Acute Care Hospital Settlement
c/o A.B. Data, Ltd.
PO Box 173034
Milwaukee, WI 53217

YOU MUST SUBMIT YOUR REGISTRATION FORM AND CLAIM FORM BY JULY 15, 2026

April 10. 2026

Submitting a Claim under the Acute Care Hospital Class Action Settlement Agreement

To make a Claim for benefits under the Acute Care Hospital Class Action Settlement Agreement reached in the litigation titled *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. David Sackler, et. al.*, No. 1:25-cv-01010 (the "Settlement"), a representative from your Acute Care Hospital must fill out the attached Registration Form and submit it via email to Sacklerinfo@acutecarehospitalsettlement.com no later than July 15, 2026.[1] Upon registration, a secure file transfer protocol ("SFTP") link will be provided for you to submit the attached Claim Form and any supporting documentation. Claim Form and documentation submissions must be completed no later than July 15, 2026. Each Acute Care Hospital making a Claim must submit a separate Registration Form and Claim Form. You may obtain extra copies of all forms at www.acutecarehospitalsettlement.com. Your Allocated Amount for each Settlement will be determined in accordance with the Plan of Allocation, available at www.acutecarehospitalsettlement.com.

Deadline: If you do not complete and submit your Registration and Claim Forms by 5:00 p.m. Central Prevailing Time on July 15, 2026, your Claim will be rejected and you will be precluded from receiving an Allocated Amount under the Acute Care Hospital Class Action Settlement Agreement. Do not send your Registration Form or Claim Form to the Court or to anyone other than the Notice and Claims Administrators.

Capitalized terms not otherwise defined shall have the meaning ascribed to them in the Acute Care Hospital Class Action Settlement Agreement in *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. David Sackler, et. al.*, No. 1:25-cv-01010, available at www.acutecarehospitalsettlement.com.

Class Members submitting Claims may be contacted by representatives of Class Counsel or the Notice and Claims Administrators for additional information regarding the Class Member's Claims.

A Class Member must do each of the following, according to the guidelines set forth below:

1. Complete the Registration Form electronically, which is a fillable PDF that can be downloaded from www.acutecarehospitalsettlement.com and must be emailed to Sacklerinfo@acutecarehospitalsettlement.com;

[1] Unless you opt for a "Quick Pay" Amount instead of an Allocated Amount, you are advised to submit the Registration Form in advance of the July 15, 2026 deadline to allow sufficient time for submission of all other required documents and information required to process your Claim.

If the "Quick Pay" option is selected on the Registration Form in Section E, a completed IRS Form W-9 (or IRS Form W-8, if applicable), which is a fillable PDF that can be downloaded from www.acutecarehospitalsettlement.com must also be emailed to Sacklerinfo@acutecarehospitalsettlement.com with the Registration Form. If the "Quick Pay" option is **NOT** selected, a Class Member must complete the steps outlined in Items 3-6 below;

2. Once the Registration Form is received, the Notice and Claims Administrators will communicate instructions to you for accessing an SFTP;

3. Complete the Business Associate and Confidentiality Agreement (the "BAA") electronically, which is a fillable PDF that can be downloaded from www.acutecarehospitalsettlement.com, and submit it via SFTP;

4. The Notice and Claims Administrators will provide you with an executed BAA via the SFTP to download for your records;

5. Complete the Claim Form, as applicable, electronically, which is a fillable PDF that can be downloaded from www.acutecarehospitalsettlement.com; and

6. Submit the completed Claim Form with all supporting documents and information requested therein, along with the requisite claims data as described in Section F.8 of the Claim Form, via SFTP.

PLEASE NOTE THAT THE BAA, CLAIM FORM, AND ACCOMPANYING CLAIMS DATA ABOVE SHALL NOT BE SUBMITTED VIA EMAIL. Instead, by submitting the Registration Form described in Item 1 above, you will receive instructions for accessing an SFTP to which the BAA, the Claim Form, and accompanying requisite claims data must be submitted.

IT IS IMPORTANT THAT YOU ANSWER ALL QUESTIONS FULLY AND ACCURATELY. FAILURE TO PROVIDE THE REQUESTED INFORMATION, DATA, AND/OR DOCUMENTATION BY THE DEADLINE WILL CAUSE YOUR CLAIM TO BE REJECTED AND YOUR ACUTE CARE HOSPITAL WILL BE PRECLUDED FROM RECEIVING AN ALLOCATED AMOUNT.

If you are an Acute Care Hospital that treated patients diagnosed with opioid use disorder and/or other opioid-related conditions, you may receive a payment from up to $174.2 million in a class action settlement.

