Exhibit 5

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

INSTRUCTIONS REGARDING CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

It is very important that you read the Class Notice in order to fully understand your rights under this Settlement.

DEADLINE FOR CLAIM FORM SUBMISSION: Submitted online or postmarked by _____.

WE STRONGLY RECOMMEND SUBMITTING YOUR CLAIM FORM ONLINE. IF THAT IS NOT FEASIBLE, PLEASE SUBMIT YOUR CLAIM FORM VIA REGISTERED OR CERTIFIED MAIL AND RETAIN YOUR RECEIPT AND A COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.

If you validly submit a Claim Form to the Settlement Notice Administrator online or postmarked no later than _____ you may elect to receive the portion of the Professional Net Settlement Fund to which you are entitled as a Medical Professional or authorized Medical Group/ Organization. A Class Member may file only one Claim Form as a Medical Professional or Medical Group/ Organization on behalf of Medical Professionals.

By submitting a Claim Form you are agreeing to be subject to the jurisdiction of the United States District Court for the Northern District of Alabama for any proceedings relating to your Claim Form. Capitalized terms used in the Instructions and Claim Form that are not otherwise defined herein are defined in the Settlement Agreement. A copy of the Settlement Agreement can be found on _____.

Relevant Definitions

- "Claimant" - For purposes of the Claim Form for the Professional Net Settlement Fund, a Claimant is a Medical Group, Medical Organization or Medical Professional who submits a Claim Form seeking payment from the Professional Net Settlement Fund.
- "Class Member" is defined in the Settlement Agreement and described in the Class Notice.
- "Medical Group" means two or more Medical Professionals, and those claiming by or through them, who practice under a single taxpayer identification number.
- "Medical Organization" means any association, partnership, corporation or other form of organization (including without limitation independent practice associations and physician hospital organizations), that arranges for care to be provided to Blue Plan Members by Medical Professionals organized under multiple taxpayer identification numbers.
- "Medical Professional" means any individual Provider, as defined in the Settlement Agreement.

Submit your completed Claim Form online or mail your completed Claim Form to the Settlement Notice Administrator at:

Settlement Notice Administrator
P.O. Box [XXXXX]
Richmond, VA 23260

NOTE: YOU MUST NOTIFY THE SETTLEMENT NOTICE ADMINISTRATOR IMMEDIATELY OF ANY CHANGE IN YOUR ADDRESS, TO AVOID HAVING YOUR MAILED CHECK RETURNED TO THE SETTLEMENT NOTICE ADMINISTRATOR AND DISTRIBUTED IN ACCORDANCE WITH PARAGRAPH 39 OF THE SETTLEMENT AGREEMENT.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

INSTRUCTIONS REGARDING CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

SECTION-BY-SECTION INSTRUCTIONS

SECTION A (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

MEDICAL GROUP/ORGANIZATION: If you are representing a Medical Group/Organization, in Section A, please write in the Medical Group/Organization name, the name of the person completing the Claim Form, and attach a list of all the Medical Professionals for whom you are filing this Claim. Medical Groups/Organizations may submit Claim Forms on behalf of Medical Professionals employed by or working with them without providing individual signatures from the Medical Professionals, if authorized to do so by the Medical Professionals and if the Medical Professionals do not also submit Claim Forms on their own behalf.

Your list of Medical Professionals should be set forth on the Rider attached to the Claim Form, and must include all of the following information for each Medical Professional:

1. Medical Professional name.

2. Medical Professional Type (e.g., MD, DO, PT, chiropractor, etc.).

3. Whether or not the Medical Professional was licensed before January 31, 2009.

4. The National Provider Identifier(s) (NPI(s)) associated with the Medical Professional (if applicable).

5. The Tax Identification Number(s) (TIN(s)) associated with the Medical Professional (if applicable) or last four digits of the Social Security Number (SSN).

6. The time period for which the Claimant is submitting the claim on behalf of the Medical Professional.

7. Range of allowed amounts determined by all Settling Individual Blue Plans in response to claims for reimbursement for the provision of Covered Services (not including services covered by standalone dental or vision insurance) submitted for each Medical Professional to Settling Individual Blue Plans during the during the time period from July 24, 2008 through October 4, 2024, as reflected in Evidences of Benefits, Remittance Advices, or similar responses to such claims for reimbursement ("Allowed Amounts").

