IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, LAW DIVISION

IN RE: ALL ASBESTOS LITIGATION	Court No.: 2009L 000000 Calendar J1 IN RE: ASBESTOS LITIGATION

SUPPLEMENTAL CASE MANAGEMENT ORDER REGARDING PLAINTIFFS UTILIZING THE GARRETSON RESOLUTION GROUP'S ASBESTOS MALIGNANCY PROGRAM

To aid in the resolution of and payment of claims in all asbestos actions filed in this Court, to manage this complex docket, to protect the interests of all parties, and in an effort to facilitate the compliance of the parties to this litigation with the requirement of "Medicare Secondary Payer Act," 42 U.S.C. Sec. 1395y, et seq (MSP) and any rules and regulations promulgated thereunder, and to facilitate Medicare's right of recovery under MSP, this Court appreciates that certain Plaintiffs have enrolled in and are utilizing the Garretson Resolution Group/Epiq's (hereafter "Garretson") Asbestos Malignancy Program (AMP), with the Court being fully advised of the premises for the pending motion

IT IS HEREBY ORDEREED that the following procedures relating to compliance with MSP shall be followed when a Plaintiff has provided Defendant(s) with written confirmation from Garretson Resolution Group/Epiq of enrollment in AMP:

For AMP enrolled Plaintiffs Only: Procedures for Distribution of Query, Consent to Release, and Reporting Information for MMSEA Sec. 111 Compliance:

1. **Form A-1 - Query Information and Form A-2 - Consent to Release:** In all asbestos-disease related cases filed after the date of entry of this Order or currently pending without a trial date assigned, each AMP enrolled Plaintiff shall complete and file electronically, on LexisNexis or

other service as the Court may order, the updated Forms A-1 (or its agreed equivalent) and A-2 as attached hereto. Each Plaintiff, including the exposed person or any authorized representative of a decedent, and loss of consortium claimant(s), must complete Form A-1 (or its agreed equivalent) and A-2. No trial setting will be given prior to submission of this information. No settlement is final and enforceable absent this information.

2. **Reporting Information:** As a condition precedent to the funding of any settlement where Plaintiff is enrolled in the Garretson AMP program, Plaintiff must provide to Defendant the Garretson AMP form demonstrating whether the settlement is processing through AMP as one involving asbestos exposure on or after December 5, 1980 as plead, claimed and/or released.

   Form B, as required pursuant to the 2012 Supplemental CMO, is modified to the attached format, Form Bv2, and is to be used in all asbestos-disease related cases resolved after the date of entry of this Order. When the Garretson AMP enrollment form is provided, the exposed Plaintiff/decedent was only enrolled in Medicare A and/or B, and only the exposed Plaintiff/decedent suffered any injury resulting in medical treatment and/or death, then Plaintiff need only complete the Form Bv2 through Section C and exposure years need not be delineated beyond indicating whether the case is processing as one with "Pre 12/5/1980" or "Post 1980" exposure, with post 1980 to mean exposure continuing on and/or after 12/5/1980 and "Pre 12/5/1980" meaning no exposure occurred nor was alleged to have occurred on or after 12/5/1980. If the exposed Plaintiff/decedent was enrolled in Medicare Part C or D, then Form Bv2 shall be completed in its entirety to the best of Plaintiff's ability based on reasonable investigation of Medicare enrollment.

3. **Reporting Inconsistencies:** If a Defendant intends to report ICD Codes or pre/post 1980 information that is inconsistent with the information provided by Plaintiff as per paragraph 2, then Defendant will make a good faith effort to notify Plaintiff's counsel of the information to be reported.

4. **Electronic Filing Only:** The filing/distribution of Forms A-1/its equivalent and A-2 (NOT reporting forms and releases and/or settlement agreements) and all related correspondence to the parties shall be made electronically on LexisNexis or other service as the Court may order so as to limit distribution of Social Security numbers and other personal/private information to the parties and their insurers.

