

MUST BE POSTMARKED
ON OR BEFORE
DECEMBER 12, 2008



Carpenters and Joiners Welfare Fund, et al.

v.

SmithKline Beecham, D.Minn., No. 04-cv-3500

THIRD-PARTY PAYOR CLAIM FORM

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 Claims Administrator at **1-800-396-5655**.

A TPP Class member or an authorized agent can complete this Claim Form. If both a Class member and its authorized agent submit a Claim Form, the Claims Administrator will only consider the Class member's Claim Form. The Claims Administrator may request supporting documentation. 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, as long as you provide the information required (as indicated below) for each Class member on whose behalf you are submitting the form.

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 or Forms for the other Class member(s). **Do not submit a Claim Form on behalf of any Class member without obtaining specific prior authorization from that Class member.**

Mail the completed Claim Form, **postmarked on or before December 12, 2008**, to:

**Pediatric Paxil® TPP Administrator
c/o Complete Claim Solutions, LLC
P.O. Box 24662
West Palm Beach, FL 33416**

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 Federal Employer Identification Numbers ("FEINs") you have used from January 1, 1998 through December 31, 2004.

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 Claims Administrator to determine what formats are acceptable.



SECTION D – TOTAL AMOUNT OF CLAIM FOR PEDIATRIC PAXIL® TPP DRUG REIMBURSEMENTS

For each Class member on whose behalf you are submitting a claim, state the total unreimbursed cost paid or reimbursed for Paxil® prescribed to persons under 18 years of age with a date of service or date of fill from January 1, 1998 through December 31, 2004, based on the amount paid by the Settlement Class member, exclusive of any co-payments, deductibles, or other amounts not paid by the Class member. If the Total Claim Amount below (after calculation of the 40% and 15% percentages) is more than \$1,000 you will need to provide additional information (See Section F). If necessary, please duplicate this section so that you use it once for each Class member on whose behalf you are submitting a claim.

Current Name of Class Member:

Amount Paid with MDD Diagnosis:

40%:

Amount Paid with other or no Diagnosis:

15%

Total Amount Paid:

Total Claim Amount:

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 – JURISDICTION OF THE COURT AND CERTIFICATION

Please duplicate this section and submit it for each TPP Class member on whose behalf you are submitting a claim.

By signing below, I hereby swear and affirm under penalty of perjury that the following is correct: (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) each entity on whose behalf I have submitted a claim is a TPP Class member; (3) 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; (4) 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 Minnesota (the "Court") for all purposes associated with this Claim Form and the settlement, including resolution of disputes relating to this Claim Form; and (5) in the event that amounts from the settlement are distributed to the Authorized Agent of a Class member, and the Class member later claims that the Authorized Agent did not have the authority to claim and receive such amounts on its behalf, the Authorized Agent, I and/or my employer will hold the Class, Counsel for the Class, Defendants, Counsel for Defendants, and the Claims Administrator harmless with respect to any claims made by said Class member.

Signature

Position

Print Name

Month/Day/Year



The following additional 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

Email Address

SECTION F – CLAIM DOCUMENTATION INSTRUCTIONS

If your Total Claim Amount in Section D above is less than \$1,000, you do not need to attach any additional information. However, even if your claim is less than \$1,000, you should retain the information required because supporting documentation may be requested.

If your Total Claim Amount in Section D above is \$1,000 or more, you must provide documentation with your Claim Form sufficient to show the amount of purchases or reimbursement of Paxil® prescribed to persons under 18 years of age during the period January 1, 1998 through December 31, 2004, exclusive of any co-payments, deductibles, or other amounts not paid by the Class member.

Please provide the required data fields as presented in the ABC Health Plan sample layout on the bottom of page 5.

