UNITED STATES DISTRICT COURT, DISTRICT OF ARIZONA

HEALTHCARE LIEN RESOLUTION QUESTIONNAIRE

To Whom It May Concern,

Should Plaintiff recover any funds on behalf of the Class in *Brian Dorazio v. Allstate Fire and Casualty Insurance Company*, Case No. CV-23-00017-PHX-KML, for the claims outlined in the attached Notice, Class Counsel will be obligated to verify and resolve any Medicare liens Class Members may have. This verification must occur ***before any recovery can be distributed to the Class***, which includes you. To be ready to verify any Medicare liens in the event of a recovery, Class Counsel has hired Epiq, a third-party lien administrator, to manage and resolve the lien resolution process.

Because lien resolution is a time-consuming process, Epiq, on behalf of Class Counsel, is kindly requesting that each Class Member provide the following documentation, which will enable Epiq to start the lien process right away and will ultimately speed up any payment you are entitled to in the event of a recovery. Below, please find a copy of the Class Member Questionnaire along with the necessary authorization form. These documents are essential to ensure the proper handling of medical liens and to uphold the rights of recovery-eligible agencies.

If there is a recovery in this case, which Class Counsel believes is likely given their success in similar cases, failure to fill out these forms will delay your payment, ***even if you do not have a lien against your recovery***, potentially for several months, or can result in higher payment to Medicare if there is a lien. If you have any questions about these forms or the Notice, please contact Class Counsel, who the Court appointed to represent you in this case:

Robert Carey
John DeStefano
Michella Kras
Hagens Berman Sobol Shapiro LLP
11 W. Jefferson Street, Suite 1000
Phoenix, AZ 85003
Phone: 602-840-5900
Email: stacking@hbsslaw.com

If you are not the Class Member and the Class Member is deceased, Medicare requires a copy of the estate documentation or a copy of the death certificate. The estate representative or informant listed on the death certificate will be the signatory of the proof of record. Class Counsel will assist you if you have questions on this issue.

As required by federal law, Class Members must reimburse their Medicare Part A and Part B health insurance plan(s) that paid for medical treatment related to the injury(ies) sustained in the auto accident should they receive a recovery. Epiq will affirmatively check with The Centers for Medicare and Medicaid for Medicare Part A and Part B enrollment. Please answer the following question(s).

Class Member Full Legal Name (at the time of the auto accident)

First | MI | Last

Full Social Security Number

___ – ___ – ____

Full Date of Birth

__ – __ – ____

MM DD YYYY

What is the date of your auto accident?

__ – __ – ____

MM DD YYYY

What injury(ies) did you sustain due to the auto accident?

_____

_____

_____

_____

Please return your completed documentation to Brian Dorazio v. Allstate Fire and Casualty Insurance Company, Notice Administrator, P.O. Box 2777, Portland, OR 97208-2777.

Should you have any questions, or if you are unable or unwilling to comply with any of the above requests, please do not hesitate to write to *Brian Dorazio v. Allstate Fire and Casualty Insurance Company*, Notice Administrator, P.O. Box 2777, Portland, OR 97208-2777.

PROOF OF REPRESENTATION

The undersigned Medicare beneficiary informs the Centers for Medicare & Medicaid Services (CMS) that they have given the specified legal representative the authority to represent them and act on their behalf with respect to any claims for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. The undersigned representative agrees that they represent the stated Medicare beneficiary.

Type of Representative:	**Authorized Representative Information:**
( ) Individual other than an Attorney: ( ) Attorney ( ) Guardian* ( ) Conservator* ( ) Power of Attorney*	_____ (Attorney/ Law Firm Name) _____ (Law Firm Address) _____ (Law Firm City, State, Zip) _____ (Phone Number)

* If the beneficiary is incapacitated, his/her guardian, conservator, power of attorney, etc. will need to submit documentation in addition to this proof of representation.

Medicare Beneficiary Information:

Beneficiary's Name (please print exactly as shown on your Medicare card):	_____	(Required)
Beneficiary's Health Insurance Claim Number **(number on Medicare card)** or Social Security Number:	_____	(Required)
Date of Illness/Injury **for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim:**	_____	(Required)

Beneficiary's Signature: _____ Date Signed: _____ (Required)

Representative's Signature: (Attorney) _____ Date Signed: _____ (Required)