐ Receipt from provider ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Bill from provider ☐ Other insurance company information
							☐ Cancelled check ☐ Receipt from provider ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Bill from provider ☐ Other insurance company information

*EOB = Explanation of Benefits
**MSN = Medicare Summary Notice

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2(b): Claims for Money Paid for Remedial Medical and Dental Treatments

This section is for claiming restitution for unreimbursed out-of-pocket medical and dental costs for remedial medical treatments and medications after receiving unnecessary or inappropriate treatments by the defendant through September 6, 2016.

Complete this section if you are requesting restitution because the patient incurred out-of-pocket costs for remedial measures as a result of being under the care of the defendant and those losses have not been reimbursed (by any source) as of the date this form is signed.

If you complete this section, you must submit the "Physician and Dentist Form," which is included in this claim package.

In this section, we are asking you to do four things:

1. **Narrative.** Tell us about your remedial treatments.
2. **Insurance.** Tell us about your health insurance that may have covered some of your costs.
3. **Costs.** List your costs.
4. **Payments.** Provide proof of payment of the costs.

2(b.1): Narrative

The defendant's unnecessary or inappropriate treatments caused me/the patient to need the following remedial medical and/or dental measures, as explained below:

2(b.2): Tell Us About the Patient's Insurance

If the patient had insurance coverage at the time of treatment with the defendant, please check all that apply:

☐ Private Health Insurance
(Please provide name of company: _____)

☐ Medicare

☐ Medicaid

☐ Veterans Administration

☐ Other Public Assistance
(Please indicate type: _____)

2(b.3): List the Patient's Costs

Patient Out-of-Pocket Costs for Remedial Measures Needed Due to Unnecessary or Inappropriate Treatments and/or Medications

Please itemize payments that have not been reimbursed and that were costs of treatments, services or purchases needed to remediate unnecessary or inappropriate treatments by the defendant. Remedial medical and/or dental treatments, services, or purchases may include but are not limited to office visits, dental services, chemotherapy port removal, medical testing, prescription medications, assistive devices (e.g., wheelchairs), physical therapy, and occupational therapy. It is necessary to submit supporting documentation for each claimed out-of-pocket cost. If covered by insurance, please list the amounts paid within deductibles or co-pays. If not covered by insurance, please document the amount paid for each item. Please provide this list by filling out Table #2 on page 8.

2(b.4): Provide Proof of Costs

In addition to listing these costs, we are asking you to provide proof that you paid the costs. It is necessary to submit supporting documentation for each claimed out-of-pocket cost. You can submit original documents or photocopies.

How to Mark the Documents That You Submit. Each document that you provide as proof should correspond to one of the rows in Table #2 on page 8. Please mark each document in the upper right-hand corner with:

1. "Table #2" and

2. The row number to which the document corresponds.

What Kinds of Documents Count as Proof? For each cost, there are two alternative ways to provide proof.

Provide Receipts. The easiest way to provide proof is to provide receipts showing that the patient paid the listed costs. The receipt should indicate the patient's name, date of service, type of service, and amount of money paid.

Show Amounts Owed, and Swear That the Patient Paid Them. If you do not have receipts showing payment, please provide proof that the amounts were owed (for example, by providing bills, Medicare Summary Notices [MSN], or Explanation of Benefits [EOB] forms). In addition, check the box below to indicate that you understand that by signing this claim, you are swearing that you, as the patient, paid all of the listed patient costs in full. Or, if you are the authorized representative of a minor or incapacitated patient or of the estate of a deceased patient, you are swearing that you have personal knowledge that the patient paid all of the listed patient costs in full.

If you have proof of payment for some listed patient costs but not for others, please submit the proof you do have and check the box below to swear that you paid the costs for which you do not have receipts.

☐ By checking this box and signing this Claim Form, I am swearing under oath and under penalty of perjury that I, as the patient, paid all of the listed patient costs in full. Or, if I am the authorized representative of a minor or incapacitated patient or of the estate of a deceased patient, I am swearing that I have personal knowledge that the patient paid all of the listed patient costs in full.

If additional pages of the table below are needed, please copy and provide as many completed pages as necessary.
NOTE: You need to fill out column #9 only if you have checked "declaration under oath" in column #8.

