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U.S. DISTRICT COURT
N.D. OF ALABAMA

Exhibit B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

IN RE: BLUE CROSS BLUE SHIELD ANTITRUST LITIGATION (MDL No.: 2406)	)	**Master File No. 2:13-CV-20000-RDP**
	)	**This document relates to: THE PROVIDER TRACK**

DECLARATION OF ROMA PETKAUSKAS ON THE IMPLEMENTATION AND ADEQUACY OF THE NOTICE PLAN AND ADMINISTRATION

I, ROMA PETKAUSKAS, declare as follows:

1. My name is Roma Petkauskas. I am a partner at BrownGreer PLC ("BrownGreer"), located at 250 Rocketts Way, Richmond, Virginia 23231. We are experts in the legal and administrative aspects of the design, approval, and implementation of notice plans, settlement programs and the design, staffing and operation of claims facilities to provide damages payments, medical monitoring, or other benefits for the resolution of multiple claims through class action settlement, bankruptcy reorganization, voluntary agreement, or other aggregation vehicles. We have played major roles in many of the largest and most complex multiple claim proceedings and multiple claim settlement programs in history, serving as administrators, special masters, trustees, or settlement counsel.

2. I am over the age of 21. I have worked in the mass claims area, including class actions, for over 20 years. I have extensive experience as an administrator designing and

implementing class action settlements; as a notice administrator designing notice plans and executing notice to claimants and counsel; as a court appointed neutral involved in multiple claim proceedings; and am a frequent presenter on class actions and other complex litigation.

3. My Amended Declaration Regarding the Proposed Notice Plan, filed with this Court on October 23, 2024, described my experience, the notice plan being developed for the proposed class action settlement of this litigation (the "Notice Plan"), and why my professional opinion was that the Notice Plan would be effective and constitute the best notice practicable under the circumstances to the members of the class involved in this Settlement, pursuant to any applicable law and rules, including Rule 23 of the Federal Rules of Civil Procedure, and constitutional due process. (Doc. No. 3207-3). I also attached exhibits presenting BrownGreer's class action notice administration experience and my personal biography.

4. On October 14, 2024, and in their supplemental supporting briefs filed October 23, 2024, Settlement Class Counsel[1] moved the Court for preliminary approval of the Settlement and nominated BrownGreer to serve as the Settlement Notice Administrator. (Doc. Nos. 3192-1, 3207.) On December 4, 2024, the Court entered its order preliminary approving the Settlement (the "Preliminary Approval Order") and appointed BrownGreer as the Settlement Notice Administrator. (Doc. No. 3225 at 49).

5. This declaration will: (a) describe actions taken to comply with applicable provisions of the Preliminary Approval Order; (b) detail BrownGreer's execution of its role as Settlement Notice Administrator; and (c) provide information regarding the successful implementation of the Notice Plan and statistics about the Settlement program's notice and claims activity, as of April 18, 2025.

[1] Unless noted otherwise, capitalized terms used in this declaration have the same meaning as in the Settlement Agreement.

6. Unless otherwise noted, the matters set forth in the Declaration are based upon my personal knowledge, training, and experience; information received from the parties in this proceeding (the "Parties"); and information provided by my colleagues at BrownGreer. I believe them to be true and correct. The opinions presented and recommendations made in this Declaration rest on my training and experience.

NOTICE PLAN SUMMARY

7. On December 4, 2024, the Court approved the Notice Plan, finding that it "satisf[ied] the requirements of Federal Rule of Civil Procedure 23 and due process." (Doc. No. 3225 at 50).

8. To implement the Notice Plan, in consultation with Settlement Class Counsel and the Settlement Administrator, BrownGreer coordinated the purchase of multiple datasets containing postal and email addresses for over 3.3 million healthcare facilities and medical professionals to effectuate individual notice to potential Class Members. With guidance from Settlement Class Counsel and the Settlement Administrator, the datasets were combined and de-duplicated to find the most likely current address for each identified Class Member.

9. The Notice Plan satisfies the notice requirements by mailing individual notice to all presumed Class Members with identifiable mailing addresses. The direct notice effort included postcard and/or email notice to all Class Members for whom we could ascertain their mailing and/or email contact information. In total, we sent more than 3.3 million direct notices. We will send reminder email and postcard notices to potential Class Members who have not yet filed a claim or opted out of the Settlement Class.

10. To reach potential Class Members who did not receive direct notice, and to reinforce the direct notice efforts, we coordinated with Signal Media to employ a tailored media

campaign that supplemented the notice mailing. Through targeted and strategically placed digital banner advertisements and placements, the paid media campaign exceeded its goal to garner 13 million gross impressions and generated over 18 million gross impressions.

11. Potential Class Members who did not receive individual notice but believe they should receive Settlement benefits because they meet the requirements of the Class definition, have an opportunity to prove their eligibility in a non-burdensome manner by completing and submitting a Professional Claim Form and/or Facilities Claim Form online or by mail.