5. **Other Data Forms:** Forms A-1, A-2 are sufficient to facilitate the determination of the status of a Plaintiff or Plaintiff's decedent as a Medicare beneficiary, thus precluding the use of any other forms. Plaintiffs will not be compelled to complete any other forms or answer any interrogatories submitted for this limited purpose except upon order of the Court or as directed by CMS. Completion of these forms will not eliminate any discovery obligations that otherwise exist under the Illinois Rules of Civil Procedure or CMO 19.

6. **Settlement Payments and Procedure:** As a condition precedent to the funding of any settlement, Plaintiff must tender the executed release and all applicable documents in compliance with this Order and as agreed between parties; this may include agreed Medicare Addenda. Any claims of untimely payment of settlement proceeds may be submitted to the Court for resolution. Such claims of untimely payment shall specifically include disputes as to

release language referencing the requirements of MMSEA Sec. 111 and the Medicare Secondary Payer Act, 42 U.S.C. Sec. 1395y, et seq. and in accordance with 735 ILCS 5/2-2301. The AMP program specifies procedures for reimbursement of conditional payments. Plaintiff and Plaintiff's Counsel's adherence to the AMP procedures is deemed to comply with the spirit of previous agreements related to escrowing funds to ensure reimbursement to Medicare.

7. Model Release Language

In the interest of streamlining the reporting process and reducing duplicative affidavits and other disclaimers the following language is recommended as a template for all parties:

If the Plaintiff is not a Medicare beneficiary nor Medicare eligible, then a Defendant should incorporate the following language in its release:

> I hereby make the following representations and warranties in affirming that I am not eligible for Medicare and that Medicare has not made any conditional payments for any medical expenses or prescription expense related to my injury: I have not applied for Medicare; I am not currently receiving Social Security Disability Benefits (SSD), or if I am, then I have been a recipient of SSD for less than 24 months; I am not in End Stage Renal Failure; I have not been diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease. Plaintiff or plaintiff's spouse assumes all responsibility for resolving all liens related to the treatment of the claimed injury, including if any are asserted by Medicare or any other entity pursuant to the Medicare, Medicaid and SCHIP Extension Act and/or the Medicare Secondary Payer Act.

If there is a loss of consortium claim filed by the plaintiff's spouse or any non-exposed plaintiff (heir) who is a Medicare beneficiary, then a Defendant should incorporate the following language in its release (if non-exposed plaintiff is not a Medicare beneficiary, then use the paragraph immediately above):

> I [plaintiff spouse] hereby represent and warrant that I have no bodily or psychological injury and received no medical treatment related to the injury of [exposed plaintiff]. More specifically, I did not seek any paid professional counseling, nor did I receive any medication as a result of psychological distress brought on by the illness of [exposed plaintiff]. I waive any and all past, present and future claims for any such injury. I am not waiving any claims that may exist from my personal exposure to asbestos. [Plaintiff's spouse] assumes all responsibility for resolving all liens related to the treatment of the claimed injury, including if any are asserted by Medicare or any other entity pursuant to the Medicare, Medicaid and SCHIP Extension Act and/or the Medicare Secondary Payer Act.

8. **Modification of Order:** This Order is subject to revision as the statutes, rules, regulations and practices of the federal government and CMS change or become more defined, including, changes to Data Forms, and for other reasons as the Court deems necessary. Any party may bring a written motion to seek revision or revocation of this order as per Illinois Rules and Code of Civil Procedure and applicable case management orders.

Date: **June 23, 2020**

Judge: Judge Clare Elizabeth McWilliams

JUN 23 2020

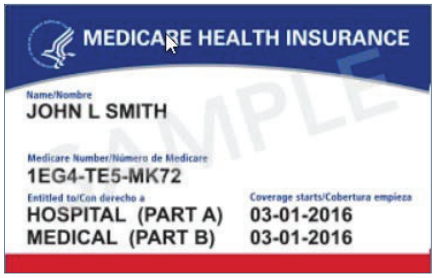
Circuit Court - 1889

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as to not inconvenience the beneficiary, and then recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Check the boxes as to which parts of Medicare you have been and/or are currently enrolled:			
☐ Part A	☐ Part B	☐ Part C	☐ Part D
If you checked any of the above, please complete the following. If not, proceed to Section II.			
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*			
Medicare Claim Number:			
Date of Birth (Mo/Day/Year)	-	-	
Social Security Number: (If Medicare Number is Unavailable)	-	-	
Sex	☐ Female	☐ Male	

** Note: If you are uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last 5 digits of your SSN in the section above.

