BACK DOCTORS v. ALLSTATE - PROVIDER CLAIM FORM

COMPLETED FORM MUST BE POSTMARKED **NO LATER THAN _____, 2014**, AND MAILED TO:

Back Doctors v. Allstate Settlement Administrator
P.O. Box 2838
Portland, OR 97208-2838

Make Sure You Sign and Date this Claim Form. You must submit a separate Claim Form for each Allstate Insured/Claimant for whose treatment you are claiming your bills were reduced.

PRINT LEGIBLY

Name **(mandatory)**: _____

Mailing Address **(mandatory)**:
Street: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Tax Identification Number (**mandatory**): _____

Amount claimed (**mandatory**): _____ (please submit any supporting documentation as to the amount claimed).

Insured/Claimant/patient name (**mandatory**): _____
Insured/Claimant/patient's date of birth: _____
Insured/Claimant/patient's Social Security Number: _____
Date of Loss: _____ Claim No. _____

AFFIRMATION
(mandatory)

I swear under penalty of perjury under the laws of the State of Illinois that I have read the Notice and this Claim Form, and that I believe I am owed the above amount of money by Allstate pursuant to the terms of this Settlement.

Dated: _____, 2014 _____
Signature