

**IMPORTANT**  
**NOTICE TO PROVIDERS, EMPLOYER GROUPS, SUBSCRIBERS, MEMBERS,**  
**CREDITORS, ATTORNEYS AND OTHER INTERESTED PARTIES**

**LIQUIDATION OF AMCARE HEALTH PLANS OF LOUISIANA, INC.**  
**HEREINAFTER REFERRED TO AS ("AmCare Health Plans of Louisiana in Receivership")**

Docket Number 499-737 – Division D  
19<sup>th</sup> Judicial District Court, Parish of East Baton Rouge, State of Louisiana

**THIS NOTICE CONTAINS IMPORTANT INFORMATION**  
**WHICH AFFECTS YOUR LEGAL RIGHTS**

**IF YOU DO NOT UNDERSTAND THIS NOTICE, CONTACT YOUR INSURANCE AGENT, YOUR**  
**ATTORNEY, OR CALL THE PHONE NUMBER LISTED ON THE BACK OF THIS NOTICE.**

**AMCARE HEALTH PLANS OF LOUISIANA, INC. HAS BEEN PLACED INTO LIQUIDATION:**

On November 12, 2002, the heretofore-mentioned Court issued an Order of Liquidation for the company listed above. The Court has appointed Marlon Harrison as Receiver and has ordered him to take title and maintain possession and control of AmCare Health Plans of Louisiana in Receivership's assets, determine all claims against it, and otherwise administer its affairs under the supervision of the Court.

**CANCELLATION OF INSURANCE POLICIES:**

The Court, pursuant to an approved Plan of Rehabilitation, cancelled all Certificates of Coverage effective midnight September 30, 2002.

**RIGHT TO FILE A CLAIM:**

You have a right to make a claim for any monies that you believe are due you. All persons must file a Proof of Claim form to be entitled to any distribution of funds made by the Receiver. If you are not due monies from AmCare Health Plans of Louisiana in Receivership, there is no need to file the Proof of Claim Form.

**HOW TO FILE A CLAIM:**

You file a claim by filling out the Proof of Claim attached to this notice. Please attach copies of all necessary documents to substantiate your claim. Keep copies of all documents and correspondence sent to and from this office for your records. To receive additional claim forms, you may contact AmCare Health Plans of Louisiana in Receivership's office at 504-849-7700.

**WHEN TO FILE YOUR CLAIM:**

Your Proof of Claim must be completed in accordance with the instructions and must be **post-marked** on or before June 15, 2003. **To protect your rights, you must file your claim timely.**

**WHERE TO FILE YOUR CLAIM:**

You must mail, via the U. S. Postal Service, the Proof of Claim form to:

AmCare Health Plans of Louisiana in Receivership  
ATTENTION: PROOFS OF CLAIM DEPARTMENT  
P. O. BOX 5920  
METAIRIE, LOUISIANA 70009-5920

**(OVER)**

**CLAIM FILING AND ASSET DISTRIBUTION:**

The liability of AmCare Health Plans of Louisiana in Receivership shall be determined from all properly filed Proofs of Claim. The general assets of AmCare Health Plans of Louisiana in Receivership shall be distributed in accordance with priorities set by the laws of the State of Louisiana.

**FIXING OF RIGHTS AND LIABILITIES:**

All rights and liabilities of AmCare Health Plans of Louisiana in Receivership and of its creditors, except those holding contingent claims, and of its employer groups, subscribers or members and of all other persons interested in its assets shall, unless otherwise ordered by the Court, be fixed as of the date of entry of the Liquidation Order, November 12, 2002.

**ABATEMENT OF LEGAL PROCEEDINGS:**

The Louisiana Insurance Code, Title 22 LSA-R.S. 749(D)(5), and the Court's order, stay all suits and seizures against AmCare Health Plans of Louisiana in Receivership, its agents and its insureds, and prohibits the commencement or maintenance of any action or proceeding in the nature of an attachment, garnishment or execution against AmCare Health Plans of Louisiana in Receivership and its insureds. Attorneys are requested to advise appropriate courts of this Notice.

**FURTHER INFORMATION:**

If you want further information about AmCare Health Plans of Louisiana in Receivership, this legal notice or its effect you may wish to contact your attorney, your insurance agent or:

AmCare Health Plans of Louisiana in Receivership  
Attention: Proofs of Claim Department  
P. O. Box 5920  
Metairie, LA 70009-5920  
504-849-7700

If you would like a copy of the Liquidation Order, it may be downloaded from the Louisiana Department of Insurance website ([WWW.LDI.STATE.LA.US](http://WWW.LDI.STATE.LA.US)).