Records show that you may qualify for a payment from the proposed settlement ("Settlement") in a class action lawsuit. The lawsuit alleges, among other things, that to sell as many prescription opioids as possible, the Settling Defendants and opioid manufacturers misrepresented the risks and safety of prescription opioid use, and conspired with others to promote their improper use, including distributors who did not properly monitor, stop, or report suspicious orders, and pharmacies who filled opioid prescriptions that were not written for legitimate medical purposes. The lawsuit further alleges that as a result, acute care hospitals must now spend additional money and resources to treat opioid-dependent patients and patients with opioid-related conditions that they would not have had to treat otherwise. The Settlement totals up to $174,215,320.82 and would resolve all claims with the Settling Defendants. Settling Defendants deny any wrongdoing.

Who is included?

Generally, you are included if you are an Acute Care Hospital in the United States that: (i) is not owned or operated by a federal, state, county, parish, city, or other municipal government; (ii) treated patients diagnosed with opioid use disorder and/or other opioid-related conditions at any time from January 1, 2009, through March 20, 2026; and (iii) is not a physician practice group. Any Acute Care Hospital whose Released Claims were released by any other settlement with Settling Defendants is excluded from the Class.

What do the Settlements provide?

The Settlement will provide up to $174,215,320.82 to pay money to Qualifying Class Members, attorneys' fees and expenses, notice and administrative costs, claims administration costs and expenses, and taxes and tax expenses.

How can I get a payment?

To make a claim for a payment from the Settlement Funds, you must submit a Registration Form and may submit a Claim Form. The deadline to submit these forms is **July 15, 2026**. These forms and the Plan of Allocation are available at www.acutecarehospitalsettlement.com.

How much will my payment be?

The amount of your payment will be based on the proposed Plan of Allocation and the option you select.

- If you select the "Quick Pay" option: You do not have to fill out a Claim Form or provide claims data, and, after an eligibility determination, you will get a $5,000 payment under the Settlement.

- If you do not select the "Quick Pay" option: You must submit a Business Associate and Confidentiality Agreement, a Claim Form and supporting claims data. You will receive an Allocated Amount for damages based on a formula detailed in the Plan of Allocation. This Allocated Amount will be, at minimum, as much as the Quick Pay amount.

What are my rights?

Even if you do nothing, you will be bound by the Court's decisions. If you want to keep your right to sue the Defendants yourself, you must exclude yourself by **May 26, 2026**. If you do not exclude yourself, you may object to the Settlement, the Plan of Allocation, and/or requests for attorneys' fees and expenses by **May 26, 2026**. Detailed instructions about how to act on your rights are available at www.acutecarehospitalsettlement.com.

The Court will hold a hearing on **July 15, 2026**, to consider if it will approve the Settlement, Plan of Allocation, and a request for reimbursement of litigation expenses and for attorneys' fees of up to one-third of the Settlement Funds. You or your own lawyer may appear and speak at the hearing at your own expense.

1-877-354-3788 **www.acutecarehospitalsettlement.com**

SACKLER PARTIES CLAIM REGISTRATION FORM / "QUICK PAY" ELECTION FORM

Claim Registration Form / "Quick Pay" Election Form Deadline (the "Registration Form Deadline"): Wednesday, July 15, 2026

Please provide the following information to the Notice and Claims Administrators by completing this Claim Registration Form (the "Registration Form") and emailing it to Sacklerinfo@acutecarehospitalsettlement.com prior to completing the Claim Form. Capitalized terms not otherwise defined shall have the meanings ascribed to them in the Class Action Settlement Agreement[1] by and between the Settling Defendants and Acute Care Hospitals (the "Settlement Agreement") in *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. Sackler Parties, et al.*, Case No. 1:25-cv-01010 (D.N.M.), ECF No. 18-2, available on the settlement website at www.acutecarehospitalsettlement.com. Each entity making a Claim ("Claimant") must submit a separate Registration Form.

To be eligible to make a Claim, the Claimant must fall within the following category: Claimant is an Acute Care Hospital in the United States that (i) treated patients diagnosed with opioid use disorder and/or other opioid-related conditions at any time from January 1, 2009, through March 20, 2026; (ii) is not owned or operated by a federal, state, county, parish, city, or other municipal government; and (iii) is not a physician practice group. To be considered an Acute Care Hospital under the Settlement Agreement, Claimant must (a) provide medical care and other related services for surgery, acute medical conditions or injuries for a period of treatment time that is, on average, less than 25 days; and (b) (i) appear as either active or inactive under its current or former name, including any hospital that has changed its name through merger, acquisition, or any other change to its corporate form, in the American Hospital Directory® as a "short term acute care" hospital or a "critical access" hospital, and (ii) have an emergency department that is subject to the Emergency Medical Treatment and Labor Act ("EMTALA").