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print)

Claim Number

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form

Date

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Consent to Release
Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation

Where to find Information on "Consent to Release" vs. "Proof of Representation"

Please refer to the PowerPoint document on this website titled: "Rules and Model Language for 'Proof of Representation' vs. 'Consent to Release' for Medicare Secondary Payer Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers' Compensation" for detailed information on

- **When to use a "consent to release" document vs. a "proof of representation" document,**
- Appropriate content for both documents,
- The need for appropriate documentation when there are two layers of representatives involved (examples: attorney 1 refers a case to attorney 2; the beneficiary's guardian hires an attorney to pursue a liability insurance claim) or when a beneficiary's representative signs a "consent to release" document on the beneficiary's behalf,
- What liability insurers (including self-insurers), no-fault insurers, and workers' compensation entities must have in order to obtain conditional payment information, and
- Use of agents by insurers' or workers' compensation.

General

A "consent to release" document is used by an individual or entity who does not represent the Medicare beneficiary but is requesting information regarding the beneficiary's conditional payment information. A "consent to release" does not authorize the individual or entity to act on behalf of the beneficiary or make decisions on behalf of the beneficiary.

Model Language

See attached. Use of the model language is not required, but any documentation submitted as a "Consent to Release" must include the information the model language requests.

Where to Submit a " Consent to Release" document:

Liability Insurance, No-Fault Insurance, Workers' Compensation:

NGHP
PO Box 138832
Oklahoma City, OK 73113
Fax: (405) 869-3309

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Medicares-Recovery-Process/Downloads/Consent-to-Release-Model-Language-.pdf (Last Visited 10/2/2019)

MODEL LANGUAGE

CONSENT TO RELEASE

The language below should be used when you, a Medicare beneficiary, want to authorize someone other than your attorney or other representative to receive information, including identifiable health information, from the Centers for Medicare & Medicaid Services (CMS) related to your liability insurance (including self-insurance), no-fault insurance or workers' compensation claim.

I, _____ (print your name exactly as shown on your Medicare card) hereby authorize the CMS, its agents and/or contractors to release, upon request, information related to my injury/illness and/or settlement for the specified date of injury/illness to the individual and/or entity listed below:

CHECK ONLY ONE OF THE FOLLOWING TO INDICATE WHO MAY RECEIVE INFORMATION AND THEN PRINT THE REQUESTED INFORMATION:

(If you intend to have your information released to more than one individual or entity, you must complete a separate release for each one.)

☐ Insurance Company ☐ Workers' Compensation Carrier ☐ Other _____
(Explain)

Name of entity: _____

Contact for above entity: _____

Address: _____

Address Line 2: _____

City/State/ZIP: _____

Telephone: _____

CHECK ONE OF THE FOLLOWING TO INDICATE HOW LONG CMS MAY RELEASE YOUR INFORMATION

(The period you check will run from when you sign and date below.):

☐ One Year ☐ Two Years ☐ Other _____
(Provide a specific period of time)

I understand that I may revoke this "consent to release information" at any time, in writing.

MEDICARE BENEFICIARY INFORMATION AND SIGNATURE:

Beneficiary Signature: _____ Date signed: _____

Note: If the beneficiary is incapacitated, the submitter of this document will need to include documentation establishing the authority of the individual signing on the beneficiary's behalf. Please visit https://go.cms.gov/cobro for further instructions.