1. **NDC Number** - Please provide the applicable NDC Number for each transaction. A list of NDC Numbers for Paxil® appears below.*

<i>PRODUCT</i>	<i>NDC</i>	<i>DOSAGE</i>	<i>MANUFACTURER</i>
PAXIL® TABLETS	00029-3211	20MG	BEECHAM DIVISION
PAXIL® TABLETS	00029-3212	30MG	SMITHKLINE BEECHAM CORP
PAXIL® TABLETS	00029-3210	10MG	
PAXIL® TABLETS	00029-3213	40MG	
PAXIL® CR TABLETS	00029-3207	25MG	
PAXIL® CR TABLETS	00029-3208	37.5MG	
PAXIL® CR TABLETS	00029-3206	12.5MG	
PAXIL® CR TABLETS	00173-3207	25MG	GLAXO WELLCOME DIVISION
PAXIL® CR TABLETS	00173-3208	37.5MG	SMITHKLINE BEECHAM CORP
PAXIL® CR TABLETS	00173-3206	12.5MG	
PAXIL® TABLETS	00173-3211	20MG	
PAXIL® TABLETS	00173-3210	10MG	
PAXIL® TABLETS	00173-3213	40MG	
PAXIL® TABLETS	00173-3212	30MG	
PAXIL® TABLETS	53873-3210	10MG	GLAXOSMITHKLINE
PAXIL® TABLETS	53873-3211	20MG	
PAXIL® TABLETS	53873-3212	30MG	
PAXIL® TABLETS	53873-3213	40MG	
PAXIL® ORAL SUSPENSION	00029-3215-48	10MG	

* This list is not exhaustive. Paxil® may have been purchased from other sources under a different NDC.

2. **Service and/or Fill Date** – If both are available, please include them.



3. **Date of Birth of Patient** – Supply date of birth of patient; however, do not supply patient identification information such as Name or Social Security Number. However, you should maintain such data in case further confirmation is needed.
4. **Diagnostic Code, if Available** – To obtain a 40% claim allowance, the records must reflect a diagnosis of Major Depressive Disorder. Generally, the ICD codes corresponding to this disorder are 296.20 through 296.36.
5. **Amount Billed** – The billed charges or the initial amount billed by the provider or providers before any adjustments.
6. **Net Amount Paid** – The final amount paid for each Paxil® prescription, exclusive of any co-payments, deductibles, or other amounts not paid by the Class member.
7. **40% if MDD** – Enter forty percent (40%) of the Net Amount Paid in this Column, if records show that the patient had been diagnosed with a Major Depressive Disorder, OR
8. **15% if MDD** – Enter fifteen percent (15%) of the Net Amount Paid in this Column, if records show a diagnosis other than Major Depressive Disorder, or if your records do not reflect the diagnosis.

SECTION G – POSSIBLE INCREASE IN CLAIM

If the available funds exceed the total of all payments to be made to claiming class members, the remaining amount left in the Settlement Fund shall be distributed as follows:

- a. Up to One Million Dollars of that remaining amount shall be donated to one or more charity organizations whose primary purpose includes mental health issues affecting children.
- b. Any remainder, after the charitable donation described above, shall be allocated to increase the amount payable to class members who have submitted qualifying claims, on a pro rata basis based upon total remaining uncompensated pediatric Paxil expenditures during the class period after the initial claims process, without regard to diagnoses or the presence or absence of diagnostic information in any Class Member's claims form.

OTHER INFORMATION

- On page 2 of this Claim Form, Section C, each TPP Class member shall provide a list of all self-funded healthcare plans ("SFPs") or other entities for which it is authorized to make a claim, including the identity of each entity on whose behalf the TPP Class member is authorized to act by name and by the Federal Employer Identification Number assigned to such entity by the United States Internal Revenue Service.
- Please provide the electronic data in either Microsoft Excel format or ASCII flat file pipe delimited "I" or fixed-width format. *Refer to the ABC Health Plan sample layout below.*

All information you provide will remain confidential and used for no purpose other than for the administration of claims in this case as ordered by the Court. All information you provide is subject to the protective order governing this action.

Please contact the Claims Administrator at 1-800-396-5655 with any questions about the required claims data.

ABC Health Plan Pediatric Paxil® Payment Data							
NDC Number	Service / Fill Date	Date of Birth	Diagnostic Code*	Amt Billed	Net Amt Paid**	40% if MDD	15% if not MDD
COLUMN TOTALS					\$	\$	\$
TOTAL CLAIM						\$	

*If available. A diagnostic code is not required, unless you are seeking the 40% reimbursement for patients with MDD diagnoses.

**Amt billed, less any co-payments, deductibles, or other amounts not paid by the Class member.