Table #2:
Out-of-pocket costs for remedial medical and/or dental treatments and medications through September 6, 2016 after unnecessary or inappropriate treatments by the defendant

1. Row #	**2. Date of Service or Purchase** (MM/DD/YYYY)	**3. Type of Service or Purchase**	**4. Cost**	**5. Was this cost covered by insurance? (Y/N)**	**6. If yes, what is the name of the insurance provider?**	**7. How much did the patient pay?**	**8. Supporting Documentation of Payment** (check all that apply)	**9. Supporting Documentation of Treatment and Cost** (check all that apply in this column <u>ONLY</u> if you checked "Declaration under oath" in column 8)
							☐ Cancelled check ☐ Receipt of payment ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Incurred but not yet paid*** ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Provider bill ☐ Other insurance company information
							☐ Cancelled check ☐ Receipt of payment ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Incurred but not yet paid*** ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Provider bill ☐ Other insurance company information
							☐ Cancelled check ☐ Receipt of payment ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Incurred but not yet paid*** ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Provider bill ☐ Other insurance company information

*EOB = Explanation of Benefits
**MSN = Medicare Summary Notice
***"Incurred but not yet paid" means that your necessary remedial treatment has been provided before or on September 6, 2016; you have received a bill for the treatment; and you have not yet paid for the remedial treatment.

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2(c): Claims for Money Paid for Mental Health Treatment

This section is for claiming restitution for unreimbursed out-of-pocket costs incurred by the patients of the defendant for mental health treatments between April 11, 2005 and September 6, 2016 (including purchases of medications prescribed between April 11, 2005 and September 6, 2016 as part of such mental health treatment).

Complete this section if you are requesting restitution because the patient incurred out-of-pocket costs for remedial measures as a result of being under the care of the defendant and those losses have not been reimbursed (by any source) as of the date this form is signed.

If you complete this section, you must submit the "Mental Health Treatment Provider Form," which is included in this claim package.

In this section, we are asking you to do four things:

1. **Narrative.** Tell us about your remedial treatments.
2. **Insurance.** Tell us about your health insurance that may have covered some of your costs.
3. **Costs.** List your costs.
4. **Payments.** Provide proof of payment of the costs.

2(c.1): Narrative

The defendant's treatments caused me/the patient to need the following mental health remedial measures, as explained below:

2(c.2): Tell Us About the Patient's Insurance

If the patient had insurance coverage at the time of treatment with the defendant, check all that apply:

☐ Private Health Insurance
(Please provide name of company: _____)

☐ Medicare

☐ Medicaid

☐ Veterans Administration

☐ Other Public Assistance
(Please indicate type: _____)

2(c.3): List the Patient's Costs

Patient Out-of-Pocket Costs for Mental Health Remedial Measures

Please itemize payments that have not been reimbursed and that were needed to provide remediation of the mental health effects of treatment by the defendant. It is necessary to submit supporting documentation for each claimed out-of-pocket cost. If covered by insurance, please list the patient costs (amounts paid within deductible or co-pays). If not covered by insurance, please document the amount paid for each service. Please provide this list by filling out Table #3 on page 11.

2(c.4): Provide Proof of Costs

In addition to listing these costs, we are asking you to provide proof that you paid the costs. It is necessary to submit supporting documentation for each claimed out-of-pocket cost. You can submit original documents or photocopies.

How to Mark the Documents That You Submit. Each document that you provide as proof should correspond to one of the rows in Table #3 on page 11. Please mark each document in the upper right-hand corner with:

1. "Table #3" and

2. The row number to which the document corresponds.

What Kinds of Documents Count as Proof? For each cost, there are two alternative ways to provide proof. You can submit original documents or photocopies.

Provide Receipts. The easiest way to provide proof is to provide receipts showing that the patient paid the listed costs. The receipt should indicate the patient's name, the date of service, the type of service, and the amount of money paid.

Show Amounts Owed, and Swear That the Patient Paid Them. If you do not have receipts showing payment, please provide proof that the amounts were owed (for example, by providing bills, Medicare Summary Notices [MSN], or Explanation of Benefits [EOB] forms). In addition, check the box below to indicate that you understand that by signing this claim, you are swearing that you, as the patient, paid all of the listed patient costs in full. Or, if you are the authorized representative of a minor or incapacitated patient or of the estate of a deceased patient, you are swearing that you have personal knowledge that the patient paid all of the listed patient costs in full.