12. In my opinion, the Notice Plan as designed and implemented, is the best notice practicable under the circumstances of this case, far exceeds the requirements of due process, and "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.'" *Mullane v. Cent. Hanover Bank & Tr. Co.*, 339 U.S. 306, 314 (1950).

NOTICE PLAN IMPLEMENTATION

Establishment and Operation of Class Member Resources

13. BrownGreer established a dedicated Post Office Box (the "P.O. Box") for the Settlement Program on November 12, 2024. The P.O. Box address is:

Blue Cross Blue Shield Provider Settlement
Settlement Notice Administrator
P.O. Box 26443
Richmond, VA 23261

The P.O. Box is where the United States Postal Service ("USPS") returns undeliverable program mail to BrownGreer and for Class Members to submit Settlement-related correspondence, including hard-copy Claim Forms and requests to opt out of the Settlement. BrownGreer monitors the P.O. Box daily and processes each item received. As of April 18, 2025, we have

received and processed 325,718 total pieces of returned mail, 15,589 total exclusion requests, and 30 pieces of Class Member correspondence.

14. BrownGreer developed a public website ("Settlement Website") in consultation with Settlement Class Counsel and the Settlement Administrator and launched it on December 16, 2024. The Settlement Website, available at www.BCBSProviderSettlement.com, allows visitors to view and download critical settlement information, and permits potential Class Members to submit their Professional claims and/or Facilities claims and any additional required documentation quickly and easily online through a secure electronic portal. The Settlement Website presents important summary information about the Program on the Home page and provides links to the Settlement Notice Administrator's contact information. We developed a set of Frequently Asked Questions and answers ("FAQs"), which visitors to the Settlement Website can review using the interactive, online menu, or by viewing a PDF version of the FAQs available on the Documents page of the Website. The Settlement Website also allows anyone with internet access to read, download, and print critical Settlement documents, including the following:

(a) Long-Form Class Notice;

(b) Settlement Agreement;

(c) Provider Plaintiffs' Motion for Preliminary Approval and Memoranda in Support of their Motion for Preliminary Approval;

(d) Preliminary Approval Order; and

(e) Professional and Facilities Claim Forms.

The Settlement Website address appeared prominently in all Notices and has been visited more than 600,000 times. As of April 18, 2025, visitors have viewed documents available on the Settlement Website, including the Long Form Notice, more than 3.6 million times.

15. BrownGreer established a toll-free telephone number, 1-888-452-3095 (the "Toll-Free Number"), on November 11, 2024. Twenty-four hours per day, Class Members can call and engage with an automated system that provides important settlement information. Callers can also speak with a live agent from 9:00 a.m. ET to 5:00 p.m. ET, Monday through Friday. The Toll-Free Number appeared prominently in all Notices, as well as on the Settlement Website, and has received 6,475 calls, as of April 18, 2025. This Toll-Free Number will remain active through the close of the Settlement Program.

16. BrownGreer created a dedicated email inbox (Administrator@BCBSProviderSettlement.com) for the Settlement Program on December 10, 2024. The inbox is monitored regularly and Class Members who email the Settlement Notice Administrator will correspond with a live agent between 9:00 a.m. ET to 5:00 p.m. ET, Monday through Friday. As of April 18, 2025, the inbox has received 2,633 emails. This inbox will remain active through the close of the Settlement Program.

Development of the Class Member List

17. In consultation with Settlement Class Counsel and the Settlement Administrator, BrownGreer coordinated the purchase of multiple healthcare and medical professional datasets and obtained: (a) from Definitive Healthcare, a specialized data vendor and provider of commercial healthcare data and analytics, postal and email addresses for 329,218 active healthcare facilities, and 2,957,152 active physicians and other healthcare providers; (b) from Redi-Data, an approved American Medical Association ("AMA") data vendor, 1,096,439 email

addresses for nurse practitioners, physician assistants, chiropractors, and other ancillary healthcare professionals; (c) from the National Provider Identifier ("NPI") Registry, 8,235,650 mailing addresses for medical providers and practices; and (d) in coordination with Signal Interactive Media LLC ("Signal"), we obtained from DataAxle, a reputable third-party list provider, postal and email addresses for 124,865 certain auxiliary providers who are aged 65 and older. Additionally, Settlement Class Counsel supplied 27 postal addresses and 46 email addresses for Providers who were identified as being entitled to receive notice of this Settlement.

18. BrownGreer undertook an extensive evaluation of these datasets, including de-duplication of email addresses and mailing addresses, validation of email addresses and mailing addresses, and manual data cleansing to eliminate or correct invalid and incomplete records. In addition, we performed a thorough overlap analysis to assess the datasets together to prevent the same Class Member from receiving multiple Notices. Lastly, at Settlement Class Counsel's and the Settlement Administrator's instruction, we removed from the Class Member List those physicians who were licensed before March 12, 2008, dentists and dental assistants, optometrists and their assistants, pharmacists and their assistants, home health aides, and government-owned facilities such as Department of Defense or Veterans Affairs hospitals. From these efforts, we developed a Class Member List of 3,014,649 medical professionals and 328,991 facilities, which served as the basis to email and mail Notices to 3,343,640 known potential Class Members.

