FORM B10 (Official Form 10)(4/98)

United States Bankruptcy Court **District of Delaware**

PROOF OF CLAIM

Name of Debtor Women First Healthcae, Inc

Case Number 04-11278
Chapter 11

NOTE This form should not be used to make a claim for an administrative expense arising after the commencement of the case A request for payment of an administrative expense may be filed pursuant to 11 U S C sec 503

Name of Creditor (The person or entity to whom the debtor owes money or property)
TN Dept of TennCare

Name and addresses where notices should be sent
TN Dept of TennCare
c/o TN Atty General, Bankruptcy Div
PO Box 20207
Nashville, TN 37202-0207

☐ Check box if you are aware that any one else has filed a proof of claim relating to your claim Attach copy of statement giving particulars

☐ Check box if you have never received any notices from the bankruptcy court in this case

☐ Check box if the address differs from the address on the envelope sent to you by the court

RECD JUN 24 2004

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Account or other number by which creditor identifies debtor
13-3919601 Labeler Code 64248

Check here ☐ replaces ☐ amends if this claim a previously filed claim dated _____

1 Basis for Claim

☐ Goods sold
☐ Services performed
☐ Money loaned
☐ Personal injury/wrongful death
☐ Taxes
☐ Other [illegible]

☐ Additional Information

☐ Retiree benefits as defined in 11 U S C sec 1114(a)
☐ Wages salaries and compensations (Fill out below)
Your SS# ___-___-___
Unpaid compensation for services performed
from _____ (date) to _____ (date)

2 Date debt was incurred [illegible] 2003

3 If court judgment, date obtained

4 Total Amount of Claim at Time Case Filed **$ 447 67**

If all or part of your claim is secured or entitled to priority also complete Item 5 or 6 below
☐ Check this box if claim includes prepetition charges in addition to the principal amount of the claim Attach itemized statement of all additional charges

5 Secured Claim ** **$0 00**

☐ Check this box if your claim is secured by collateral (including a right of setoff)

Brief description of collateral
☐ Real Estate ☐ Motor Vehicle
☐ Other _____

Value of Collateral $_____

Amount of arrearage and other charges at time case filed included in secured claim above if any $ _____

****Upon notice and proof from debtor that part or all of this claim is unsecured by operation of 11 USC sec 506(a), creditor reserves the right to claim such unsecured portion as a priority claim under 11 USC sec 507(a)(8)**

6 Unsecured Priority Claim

☐ Check this box if you have an unsecured priority claim
Amount entitled to priority **$ 0 00**
Specify the priority of the claim

☐ Wages salaries or commissions (up to $4 300)* earned not more than 90 days before filing of the bankruptcy petition or cessation of the debtor s business whichever is earlier 11 U S C sec 507(a)(3)
☐ Contributions to an employee benefit plan 11 U S C sec 507(a)(4)
☐ Up to $1 950* of deposits toward purchase lease or rental of property or services for personal family or household use 11 U S C sec 507(a)(6)
☐ Alimony maintenance or support owed to a spouse former spouse or child 11 U S C sec 507(a)(7)
☐ Taxes or penalties of governmental units 11 U S C sec 507(a)(8)
☐ Other Specify applicable paragraph of 11 U S C sec 507(a)(____)

**Amounts are subject to adjustment on 4/1/98 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment*

7 Credits The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim

8 Supporting Documents *Attach copies of supporting documents* such as promissory notes purchase orders invoices itemized statements of running accounts contracts court judgments mortgages security agreements and evidence of perfection of lien DO NOT SEND ORIGINAL DOCUMENTS If the documents are not available explain If the documents are voluminous attach a summary

9 Date-Stamped Copy To receive an acknowledgement of the filing of your claim enclose a stamped self addressed envelope and copy of this proof of claim

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Women First Healthcare Inc
00026

Date
June 03, 2004

Sign and print the name and title if any of the creditor or other person authorized to file this claim (attach copy of power of attorney if any)

Gina Baker Hantel Assistant Attorney General

Penalty for presenting fraudulent claim Fine of up to $500 000 or imprisonment for up to 5 years or both 18 U S C sec 152 and 3571

STATE OF TENNESSEE
TENNESSEE DEPT OF HEALTH-MEDICAID AGENCY

SOURCE STATE AGENCIES
TARGET HCFA/MANUFACTURERS

TENNCARE/BHO DRUG REBATE INVOICE

OMB NO 0938-058
HCFA-R-144

MANUFACTURER WOMEN FIRST HEALTHCARE, INC
ADDRESS 1 5355 MIRA SORRENTO PLACE
ADDRESS 2
ADDRESS 3
CITY SAN DIEGO STATE CA ZIP 92121

STATE CODE TN INVOICE # 02040374
FOUTH QUARTER 2003 FF

NDC NUMBER	DRUG NAME	REBATE AMT PER UNIT	TOTAL UNITS REIMB.	TOTAL REBATE AMT. CLAIMED	NO OF SCRIPTS	TOTAL AMOUNT REIMB.	COR FLC
64248 0004 10	BACTRIM	0 000000	162 000	0 00	5	43 10	0
64248 0091 10	EQUAGESIC	0 000000	2,819 000	0 00	40	2,968 49	0
64248 0101 01	ORTHO-EST	0 000000	699 000	0 00	26	360 01	0
64248 0102 01	ORTHO-EST	0 000000	766 000	0 00	25	500 36	0
64248 0117 10	BACTRIM DS	0 856900	318 000	272 49	23	177 46	0
64248 0310 01	ESCLIM	0 000000	118 000	0 00	15	423 10	0
64248 0320 01	ESCLIM	1 205300	136 000	163 92	18	495 37	0
64248 0330 01	ESCLIM	0 000000	720 000	0 00	90	2,597 11	0
64248 0340 01	ESCLIM	0 351900	32 000	11 26	4	122 44	0
64248 0350 01	ESCLIM	0 000000	324 000	0 00	42	1,223 44	0
64248 0419 10	SYNALGOS-D	0 000000	768 000	0 00	18	924 31	0
64248 0419 12	SYNALGOS-D	0 000000	497 000	0 00	18	608 60	0
	MANUFACTURER TOTAL		7,359 000	X447 67 *	324	10,443 79	

* PLEASE REMIT THIS AMOUNT TO TENNESSEE DEPT OF HEALTH-MEDICAID AGENCY
ADDRESS 729 CHURCH STREET
NASHVILLE, TN 37247
ATTN SYBIL CREEKMORE - 1ST FLOOR

X written off due to bankruptcy
A.J.