SECTION B (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

Individual Medical Professionals and Medical Groups/Organizations who submit Claim Forms on behalf of Medical Professionals are entitled to receive a portion of the Professional Net Settlement Fund. The settlement payment attributable to a Medical Professional will be based upon the Allowed Amounts determined by Settling Individual Blue Plans for that Medical Professional's provision of Covered Services to Settling Individual Blue Plan Members during the time period from July 24, 2008 through October 4, 2024. For purposes of determining which box to check in this section, "Blue Plan" means any of the settling Blue Plans listed in the Class Notice.

For purposes of determining which box to check in this section:

"Covered Services" means healthcare services, equipment, or supplies covered under an individual's Commercial Health Benefit Product administered by any Settling Individual Blue Plan.

"Commercial Health Benefit Product" means any product or plan providing for the payment or administration of healthcare services (including but not limited to medical, pharmacy, dental, and vision products and services) or expenses through insurance, reimbursement, or other similar healthcare financing mechanism, for Members in the U.S. (however funded, including insured or self-funded) other than a product or plan purchased or offered by a Government Entity, including but not limited to those offered under the Children with Special Health Care Needs Program (CSHCN); Children's Health Insurance Program (CHIP); Civilian Health and Medical Program of the Department of Veteran's Affairs (CHAMPVA); Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Indian Health Service, Tribal, and Urban Indian Health Plan; Medicaid; Medicare; Medicare Advantage (including but not limited to Medicare Advantage Prescription Drug Plans and Special Needs Plans, including but not limited to Medicare-Medicaid or Dual-Eligible Plans); Medicare Stand-Alone Prescription Drug Plans; Refugee Medical Assistance Program; State Maternal and Child Health Program (MCH); or TriCare.

The Settling Individual Blue Plans are listed in the Settlement Agreement.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

INSTRUCTIONS REGARDING CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

SECTION-BY-SECTION INSTRUCTIONS (CONTINUED)

SECTION B (CONTINUED)

You should check ONE of the boxes in Section B, as described below:

Box I: Medical Professionals who had total Allowed Amounts of less than or equal to $250,000 during the time period from July 24, 2008 through October 4, 2024, should check **Box I**, and will be assigned one (1) "Point" to be used to calculate their settlement payment.

Box II: Medical Professionals who had Allowed Amounts of more than $250,000, and less than or equal to $500,000 during the time period from July 24, 2008 through October 4, 2024, should check **Box II**, and will be assigned two (2) Points to be used to calculate their settlement payment.

Box III: Medical Professionals who had Allowed Amounts of more than $500,000, and less than or equal to $750,000 during the time period from July 24, 2008 through October 4, 2024, should check **Box III**, and will be assigned three (3) Points to be used to calculate their settlement payment.

Box IV: Medical Professionals who had Allowed Amounts of more than $750,000, and less than or equal to $1,000,000 during the time period from July 24, 2008 through October 4, 2024, should check **Box IV**, and will be assigned four (4) Points to be used to calculate their settlement payment.

Box V: Medical Professionals who had Allowed Amounts of more than $1,000,000 during the time period from July 24, 2008 through October 4, 2024, should check **Box V**, and will be assigned five (5) Points to be used to calculate their settlement payment.

To simplify the process of obtaining payment from the Professional Net Settlement Fund, Claimants submitting Claim Forms on behalf of Medical Professionals may check one of the boxes described above in Section B and submit their Claim Forms to the Settlement Notice Administrator without any additional documentation. (The Settlement Notice Administrator may request more information after a claim is submitted.) The amount of the Professional Net Settlement Fund attributable to each Medical Professional shall be determined based upon the certification of the Claimant as to the applicable range of Allowed Amounts.

As further explained in the Class Notice, each Medical Professional for which a Claimant submits a claim will also be assigned a number of "Adjusted Points" equal to the points that correspond to that Medical Professional's range of Allowed Amounts, multiplied by a number based on the coefficient for the state or other area in which the Medical Professional is located, as shown in the table below:

Harm Coefficients	Points Multiplier
Less than 2	1
2 to 3	2.5
3 to 4	3.5
4 to 5	4.5
5 or higher	5.3

The settlement payment to be made for each Medical Professional for which a Claimant submits a claim will be determined based on the following payment formula:

Medical Professionals' Payment Formula
NPI or TIN Adjusted Points ÷ Total Adjusted Points for All Medical Professionals Who Filed Claims × Professional Net Settlement Fund

The Settlement Notice Administrator will make the final decision on any dispute regarding the eligibility of a Claimant to receive payment from the Professional Net Settlement Fund or the amount of any such payment.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

INSTRUCTIONS REGARDING CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

SECTION-BY-SECTION INSTRUCTIONS (CONTINUED)

SECTION B (CONTINUED)

If you have any questions, please contact the Settlement Notice Administrator by telephone at _____ or by email at _____.