19. BrownGreer assigned unique identifiers to all records in the Class Member List ("Notice ID Numbers") to track information about each Class Member's Settlement Program activity and monitor returned Notices. Throughout the Notice period, we will further develop the Class Member List to include any forwarding addresses received from the USPS and updates received from additional address data research.

Direct Notice

20. Following the entry of the Preliminary Approval Order, BrownGreer, in consultation with Settlement Class Counsel and the Settlement Administrator, finalized the format and contents of the Settlement Notice to be sent by email and mail, by inserting: (a) the appropriate Notice ID Number for each potential Class Member, (b) the Settlement Website address, (c) P.O. Box address, (d) Toll-Free Number, (e) the date and time of the Final Approval Hearing, and (f) the deadlines to submit a claim for payment, opt out of the Settlement, and object to the Settlement. The finalized Postcard Notice and Email Notice appear as Exhibits 1 and 2 to this Declaration, respectively.

21. The Notice Plan required the Settlement Notice Administrator to send Notice by email to all Class Members for whom an email address is available in the Class Member List. The Initial Class Member List contained email addresses for 1,399,234 potential Class Members. We analyzed these email addresses and removed 18,381 email addresses that were facially invalid (*i.e.*, the email address was missing a required component, such as the "@" or the ".com," or was not provided in the required format), duplicative, or found to be inactive by our email address verification research. Based on the above criteria, we identified 1,380,853 unique email addresses for potential Class Members to which we could attempt to send the Notice by email.

22. From December 16, 2024, to December 20, 2024, we attempted to send Notice by email to each of these 1,380,853 potential Class Members. Every emailed Notice included a unique message identifier to track instances of "soft" and "hard" bounces. "Soft" bounces are emails that reach the mail server but are returned for temporary reasons that include an unresponsive Internet Service Provider or the recipient's mailbox being full. "Hard" bounces are

emails that are permanently undeliverable for reasons that include a deleted account or the recipient blocking the sender's server. Over the course of the initial email campaign, 236,966 (17.2%) emails "soft" bounced and 34,923 (2.5%) emails "hard" bounced. We reattempted to send the Email Notice for those that "soft" bounced after the initial effort, and 71,321 total emails remained unsent; thus reflecting an email deliverability rate of 94.8% for the 1,380,852 potential Class Members to whom we sent notice by email. Of the 71,321 bounced emails, there were 55,876 email addresses belonging to potential Class Members for whom we compiled address information from the Class Member List and sent Postcard Notices to them by mail.

23. Before mailing, all addresses were checked against the National Change of Address ("NCOA") database maintained by the USPS.[2] In addition, the addresses were certified via the Coding Accuracy Support System ("CASS") to ensure the quality of the zip codes. These processes are pre-mailing tools used to update, validate, and standardize mailing data.

24. On December 20, 2024, BrownGreer caused the Postcard Notice to be mailed to 1,944,406 potential Class Members at their last known mailing addresses. When the USPS could not deliver a Notice, it returned the Notice to the Program's P.O. Box. Of the 1,944,406 total mailed Notices, 1,502 mailed Notices returned to us as undeliverable with a forwarding address identified by the USPS, and 325,718 returned as undeliverable without a forwarding address. For the 325,718 potential Class Members whose Notices returned as undeliverable without a forwarding address, we attempted to ascertain alternative mailing addresses through PacificEast, a data curation company that specializes in data enhancement and address verification, and through that research, we found 18,836 secondary addresses. BrownGreer issued second-effort

[2] The NCOA database contains records of all permanent change of address submissions received by the USPS from individuals and businesses for the past four years. The class data is cross-checked against the database, and a Class Member's address is automatically updated with the new address from USPS data based on a comparison with the Class Member's name and last known address.

Postcard Notices to the 1,502 Class Members whose Notices returned as undeliverable with forwarding addresses and 18,836 Class Members whose Notices returned as undeliverable without a forwarding address, but for whom a secondary mailing address was found through additional address research. The second-effort Postcard Notice population also included the 55,876 to potential Class Members whose emails were undeliverable, but for whom we had a mailing address. As of the date of this Declaration, approximately 16.2% Postcard Notices (325,310 Postcard Notices) remain undeliverable, reflecting a deliverability rate of 83.8% for the 2,000,282 potential Class Members to whom we issued Postcard Notices.

25. In total, BrownGreer attempted to send direct Notice to 3,343,640 potential Class Members, and, as of April 18, 2025, we have reached 1,327,913 potential Class Members by email and 1,674,972 potential Class Members by mail. Altogether, the direct Notice campaign reached 3,002,885 (89.8%) of all known potential Class Members.[3]

26. BrownGreer will send reminder email and postcard notices to potential Class Members who have not yet filed a claim or opted out of the Settlement Class. The delivery of these reminder notices will afford potential Class Members enough time to submit their claims before the July 29, 2025 claims submission deadline.

