



**MUST BE POSTMARKED
ON OR BEFORE FEBRUARY 28, 2011**

FOR OFFICIAL USE ONLY



**MEDICARE PART B CLAIM FORM
BMS AWP SETTLEMENT**

Section A: Patient Information

Your contact information in our records is printed below. Please review the preprinted information below and fill in any missing information. If you need to make corrections, please make them in the space provided.

Patient Name: _____

Patient Mailing Address: _____

City: _____ State: ____ Zip Code: _____

Daytime Telephone Number: (____) _____ - _____

Evening Telephone Number: (____) _____ - _____

Section B: Patient Representative Information

If you are the patient, **DO NOT** complete this section. Complete this section only if you are a representative (such as a spouse, guardian, executor or personal representative) filing this claim on behalf of the patient listed above.

Representative's Name: _____ Relationship to Patient: _____

Representative's Mailing Address: _____

City: _____ State: ____ Zip Code: _____

Daytime Telephone Number: (____) _____ - _____

Evening Telephone Number: (____) _____ - _____



Section C - Instructions for Completing Medicare Part B Purchase Information

Look carefully at the list of covered drugs found on page 1 of the Notice. If you were administered any of these drugs as a Medicare recipient between January 1, 1991 through December 31, 2004 , you may add those drugs to the chart **below**. To do so:

If you were administered any of the covered drugs listed in the Notice during the class period January 1, 1991 through December 31, 2004 and they are not listed in the chart below and 1) you received them as a Medicare Part B participant and 2) you paid out-of-pocket for some or all of a percentage co-payment under Medicare (as opposed to a flat co-payment through supplemental insurance), you may, in the space provided after the pre-printed information:

- (1) Enter the name of the drug in Column A;
- (2) Enter dates of administration in Column B;
- (3) Enter the amount paid in Column C; and
- (4) Provide one of the following acceptable proofs of a percentage co-payment for each additional covered drug:

Any one of the following are acceptable as proof of a percentage co-payment for one of the Class Drugs:

- (1) A receipt, cancelled check, or credit card statement that shows a payment for one of the drugs (other than a flat co-payment); or
- (2) A letter from a doctor saying that he or she prescribed one of the drugs and you paid part or all of the cost of one of the drugs (other than a flat co-payment) at least once; or
- (3) Billing records from a doctor or other health care provider showing that you made or are obligated to make part or all of the cost of one of the BMS Drugs (other than a flat co-payment); or
- (4) An EOB (explanation of benefits) from your insurer that shows you made or are obligated to make percentage co-payments for the BMS Drugs; or
- (5) Any combination of (1)-(4) above.

Do not add additional drug administrations to the chart below if you had supplemental insurance that covered all of your percentage co-payments under Medicare Part B for the additional drugs, or if you paid a flat co-payment through supplemental insurance. A flat co-payment is one that does not differ with the cost of the drug.

-- Attach additional pages if needed --



Section C Continued:

Medicare Part B Purchase Information Chart

	COLUMN A	COLUMN B	COLUMN C
	Name of Drug	Date of Administration	Patient Responsibility <i>(Percentage co-payment made or incurred by claimant)</i>
1			
2			
3			
4			
5			
6			
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Section D - Sign and Date Your Claim Form

I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I made a percentage co-pay for one or more of the drugs as indicated in this claim form at some time during the period from January 1, 1991 through December 31, 2004. If not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above.

Signature: _____

Print Name: _____

Month/ Day /Year: ____ / ____ / _____

Section E - Mail Your Claim Form

Claim Forms, along with proof of payment, must be postmarked by February 28, 2011 and mailed to:

BMS Class 1 Settlement Administrator
P.O. Box 2364
Faribault, MN 55021-9064

If you have any questions, please call 1-877-690-7097 or visit the website at www.BMSAWPSettlement.com.

