

MUST BE
POSTMARKED
NO LATER THAN
JULY 9, 2009



OFFICIAL USE ONLY

In re: New England Carpenters v. McKesson
Docket No. C.A. No. 1:05-CV-11148-PBS

McKESSON SETTLEMENT THIRD-PARTY PAYOR CLAIM FORM

To receive a share of the Settlement Fund you need to complete and sign this Claim Form and mail it postmarked no later than **July 9, 2009** to McKesson Settlement Administrator, c/o Rust Consulting, Inc., P.O. Box 24607, West Palm Beach, FL 33416.

The information you provide will be kept confidential and will be used only for administering this settlement. If you have any questions, please call the Settlement Administrator at **1-877-625-9414**. For updated information about any decisions by the Court affecting the Class or the Settlement, please refer to the McKesson Settlement website at www.McKessonAWPSettlement.com or visit www.AWPclassactions.com.

A Third-Party Payor ("TPP") Settlement Class Member ("Class Member") or an authorized agent may complete this Claim Form. If both a Class Member and its authorized agent submit a Claim Form, the Settlement Administrator will only consider the Class Member's Claim Form. The Settlement Administrator may request support documentation at the Settlement Administrator's discretion. The claim may be rejected if any requested documentation is not provided.

If one or more Class Members has authorized you to submit a Claim Form on its behalf, you must provide the information requested in Section B in addition to the other information requested by this Claim Form. You may submit a separate Claim Form for each Class Member that has duly authorized you to do so, OR you may submit one Claim Form for all such Class Members that have authorized you to do so. If you are submitting Claim Forms both on your own behalf as a Class Member AND on behalf of one or more Class Members that have authorized you to do so, you should submit one Claim Form for yourself and another Claim Form for the other Class Member(s). **Do not submit a Claim Form on behalf of any Class Member without prior authorization from that Class Member.**

SECTION A – CLAIMANT IDENTIFICATION

Please indicate whether you are claiming on your own behalf as a Class Member or as the authorized agent of one or more Class Members by placing an "X" in the appropriate space below. If you wish to make a claim as a Class Member *and also* as the authorized agent of other Class Members, please complete one Claim Form for your claim as a Class Member and a separate Claim Form for those Class Members for whom you are authorized to submit a claim:

- I am the Class Member
 I am filing as the Authorized Agent of a Class Member**

** As Authorized Agent, please check how your relationship with the Class Member is best described:

- Third Party Administrator (other than a Pharmacy Benefits Manager)
 Pharmacy Benefits Manager
 Other (Explain): _____



SECTION B – CLASS MEMBER OR AGENT INFORMATION

Class Member's/Authorized Agent's Name

Street Address

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Area Code - Fax Number

*Class Member's/Authorized Agent's
Tax Identification Number*

If you file as a Class Member, list other names by which you have been known or other FEINs you have used from January 1, 1991 through March 1, 2008.

If you are filing as the Class Member, check the term below that best describes your company/entity:

- Health Insurance Company/HMO
- Self-Insured Employee Health Plan
- Self-Insured Union Health & Welfare Fund
- Other (Explain): _____

SECTION C – CLAIM BY AUTHORIZED AGENT

Please list the Federal Employer Identification Number and the name of every Class Member for whom you have been duly authorized to submit this Claim Form (attach additional sheets to this Claim Form as necessary). Alternatively, you may submit the requested list of Class Member names and FEINs in an acceptable electronic format. Please contact the Settlement Administrator to determine what formats are acceptable.



SECTION D – TOTAL AMOUNT OF SUBJECT DRUG PURCHASES

For each Class Member on whose behalf you are submitting a claim, state the total and final Net Amount Paid or reimbursed. The Net Amount Paid is the allowable amount (generally the ingredient cost plus the pharmacy dispensing fee) net of chargebacks, co-pays, and/or co-insurance for each of the Subject Drugs set out in the chart below with a date of service or date of fill from August 1, 2001 to December 31, 2003. The NDC codes from this list can be downloaded at www.McKessonAWPSettlement.com or www.AWPclassactions.com.

Drug Name	Net Amount Paid August 1, 2001 – December 31, 2003
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
TOTAL	\$

Claimant certifies that the figures are true and accurate and are based upon actual records maintained by or otherwise available to the claimant.