Supplemental Media Notice

27. To supplement the extensive and widespread direct notice efforts described above and to amplify the Notice's reach and effectiveness, in consultation with Settlement Class Counsel and the Settlement Administrator, BrownGreer coordinated with Signal, who developed a paid media campaign to target and notify (a) Providers who worked during the Settlement

[3] For the purposes of this Declaration, a potential Class Member is considered "reached" by direct Notice if: (1) a Notice mailed to the potential Class Member has not been returned by the USPS as undeliverable, or (2) an emailed Notice sent to the potential Class Member has not bounced back as undeliverable. These figures may continue to change slightly as more Notices return as undeliverable.

Class Period but may not have appeared in the information and records received from the various data sources because they have since retired, or are ancillary service providers; (b) Providers who are practicing dentists in certain states where mandatory benefit laws require that certain dental services be covered by health insurance, as opposed to standalone dental insurance, which was not at issue in this litigation; (c) optometrists; and (d) ancillary Providers who could not be reached by direct notice because their identities are unknown, their current mailing or email addresses are unavailable, or mailed notices are returned to us by USPS as undeliverable and were unable to find an updated address. The media campaign included digital banner advertisements and placements estimated to garner 13 million gross impressions[4] using strategies such as job title targeting, behavioral targeting based on site browsing behavior; and geotargeting of household addresses matching the job titles of ancillary healthcare Providers. (*See* Wheatman Declaration, ⁋⁋ 14-17). Digital advertisements were also placed on digital inventory, such as publishers' networks of sites or email lists owned by relevant professional associations (*e.g.*, the American Association of Nurse Practitioners, National Association of Social Workers, American Academy of Physician Associates, American Counseling Association, American Psychological Association, and others). *Id.* These paid media efforts generated over 18 million gross impressions. Signal also issued a national press release to reach potential Class Members through online and traditional media resources. For a detailed discussion of the media notice campaign and its results, *see* Declaration of Shannon R. Wheatman, PH.D. on Implementation of the Notice Plan.

[4] "Gross impressions are the total number of times a digital ad is shown. This figure does not represent the total number of unique viewers of the ad, as some viewers may see an ad more than once." Amended Declaration of Shannon Wheatman, PH. D on Adequacy of Notices and Notice Plan ("Wheatman Declaration"), Doc. 3207-4, at 7 n.4.

OPT OUTS

28. The deadline to request exclusion from the Settlement Class or to object to the Settlement was March 4, 2025. As of April 18, 2025, BrownGreer has received 15,589 requests for exclusion from this Settlement Class. Pursuant to Paragraph 17 of the Preliminary Approval Order, BrownGreer has collaborated with Settlement Class Counsel and the Settlement Administrator to develop a list of all Providers who have submitted timely, facially valid opt out requests in accordance with the terms of the Settlement Agreement, for filing with the Court before the Final Fairness Hearing on July 29, 2025. A list of those opt-out requests is attached to the Provider Plaintiffs' motion for final approval of the Settlement. I understand that the list will be updated before the Final Fairness Hearing.

29. Almost half of the requests for exclusion were signed by Lisha Falk of SCP Health. These requests ask for exclusion on behalf of individual professionals and their medical groups. These requests cover 7,012 professionals and 88 medical groups.

OBJECTIONS

30. Paragraph 20 of the Preliminary Approval Order instructs those Class Members who wish to object to the Settlement to send their written objections to "the Settlement Administrator, Provider Co-Lead Counsel, and Settling Defendants' counsel at the addresses listed in the Long Form Notice available on the Settlement Website, and postmarked by no later than the objection deadline March 4, 2025." As of April 18, 2025, BrownGreer has received three objections to the Settlement (one from North Texas Division, Inc.; one from Allatoona Emergency Group, PC and Alabama Emergency Physician Partners, LLC; and one from Kyle Egner, DC), and 24 conditional objections from clients of Paul Hastings LLP.

CLAIM ACTIVITY

31. Settlement Class Members seeking their Settlement payment must submit a claim to the Settlement Notice Administrator no later than July 29, 2025. Settlement Class Members can submit claims online using the electronic Claim Form available on the Settlement Website. To accommodate Settlement Class Members who are unable to submit an electronic Claim Form, in conjunction with Settlement Class Counsel and the Settlement Administrator, BrownGreer designed and made available on the Settlement Website a hard copy version of the Professionals Claim Form and Facilities Claim Form, which appear as Exhibits 3 and 4 to this Declaration, respectively. All versions of the Claim Form allow Settlement Class Members the option to receive their settlement payment by check or electronically.

32. BrownGreer and Patrick Sheehan of Whatley Kallas LLP have hosted regular webinars to explain the claim filing process for facilities and professionals. Through April 11, 2025, 3,523 potential Settlement Class Members have attended these webinars.