**THE DEADLINE FOR FILING YOUR PROOF OF CLAIM (completed  
in accordance with the instructions) IS JUNE 15, 2003**

For Receivership Office Use Only	POC#	For Receivership Office Use Only
Post Mark Date		Date Received

## PROOF OF CLAIM FORM

**Liquidation of AmCare Health Plans of Louisiana, Inc. ~~in~~ Receivership**

**POC #**

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### Section 1. Instructions:

1. Verify the information in Section 2 "General Information" is correct. Mark all changes in the space provided below.
2. Complete Section 3 "Claim Information" if you are a vendor, provider, employer group, subscriber, member, third party claimant, agent, payee on a note, or other creditor of AmCare Health Plans of Louisiana, Inc., and **you are still owed money**. (Copies of all supporting documentation such as invoices, statements, cancelled checks, HCFA 1500s, UB92s, or other claim forms are required to have a complete Proof of Claim.)
3. Complete Section 4 "Certification of Right to File Claim". The claimant's signature must be witnessed by 2 persons.
4. Complete Section 5 "Assignment of Claim" **ONLY** if you want to assign your claim. You may assign your refund or claim benefits to an attorney or other person or business. **This assignment must be notarized.**
5. **Note: All Proof of Claim forms must be completed according to instructions, mailed via the US Postal Service to the address below, and post-marked on or before June 15, 2003. You may lose your right to file a claim if you do not file timely.** Address to: **Proofs of Claims Department  
P.O. Box 5920  
Metairie, LA 70009-5920**
6. You may contact AmCare Health Plans of Louisiana in Receivership at 504-849-7700.

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### Section 2. General Information : (Name and address of Claimant)

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Tax ID #: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Day Time Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

#### General Information corrections may be submitted for the following:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_  
 Day Time Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

For Receivership Office Use Only	POC#	For Receivership Office Use Only
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**Section 3. Claim Information** (Information regarding money you are owed)

- | <u>Type of Claim</u>                          | <u>Amount of Claim</u> | <u>Circle One</u> |
|---|------------------------|-------------------|
| A. <input type="checkbox"/> Return of Premium | \$ _____               | Employer / Member |
| B. <input type="checkbox"/> Medical Claim     | \$ _____               | Provider / Member |
| C. <input type="checkbox"/> Commission        | \$ _____               | Agent / Broker    |
| D. <input type="checkbox"/> General Creditor  | \$ _____               | Attorney / Vendor |
| E. <input type="checkbox"/> Other _____       | \$ _____               |                   |

Total Amount Due to You:  
(Add lines A through E)

\$ _____ (To be filled out by ALL claimants)
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Briefly describe your claim. Continue the explanation on a separate sheet, if needed:

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**Section 4. Certification of Right to File Claims** (To be filled out by ALL claimants)

STATE OF: \_\_\_\_\_ PARISH/COUNTY OF: \_\_\_\_\_

I, \_\_\_\_\_, certify that I am the claimant or that I am authorized to make a claim on behalf of the claimant (you must attach a copy of the Power of Attorney if this form is not signed by the claimant), and that to the best of my knowledge and belief, the statements contained in this claim form are true and complete.

Witness \_\_\_\_\_

Signature of Claimant or Individual holding Power of Attorney

Witness

**Section 5. Assignment of Claim** (See Section 1 Instructions. This assignment must be notarized).

STATE OF: \_\_\_\_\_ PARISH/COUNTY OF: \_\_\_\_\_

I, \_\_\_\_\_, assign any and all monies to be paid by AmCare Health Plans of Louisiana in

Receivership to:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax: \_\_\_\_\_

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 2003.

Notary Public

Signature of Claimant or Individual holding Power of Attorney

**AmCare Health Plans of Louisiana in Receivership  
(Hereafter referred to as "AmCare LA")  
Proof of Claim (POC)  
Submission Guidelines  
and  
Frequently Asked Questions**

**A. Submission Guidelines:**

**To ensure your Proof of Claim (POC) form is properly completed, please follow these instructions:**

1) Completing the POC Form:

➤ Section 2: General Information

- ◆ Please review the information in this area very carefully to confirm our records. If this section contains incorrect information, please indicate the corrections that are needed.

➤ Section 3: Claim Information

- ◆ Please indicate the type of claim you are submitting.
- ◆ Please circle your claimant type.
- ◆ You must indicate the total amount due to you. If you do not know the exact amount due to you, please indicate an estimated amount.

➤ Section 4: Certification of Right to File Claims

- ◆ You must include the signature of claimant or individual holding Power of Attorney.
- ◆ You must obtain two witness signatures.
- ◆ Each POC form submission requires original signatures.