Medicare ID (The number on your Medicare card.): _____

Date of Injury/Illness: _____

Medicare Confidential Reporting Information* [FORM Bv2]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 01-2020)

Case Name:	Case Number:	16. State of Venue: (USPS Abbreviation)
Defendant Name:		

Is exposed party presently or previously qualified for Medicare and/or enrolled in:

Part A	**Part B**	**Part C**	**Part D**	Is exposed party enrolled in a non-AMP resolution program (if yes, list name):
❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No	❒ No ❒ Yes:_____

Section AMP **DISCLOSURE REGARDING AMP – IF EXPOSED CLAIMANT IS IN AMP THEN NO NEED TO REPORT PER CMS**

Is the exposed claimant's case processing through the Garretson Resolution Group's Asbestos Malignancy Program (AMP)?
❒ Yes ❒ No

If yes, is the exposed claimant's case processing through AMP as a case involving **post-1980 exposure as to <u>this</u> defendant?**	If yes, is the exposed claimant's case processing through AMP as a case involving **post-1980 exposure as to other defendant(s)?**
❒ Yes ❒ No	❒ Yes ❒ No

Section A **ALLEGED EXPOSED PARTY INFORMATION (*If living, provide address in Section G)***

4. Medicare Number: (also known as HICN)

5. Social Security Number:	6. Exposed Party Last Name: (Please print name as it appears on Social Security card.)
7. Exposed Party First Name: (Please print name as it appears on Social Security card.)	8. Exposed Party Middle Name: (Please print name as it appears on Social Security card.)

9. Gender: ❒ Male ❒ Female	10. Date of Birth: (MM/DD/YYYY)	Deceased? ❒ Yes ❒ No	Date of Death: (MM/DD/YYYY)

Section B **ALLEGED INCIDENT INFORMATION**

12. CMS Date of Incident: Please state the date of the accident or date of **first exposure**, ingestion, or implantation with respect to settling defendant's product and/or premises (MM/DD/YYYY):

13. Industry Date of Incident: Please state the date of accident or date of **last exposure**, ingestion, or implantation with respect to settling defendant's product and/or premises (MM/DD/YYYY):

15. *Alleged Cause of Injury, Illness or Incident (ICD-9 "E" codes only; ICD-10 "V, W, X, Y" codes only; must not be excluded ICD9/ICD-10 Code) optional field:*

[17."9"] 18. ICD-9 Diagnosis Code 1:	19. ICD-9:	20. ICD-9:	22. ICD-9:	23. ICD-9:
[17."0"] 18. ICD-10 Diagnosis Code 1:	19. ICD-10:	20. ICD-10:	22. ICD-10:	23. ICD-10:

Description of Illness/Injury (Free Form Text Description):

Section C **ALLEGED EXPOSED PARTY'S ATTORNEY or OTHER REPRESENTATIVE INFORMATION**

64. Claimant Representative Type (please check one):
❒ A=Attorney ❒ P=Power of Attorney ❒ G=Guardian/Conservator ❒ O=Other

65. Representative's Last Name:	65. Representative's First Name:	65. Representative's Firm Name:

68. Firm's TIN/EIN; SSN if Individual:	69-70. Representative's Mailing Address:

71. City:	72. State:	73-74. Zip Code +4:	75. Phone:	76. Ext. (if any):

OPTIONAL **CLAIMANT 1 INFORMATION** *(Use only if Alleged Exposed Party in Section A is deceased)*
Section D If Section D Claimant has representative other than Section C, complete Section F

84. Claimant Relationship to Alleged Exposed Party (please check one):
❒ E=Estate (Individual) ❒ X=Estate (Entity) ❒ F=Family (Individual) ❒ F=Family (Entity) ❒ O=Other (Individual) ❒ Z=Other (Entity)

85. TIN/EIN (Social Security, if individuals):	*86. Claimant Last Name:*
87. Claimant First Name:	*88. Claimant Middle Name:*

89. Claimant Entity/Organization Name:

90-91. Mailing Address:

92. City:	93. State:	94-95. Zip Code +4:	96. Phone:	97. Ext. (if any):

Section E **SETTLEMENT INFORMATION**

81. Amount of Settlement:

Medicare Confidential Reporting Information* [FORM Bv2]

Pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Action of 2007 (Rev 10-19)

Section A-LOC **LOSS OF CONSORTIUM PLAINTIFF INFORMATION**
THIS SECTION MUST BE COMPLETED ONLY IF THE NON-EXPOSED PLAINTIFF(S) ALLEGES LOSS OF CONSORTIUM, IS MEDICARE ELIGIBLE AND EFFECTIVELY RELEASES MEDICAL CARE/TREATMENT PROVIDE ESTATE INFORMATION IN SECTION D

4-LOC. Medicare Claim Number:
(also known as HICN)

5-LOC. Social Security Number:	6-LOC. Last Name: (Please print name exactly as it appears on Social Security card.)
7-LOC. First Name: (Please print name exactly as it appears on Social Security card.)	8-LOC. Middle Name: (Please print name/initial exactly as it appears on Social Security card.)