33. The claim submission period commenced on December 16, 2024, and will end on July 29, 2025. Thus far, 282,810 claimants have initiated a claim using the online submission feature. Of those, 215,063 claimants have completed the Professionals Claim Form, selected a payment method, and submitted their claim. These 215,063 Professionals claims include 28,121 riders, suggesting that these claimants filed on behalf of 28,121 additional medical professionals, organizations, or groups. Additionally, 7,607 claimants have completed the Facilities Claim Form, selected a payment method,[5] and submitted their claim. Over 95% of Facilities Claim Forms have selected the Default Method for calculating the Settlement payment amounts. These

[5] Of the 222,670 submitted Professional and Facilities claims, 4,748 claimants (2.1%) elected to receive their settlement payment by check, and 212,535 claimants (95.5%) elected to receive a digital payment using Venmo, PayPal, or Virtual Mastercard, and 5,387 claimants (2.4%) elected to receive a transfer by ACH or wire.

7,607 Facilities claims include 8,398 riders, suggesting that these claimants filed on behalf of 8,398 additional facilities. Consistent with the Preliminary Approval Order, BrownGreer has tracked the claims it has received but has not determined their validity.

34. Through routine claims monitoring processes, BrownGreer observed an abnormal increase in claims activity and identified common characteristics in approximately 177,000 filings that suggested irregular behavior. These characteristics included suspicious email addresses that are seemingly unrelated to the filing Settlement Class Members, claim submissions that were completed within three minutes of account creation, and a disproportionately high selection of a digital payment method for certain website domains (e.g., a high number of email addresses ending in "aol.com" selecting PayPal as the payment method). We have and will continue to flag claims that appear suspicious because they share common characteristics with other claims at a questionable rate. Further, we have implemented robust measures to mitigate these types of filings resulting from invalid, automated processes created by non-Settlement Class Members.

35. BrownGreer will send a reminder email to any claimants who started, but did not fully submit, their claim, before the claim submission period closes on July 29, 2025.

CONCLUSION

The extensive Notice Plan effectively provided individual notice and digital media efforts that reached at least 89.8% of the Class Members. The foregoing establishes that the Settlement is being implemented fully, properly, and successfully as of the date of this Declaration.

I declare under penalty of perjury that the foregoing is true and correct. Executed on April 22, 2025, in Richmond, VA.

Roma Petkauskas

Roma Petkauskas

Exhibit 1

Did you or your business provide healthcare services, equipment, or supplies to Blue Plan patients?

A $2.8 billion Settlement could affect your rights.

A court authorized this notice. You are not being sued. This is not a solicitation from a lawyer.

Blue Cross Blue Shield Provider Settlement
Notice Administrator
P.O. Box 26443
Richmond, VA 23261
Toll-Free (888) 452-3095
www.BCBSProviderSettlement.com

FIRST-CLASS MAIL U.S. POSTAGE PAID PERMIT NO 1234

Administrative Use Only

Notice ID: [12345678]

Jane Claimant
123 Main St.
Apt. 001
Richmond, VA 23260

A Settlement has been reached with Blue Cross Blue Shield Association ("BCBSA") and Settling Individual Blue Plans (together called "Settling Defendants"). The Provider plaintiffs claimed that the Settling Defendants divided the United States into "Service Areas" and agreed not to compete in those areas. They also claim that the Settling Defendants fixed prices for services provided. Settling Defendants deny these allegations.

Are you included? The Settlement Class includes all Providers in the U.S. (other than Excluded Providers, who are not part of the Settlement Class) who currently provide or provided healthcare services, equipment, or supplies to any patient who was insured by, or was a Member of or a beneficiary of, any plan administered by any Settling Individual Blue Plan from July 24, 2008 to October 4, 2024. Information on Excluded Providers is available at the website below.

What can you get from the Settlement? If approved by the Court, the Settlement will establish a $2.8 billion Settlement Fund. $100 million has been set aside for notice and administration. Settling Defendants will also make changes in the way they do business that will, among other things, increase the opportunities for competition in the market for the purchase of goods and services from healthcare providers, transform the BlueCard program, and improve Providers' interactions with the Settling Individual Blue Plans.

How to get a payment? File a claim form online or by mail by **July 29, 2025** to be eligible for a payment. Claim forms are available at the website below.

What are your options? Even if you do nothing you will be bound by the Court's decisions. If you want to keep your right to sue the Settling Defendants for the claims at issue in this case, you must exclude yourself from the Settlement Class by **March 4, 2025**, but you will not receive the monetary or injunctive relief benefits of the Settlement. If you stay in the Settlement Class, you may object to the Settlement by **March 4, 2025**. The Court will hold a hearing on **July 29, 2025** to consider whether to approve the Settlement, a request for attorneys' fees of up to 25% of the Settlement, and a request for reimbursement of expenses of approximately $100 million to be paid out of the Settlement Fund. You or your own lawyer may appear at the hearing at your own expense.

