

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 Agreement¹ 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:

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 Registration 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.

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 Releasers 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: _____