9-LOC. Gender: ❒ Male ❒ Female	10-LOC. Date of Birth: (MM/DD/YYYY)	Deceased? ❒ Yes ❒ No	Date of Death: (MM/DD/YYYY):

15-LOC. Alleged Cause of Injury, Illness or Incident (ICD-9 "E" codes only; ICD-10 "V, W, X, Y" codes only; must not be excluded ICD9/ICD-10 Code) optional field:

(Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 18-LOC)

[17."9"] 18. ICD-9 Diagnosis Code 1:

(Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 15-LOC)

[17."0"] 18. ICD-10 Diagnosis Code 1:

(Use "NOINJ" code if LOC claimant did not have treatment nor submit medical expense to Medicare, if NOINJ is used here, it must be used in Field 15-LOC)

Description of Illness/Injury (Free Form Text Description):

Section E **DISCLOSURE REGARDING MEDICARE PARTS C & D**

Did any Claimant enroll in **Medicare Part C** coverage, known as Medicare Advantage? Exposed Party: ❒ Yes ❒ No Spouse and/or Consortium Claimant: ❒ Yes ❒ No	If you answered yes, please provide the name of each provider of the **Medicare Part C (Medicare Advantage)** coverage since onset of symptoms and dates of coverage: **Exposed Party:** **Spouse/Consortium Claimant:**
Did any Claimant enroll in **Medicare Part D** coverage, known as prescription coverage? Exposed Party: ❒ Yes ❒ No Spouse and/or Consortium Claimant: ❒ Yes ❒ No	If you answered yes, please provide the name of each provider of the **Medicare Part D (prescription drug)** coverage since onset of symptoms and dates of coverage: **Exposed Party:** **Spouse/Consortium Claimant:**

Signature of Attorney representing Plaintiff/Claimant(s) **Date** **Printed Name**

The signature of the attorney hereto constitutes certification that he/she has read the information supplied in this form and that all information stated herein is well grounded in fact to the best of his/her knowledge, information and belief formed after reasonably inquiry.

*Numbers reflect claim input file field numbers, as set forth in Version 5.6 of the Official NGHP User Guide by CMS.

Case Name:	Case Number:	State of Venue: (USPS Abbreviation)
Defendant Name:		

Optional Section F	**CLAIMANT'S 1'S (found in Section D) ATTORNEY OR OTHER REPRESENTATIVE INFORMATION**	
99. Claimant Representative Type (please check one):		
❒ A=Attorney ❒ P=Power of Attorney ❒ G=Guardian/Conservator ❒ O=Other		
100. Claimant Representative Last Name:	101. Claimant Representative First Name:	101. Claimant Representative Firm Name:

103. TIN/EIN, if Firm Entity; SSN if Individual:		104-105. Representative Mailing Address:		
106. City:	107. State:	108-109. Zip Code +4:	110. Phone:	111. Ext. (if any):

Section G	**ALLEGEDEXPOSED PARTY'S ADDRESS**			
Representative Mailing Address:				
City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Optional Section D cont.	**ADDITIONAL CLAIMANT INFORMATION** *(Use only if Alleged Injured Party in Section A is deceased)*			
Claimant Relationship to Alleged Injured Party (please check one): ❒ E=Estate (Individual) ❒ X=Estate (Entity) ❒ F=Family (Individual) ❒ F=Family (Entity) ❒ O=Other (Individual) ❒ Z=Other (Entity)				
TIN/EIN (Social Security, if individuals):		*Claimant Last Name:*		
Claimant First Name:		*Claimant Middle Name:*		
Claimant Entity/Organization Name:				
Mailing Address:				
City:	*State:*	*Zip Code +4:*	*Phone:*	*Ext. (if any):*

