

MONTHLY CARRIER REPORT ON MEDICARE SECONDARY PAYER SAVINGS

CARRIER NAME	NUMBER	STATE	REPORTING PERIOD (MO. & YR.)
--------------	--------	-------	------------------------------

	TOTAL (i)	WORKER'S COMP BLACK LUNG & VA (ii)	WORKING AGED (iii)	ESRD (iv)	AUTO/ NFLT (v)	DISABLED (vi)	LIABILITY (vii)
Unpaid (Cost Avoided) MSP Claims							
1. Number							
2. Dollar Value							
Full Recoveries							
3. Number							
4. Dollar Value							
Partial Recoveries							
5. Number							
6. Dollar Value							
Special Projects							
7. Number							
8. Dollar Value							
Totals							
9. Number (Lines 1+3+5+7)							
10. Dollar Value (Lines 2+4+6+8)							

REMARKS

SIGNATURE	TITLE	DATE
-----------	-------	------