SECTION E – CLAIM DOCUMENTATION INSTRUCTIONS

You must provide electronic documentation with your Claim Form to have your claim considered by the Settlement Administrator. You may provide this documentation in one of two forms:

IMPORTANT: You are only required to provide patient information for members whose cost share was a percentage co-insurance or percentage co-payment. Do **NOT** provide patient information for members who only paid flat co-payment amounts. If a member made both percentage co-insurance or percentage co-payments and flat co-payments during the relevant period, include the patient information and **ONLY** the percentage co-insurance or percentage co-payment amounts.

1. You may provide the below fields in a comma separated text file with quoted identifiers and a header row. Below are the necessary fields, a brief description of each, and an example of what the data would look like. Please provide data for these fields for each claim payment:
 - a. **Patient First Name – The first name of the person who took the medication.**
Mary
 - b. **Patient Middle Name – The middle name, if any, of the person who took the medication.**
Jane
 - c. **Patient Current Last Name – The current last name of the person who took the medication.**
Doe
 - d. **Patient Social Security Number – The social security number of the person that took the medication.**
999-99-9999
 - e. **Patient Date of Birth – The date of birth of the person that took the medication. Formatted mm/dd/yyyy.**
01/01/1900
 - f. **Patient Address: Street Number – The current street number of the person that took the medication.**
100
 - g. **Patient Address: Street 1 – The street name for the home residence of the person that took the medication at the time of taking the medication.**
Fake Street
 - h. **Patient Address: Street 2 – Any additional identifier of the street location for the home residence of the person that took the medication at the time of taking the medication, such as apartment number.**
Apt. #3
 - i. **Patient City – The city of residence for the person that took the medication at the time they took the medication.**
Springfield
 - j. **Patient State – The two character abbreviation of the current state of residence for the person that took the medication.**
NY
 - k. **Patient Zip Code – The current zip code of the person that took the medication.**
10003
 - l. **NDC Code**
0000000000
 - m. **Fill Date. Formatted mm/dd/yyyy.**
01/01/2002
 - n. **Amount Billed**
100.00
 - o. **Amount Paid – The allowable amount (generally the ingredient cost plus the pharmacy dispensing fee).**
80.00
 - p. **Patient Percentage Cost Share – The amount the patient paid as coinsurance or copayment which was calculated as a percentage of the allowable amount. Flat co-pays amounts are NOT to be provided and are not to be included in this field.**
11.00
2. You may provide the data in a Excel spreadsheet if your supporting data is a size that will fit within one Excel spreadsheet. Attached is a mock spreadsheet reflecting the required data fields necessary for your participation as a TPP Class Member. Please provide the required data fields as presented in the attached mock spreadsheet, for all paid claims with a date of fill between August 1, 2001 to December 31, 2003. Please provide this data along with the Claim Form to the Settlement Administrator no later than **July 9, 2009**.



ADDITIONAL INFORMATION

Please provide a list of all self-funded healthcare plans (“SFPs”) for which you are making a claim. Include the SFP name, and tax identification number.

All information you provide is subject to the protective order governing this action.

SECTION F – JURISDICTION OF THE COURT AND CERTIFICATION

By signing below, I hereby swear and affirm that: (1) I have authority to submit this Claim Form either directly or on behalf of the Class Member or as its Authorized Agent, and, in turn, have been given the authority to submit this Claim Form by each Class Member identified in this Claim Form and in any attachments to it, and to receive on behalf of each such Class Member any and all amounts that may be allocated from the TPP Settlement Pool to such Class Member; (2) the information contained in this Claim Form and any attachments hereto is true and accurate, based on records maintained by or otherwise available to me; and (3) I, the Authorized Agent (if any), and the Class Member on whose behalf this Claim Form is submitted, hereby submit to the jurisdiction of the United States District Court for the District of Massachusetts (the “Court”) for all purposes associated with this Claim Form and the Settlement, including resolution of disputes relating to this Claim Form.

Signature

Position

Print Name

Month/Day/Year

The following information is to be provided by the Individual that signs and certifies this Claim Form: I am filing this Claim Form as the authorized employee of the following Class Member or Authorized Agent for Class Member:

Name of Individual’s Employer

Business Address

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Area Code - Fax Number

E-mail Address

Mail the completed Claim Form, postmarked no later than **July 9, 2009** to:

McKesson Settlement Administrator
c/o Rust Consulting, Inc.
P.O. Box 24607
West Palm Beach, FL 33416