A Claimant is ineligible for recovery under the Settlement Agreement if any of its Released Claims were released in any other settlement with the Settling Defendant(s) that are party to the Settlement Agreement.

A Claimant that submits a Registration Form or Claim Form may be contacted by representatives of Class Counsel or by the Notice and Claims Administrators for additional information regarding the Class Member's Claims.

The Claim Deadline is 5:00 p.m. Central Prevailing Time Wednesday, July 15, 2026. **HOWEVER, unless you are electing to receive a "Quick Pay Amount", you should submit this Registration Form in advance of the Registration Form Deadline on Wednesday, July 15, 2026 to allow sufficient time for submission of all other required documents and information required to process your Claim.** Your Claim will be rejected and you will be precluded from receiving an Allocated Amount by the Settlement Agreement if this Registration Form is not received by the Registration Form Deadline. Do not send your Registration Form and Claim Form to the Court or to anyone other than the Notice and Claims Administrators.

[1] A complete copy of the Settlement Agreement is available at www.acutecarehospitalsettlement.com.

A person who files a fraudulent Claim on behalf of a Class Member may, at a minimum, be fined up to $500,000.00, imprisoned for up to five years, or both, in accordance with 18 U.S.C. §§ 152, 157. Class Members shall provide the information requested that is, to the best of their knowledge, current and valid as of the date this Registration Form is completed and delivered to the Notice and Claims Administrators.

A. Claimant Information

Please provide the information in Section A.1 for the operating entity that owns one or more hospitals/facilities ("Operating Entity").

1. Operating Entity

1. Name of Operating Entity:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Federal Employer Identification Number of Operating Entity:	_____ - _____		

2. Acute Care Hospital Information

Please provide the information in Section A.2 for the Acute Care Hospital owned and/or operated by the above referenced Claimant in Section A.1 for which the Claim is filed.

1. Name of Acute Care Hospital:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. a) Ownership (Check the one that applies):	Current Owner ☐	Former Owner ☐	
b) Duration of Ownership:	Date Acquired/Opened / /	Date Sold/Closed / /	

4. If the Acute Care Hospital listed in Section A.2 timely filed a Claim to the Notice and Claims Administrators in the San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. Johnson & Johnson, et al., Case No. 1:23-cv-00903-KWR-JFR in the United States District Court for the District of New Mexico, please provide that four or five digit Claimant Number:_____

B. Contact Information

Please provide the information in Section B where notices should be sent:

<table>
<tr><td>1. Contact Name:</td><td colspan="3"></td></tr>
<tr><td>2. Contact Title:</td><td colspan="3"></td></tr>
<tr><td rowspan="3">3. Address:</td><td colspan="3">Street Address Line 1</td></tr>
<tr><td colspan="3">Street Address Line 2</td></tr>
<tr><td>City</td><td>State:</td><td>Zip:</td></tr>
<tr><td>4. Phone:</td><td colspan="3">( ) –</td></tr>
<tr><td>5. Email:</td><td colspan="3"></td></tr>
<tr><td colspan="4">By filling out this Registration Form, you are deemed to consent to receipt of this notice by email.</td></tr>
</table>

For promptness and accuracy, we prefer to contact you by email and will do so if possible. Accordingly, please provide your email address. If necessary, we may also contact you by phone or by U.S. mail.

C. Attorney Information

1. Is your Acute Care Hospital submitting this Registration Form with the assistance of an attorney?

   Yes ☐
   No ☐

If yes, please provide the following information:

1. Attorney Contact Name:			
2. Law Firm Name:			
3. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
4. Phone:	( ) -		
5. Email:			
By filling out this Registration Form, you are deemed to consent to receipt of this notice by email.			

2. Do you want any potential payment mailed to your attorney?

   Yes ☐
   No ☐

D. Aggregator Information

1. Is your Acute Care Hospital submitting this Registration Form with the assistance of an aggregator?

Yes ☐
No ☐

If yes, please provide the following information:

1. Aggregator Contact Name:			
2. Company Name:			
3. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
4. Phone:	( ) -		
5. Email:			
By filling out this Registration Form, you are deemed to consent to receipt of this notice by email.			

E. Calculation of Allocated Amount and Quick Pay Election

The Class Action Settlement Agreement by and between the Settling Defendants and Acute Care Hospitals provides benefits to certain Claimants who can establish "Eligible Damages," and allocates available settlement funds to Qualifying Class Members ("Allocated Amount"). A copy of the Settlement Agreement and Plan of Allocation may be found at www.acutecarehospitalsettlement.com. To determine your Allocated Amount under the Settlement Agreement, you must submit Claims data. For purposes of the Settlement, you, as a Class Member, are eligible for an Allocated Amount if you are a Qualified Class Member that treated patients with OUD and/or other opioid-related conditions and, as a result of that care, you suffered identifiable operational losses reflected in your Claims data, including losses reflected in the charges to payments ratio for various treatment codes.