Claimant Representative Type (please check one): ❒ A=Attorney ❒ P=Power of Attorney ❒ G=Guardian/Conservator ❒ O=Other		
Claimant Representative Last Name:	Claimant Representative First Name:	Claimant Representative Firm Name:

TIN/EIN, if Firm Entity; SSN if Individual:		Representative Mailing Address:		
City:	State:	Zip Code +4:	Phone:	Ext. (if any):

Field#	Field Name	Definition:
4	MEDICARE CLAIM NUMBER (HICN)	Provide Alleged Injured Party's Medicare Health Insurance Claim Number (if one has been issued). This number can be found on Medicare Card if available.
5	SOCIAL SECURITY NUMBER	Provide Alleged Injured Party's Social Security Number if Medicare Claim Number (HICN) is not available.
6	LAST NAME	Provide last name of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD** or Medicare Card if available.
7	FIRST NAME	Provide first name of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD** or Medicare Card if available.
8	MIDDLE INITIAL	Provide middle initial of Alleged Injured Party **EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD** or Medicare Card if available.
9	GENDER	Indicate Alleged Injured Party's gender by selecting MALE or FEMALE.
10	DATE OF BIRTH	Provide Alleged Injured Party's Date of Birth.
	DECEASED?	Indicate if the Alleged Injured Party is deceased by selecting YES or NO.
	DATE OF DEATH	Provide the date the Alleged Injured Party deceased.
12	CMS DATE OF INCIDENT	Provide Date of Incident (DOI). DOI as defined by CMS: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure (including, for example, occupational disease and any associated cumulative injury) the DOI is the date of FIRST exposure. For claims involving ingestion (for example, a recalled drug), it is the date of FIRST ingestion. For claims involving implants it is the date of the implant (or date of the first implant if there are multiple implants).
13	INDUSTRY DATE OF INCIDENT	Provide Industry Date of Incident (DOI) routinely used by the insurance/workers' compensation industry: For an automobile wreck or other accident, the date of incident is the date of the accident. For claims involving exposure, or implantation, the date of incident is the date of LAST exposure, ingestion, or implantation.
15	OPTIONAL FIELD ALLEGED CAUSE OF INJURY, ILLNESS OR INCIDENT	ICD-9-CM/ICD-10-CM (International Classification of Diseases, Ninth/Tenth Revision, Clinical Modification) External Cause of Injury Code describing the alleged cause of injury/illness. See the NGHP User Guide Technical Information Chapter (Section 6.2.5) for complete information. In this field only, an ICD-9 code must begin with the "E" and ICD-10 code must begin with "V", "W', "X", or "Y." Codes in this field must NOT be on the list of Excluded ICD-9/ICD-10 Diagnosis Codes found in Appendix I. If "NOINJ" is submitted in Field 15, then "NOINJ" must be submitted in Field 18; relevant to loss of consortium claim reporting.
16	STATE OF VENUE	Provide the US postal abbreviation corresponding to the US State whose state law controls resolution of the claim. Use "US" where the claim is a Federal Tor Claims Act liability insurance matter or a Federal workers' compensation claim.
17	ICD INDICATOR	Code to reflect the type of ICD diagnosis codes submitted on the record. "0" = ICD-10-CM diagnoses codes. "9" = ICD-9-CM diagnoses codes. Claims submitted with a CMS DOI (Field 12) on or after October 1, 2015 that contain a ICD indicator of "9" or space will be rejected with a C131 error.
18-22	ICD DIAGNOSIS CODE 1 - 5	Complete entirely as at least one set of codes. ICD-9-CM/ICD-10-CM Diagnosis Code describing the alleged injury/illness. See the NGHP User Guide Technical Information Chapter (Section 6.2.5) for complete information. ICD-9 codes cannot begin with the letter "E" and cannot begin with the letter "V." ICD-10 codes cannot begin with the letters "V", "W', "X", or "Y." Codes used here must NOT be on the list of Excluded ICD-9/ICD-10 Diagnosis Codes found in Appendix I. If there are more diagnosis codes relevant to a claim, then include more codes. If "NOINJ" is submitted in Field 15, then "NOINJ" must be submitted in Field 18; relevant to loss of consortium claim reporting.
64	REPRESENTATIVE TYPE	Indicate the type of representative that the Alleged Injured Party has. Select from the options provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O= Other. If Alleged Injured Party has more than one representative, provide attorney information, if available.
65	REPRESENTATIVE LAST NAME	Provide Last Name of Representative.
66	REPRESENTATIVE FIRST NAME	Provide First Name of Representative.
67	REPRESENTATIVE FIRM NAME	Provide the Name of the Representative's Firm.
68	TIN/EIN, IF FIRM/ENTITY; SOCIAL SECURITY NUMBER IF INDIVIDUAL	Provide Alleged Injury Party's Representative's Federal Tax Identification Number (TIN). If representative is part of a firm, supply the firm's Employer Identification Number (EIN), otherwise supply the representative's Social Security Number (SSN).
69-70	MAILING ADDRESS	Provide mailing address for the alleged injured party's representative named above.
71	CITY	Provide mailing address city for the alleged injured party's representative named above.
72	STATE	Provide mailing address state for the alleged injured party's representative named above
73-74	ZIP CODE +4	Provide mailing address zip code for the alleged injured party's representative named above. IncludeZip+4 code if known; if not known enter 0000.
75	PHONE	Provide telephone number of alleged injured party's representative.
76	PHONE EXTENSION, IF ANY	Provide telephone extension of alleged injured party's representative, if extension is available.
81	AMOUNT OF SETTLEMENT	Provide total amount of Settlement
84	CLAIMANT'S RELATIONSHIP TO ALLEGED INJURED PARTY	Indicate relationship of the claimant to the alleged injured party/Medicare beneficiary by selecting from the options provided: E = Estate, individual Name Provided F = Family Member, Individual Name Provided O = Other, Individual Name Provided X = Estate, Entity Name Provided (e.g. "The Estate of John Doe"), Y = Family, Entity Name Provided (e.g. "The Family of John Doe") Z = Other, Entity Name Provided (e.g. "The Trust of John Doe") Blank = Not applicable (rest of the section will be ignored)
85	TIN/EIN, IF ENTITY; SOCIAL SECURITY NUMBER, IF INDIVIDUAL	Provide Claimant's Social Security Number (SSN) if individual or Federal Tax Identification Number (TIN)/Employer Identification Number (EIN) if claimant is an entity.
86	CLAIMANT LAST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide last name.