This is just a summary. For more information visit www.BCBSProviderSettlement.com or call (888) 452-3095.

Exhibit 2

From: Administrator@Alerts.BCBSProviderSettlement.com
Subject: Notice of Blue Cross Blue Shield Provider Settlement

A court authorized this notice. You are not being sued. This is not a solicitation from a lawyer.

Notice ID: [12345678]

Did you or your business provide healthcare services, equipment, or supplies to Blue Plan patients?

A large Settlement could affect your rights.

Visit www.BCBSProviderSettlement.com for more info and to file a claim.

A Settlement has been reached with Blue Cross Blue Shield Association ("BCBSA") and Settling Individual Blue Plans (together called "Settling Defendants"). The Provider plaintiffs claimed that the Settling Defendants divided the United States into "Service Areas" and agreed not to compete in those areas. They also claim that the Settling Defendants fixed prices for services provided. Settling Defendants deny all allegations of wrongdoing.

Are you included? The Settlement Class includes all Providers in the U.S. (other than Excluded Providers, who are not part of the Settlement Class) who currently provide or provided healthcare services, equipment, or supplies to any patient who was insured by, or was a Member of or a beneficiary of, any plan administered by any Settling Individual Blue Plan from July 24, 2008 to October 4, 2024. Information on Excluded Providers is available at the website below.

What can you get from the Settlement? If approved by the Court, the Settlement will establish a Settlement Fund. A portion of the fund has been set aside for notice and administration. Settling Defendants will also make changes in the way they do business that will, among other things, increase the opportunities for competition in the market for the purchase of goods and services from healthcare providers, transform the BlueCard program, and improve Providers' interactions with the Settling Individual Blue Plans.

How to get a payment? File a claim form online or by mail by **July 29, 2025** to be eligible for a payment. Claim forms are available at www.BCBSProviderSettlement.com.

What are your options? Even if you do nothing you will be bound by the Court's decisions. If you want to keep your right to sue the Settling Defendants for the claims at issue in this case, you must exclude yourself from the Settlement Class by **March 4, 2025**, but you will not receive the monetary or injunctive relief benefits of the Settlement. If you stay in the Settlement Class, you may object to the Settlement by **March 4, 2025**. The Court will hold a hearing on **July 29, 2025** to consider whether to approve the Settlement, a request for attorneys' fees of up to 25% of the Settlement, and a request for reimbursement of expenses to be paid out of the Settlement Fund. You or your own lawyer may appear at the hearing at your own expense.

This is just a summary. For more information visit www.BCBSProviderSettlement.com or call (888) 452-3095.

Exhibit 3

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 July 29, 2025.

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 July 29, 2025 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 at www.BCBSProviderSettlement.com.

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 26443
Richmond, VA 23261

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. The business address at which the Medical Professional practices or practiced.

4. Whether or not the Medical Professional was licensed before March 12, 2008.

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

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

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

8. 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 (888) 452-3095 or by email at Administrator@BCBSProviderSettlement.com.

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 March 12, 2008? ☐ **Yes** ☐ **No**

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

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

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 D is that of the heir or estate.

If you are a lawyer or law firm representing the Claimant, provide the information below.

Lawyer Name		*Law Firm Name*
Address 1		*Address 2*
City	*State*	*Zip Code*
Lawyer/Law Firm Email Address		*Lawyer/Law Firm Phone Number*

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).

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)

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.
☐	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 PAYMENT**
(For any payment amount; for payments less than $100,000, there may be a fee of up to $25 for this payment method; for payments of $100,000 or more, there may be a fee of up to $100 for this payment method.)

The check will be made payable to the Medical Group/Organization or Medical Professional listed in Section A. If the payment address is different than the business address listed in Section A, provide the address to which you would like the check issued below.

Address 1	*Address 2*

City	*State*	*Zip Code*

☐ **ACH PAYMENT**
(For any payment amount; there are no fees associated with this payment method.)

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 3-5 business days after the initiation of the payment.

Account Name: ____

Account Type (Checking/Savings): ________________________________

Bank ACH Routing Number (9 Digits): _____________________________

Account Number (Up to 16 Digits): _______________________________

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**
(For payment amounts of $250,000 or more; there may be a fee of up to $100 for this payment method.)

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 1-3 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.*

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**
(For payment amounts $10,000 or less; there are <u>no</u> fees associated with this payment method.)

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. There is no charge to receive a PayPal payment and no fees will be deducted from your award.

Email Address Associated with PayPal Account: ____

☐ **VENMO**
(For payment amounts $10,000 or less; there are <u>no</u> fees associated with this payment method.)

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. There is no charge to receive a Venmo payment and no fees will be deducted from your award.

Email Address Associated with Venmo Account: ____

Phone Number Associated with Venmo Account: ____

☐ **VIRTUAL MASTERCARD**
(For payment amounts $10,000 or less; there are <u>no</u> fees associated with this payment method.)

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. There is no charge to receive a Virtual Mastercard payment and no fees will be deducted from your award.