If you do not wish to complete a Claim Form and submit the data necessary to calculate an Allocated Amount, you may elect to receive your "Quick Pay Amount" instead. Subject to the Plan of Allocation, the Quick Pay Amount is $5,000 and will be disbursed as promptly as practicable after the Class Settlement Effective Date. Any eligible Class Member may elect to receive their Quick Pay Amount by answering the questions below:

1. **Do you agree to be bound by the terms of the Class Action Settlement Agreement and to participate in the Quick Pay option?**

   ☐Yes ☐No

   If yes, please sign, verify below and complete the IRS Form W-9 (or IRS Form W-8, if applicable), which is a fillable PDF that can be downloaded from www.acutecarehospitalsettlement.com, and return it with this Registration Form for the Claimant identified in Section A above. The entity name and the EIN number noted in the W-9 (or W-8, if applicable) must match the Operating Entity Name and EIN noted in Section A.1 above:

I, _____, am authorized on behalf of _____ , ("Participant") to elect to participate in the "Quick Pay" option under the Plan of Allocation. By completing this "Quick Pay" box and signing my name, I understand that the Participant waives any objection to the Class Action Settlement Agreement, requests payment of the Quick Pay Amount of $5,000, and that the Participant will be ineligible for any further Allocated Amount under the Settlement Agreement.

☐I direct and authorize the Notice and Claims Administrators to process the Participant's Claim as a "Quick Pay" for the Participant to receive its Quick Pay Amount under the Plan of Allocation. Payment checks will be mailed to the law firm identified in Section C of this Claim Form if Yes was selected in Section C.2. If not working with an attorney or if No was selected in Section C.2, the check will be mailed to the contact person identified in Section B.

Signed: _____

Printed Name:_____

Printed Title:_____

F. Supporting Documentation

Important notices regarding submission to the jurisdiction of the Court in New Mexico

By the filing of this Registration Form, you hereby submit to the jurisdiction of the United States District Court, for the District of New Mexico for the purposes of this Claim.

Verification of Properly Submitted Claim

The benefits provided by the Class Action Settlement Agreement by and between the Settling Defendants and Acute Care Hospitals are for the operational losses to Class Members resulting from providing treatment to individuals with substance use disorder, opioid use disorder, or other opioid-related conditions. By submitting this Registration Form, you verify that other than what you disclosed in this Registration Form, you have not otherwise been reimbursed or compensated by the Settling Defendants for the costs and expenses you are seeking.

By submitting this Registration Form, you verify, under oath and penalty of perjury, that, to the best of your knowledge, all the damages for which you seek benefits in this Registration Form relate to your provision of medical treatment in an emergency department, inpatient, or outpatient setting at an Acute Care Hospital.

G. Certification

I certify that I am authorized to sign this Registration Form, and I understand that an authorized signature on this Registration Form serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I certify that the Settlement Class Member has authority to release all Released Claims as identified in the Settlement Agreement on behalf of itself and all other entities who are Releasors by virtue of their relationship or association with it.

I certify that the Settlement Class Member I am submitting this Registration Form on behalf of is eligible to receive funds under the Settlement Agreement.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Your typed signature and submission of this Registration Form will have the same force and effect as if you signed the Registration Form on paper, which you may do alternatively.

Signature: _____

Executed on date (MM/DD/YYYY): _____

Print the name of the person who is completing and signing this Claim.

Name (First Middle Last): _____

Title: _____

Acute Care Hospital: _____

Address: _____

_____

_____

Contact Phone: _____

Email: _____

172316409v3

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

SACKLER PARTIES CLAIM FORM

Claim Deadline: Wednesday, July 15, 2026

Please read the instructions carefully before filling out this Claim Form (this "Claim Form"). Capitalized terms not otherwise defined shall have the meanings ascribed to them in the Class Action Settlement Agreement (the "Settlement Agreement") by and between the Settling Defendants and Acute Care Hospitals in *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. David Sackler, et al.*, Case No. 1:25-cv-01010 (D.N.M.), ECF No. 18-2, available on the settlement website at www.acutecarehospitalsettlement.com. Each entity making a Claim ("Claimant") must submit a separate Claim Form.