87	CLAIMANT FIRST NAME	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide first name.
88	CLAIMANT MIDDLE INITIAL	If claimant is an individual (claimant relationship is 'E','F', or 'O'), provide middle initial.
89	CLAIMANT ENTITY/ORGANIZATION NAME	If claimant is an entity or organization (claimant relationship is 'X', 'Y', or 'Z'), provide entity name; e.g. "The Estate of John Doe", "The Family of John Doe", "The Trust of John Doe", etc.
90-91	MAILING ADDRESS	Provide mailing address for claimant.
92	CITY	Provide mailing address city of the claimant.
93	STATE	Provide mailing address state of the claimant.
94-95	ZIP CODE +4	Provide mailing address zip code for the claimant. Include Zip +4 code if available.
96	PHONE	Provide telephone number of the claimant
97	PHONE EXTENSION, IF ANY	Provide telephone extension of claimant, if extension is available.
99	CLAIMANT 1's REPRESENTATIVE TYPE	Indicate the type of representative the claimant has by selecting from the option types provided: A = Attorney G = Guardian/Conservator P = Power of Attorney O = Other Blank = Not applicable (rest of the section will be ignored
100	C1 REPRESENTATIVE LAST NAME	Provide the last name of representative for Claimant 1.
101	C1 REPRESENTATIVE FIRST NAME	Provide the first name of representative for Claimant 1.
102	C1 REPRESENTATIVE'S NAME	Provide law firm name of representative for Claimant 1.
103	C1 REPRESENTATIVE'S TIN	Provide TIN of law firm of representative for Claimant 1.
104-105	C1 REPRESENTATIVE'S MAILING ADDRESS	Provide mailing address of representative for Claimant 1.
106	C1 REPRESENTATIVE'S CITY	Provide mailing address city of representative for Claimant 1.
107	C1 REPRESENTATIVE'S STATE	Provide mailing address state of representative for Claimant 1.
108-109	C1 REPRESENTATIVE'S ZIP CODE +4	Provide mailing address zip code of representative for Claimant 1.
110	C1 REPRESENTATIVE'S PHONE	Provide telephone extension of C1's representative.
111	C1 REPRESENTATIVE'S EXTENSION, IF ANY	Provide telephone extension of C1's representative.