If you have proof of payment for some listed patient costs but not for others, please submit the proof you do have and check the box below to swear that you paid the costs for which you do not have receipts.

☐ By checking this box and signing this Claim Form, I am swearing under oath and under penalty of perjury that I, as the patient, paid all of the listed patient costs in full. Or, if I am the authorized representative of a minor or incapacitated patient or of the estate of a deceased patient, that I have personal knowledge that the patient paid all of the listed patient costs in full.

If additional pages of the table below are needed, please copy and provide as many completed pages as necessary.
NOTE: You need to fill out column #9 only if you have checked "declaration under oath" in column #8.

Table #3:
Patient Out-of-Pocket Costs for Mental Health Remedial Measures between April 11, 2005 and September 6, 2016

1. Row #	**2. Date of Service or Date Rx Filled** (MM/DD/YYYY)	**3. Type of Service or Rx**	**4. Cost**	**5. Was this cost covered by insurance? (Y/N)**	**6. If yes, what is the name of the insurance provider?**	**7. How much did the patient pay?**	**8. Supporting Documentation of Payment** (check all that apply)	**9. Supporting Documentation of Treatment and Cost** (check all that apply in this column ONLY if you checked "Declaration under oath" in column 8)
							☐ Cancelled check ☐ Receipt of payment ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Incurred but not yet paid*** ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Provider bill ☐ Other insurance company information
							☐ Cancelled check ☐ Receipt of payment ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Incurred but not yet paid*** ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Provider bill ☐ Other insurance company information
							☐ Cancelled check ☐ Receipt of payment ☐ Credit card statement *(circle payment line)* ☐ Receipt or Summary of Rx payments from pharmacy ☐ Incurred but not yet paid*** ☐ Declaration under oath	☐ EOB* ☐ MSN** ☐ Provider bill ☐ Other insurance company information

*EOB = Explanation of Benefits
**MSN = Medicare Summary Notice
***"Incurred but not yet paid" means that your necessary remedial treatment has been provided before or on September 6, 2016; you have received a bill for the treatment; and you have not yet been paid for the remedial treatment.

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2(d): Claims for Money Paid for Funeral Costs

This section is for claiming funeral costs paid by family members.

If you would like to be considered for reimbursement in this category, please complete the following:

2(d.1): Details About Patient's Death

Patient's Date of Death: ☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY

With your Claim Form submission, you must include a copy of the death certificate.

Death Certificate included: ☐ Yes ☐ No

2(d.2): Proof That Deceased Was a Patient of the Defendant

The government has records containing the names of some of the defendant's patients. However, those records are not complete.

Please provide one document establishing that the deceased was a patient of the defendant. You may submit originals of documents or photocopies. Examples of documents you may provide:

- MHO bill with patient's name and showing treatment by the defendant
- EOB or MSN with patient's name and showing treatment by the defendant
- A page from patient's medical file showing patient's name and the defendant's name

Patient of defendant documentation included: ☐ Yes ☐ No

Describe document included: _____

2(d.3): Your Relationship to the Deceased

Are you a family member of the deceased? ☐ Yes ☐ No

If yes, please indicate the nature of the family relationship (child, spouse, etc.):

2(d.4): Details About Funeral

Date of Funeral: ☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY

Place of Funeral

Address

City State ZIP Code

Phone Number
☐☐☐ – ☐☐☐ – ☐☐☐☐

Was an obituary published: ☐ Yes ☐ No Where? _____

If yes, you must include at least one copy of the obituary with this form.

Obituary included: ☐ Yes ☐ No

2(d.5): Funeral Costs

What was the cost of the funeral?

$, .

What amount did you personally pay as an unreimbursed out-of-pocket cost towards the funeral?

$, .

If you did not pay the entire cost of the funeral, who else contributed to paying for the funeral? (Provide names and relationships to the deceased.)

First Name | MI | Last Name

Relationship

First Name | MI | Last Name

Relationship

Check the box below to indicate that you understand that by signing this claim, you are swearing that you paid for the funeral costs listed above.

