In re: Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation, MDL No. 1401

Application for Payment of Coinsurance and/or Deductible Payments
From Class Members' Class Action Settlement Benefits

Instructions for Completing this Form:

- This Form should be completed by a health care provider ("Provider") who believes he or she is owed money by an Affected Product Recipient for unpaid coinsurance or deductible payments.
- For purposes of this form "coinsurance" is the fixed percentage of the total amount paid for health care services that is the responsibility of the Class Member and "deductible" is the amount of medical services that must be incurred before benefits (subject to the deductible) becomes payable. Coinsurance and deductibles do not include any amounts above a provider's contracted reimbursement rate or fee schedule established by a third-party payor.
- This Form must be fully completed for the Claims Administrator to process payment. The Claims Administrator shall only make payments to Providers pursuant to this Form if the Affected Product Recipient whose Claim is affected consents in writing, by signing this Form.
- All payments made pursuant to this Form shall be made from the Class Member's Settlement benefits, if any, after the Class Member makes appropriate application as required by the Settlement Agreement and after the Class Member's Claim for benefits has been processed by the Claims Administrator in accordance with the Settlement Agreement.
- All capitalized terms not defined in this Form shall have the meaning given them in the Settlement Agreement in *In re: Sulzer Hip Prosthesis and Knee Prosthesis Product Liability Litigation,* MDL No. 1401.
- If this Form does not have the Class Member's signature authorizing payment from his or her Settlement benefits, the Claims Administrator shall forward this Form to the Class Member for his or her signature. If the Class Member fails to return a signed copy of this Form to the Claims Administrator, the Claims Administrator shall not pay any amount to the requesting Provider unless the Court issues an order directing such payment. If the Class Member does not authorize this deduction, the Class Member is responsible for making payments to the submitting Provider for the coinsurance and deductible obligations relating to an Affected Product Revision Surgery.
- **Payments made pursuant to this Form are not an additional benefit for Class Members or Third Party Payors or other health care providers. Payments pursuant to this Form are a deduction from Class Members' Settlement benefits. By way of example, if a Class Member agrees to payment of $1,000 pursuant to this Form, and was otherwise eligible for Settlement benefits in the amount of $160,000, the Claims Administrator shall pay $159,000 to the Class Member, and $1,000 to the Provider named in this Form. No payment made pursuant to this Form shall be deducted from a Class Member's GPO Payment, if any.**
- **This Form must be completed by the Provider and the Affected Product Recipient and/or the Representative Claimant to whom it applies no later than 10 days after the Claims Administrator issues a Final Determination regarding the Class Member's Claim.**

1.	Name and Address of Affected Product Recipient.	

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2.	Name and Address of Representative Claimant, if any and if known, of Affected Product Recipient. (Representative Claimants are the estate, administrator or other legal representative, trust or "special needs trust" of an Affected Product Recipient).	
3.	Name, address, and telephone number of Provider claiming that Affected Product Recipient owes coinsurance or deductible. (Include contact person at Provider's billing department, office or finance department).	
4.	Dates and nature of services provided for which coinsurance or deductible is owed to Provider.	**Provider must attach to this Form the claim form for services rendered (i.e., the HCFA-1500 or UB-92 forms).**
5.	Total amount that Provider seeks to be paid for coinsurance and/or deductibles.	**In addition to noting in this block the total amount Provider requests, Provider must attach to this Form a copy of the remittance advice or explanation of benefits (EOB) received from the Affected Product Recipient's third-party payor.**

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6.	Signature of Provider seeking payment of coinsurance or deductible.	I certify that the above-stated amounts are due and owing from the Class Member to the Provider identified above in Line 3. I am authorized to act on behalf of the Provider identified in Line 3. I agree that neither the Sulzer Settlement Trust, nor the Claims Administrator, nor any of his agents or employees are responsible for any lien payment, or failure to make a lien payment, as described in this form. I understand that the Claims Administrator shall not make any payment to me on behalf of the Provider in Line 3 unless and until the Affected Product Recipient or Representative Claimant identified in Lines 1 and 2 agree to the payment or until the Claims Administrator receives an Order from the United States District Court for the Northern District of Ohio directing such payment. I understand that no payment made pursuant to this Form shall be made from a Class Member's Guaranteed Payment Option payment, if any. I agree to hold the Sulzer Settlement Trust, the Claims Administrator, and any or his agents or employees harmless for any action arising from payment, or not, pursuant to this Form. ____________ __________________ Date Provider Signature / Title

Instructions to the Affected Product Recipient and/or Representative Claimant:

- By signing this Form, you authorize the Claims Administrator to pay the Provider named above the amount specified above from your Settlement Benefits. Any amount paid pursuant to this Form will reduce the amount of Settlement benefits paid to you by the same amount.

- **Payments made pursuant to this Form are not an additional benefit for Class Members or Third Party Payors or other health care providers. Payments pursuant to this Form are a deduction from Class Members' Settlement benefits. By way of example, if a Class Member agrees to payment of $1,000 pursuant to this Form, and was otherwise eligible for Settlement benefits in the amount of $160,000, the Claims Administrator shall pay $159,000 to the Class Member, and $1,000 to the Provider named in this Form. <u>No payment made pursuant to this Form shall be deducted from a Class Member's GPO Payment, if any.</u>**

- Sign this Form as indicated in Row 7 if you agree to payment to the Provider named in this Form as indicated above. After signing return this Form to the Claims Administrator at:

  Claims Administrator (c/o Sulzer Settlement Trust)
  P.O. Box 94558
  Cleveland, Ohio 44101-4558

- **The Claims Administrator must receive this Form no later than 10 days after issuing a Class Member's Final Determination.**

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7.	Signature of Affected Product Recipient.	I authorize the Claims Administrator to deduct the amount in Line 5 above from my Settlement benefit award, if any, and to pay that amount directly to the Provider identified on Line 3. I agree that neither the Sulzer Settlement Trust, nor the Claims Administrator, nor any of his agents or employees are responsible for any lien payment, or failure to make a lien payment, as described in this Form and shall not be held liable by me and shall be held harmless by me for any action arising from any payment, or not, pursuant to this Form. __________ ________________ Date Affected Product Recipient Signature (or Representative Claimant if applicable).