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, enter either a Social Security Number (SSN) or Employer Identification Number (EIN). For Medical Groups/Organizations, enter your Employer Identification Number.

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 D required to avoid backup withholding.

Signature of Claimant	*Date*

Any Claim Form submitted online or postmarked after July 29, 2025 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.**

- **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 26443, Richmond, VA 23261.

If you have any questions, please contact the Settlement Notice Administrator by telephone at (888) 452-3095 or by email at Administrator@BCBSProviderSettlement.com.

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		
Business Address 1 (Address at which Medical Professional Practices/Practiced)	*Business Address 2*	
Business City	*Business State*	*Business Zip Code*

Was Medical Professional Licensed Prior to March 12, 2008? ☐ **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		
Business Address 1 (Address at which Medical Professional Practices/Practiced)	*Business Address 2*	
Business City	*Business State*	*Business Zip Code*

Was Medical Professional Licensed Prior to March 12, 2008? ☐ **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.

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

Business Address 1 (Address at which Medical Professional Practices/Practiced) | *Business Address 2*

Business City | *Business State* | *Business Zip Code*

Was Medical Professional Licensed Prior to March 12, 2008? ☐ **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

Business Address 1 (Address at which Medical Professional Practices/Practiced) | *Business Address 2*

Business City | *Business State* | *Business Zip Code*

Was Medical Professional Licensed Prior to March 12, 2008? ☐ **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, you may print and use extra copies of this 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.

Exhibit 4

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

INSTRUCTIONS REGARDING CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD ANTITRUST LITIGATION HOSPITAL/FACILITY 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 July 29, 2025.

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 July 29, 2025 you may elect to receive the portion of the Hospital/Facility Net Settlement Fund to which you are entitled as a Health Care Facility or authorized Health Care System. A Class Member may file only one Claim Form as a Health Care Facility or a Health Care System on behalf of Health Care Facilities.

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 at www.BCBSProviderSettlement.com.

Relevant Definitions

- "Claimant" - For purposes of the Claim Form for the Hospital/Facility Net Settlement Fund, a Claimant is a Health Care Facility or Health Care System that submits a submits a Claim Form seeking payment from the Health Care Facilities' Settlement Fund.
- "Class Member" is defined in the Settlement Agreement and described in the Class Notice.
- "Health Care Facility" means any facility, such as a hospital, ambulatory surgery center, dialysis center, imaging center or other facility in which health care services are or were delivered to Blue Plan Members.
- "Health Care System" means any association, partnership, corporation or other form of organization that arranges for care to be provided to Blue Plan Members by two or more Health Care Facilities organized under multiple taxpayer identification numbers.

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

Settlement Notice Administrator
P.O. Box 26443
Richmond, VA 23261

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 HOSPITAL/FACILITY NET SETTLEMENT FUND

SECTION-BY-SECTION INSTRUCTIONS

SECTION A (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

In Section A, please write in the Health Care System or Health Care Facility name and the name of the person completing the Claim Form. If you are representing a Health Care System, attach a list of all the Health Care Facilities for whom you are filing this Claim. Health Care Systems may submit Claim Forms on behalf of multiple Health Care Facilities without providing individual signatures from the Health Care Facilities, if authorized to do so by the Health Care Facilities and the Health Care Facilities do not also submit Claim Forms on their own behalf.

Your list of Health Care Facilities should be set forth on the Rider attached to the Claim Form, and must include all of the following information for each Health Care Facility:

1. Health Care Facility name.
2. Health Care Facility Type (e.g. Hospital, Surgery Center, Dialysis Center, Imaging Center, Clinic, etc)
3. The business address of the Health Care Facility.
4. The National Provider Identifier(s) (NPI(s)) associated with the Health Care Facility.
5. The Tax Identification Numbers (TIN(s)) associated with the Health Care Facility.
6. The First Date of Service during the period from July 24, 2008 through October 4, 2024.
7. The Last Date of Service during the period from July 24, 2008 through October 4, 2024.
8. Whether the Health Care Facility Provides Inpatient Services, Outpatient Services or both.
9. The time period for which the Claimant is submitting the claim on behalf of the Health Care Facility.

SECTION B (ALL CLAIMANTS MUST COMPLETE THIS SECTION)

Individual Health Care Facilities and Health Care Systems who submit Claim Forms on behalf of Health Care Facilities are entitled to receive a portion of the Hospital/Facility Net Settlement Fund. The settlement payment attributable to a Health Care Facility will be based upon the allowed amounts determined by all Settling Individual Blue Plans in response to claims for reimbursement for the provision of Covered Services submitted for each Health Care Facility to Settling Individual Blue Plans 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”).

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.

SECTION-BY-SECTION INSTRUCTIONS (CONTINUED)

SECTION B (CONTINUED)

You should select only ONE of the options in Section B, as described below:

Option A (the "Default Method") permits a Health Care System or Health Care Facility to submit the information requested in the Rider attached to the Claim Form **EXCEPT FOR** the estimated Allowed Amounts so that the Settlement Notice Administrator can query the claims data available to it to estimate the Health Care System's or Health Care Facility's Allowed Amounts.