☐ By checking this box and signing this Claim Form, I am swearing under oath and under penalty of perjury that I paid for the funeral costs listed above, and I have not been reimbursed for those costs.

3 Section 3: Compensation From Other Sources

If a patient seeks a monetary remedy in another forum, any amount ordered as restitution in this case must be reduced by any amount recovered for the same loss in any related proceeding. Accordingly, if a patient has received or will receive compensation from insurance, disability, a crime victim's compensation fund, a civil lawsuit, or any other source with respect to a particular loss, the patient must disclose the compensation in this restitution process.

This section asks you about any compensation the patient may have received from other sources.

3(a): Lawsuits

Has the patient (or patient's representative) filed a lawsuit against the defendant or against other entities involving treatments provided by or ordered by the defendant?

☐ Yes ☐ No

If yes, for each lawsuit, please provide the name of the case below:

For example, *Mary Smith vs. Farid Fata*:

Court in which case was filed: _____

Case Number: _____

Have there been any monies received as a result of the above lawsuit?

☐ Yes ☐ No

If yes, please complete Table #4, below, as to any amounts received.

Table #4: Compensation From Other Sources			
	Identity of Payor (Who provided the compensation?)	Amount Received	What Specific Loss Is This Award Supposed to Compensate? (For example, pain and suffering, out-of-pocket costs, etc.)
Payment #1:			
Payment #2:			
Payment #3:			

Please use additional sheets if necessary.

Has the patient applied for Crime Victim Compensation from the Michigan Department of Community Health?

☐ Yes ☐ No

If yes, has the patient received compensation as a result of the above application?

☐ Yes ☐ No

If yes, please record the amounts in Table #4, above.

Has the patient (or patient's representative) applied and/or received compensation from any other source not already identified in this Claim Form?

☐ Yes ☐ No

If yes, please record the amounts in Table #4, above.

PLEASE NOTE: If the patient receives compensation from another source after this Claim Form is filed, you have an ongoing obligation to report that compensation. To file a report, please call 1-877-202-3282 from Monday through Friday between the hours of 9:00 a.m. and 8:00 p.m. Eastern Time.

4 Section 4: Who Can Communicate for You Regarding Your Claim Form

As your claim is being processed, you may want to call or write with questions or concerns that arise. You may prefer to handle those communications yourself, or you may wish to involve a friend, family member, or other person in those communications. We will communicate only with you unless we have written permission from you to communicate with someone else on your behalf.

If you would like to give permission for someone else to speak to us on your behalf, please indicate that person's name and contact information below.

First Name | MI | Last Name

Address

City | State | ZIP Code

Relationship to Patient

Phone Number

– –

5 Section 5: Swearing That Contents of the Claim Form Are True

I am submitting a claim for restitution because I have a good faith belief that the costs for which I am claiming reimbursement were the result of overtreatment, mistreatment, unnecessary treatment, and/or material misrepresentations regarding my disease and/or treatment by the defendant. I understand that the information I am providing in support of this claim will be relied upon for purposes of determining my right to receive restitution. I hereby declare, under penalty of perjury under the laws of the United States of America, that I believe the information I am providing in support of a claim for restitution is true and correct. I further certify that any documents I have submitted in support of this claim consist of either unaltered originals or unaltered copies of documents that are in my possession. I understand that, if I receive compensation from another source after this Claim Form is filed, I must disclose the compensation to the Facilitator.

Relationship to Patient (if applicable)

Signature of Patient or Claimant/Authorized Representative of Patient or Representative of the Patient's Estate

Date: MM – DD – YYYY

THIS CLAIMS PROCESS IS YOUR ONLY OPPORTUNITY FOR COMPENSATION IN THIS FEDERAL CRIMINAL CASE. YOUR CLAIM FORM MUST BE POSTMARKED BEFORE OR ON NOVEMBER 14, 2016. IF YOU HAVE ANY QUESTIONS ABOUT HOW TO COMPLETE THE CLAIM FORM, PLEASE CALL 1-877-202-3282 MONDAY - FRIDAY FROM 9:00 A.M. TO 8:00 P.M. EASTERN TIME.