SECTION C (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

This Section will allow you to select whether you want to receive a settlement payment,if eligible, by check, electronic transfer (ACH or wire), or by digital payment (PayPal, Venmo, Virtual Mastercard).

SECTION D (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

This Section will dictate to whom the payment is addressed. If you submit a Claim Form on behalf of a Medical Group/Organization, the payment will be made to the Medical Group/Organization for distribution by the Medical Group/Organization to individual Medical Professionals.

SECTION E (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

Read, sign, and date the Certification.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

You must read the Class Notice and Claim Instructions before completing this Claim Form.

SECTION A: CLAIMANT INFORMATION - ALL CLAIMANTS MUST COMPLETE THIS SECTION (EITHER THROUGH A MEDICAL GROUP/ORGANIZATION OR INDIVIDUALLY, BUT NOT BOTH).

Indicate whether the Claimant is a Medical Group/Organization or an Individual Medical Professional and complete the information below. Check one.

☐ **MEDICAL GROUP/ORGANIZATION**	If Medical Group/Organization, please indicate the number of Medical Professionals for whom you are filing this claim.	

Medical Group or Organization Name	*National Provider Identifier (NPI, if applicable)*
Name and Title of Person Filing	*Phone Number*
Email Address of Person Filing	

Medical Groups/Organizations: Please see Instructions. You must complete the Rider to this Claim Form and provide the required information regarding all Medical Professionals for which you are filing a claim.

☐ **INDIVIDUAL MEDICAL PROFESSIONAL**	*Please Indicate Your Medical Professional Type*
Name of Medical Professional	*National Provider Identifier (NPI)*
Name of Representative (if Medical Professional is Deceased)	*Phone Number*
Email Address of Medical Professional (or Representative, if Medical Professional is Deceased)	

Were you first licensed to practice before January 31, 2009? ☐ **Yes** ☐ **No**

If you are the legal heir or representative of a deceased Class Member, you must attach documentation including a death certificate and letters of administration for an estate to confirm your status. The Tax I.D. requested in Section C is that of the heir or estate.

Provide the mailing address for the Medical Group/Organization or Individual Medical Professional.

Address 1	*Address 2*	
City	*State*	*Zip Code*

SECTION B: ALL CLAIMANTS MUST COMPLETE THIS SECTION

☐	By checking the box to the left, I certify that I have reviewed the Class Notice and that I am a Class Member (as described in the Class Notice).

Check **ONLY ONE** of the boxes below or on the next page to designate the range of Allowed Amounts that are the basis of this claim. **Medical Groups/Organizations must complete the Rider attached to this Claim Form** (or attach a list in substantially the same form) that designates the range of Allowed Amounts for each Medical Professional for which this Claim Form is being submitted rather than check any boxes below.

☐	By checking this box, I certify that my total Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were less than or equal to $250,000.
☐	By checking this box, I certify that my Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were more than $250,000 but less than or equal to $500,000.

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

SECTION B (CONTINUED)

☐	By checking this box, I certify that my Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were more than $500,000 but less than or equal to $750,000.
☐	By checking this box, I certify that my Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were more than $750,000 but less than or equal to $1,000,000.
☐	By checking this box, I certify that my Allowed Amounts during the time period from July 24, 2008 through October 4, 2024 were more than $1,000,000.

Reminder: Although Claimants are not required to calculate exact Allowed Amounts, a good-faith estimate is required. Knowingly certifying Allowed Amounts without a good-faith basis may result in denial of the claim.

SECTION C: ALL CLAIMANTS MUST COMPLETE THIS SECTION

If the Settlement Notice Administrator determines you are eligible for a settlement award, you may choose to receive your payment as a check mailed to the address you provided on the previous page, by electronic transfer (ACH or wire), or by digital payment (virtual Mastercard, PayPal, or Venmo). Claimants with awards greater than $10,000 must choose check, ACH, or wire, and cannot select PayPal, Venmo, or Virtual Mastercard. The Settlement Notice Administrator will issue your entire payment using the single payment method you select, and you may not split your award across multiple payment types.

Select your preferred method of payment and enter the required information. If you elect to receive an electronic or digital payment and the information you enter is incorrect or incomplete, the Settlement Administrator will convert your award to a check payment. Be sure to double check that the payment information you provide is up-to-date and you're the payment details you provide are correct and associated with the correct account.

