



CONCUSSION SETTLEMENT

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION
No. 2:12-md-02323 (E.D. Pa.)

HEALTH CARE PROVIDER HISTORY FORM

I. RETIRED NFL FOOTBALL PLAYER INFORMATION

Settlement Program ID									
Player Name	First	M.I.	Last					Suffix	

II. HEALTH CARE PROVIDERS

Each Claimant shall disclose all of the Retired NFL Football Player's healthcare providers related to his Qualifying Diagnosis. This should include doctors' visits that did not lead to a Qualifying Diagnosis but which occurred within the Pertinent Time Period related to the Qualifying Diagnosis. The Pertinent Time Period starts at the earlier of (1) three years before the Qualifying Diagnosis or (2) the date of the first medical record submitted in support of the Qualifying Diagnosis. The Pertinent Time Period ends on the date a Claimant submits a claim. If you need more space, attach supplemental pages.

1.	Name:							
	Address:	Street						
		City	State	Zip Code	Phone			
	Specialty:							
	Date(s) of Service:							
	Who referred you to this Provider:							
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:	☐ Yes ☐ No						
2.	Name:							
	Address:	Street						
		City	State	Zip Code	Phone			
	Specialty:							
	Date(s) of Service:							
	Who referred you to this Provider:							
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:	☐ Yes ☐ No						

HEALTH CARE PROVIDER HISTORY FORM

3.	Name:				
	Address:	Street			
		City	State	Zip Code	Phone
	Specialty:				
	Date(s) of Service:				
	Who referred you to this Provider:				
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:			☐ Yes	☐ No

4.	Name:				
	Address:	Street			
		City	State	Zip Code	Phone
	Specialty:				
	Date(s) of Service:				
	Who referred you to this Provider:				
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:			☐ Yes	☐ No

5.	Name:				
	Address:	Street			
		City	State	Zip Code	Phone
	Specialty:				
	Date(s) of Service:				
	Who referred you to this Provider:				
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:			☐ Yes	☐ No

HEALTH CARE PROVIDER HISTORY FORM

6.	Name:				
	Address:	Street			
		City	State	Zip Code	Phone
	Specialty:				
	Date(s) of Service:				
	Who referred you to this Provider:				
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:			☐ Yes ☐ No	
7.	Name:				
	Address:	Street			
		City	State	Zip Code	Phone
	Specialty:				
	Date(s) of Service:				
	Who referred you to this Provider:				
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:			☐ Yes ☐ No	
8.	Name:				
	Address:	Street			
		City	State	Zip Code	Phone
	Specialty:				
	Date(s) of Service:				
	Who referred you to this Provider:				
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:			☐ Yes ☐ No	

HEALTH CARE PROVIDER HISTORY FORM

9.	Name:				
	Address:	Street			
		City	State	Zip Code	Phone
	Specialty:				
	Date(s) of Service:				
	Who referred you to this Provider:				
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:			☐ Yes ☐ No	

10.	Name:				
	Address:	Street			
		City	State	Zip Code	Phone
	Specialty:				
	Date(s) of Service:				
	Who referred you to this Provider:				
	Did your Attorney pay for all or part of this Provider's services, either directly or indirectly:			☐ Yes ☐ No	

III. SIGNATURE

By signing below, I declare under penalty of perjury, pursuant to 28 U.S.C. § 1746, that all information provided in this Healthcare Provider History Form is true and correct to the best of my knowledge, information and belief.

Signature				
Printed Name	First	M.I.	Last	Suffix

HEALTH CARE PROVIDER HISTORY FORM

IV. HOW TO SUBMIT THIS FORM

You can use your NFL Settlement Portal to submit this Form. If you do not use the Portal, submit your Form in one of the following ways:

By Mail:	NFL Concussion Settlement Claims Administrator P.O. Box 25369 Richmond, VA 23260
By Delivery:	NFL Concussion Settlement c/o BrownGreer PLC 250 Rocketts Way Richmond, VA 23231