

CASE NAME:

CASE NUMBER:

**ADDITIONAL MEDICAL SERVICE PROVIDERS ATTACHMENT
TO PETITION FOR APPROVAL OF COMPROMISE OF CLAIM OR
ACTION OR DISPOSITION OF PROCEEDS OF JUDGMENT**

If you are using form MC-350 to petition for court approval of the compromise of a claim or action or the disposition of the proceeds of a judgment for a minor or person with a disability, you must provide complete information, in item 12b(5) of form MC-350, about any medical service providers that (1) have liens for payment of charges for medical services provided to the minor or person with a disability or (2) you paid (or will pay from the proceeds), for which payment you request reimbursement from the proceeds of the compromise or judgment. If you don't have enough room on form MC-350, you may use one or more copies of this form to provide the required information about additional medical service providers.

Attachment 12b(5) to form MC-350

12. b. (5) (b) Each medical service provider that furnished care and treatment to claimant and (1) has a lien for all or any part of the charges or (2) was paid (or will be paid from the proceeds) by petitioner, for which payment petitioner requests reimbursement; the amounts charged and paid; the amount of negotiated reductions of charges, if any; and the amount to be paid from the proceeds of the settlement or judgment to each provider are as follows:

____(A) Provider (name):
____(B) Address:

(C) Amount charged: \$ _____
(D) Amount paid (whether or not by insurance): (\$ _____)
(E) Negotiated reduction, if any: (\$ _____)
(F) Amount to be paid from proceeds of settlement or judgment: \$ _____

____(A) Provider (name):
____(B) Address:

(C) Amount charged: \$ _____
(D) Amount paid (whether or not by insurance): (\$ _____)
(E) Negotiated reduction, if any: (\$ _____)
(F) Amount to be paid from proceeds of settlement or judgment: \$ _____

____(A) Provider (name):
____(B) Address:

(C) Amount charged: \$ _____
(D) Amount paid (whether or not by insurance): (\$ _____)
(E) Negotiated reduction, if any: (\$ _____)
(F) Amount to be paid from proceeds of settlement or judgment: \$ _____

____(A) Provider (name):
____(B) Address:

(C) Amount charged: \$ _____
(D) Amount paid (whether or not by insurance): (\$ _____)
(E) Negotiated reduction, if any: (\$ _____)
(F) Amount to be paid from proceeds of settlement or judgment: \$ _____

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