Select one and complete the required information.

☐ **Check (Any Award Amount)**	The check will be made payable to the Medical Group/Organization or Medical Professional listed on the previous page. *If you choose to receive a payment by check, the Settlement Notice Administrator will deduct from your payment the cost of issuing and mailing the check.*
☐ **ACH Payment (Any Award Amount)**	An Automated Clearing House (ACH) payment is a type of electronic bank-to-bank payment and is a way to transfer money between bank accounts, rather than using card networks, wire transfers, or paper checks. ACH Electronic Transfers are quicker than standard checks and typically arrive within 1-3 business days after the initiation of the payment.

Provide the information below to receive an ACH payment.

Account Name: _____

Account Type (Checking/Savings): _____

Bank ACH Routing Number (9 Digits): _____

Account Number (Up to 16 Digits): _____

☐ **Wire Transfer (Any Award Amount)**	A wire transfer is a common way to electronically move money from one bank account to another. Wire transfers are quicker than standard checks, but depending on your bank or financial institution, may arrive within 3-5 business days after the initiation of the payment. *If you choose to receive payment by wire transfer, the Settlement Notice Administrator will deduct from your payment any costs associated with issuing the wire transfer. In addition, your financial institution may charge fees to receive incoming wire transfers.*

(CONTINUED ON NEXT PAGE)

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

SECTION C (CONTINUED): ALL CLAIMANTS MUST COMPLETE THIS SECTION

(**WIRE TRANSFER**: CONTINUED FROM PREVIOUS PAGE)

Provide the information below to receive a wire transfer.

Account Name: _____

Bank Name: _____

Bank ABA Fedwire Routing Number (9 Digits): _____

Account Number (Up to 16 Digits): _____

If your wire instructions include an intermediary bank, provide the intermediary bank information below.

Intermediary Bank Name: _____

Intermediary Bank ABA Fedwire Routing Number (9 Digits): _____

If your wire instructions include additional references in order to apply funds, indicate that information below.

Instructions 1: _____

Instructions 2: _____

Instructions 3: _____

☐ **PayPal ($10,000 or less)**

The PayPal payment will be issued to the Medical Group/Organization or Medical Professional identified on the first page. Be sure that the email address below is for the PayPal account to which funds are to be paid.

Email Address Associated with PayPal Account: _____

☐ **Venmo ($10,000 or less)**

The Venmo payment will be issued to Medical Group/Organization or Medical Professional identified on the first page. Be sure that the email address and phone number below is for the Venmo account to which funds are to be paid.

Email Address Associated with Venmo Account: _____

Phone Number Associated with Venmo Account: _____

☐ **Virtual Mastercard ($10,000 or less)**

The Virtual Mastercard will be issued to the Medical Group/Organization or Medical Professional identified on the first page. Be sure that the email address below is for the Medical Group/Organization or Medical Professional.

Email Address: _____

(CLAIM FORM CONTINUES ON NEXT PAGE)

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

SECTION D: SUBSTITUTE FORM W-9 - ALL CLAIMANTS MUST COMPLETE THIS SECTION

Enter the Social Security Number or Employer Identification Number of the Claimant whose name will appear on any check and related Form-1099. For individuals, this is your Social Security Number (SSN). For Medical Groups/ Organizations, this is your Employer Identification Number (EIN).

Social Security Number (SSN, Format XXX-XX-XXXX)	*Employer Identification Number (EIN, Format XX-XXXXXXX)*

By signing this Claim Form, I certify that:

1. The number shown on this form above is the correct Social Security Number or Employer Identification Number for this Claimant; and

2. The Claimant is not subject to backup withholding because the Claimant: (a) is exempt from backup withholding, or (b) has not been notified by the Internal Revenue Service (IRS) that the Claimant is subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the Claimant that the Claimant is no longer subject to backup withholding.

NOTE: Backup withholding is extra tax withholding that occurs when a taxpayer has underreported interest or dividends in a previous year. The IRS notifies taxpayers who are subject to backup withholding. If you (the Claimant) have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return, you must cross out item 2 above by placing a line through the section.

SECTION E: ALL CLAIMANTS MUST COMPLETE THIS SECTION

I do declare and certify as follows:

- I am an authorized representative of the Class Member identified above;
- I am not submitting a claim on behalf of any Class Members who have submitted a request to opt out of the Class and Settlement;
- I am not submitting claims on behalf of any Class Members who are submitting separate claims on their own behalf based on the same Covered Services; and
- All of the statements and information provided in this Claim Form are true, correct and complete, to the best of my knowledge.