To be eligible to make a Claim, the Claimant must fall within the following category: Claimant is an Acute Care Hospital in the United States that (i) treated patients diagnosed with opioid use disorder and/or other opioid-related conditions at any time from January 1, 2009, through March 20, 2026; (ii) is not owned or operated by a federal, state, county, parish, city, or other municipal government; and (iii) is not a physician practice group. To be considered an Acute Care Hospital under the Settlement Agreement, Claimant must (a) provide medical care and other related services for surgery, acute medical conditions or injuries for a period of treatment time that is, on average, less than 25 days; and (b) (i) appear as either active or inactive under its current or former name, including any hospital that has changed its name through merger, acquisition, or any other change to its corporate form, in the American Hospital Directory® as a "short term acute care" hospital or a "critical access" hospital, and (ii) have an emergency department that is subject to the Emergency Medical Treatment and Labor Act ("EMTALA").

A Claimant is ineligible for recovery under the Settlement Agreement if any of its Released Claims were released in any other settlement with the Settling Defendant(s) that are party to the Settlement Agreement.

A Claimant that submits a Registration Form or Claim Form may be contacted by representatives of Class Counsel or by the Notice and Claims Administrators for additional information regarding the Class Member's claims.

The submission of this Claim Form by the Claim Deadline of 5:00 p.m., Central Prevailing Time, on Wednesday, July 15, 2026 (the "Claim Deadline") is a prerequisite to eligibility for an Allocated Amount but does not guarantee that a Class Member will be deemed eligible to receive an Allocated Amount. If a Class Member is deemed eligible to receive an Allocated Amount, the information provided in this Claim Form will be used to determine each such Allocated Amount. Class Members may redact information on this Claim Form or any attached documents as they deem necessary, although redactions may impact the Notice and Claims Administrators' determinations as to eligibility or the Allocated Amount. A Class Member shall only submit through the Secure File Transfer Protocol ("SFTP") link *copies* of any documents that support a Claim and shall not mail or transmit hard copies or original documents; documents submitted may be destroyed after scanning and will not be returned to the Class Member.

A person who files a fraudulent claim on behalf of a Class Member may, at a minimum, be fined up to $500,000.00, imprisoned for up to five years, or both, in accordance with 18 U.S.C. §§ 152, 157. Class Members shall provide the information requested that is, to the best of their knowledge, current and valid as of the date this Claim Form is completed and delivered to the Notice and Claims Administrators.

Please provide the following information to the Notice and Claims Administrators by delivering this completed Claim Form by SFTP according to the instructions that will be provided to you once you register prior to the Claim Form Deadline set forth on page 1 of this Claim Form.

Failure to submit a completed copy of this Claim Form and Requisite Claims Data (as described in Item F.8) herein by the Claim Deadline set forth on page 1 of this Claim Form may disqualify you from receiving an Allocated Amount. Additionally, failure to complete any portion of the Claim Form or to provide Requisite Claims Data (as described herein) may result in a reduced Allocated Amount or disqualification from receiving an Allocated Amount.

A. Claimant Information

Please provide the information in Section A.1 for the operating entity that owns one or more hospitals/facilities ("Operating Entity").

1. Operating Entity

1. Name of Operating Entity:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Federal Employer Identification Number of Operating Entity:	_____ - _____		
4. Claim Number: If you received a Claim Number after you completed your Registration Form, please provide that six-digit Claim Number.	_____		

2. Acute Care Hospital Information

Please provide the information in Section A.2 for the Acute Care Hospital owned and/or operated by the above referenced Claimant in Section A.1 for which the Claim is filed.

1. Name of Acute Care Hospital:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Number of Staffed Beds[1]:			

B. Contact Information

Please provide the information in Section B where notices should be sent:

1. Contact Name:			
2. Contact Title:			
3. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State:	Zip:
4. Phone:			
5. Email:			
By filling out this Claim Form, you are deemed to consent to receipt of this notice by email.			

For promptness and accuracy, we prefer to contact you by email and will do so if possible. Accordingly, please provide your email address. If necessary, we may also contact you by phone or by U.S. mail.

[1] The number of beds reported from a hospital's most recent Medicare cost report (W/S S-3, Part I, line 7 column 2). Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long-term, or domiciliary areas of the hospital. Beds in labor room, birthing room, post-anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes."