➤ Section 5: Assignment of Claim

- ◆ If you want someone other than yourself to receive any payments pursuant to your claim, you must complete this section.
- ◆ If this section of the POC form is completed, you must have your POC form notarized.
- ◆ If you do not wish for your payments to be paid to someone else, you do not have to complete this section and you do not need to have your POC form notarized.

2) The submission of your completed POC form must include your completed POC form, UB92s (when applicable), HCFA 1500s (when applicable) and all supporting documentation.

AmCare Health Plans of Louisiana members will need to obtain a copy of the UB92 and/or HCFA 1500 from the provider who rendered services for the claims you are submitting with your completed POC form.

3) If you have an adjustment request and/or appeals request for review, please include all supporting documentation with your claim and completed POC form submission.

4) POC forms and supporting documentation must be mailed via the U.S. Postal Service.

5) Please mail completed POC forms, UB92s, HCFA 1500s and all supporting documentation to:

AmCare Health Plans of Louisiana in Receivership  
Attention: Proofs of Claim Department  
P.O. Box 5920  
Metairie, LA 70009-5920

6) If you have questions, please visit the Louisiana Department of Insurance website at [www.ldi.state.la.us](http://www.ldi.state.la.us) or you may contact our Customer Service Department at (504) 849-7700.

## B. Frequently Asked Questions

**1) Do I have to send a Proof of Claim (POC) Form with every claim?**

- ◆ No, all of your claims may be included with one POC Form.
- ◆ **Initial POC Form Submission:** Only one (1) completed POC Form is required with each submission. All UB92s, HCFA 1500s and supporting documentation must be attached.
- ◆ **Additional POC Form Submission(s):** If after submitting your initial POC Form you choose to send subsequent submissions, you must complete another POC Form and send it to us with the UB92s, HCFA 1500s and supporting documentation for the additional POC submission.
- ◆ Please Note: All POC Forms must be mailed via the U. S. Postal Service.

**2) Can I make copies of the POC Form?**

Yes. You may make copies of the POC Form. All applicable sections of the POC Form must be completed with UB92s, HCFA 1500s and all supporting documentation attached when submitting to us for processing. All POCs submitted must have original signatures.

**3) Do I have to provide a total amount due to me from AmCare LA?**

Yes. In Section 3 of the POC Form, Claim Information, you are required to provide a total amount due to you from AmCare LA. If you do not know the exact amount due to you, please provide the best possible estimation.

**4) Do I have to obtain two witness signatures?**

- ◆ Yes, Section 4 of the POC Form, Certification of Right to File Claims, the claimant's signature and two (2) witness signatures are required.
- ◆ A POC Form received without required signatures cannot be processed by AmCare LA. The POC Form will be considered incomplete and will be returned to you for completion.

**5) Do I have to get my POC notarized before sending it to AmCare LA?**

- ◆ Only if you want someone else to receive any payments pursuant to your claim.
- ◆ Section 5 of the POC Form, Assignment of Claim, requires notarizing if you are assigning any and all monies paid by AmCare LA to another party. This means if you are submitting the POC Form and want the payment of any and all monies paid to someone other than yourself, you will need to have the POC Form notarized.
- ◆ If AmCare LA receives your POC Form and Section 5, Assignment of Claim is filled in but is not notarized, the POC Form will be considered incomplete and will be returned to you for completion.

**6) Can I fax my POC?**

No. All completed POCs with UB92s, HCFA 1500s and supporting documentation must be submitted via the U. S. Postal Service.

**7) Do I have to file a POC if I am not due monies from AmCare LA?**

No. The POC form should only be submitted if you believe you are due monies from AmCare LA.

**8) Do AmCare LA members employed by the State of Louisiana and providers who rendered care and services to AmCare LA State of Louisiana members need to submit a POC form?**

No. You do not need to submit a POC form. If you have questions regarding your claims, please contact FARA Benefits at (800) 427-4511.

**9) When is the last day that I can submit my POC Form?**

You should file your claim as soon as possible. Your completed POC form with UB92s, HCFA 1500s and all supporting documentation must be post-marked on or before June 15, 2003. To protect your rights, you must file your claim timely.

**10) How do I get additional copies of the POC Form?**

Please visit the Louisiana Department of Insurance website at [www.lidi.state.la.us](http://www.lidi.state.la.us) or you may contact Customer Service at 504-849-7700.

**11) Where do I mail my POC Form?**

Please mail completed POC Forms, UB92s, HCFA 1500s and supporting documentation to:

AmCare Health Plans of Louisiana in Receivership  
Attention: Proofs of Claim Department  
P.O. Box 5920  
Metairie, LA 70009-5920