NOTE: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications in Section C required to avoid backup withholding.

Signature of Claimant	*Date*

Any Claim Form submitted online or postmarked after _____ is not a Valid Claim Form and will be denied by the Settlement Notice Administrator.

Before submitting your Claim Form, please be sure to:

- **Complete Section A – Claimant Information**
- **Complete Section B and the attached Rider listing the Health Care Facilities for which you are submitting this Claim Form and listing the required key information.**
- **Complete Section C.**
- **Complete Section D.**

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL NO. 2406)

CLAIM FORM FOR THE BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION PROFESSIONAL NET SETTLEMENT FUND

- **Sign the Certification in Section E.**

WE STRONGLY RECOMMEND SUBMITTING YOUR CLAIM FORM ONLINE. IF THAT IS NOT FEASIBLE, PLEASE SUBMIT YOUR CLAIM FORM VIA REGISTERED OR CERTIFIED MAIL AND RETAIN YOUR RECEIPT AND A COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.

Claim Forms must be sent to the Settlement Notice Administrator at P.O. Box [XXXXX], Richmond, VA 23260.

If you have any questions, please contact the Settlement Notice Administrator by telephone at _____ or by email at _____.

Medical Groups/Organizations: You must complete the Rider on the next page and provide the required information regarding all Medical Professionals for which you are filing a claim.

RIDER FOR MEDICAL GROUPS/ORGANIZATIONS THAT ARE FILING CLAIMS ON BEHALF OF MEDICAL PROFESSIONALS

Medical Group or Organization Name

Name and Title of Person Filing	*Phone Number*

Email Address of Person Filing

List of Individual Medical Professionals and Key Information, For EACH Medical Professional for Whom You Are Submitting Claims (Please attach additional pages of this form, if necessary)

Medical Professional Name:

Medical Professional Type

Was Medical Professional Licensed Prior to January 31, 2009? ☐ **Yes** ☐ **No**

National Provider Identifier (NPI, if applicable)	*Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)*

Time Period for Which Claimant is Submitting Claim on behalf of Medical Professional (Format: MM/DD/YYYY to MM/DD/YYYY)	*Points Based on Range of Allowed Amounts (1, 2, 3, 4, or 5)*

Medical Professional Name:

Medical Professional Type

Was Medical Professional Licensed Prior to January 31, 2009? ☐ **Yes** ☐ **No**

National Provider Identifier (NPI, if applicable)	*Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)*

Time Period for Which Claimant is Submitting Claim on behalf of Medical Professional (Format: MM/DD/YYYY to MM/DD/YYYY)	*Points Based on Range of Allowed Amounts (1, 2, 3, 4, or 5)*

To add information for more Medical Professionals, use the next page. You may print and use extra copies of the next page as many times as needed to submit information for each Medical Professional. Remember to include all pages with your Claim Form submission. You may also provide the information requested in an Excel spreadsheet by upload through the Settlement Website or by mailing a thumb drive with your Claim Form.

Medical Professional Name:

Medical Professional Type

Was Medical Professional Licensed Prior to January 31, 2009? ☐ Yes ☐ No

National Provider Identifier (NPI, if applicable)	*Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)*
Time Period for Which Claimant is Submitting Claim on behalf of Medical Professional (Format: MM/DD/YYYY to MM/DD/YYYY)	*Points Based on Range of Allowed Amounts (1, 2, 3, 4, or 5)*

Medical Professional Name:

Medical Professional Type

Was Medical Professional Licensed Prior to January 31, 2009? ☐ Yes ☐ No

National Provider Identifier (NPI, if applicable)	*Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)*
Time Period for Which Claimant is Submitting Claim on behalf of Medical Professional (Format: MM/DD/YYYY to MM/DD/YYYY)	*Points Based on Range of Allowed Amounts (1, 2, 3, 4, or 5)*

Medical Professional Name:

Medical Professional Type

Was Medical Professional Licensed Prior to January 31, 2009? ☐ Yes ☐ No

National Provider Identifier (NPI, if applicable)	*Tax Identification Number (TIN) or Last Four Digits of Social Security Number (SSN)*
Time Period for Which Claimant is Submitting Claim on behalf of Medical Professional (Format: MM/DD/YYYY to MM/DD/YYYY)	*Points Based on Range of Allowed Amounts (1, 2, 3, 4, or 5)*