C. Attorney Information

1. Is your Acute Care Hospital submitting this Claim Form with the assistance of an attorney?

Yes ☐
No ☐

If yes, please provide the following information:

<table>
<tr><td>1. Attorney Contact Name:</td><td colspan="3"></td></tr>
<tr><td>2. Law Firm Name:</td><td colspan="3"></td></tr>
<tr><td rowspan="3">3. Address:</td><td colspan="3">Street Address Line 1</td></tr>
<tr><td colspan="3">Street Address Line 2</td></tr>
<tr><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td>4. Phone:</td><td colspan="3"></td></tr>
<tr><td>5. Email:</td><td colspan="3"></td></tr>
<tr><td colspan="4">By filling out this Claim Form, you are deemed to consent to receipt of this notice by email.</td></tr>
</table>

2. Do you want any potential payment mailed to your attorney?

Yes ☐
No ☐

D. Aggregator Information

1. Is your Acute Care Hospital submitting this Claim Form with the assistance of an aggregator?

☐ Yes ☐ No

If yes, please provide the following information:

1. Aggregator Contact Name:			
2. Company Name:			
3. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
4. Phone:			
5. Email:			
By filling out this Claim Form, you are deemed to consent to receipt of this notice by email.			

E. Payment Information

Payment checks will be mailed to the law firm identified in Section C of this Claim Form if Yes was selected in Section C.2. If working with an aggregator, the check will be mailed to the Operating Entity identified in Section A.1 above. If not working with an attorney or an aggregator, or if No was selected in Section C.2, the check will be mailed to the contact person identified in Section B of this Claim Form.

F. Additional information for Claimants seeking an Allocated Amount (non-Quick-Pay option)

If you wish to claim an Allocated Amount on the basis of a calculated amount, and not the Quick-Pay option as defined in the Registration Form and Plan of Allocation, you must complete this Section F, including all of the data identified in Item F.8 below.[2] **Failure to provide claims data for the entire time period from January 1, 2015 through December 31, 2020 may result in a reduction in Operational Impact, as defined in the Plan of Allocation.**

1. Are you a named plaintiff in any active cause of action against the Settling Defendants, and/or their alleged co-conspirators, as specified in the Complaint? ☐ Yes ☐ No

    a. If yes, please provide whether the active cause of action is filed (check one):

        i. in the Multidistrict Litigation, Case No. 1:17-md-2804: ☐

        ii. in state court: ☐

    b. If yes, attach a copy of the most recently filed complaint.

2. Is the hospital/facility listed above an Acute Care Hospital in the United States that treated patients diagnosed with opioid use disorder and/or other opioid-related conditions from January 1, 2009, through March 20, 2026, is not owned or operated by a federal, state, county, parish, city, or other municipal government and not a physician practice group that (i) provides medical care and other related services for surgery, acute medical conditions, or injuries for a period of treatment time that is, on average, less than 25 days; and (ii) (a) appear as active or inactive under its current or former name, including any hospital that has changed its name through merger, acquisition, or any other change to its corporate form, in the American Hospital Directory® as a "short term acute care" hospital or a "critical access" hospital, and (b) includes an emergency department that is subject to the Emergency Medical Treatment and Labor Act ("EMTALA");

    ☐ Yes ☐ No

3. Has the Acute Care Hospital listed above hosted experts' visits at the Acute Care Hospital for the purpose of enabling the experts to engage with hospital personnel on the opioid epidemic at the hospital, and to review hospital policies, procedures, and programs regarding opioids? ☐ Yes ☐ No

[2] The Notice and Claims Administrators and the Special Master shall have complete discretion to determine whether a Claimant has complied with this requirement.

4. Has the Acute Care Hospital listed above produced claims data (as described in Item 8 below herein) to the Settling Defendants and/or their alleged co-conspirators, as specified in the Complaint, for the cause of action noted in Item 1a) above?
☐ Yes ☐ No

5. Has the Acute Care Hospital listed above actively engaged in discovery, for the cause of action, if any, noted in Item F1.a above? ☐ Yes ☐ No

   If yes, please indicate below those activities in which the Acute Care Hospital has actively engaged[3]:

   a. Responded to interrogatories and requests for production and requests for admissions?
   ☐ Yes ☐ No

   b. Supplied hospital financial documents, policies and procedures, custodial emails, dispensing and discharge prescription data in response to requests by Settling Defendants and/or their alleged co-conspirators, as specified in the Complaint, or orders of a court? ☐ Yes ☐ No

   c. Provided 30(b)(6) and/or fact witness testimony? ☐ Yes ☐ No

   d. Propounded discovery to Settling Defendants and/or their alleged co-conspirators, as specified in the Complaint?
   ☐ Yes ☐ No

   e. Formally disclosed expert opinions consistent with federal and/or state court rules?
   ☐ Yes ☐ No

   f. Engaged in motion practice before a court and/or a special master?
   ☐ Yes ☐ No

6. Did the Acute Care Hospital listed above have a court-ordered trial date, for the cause of action, if any, noted in Item F1.a above?

   ☐ Yes ☐ No

   If yes, please enter the court ordered trial date: _____

[3] To receive the 5% weight for this participation factor, the Acute Care Hospital must have participated in at least three of the six identified activities.

