

CLAIM FORM

Re: *Hockfield & Kasher, PA v. Star Med, LLC*, Docket No.: CAM-L-813-17, Superior Court of New Jersey, Law Division, Camden County

THE DEADLINE TO SUBMIT THIS CLAIM FORM IS November 26, 2018.



/J13893-Star Med

JOHN Q SAMPLE
12345 MAIN ST
CITY, ST 12345-6789

This is the official Claim Form you must use to make a claim in the above matter. Please read this form carefully before filling it out. With this Claim Form, you received a "Notice of Pendency of Class Action and Proposed Settlement," which more fully explains this matter and the terms of the proposed settlement therein. As set forth in the Notice, in order for you to become eligible to receive any settlement payment you must be a member of the proposed class and complete all portions of this Claim Form, sign the Claim Form under penalty of perjury, attach all documents required herein, and mail or fax the signed, completed Claim Form to:

**First Class, Inc./ J13893-Star Med
5410 W. Roosevelt Rd., Ste 222
Chicago, IL 60644-1490
OR
877-250-9986**

THIS COMPLETED FORM MUST BE POSTMARKED OR FAXED NO LATER THAN November 26, 2018.

Please note that if a law firm requested and obtained medical records via electronic means (i.e. CD or online portal) from Defendant, the Notice and this Claim Form are being sent to both the law firm requestor and the patient whose records were requested. Both the law firm requestor and the patient, however, cannot recover for the same production of medical records. If the patient did reimburse the law firm for the payment of Defendant's bill for the medical records by any means (i.e. retainer, direct payment, deduction from settlement proceeds, or cost judgment), only the patient is potentially eligible to recover under this settlement. If the patient did not reimburse the law firm for the payment of Defendant's bill for the medical records, only the law firm is potentially eligible to recover under this settlement.

Please further note that if you are a law firm, only law firms that requested patient medical records in the course of representing the patient (i.e. not a defense law firm or other law firm not acting on behalf of the patient) are potentially eligible to recover under this settlement.

If you have any questions please contact class counsel, Stephen P. DeNittis, Esquire, at 856-797-9951 or via email at sdenittis@denittislaw.com.

The list below identifies the potential qualifying requests for medical records produced via electronic means (i.e. CD or online portal):

Patient Name	Requestor Name	Request Date	Invoice Number	Number of Pages

TO BE COMPLETED BY A PATIENT SUBMITTING A CLAIM:

Patient Information

Full Name: _____

New Jersey Address: _____

Phone Number: _____

Email: _____

Qualifying Request(s)

Identify by Invoice Number any invoice from the above list where you paid Defendant's invoice.

Invoice Number(s): _____

SUPPORTING DOCUMENTATION REQUIRED: You must attach proof of your payment of Defendant's invoice.

Identify by Invoice Number any invoice from the above list where (1) your attorney requested and received medical records in the course of representing you (i.e. not a defense law firm or other law firm not acting on your behalf); and (2) you reimbursed your attorney for the payment of Defendant's invoice.

Invoice Number(s): _____

SUPPORTING DOCUMENTATION REQUIRED: If you reimbursed your attorney for the payment of the invoice, you must attach a statement, bill, invoice, or certification from the law firm confirming said reimbursement.

I, (*print your name*) _____, DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I AM A CITIZEN OF NEW JERSEY AND PAID OR REIMBURSED MY ATTORNEY FOR THE INVOICE(S) LISTED ABOVE.

Patient Signature

TO BE COMPLETED BY A LAW FIRM SUBMITTING CLAIM:

Law Firm Information

Name and Title of Person Completing Claim Form: _____

Name of Law Firm: _____

New Jersey Address: _____

Phone Number: _____

Email: _____

Qualifying Request(s)

Identify by Invoice Number any invoice from the above list where your law firm (1) requested and received in the course of representing the patient (i.e. not a defense law firm or other law firm not acting on behalf of the patient) the records pertaining to said invoice; (2) paid the invoice; and (3) was not reimbursed by the patient or through recovery, by any means (i.e. retainer, direct payment, deduction from settlement proceeds, or cost judgment), for the payment of the invoice.

Invoice Number(s): _____

SUPPORTING DOCUMENTATION REQUIRED: You must attach proof of your payment of Defendant's invoice.

I, (*print your name*) _____, DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I AM AUTHORIZED TO EXECUTE THIS CLAIM FORM ON BEHALF OF (*print law firm name*) _____, THAT MY LAW FIRM HAS A NEW JERSEY OFFICE, AND THAT MY FIRM HAS NOT BEEN REIMBURSED BY THE PATIENT OR THROUGH RECOVERY FOR THE INVOICE(S) LISTED ABOVE.

Signature