Section A-LOC LOSS OF CONSORTIUM PLAINTIFF INFORMATION

THIS SECTION MUST BE COMPLETED ONLY IF THE NON-EXPOSED PLAINTIFF(S) ALLEGES LOSS OF CONSORTIUM, IS MEDICARE ELIGIBLE AND EFFECTIVELY RELEASES MEDICAL CARE/TREATMENT PROVIDE ESTATE INFORMATION IN SECTION D

Field#	Field Name	Definition:
4-LOC	MEDICARE CLAIM NUMBER (HICN)	Provide Alleged Loss of Consortium Plaintiffs Medicare Health Insurance Claim Number (if one has been issued). This number can be found on Medicare Card if available.
5	SOCIAL SECURITY NUMBER	Provide Alleged Loss of Consortium Plaintiffs Social Security Number if Medicare Claim Number (HICN) is not available.
6	LAST NAME	Provide Alleged Loss of Consortium Plaintiff's last name EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD or Medicare Card if available.
7	FIRST NAME	Provide Alleged Loss of Consortium Plaintiffs first name EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD or Medicare Card if available.
8	MIDDLE INITIAL	Provide Alleged Loss of Consortium Plaintiffs middle initial EXACTLY AS IT APPEARS ON SOCIAL SECURITY CARD or Medicare Card if available.
9	GENDER	Provide Alleged Loss of Consortium Plaintiffs gender by selecting MALE or FEMALE.
10	DATE OF BIRTH	Provide Alleged Loss of Consortium Plaintiffs Date of Birth.
	DECEASED?	Indicate if the Alleged Injured Party is deceased by selecting YES or NO.
	DATE OF DEATH	Provide the date the Alleged Injured Party deceased.
15	OPTIONAL FIELD ALLEGED CAUSE OF INJURY, ILLNESS OR INCIDENT	ICD-9-CM/JCD-10-CM (International Classification of Diseases, Ninth/Tenth Revision, Clinical Modification) External Cause of Injury Code describing the alleged cause of injury/illness. See the NGHP User Guide Technical Information Chapter (Section 6.2.5) for complete information. In this field only, an ICD-9 code must begin with the letter "E," and an ICD-10 code must begin with 'V," 'W.'' "X," or "Y." Codes in this field must NOT be on the list of Excluded ICD-9/ICD-10 Diagnosis Codes found in Appendix I. If "NOINJ" is submitted in Field 15, then "NOINJ" must be submitted in Field 18; relevant to loss of consortium claim reporting.
18	ICD DIAGNOSIS CODE 1	ICD-9-CM/ICD-10-CM Diagnosis Code describing the alleged injury/illness. See the NGHP User Guide Technical Information Chapter (Section 6.2.5) for complete information. ICD-9 codes cannot begin with the letter "E" and cannot begin with the letter "V." ICD-10 codes cannot begin with the letters "V," 'W," "X," or "Y." Codes used here must NOT be on the list of Excluded ICD-9/ICD-10 Diagnosis Codes found in Appendix I. If there are more diagnosis codes relevant to a claim, then include more codes on additional paper. If "NOINJ" is submitted in Field 15, then "NOINJ" must be submitted in Field 18; relevant to loss of consortium claim reporting.