7. Did the Acute Care Hospital listed in Section A.2 timely file a claim to the Notice and Claims Administrators in the *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. Johnson & Johnson, et al*., Case No. 1:23-cv-00903-KWR-JFR in the United States District Court for the District of New Mexico?

☐ Yes ☐ No

   a. If Yes, to the best of your knowledge, (a) did you provide all of the Requisite Claims Data from January 1, 2015 through December 31, 2020, (b) were you approved for an Allocated Amount, and (c) do you wish to utilize the Requisite Claims Data previously provided for this Claim and the Acute Care Hospital noted in Section A.2 above?

   ☐ Yes ☐ No

      i. If Yes, then proceed to Item F.9.

      ii. If No to Item F.7 or F.7.a, then proceed to Item F.8.

8. For all inpatient and outpatient discharges during the period January 1, 2015 through December 31, 2020, from the Acute Care Hospital listed in Section A.2 above, please provide the following data in CSV (Comma Delimited) Electronic File or Pipe-Delimited Electronic Text File to be used in connection with the determination of the Allocated Amount. **An example of the data formatting is set forth in Exhibit A**. **This data should be in a separate CSV (Comma Delimited) Electronic File or Pipe-Delimited Electronic Text File for each Acute Care Hospital**. Physician office visits and non-acute care visits should **NOT** be included in data provided.

   For the CSV (Comma Delimited) Electronic File or Pipe-Delimited Electronic Text File, please include in the file name the Name of the Acute Care Hospital, City and State where located and Date Range of Data Provided, for example, PhoenixGeneral-Phoenix-AZ-Jan09-Dec12.csv. If more than one file is provided due to size limitations, each file name will be the same with only the date range of the data provided changing (e.g., PhoenixGeneral-Phoenix-AZ-Jan13-Dec20.csv).

   It is important to note, and as further described below, that the following data for each visit/discharge will need to be repeated on each row corresponding to each different ICD diagnosis code (except for ICD diagnosis code, ICD diagnosis code description and ICD diagnosis code priority). The data for the ICD diagnosis codes, ICD diagnosis code descriptions and ICD diagnosis code priority for each visit/discharge will therefore be unique to each row. For example, if a visit has 18 ICD diagnosis codes, there would be 18 rows/lines for that visit/discharge with each line containing a different ICD diagnosis code, ICD diagnosis code description and ICD diagnosis code priority. For all other data fields such as Patient Medical Record Number, Date of Discharge, etc. this data will be the same, and thus repeated, on all 18 rows/lines for that visit/discharge.

To the extent the qualifying Acute Care Hospital utilizes a coding system for any columns/data fields, please provide an index to explain the contents of any column/data field to the secure portal provided by the Notice and Claims Administrators. For example, the Patient Type data provided includes a 1, 2, or 3 and these respective contents are 1=Inpatient, 2=Outpatient, and 3=Emergency.

If sending the requested data in a CSV (Comma Delimited) Electronic File, please also ensure that all columns/data fields that may contain commas are updated so that such columns/data fields are placed in quotations when populating the CSV or Pipe-Delimited Electronic Text File. The columns/data fields that often contain commas include, but are not limited to, Attending Physician Name, DRG and ICD Diagnosis Code Descriptions.

Once the CSV (Comma Delimited) or Pipe-Delimited Electronic Text File is prepared, **please review the data VERY CAREFULLY** to confirm the data in each column contains the applicable data for that respective column's data field description. For example, payment amounts (Total Payments) should not be shown in the DRG Code column/data field or ICD Diagnosis Code column/data field should not be blank or designated null for a patient visit without an explanation, etc. In conducting your review, this will require that you "reality test" your data before submission to ensure that it does not contain obvious errors and inconsistencies. **After submission of the Registration Form, each Class Member will be provided a secure portal (SFTP) by the Notice and Claims Administrators to upload an executed BAA (as described in Section F.9 of this Claim Form), and then upload this Requisite Claims Data to the SFTP.**

Column	Data Fields	Definitions and Clarifications
a.	**Name**	Name of hospital/facility for which data is provided.
b.	**Address**	Address of hospital/facility for which data is provided.
c.	**City**	City of hospital/facility for which data is provided.
d.	**State**	State of hospital/facility for which data is provided.
e.	**Zip Code**	Zip Code of hospital/facility for which data is provided.
f.	**CMS Certification Number**	Center for Medicare & Medicaid Services Certification Number – Formerly known as the Medicare Provider Number. This should be a six-digit Medicare certification number for which the data is provided.
g.	**Patient Medical Record #**	
h.	**Patient Account #**	
i.	**Payor Financial Class**	e.g., Blue Cross, Medicaid, Private Pay, etc.

