Bradley County Jail Settlement, No. 1:18-cv-217-CHS (E.D. Tenn.) – Medicare/Medicaid/Secondary Payer Information Form and Release

****IMPORTANT – ALL CLAIMANTS MUST COMPLETE THE FOLLOWING FORM TO BE ELIGIBLE TO RECEIVE PAYMENT AS PART OF THIS SETTLEMENT****

Federal and state law require consideration of the interests of publicly funded health insurance programs – namely **Medicare**, **Medicaid**, **TennCare (or other state programs)**, and **VA health care** ("government healthcare programs"). Under certain circumstances, recipients of damages awards or settlements for personal injury – like this settlement – can be required to report those settlements to government healthcare programs so that those programs can determine whether they are entitled to some portion of the settlement funds for payments conditionally made as a "secondary payer." If the government health care programs' interests are not adequately considered or protected in a settlement, then those programs **MAY**: (1) refuse to pay for medical expenses; (2) suspend or terminate benefits; (3) require repayment of conditional payment claims paid by the program; and/or (4) file suit against any of the parties to the settlement and recover double damages plus interest.

For that reason, we are gathering information from claimants in the Bradley County Jail Settlement for submission to the relevant government agency or program, if any. Accordingly, you **MUST**

1. **Complete and return this form by email or U.S. Mail, as follows:**

   jaj@smrw.com

   OR

   Bradley County Jail Settlement Class Counsel
   Spears, Moore, Rebman & Williams, P.C.
   601 Market Street, Suite 400
   Chattanooga, TN 37402

   AND

2. **If you are insured through or receive care from any of those government healthcare programs, contact Class Counsel as soon as possible (at jaj@smrw.com or 423.757.0404) for guidance in executing any additional documents needed to make the necessary reports and provide proof of Class Counsel's representation.**

ALL CLAIMANTS MUST COMPLETE THIS FORM, EVEN IF THEY ARE NOT BENEFICIARIES OF GOVERNMENT HEALTHCARE PROGRAMS.

Government Healthcare Program Participation –
Please Provide Information for ALL Applicable Programs

1. **General Information**

   a. **Full Name:** _____

   b. **Date of Birth:** _____

   c. **Social Security Number:** _____

   d. **Gender:** _____

   e. **Address:** _____

   f. **Telephone Number:** _____

I am a beneficiary of the following program(s) (or, in the case of Medicare, may become a beneficiary within thirty (30) months of the date I am completing this form) (**CHECK ALL THAT APPLY**):

Medicare	☐
Medicaid	☐
TennCare	☐
VA healthcare	☐
Other (*e.g.*, other state medical insurance program)	☐

If "Other," please describe: _____

2. **Medicare: You must complete this section if you are EITHER (a) a CURRENT Medicare beneficiary OR (b) may become a Medicare beneficiary within (approximately) thirty (30) months, *i.e.*, are sixty-two and a half years old (or older) or have applied for Social Security Disability Insurance (SSDI) benefits.**

   Dates of Medicare Coverage: _____

   Medicare Number: _____

3. **<u>Medicaid</u>: You must complete this section if you are a current recipient of Medicaid OTHER THAN TennCare:**

   Dates of Medicaid Coverage: _____

   Medicaid Number: _____

4. **<u>TennCare</u>**: You must complete this section if you are or have ever been a TennCare beneficiary:

   Dates of TennCare Coverage: _____

   TennCare or MCO ID #: _____

5. **VA health Care:** You must complete

   VHIC Member ID #: _____

   VHIC Plan ID #: _____

6. **Other**

   If you are a beneficiary of publicly funded health care or health insurance benefits *not* listed above, please describe and provide relevant identification numbers of same:

_____

_____

_____

I understand, acknowledge, and agree that my receipt of payment in connection with the above-referenced action is contingent upon my completion of this form and cooperation with Class Counsel in providing any additional documentation that may be required to report my claims to the appropriate program or agency.

I certify under penalty of perjury that the information provided above is true and accurate to the best of my knowledge. I agree to indemnify and hold harmless all persons and entities, including Class Counsel, Defendants in the above-referenced action, and Defendants' counsel, from any and all liability arising from any inaccurate, false, or misleading information contained herein.

Date: _____

Name of Claimant or Authorized Person (Please Print): _____

Signature of Claimant or Authorized Person:

_____