KNOWN CLAIM FORM FOR
Columbia United Providers Dissolution

Read Carefully Before Completing This Form

Please Print or Type

FOR COMPANY USE ONLY

DATE KNOWN
CLAIM RECEIVED _____

COLUMBIA UNITED PROVIDERS
KNOWN CLAIM # _____

Deadline for Filing Non-Medical Claims is September 6, 2016.

Please note: *If you are a* ***medical provider****, you are not required to complete this form to submit* ***medical claims*** *to Columbia United Providers. Medical providers should submit all remaining medical claims to Columbia United Providers, P.O. Box 87400, Vancouver, WA 98687 within the following timeframes: (a) timely filing is six months from date of service for contracted providers; (b) timely filing is twelve months from date of service for non-contracted providers and some specific contracted providers.*

Claimants

You have a claim if you know or believe that Columbia United Providers owes you money. To have your claim considered, your claim must be received by Columbia United Providers by no later than September 6, 2016. Failure to return this completed form will result in YOUR CLAIM BEING BARRED. ***You should complete this form if you believe you have an actual or potential claim against Columbia United Providers.*** **You are advised to retain a copy of this completed form for your records.**

1. Claimant's Name: _____

2. Claimant's Address: _____

_____

3. Claimant's Telephone Number, with area code: _____
Fax Number, with area code: _____
Email address: _____

4. Claimant's Social Security Number, Tax ID Number or Employer ID Number: _____

5. Claim is submitted by (check one):
____Medical Provider
____General Creditor
____Other. Describe in detail the nature of your claim:_____
_____

6. Indicate the total dollar amount of your claim. If you were a Columbia United Providers medical provider who rendered services, you must indicate a dollar amount. For all other creditors, if the amount of your claim is unknown, write the word "unknown."

$_____ (if claim is unknown, write the word "unknown").

Is there any set off, counterclaim or defense to your claim? If so, describe in detail:_____
_____
_____

7. If you are a claimant of Columbia United Providers and were not a Columbia United Providers medical provider, describe, in detail, the nature of your claim and the date your claim was incurred. Attach all relevant documentation in support of your claim:

_____
_____

9. **Print the name, address, telephone number and email address of the person who has completed this form.**

Name: _____
Address: _____
Telephone #: _____
Email address: _____

10. If represented by legal counsel, please supply the following information:

a. Name of attorney: _____
b. Name of law firm: _____
c. Address of law firm: _____
d. Attorney's telephone and fax number: _____
e. Attorney's email address: _____

11. Complete the following:

I, _____ (insert claimant's name) subscribe and affirm as true, under the penalty of perjury as follows: that I have read the foregoing known claim form and know the contents thereof, that this claim in the amount of _____ DOLLARS ($_____) against Columbia United Providers is justly owed, and that the matters set forth above or in any accompanying statements are true to the best of my knowledge and belief.

_____ _____
Claimant's signature Date

12. Return this completed Proof of Claim Form by **September 6, 2016 to:**

Known Claim Form
Columbia United Providers
P.O. Box 87400
Vancouver, WA 98687

You should complete this form if you believe you have an actual or potential claim against Columbia United Providers.