Column	Data Fields	Definitions and Clarifications
	Description	
j.	**Patient Type**	e.g., Inpatient or Outpatient. Hospital-related clinics or physician office visits should NOT be included in data provided.
k.	**Custom Patient Type**	e.g., Inpatient Psych, Outpatient Single Visit, Surgery, Lab, etc. Hospital related clinics or physician office visits should NOT be included in data provided.
l.	**Date of Admission**	Date formats must be consistent within each file provided.
m.	**Date of Discharge**	Date formats must be consistent within each file provided.
n.	**Length of Stay (days)**	
o.	**Admission Type Description**	e.g., Emergency, Reservation, Reference Lab, etc.
p.	**Discharge Disposition Description**	e.g., Discharge Home, Nursing Home, Expired, etc.
q.	**Patient Date of Birth**	
r.	**Patient Age at Discharge**	
s.	**Patient Gender**	
t.	**Patient Race**	
u.	**Patient City**	
v.	**Patient State**	
w.	**Patient Zip Code**	
x.	**Attending Physician Name**	
y.	**Total Charges**	
z.	**Total Payments**	Total Payments should only contain actual payments received (e.g., insurance/self-pay). It should NOT include adjustments, bad debt, write-offs or contractual adjustments.
aa.	**DRG Code**	Diagnosis-Related Group ("DRG") code for each inpatient visit/discharge.
ab.	**DRG Code Description**	Provide a DRG code description for the above DRG code.
ac.	**All ICD Diagnosis Codes**	All International Classification of Disease (ICD) diagnosis codes (ICD-9 or ICD-10, as applicable) associated with each patient visit/discharge. Note: In most instances there should be multiple ICD codes for a patient visit/discharge. Each of these ICD Diagnosis Codes related to each patient's visit

Column	Data Fields	Definitions and Clarifications
		should NOT be listed in multiple columns but rather each ICD Code should be listed in the same single column with each ICD Code shown on separate rows within the same single column. See Exhibit A.
ad.	**ICD Diagnosis Code Descriptions**	ICD Diagnosis Code descriptions for the above ICD Diagnosis Codes.
ae.	**ICD Diagnosis Code Priority**	Indicate whether each ICD Diagnosis Code is a Primary, Secondary, Tertiary, etc. diagnosis. These categories must be expressed in terms of a numerical code such as 1=Primary, 2=Secondary, 3=Tertiary, etc. ADD "Location of Service (LOS) or Place of Service (POS) as i.e. Office, Home, Telehealth, etc.
af.	**Mother's MRN (if applicable)**	This field pertains only to Acute Care Hospitals that deliver newborn babies or have a neonatal unit. If this visit/charge is for a birth mother, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a baby, then this field should contain the mother's MRN so that there can be a mother/baby link associated therewith.
ag.	**Baby's MRN (if applicable)**	This field pertains only to Acute Care Hospitals that deliver newborn babies or have a neonatal unit. If this visit/charge is for a baby, then this field should be blank as it would be the same MRN as the patient reported in # g. above. However, if this visit/charge pertains to a birth mother, then this field should contain the Baby's MRN so that there can be a mother/baby link associated therewith.

9. Please execute and submit a Business Associate and Confidentiality Agreement ("BAA") to Cherry Bekaert Advisory, LLC (formerly known as Legier & Company, apac) as attached as Exhibit B and return with this Claim Form for the Operating Entity listed in Section A.1 above. This BAA is not subject to revision or update.

10. Please complete the IRS Form W-9 attached hereto (or IRS Form W-8, if applicable) and return it with this Claim Form for the claimant identified in Section A above. The entity name and the EIN number noted in the W-9 (or W-8, if applicable) must match the Operating Entity Name and EIN noted in Section A.1 above.

G. Certification

I certify that I am authorized to sign this Claim Form and I understand that an authorized signature on this Claim Form serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I certify that the Settlement Class Member has authority to release all Released Claims as identified in the Settlement Agreement on behalf of itself and all other entities who are Releasors by virtue of their relationship or association with it.

I certify that the Settlement Class Member I am submitting this Claim Form on behalf of is eligible to receive funds under the Settlement Agreement.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Your typed signature and submission of this Claim Form will have the same force and effect as if you signed the Claim Form on paper, which you may do alternatively.

Signature: _____

Executed on date (MM/DD/YYYY): _____

Print the name of the person who is completing and signing this Claim.

Name (First Middle Last): _____

Title: _____

Acute Care Hospital: _____

Address: _____

_____

_____

Contact Phone: _____

Email: _____