IMPORTANT: Please note that Option A (the Default Method) is not available for Health Care Facilities located in Arizona, Iowa, Louisiana, Maryland, New Jersey, South Dakota, CareFirst's service area in Virginia, the District of Columbia and Puerto Rico, as well as Health Care Facilities that were not open prior to January 1, 2015.

Option B (the "Alternative Method") permits a Health Care System or Health Care Facility to submit its own estimated Allowed Amounts, which will be validated by the Settlement Notice Administrator. Estimated Allowed Amounts must be provided for Health Care Facilities not open prior to January 1, 2015. If the Settlement Notice Administrator is unable to validate the Allowed Amounts you have claimed, you may later be required to submit documentation to support your claimed Allowed Amounts.

IMPORTANT: Please note that, if a Health Care System or Health Care Facility is only able to submit their own estimated Allowed Amounts for certain years and not others during the period from July 24, 2008 through October 4, 2024, it should still do so, and the Provider Plaintiffs' experts will use the Consumer Price Index for hospital and related services to backcast the Allowed Amounts for prior years, forecast the Allowed Amounts for later years and interpolate, assuming linear growth, the Allowed Amounts for years in between years with Allowed Amounts.

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

If you have any questions, please contact the Settlement Notice Administrator by telephone at (888) 452-3095 or by email at Administrator@BCBSProviderSettlement.com.

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 Health Care System, the payment will be made to the Health Care System for distribution by the Health Care System to individual Health Care Facilities.

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 HOSPITAL/FACILITY 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 HEALTH CARE SYSTEM OR INDIVIDUALLY, BUT NOT BOTH).

Indicate whether the Claimant is a Health Care System or Health Care Facility and complete the information below. Check one only.

☐ **HEALTH CARE SYSTEM**	If Health Care System, please indicate the number of Health Care Facilities for whom you are filing this claim.	

Health Care System Name	*National Provider Identifier (NPI)*
Name and Title of Person Filing	*Phone Number*
Email Address of Person Filing	

Health Care System: Please see Instructions. You must complete the Rider to this Claim Form and provide the required information regarding all Health Care Facilities for which you are filing a claim.

☐ **HEALTH CARE FACILITY**	*Health Care Facility Name*
National Provider Identifier (NPI)	*Phone Number*
Name and Title of Person Filing	
Email Address of Person Filing	

Provide the business address for the Health Care System or Health Care Facility.

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

If you are a lawyer or law firm representing the Claimant, provide the information below.

Lawyer Name	*Law Firm Name*	
Address 1	*Address 2*	
City	*State*	*Zip Code*
Lawyer/Law Firm Email Address	*Lawyer/Law Firm Phone Number*	

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 the Health Care System or Health Care Facility identified above is, or includes, a Class Member (as described in the Class Notice).

Check **ONLY ONE** of the boxes below to designate the method that the Claimant wishes to determine the Allowed Amounts that will form the basis of this claim.

Option A (the "Default Method") permits a Health Care System or Health Care Facility to submit the information requested in the attached Rider **EXCEPT FOR** the estimated Allowed Amounts so that the Settlement Notice Administrator can query the claims data available to it to estimate the Health Care System's or Health Care Facility's Allowed Amounts.

Option B (the Alternative Method") permits a Health Care System or Health Care Facility to submit its own estimated Allowed Amounts for the time period from July 24, 2008 through October 4, 2024, which will be validated by the Settlement Notice Administrator.

(Claim Form 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 HOSPITAL/FACILITY NET SETTLEMENT FUND

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

☐ **Option A (the "Default Method")**

A Health Care System or Health Care Facility that checks Option A must provide all the information requested in the attached Rider **EXCEPT FOR** the estimated Allowed Amounts for each Health Care Facility for which it is submitting a claim.

☐ **Option B (the "Alternative Method")**

A Health Care System or Health Care Facility that checks Option B must provide all the information requested in the attached Rider **INCLUDING** the estimated Allowed Amounts for each Health Care Facility for which it is submitting a claim. Estimated Allowed Amounts must be provided for Health Care Facilities not open prior to January 1, 2015. If the Settlement Notice Administrator is unable to validate the Allowed Amounts you have claimed, you may later be required to submit documentation to support your claimed Allowed Amounts.

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 PAYMENT**
(For any payment amount; for payments less than $100,000, there may be a fee of up to $25 for this payment method; for payments of $100,000 or more, there may be a fee of up to $100 for this payment method.)

The check will be made payable to the Health Care System or Health Care Facility listed in Section A. If the payment address is different than the business address listed in Section A, provide the address to which you would like the check issued below.

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

☐ **ACH PAYMENT**
(For any payment amount; there are no fees associated with this payment method.)

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 3-5 business days after the initiation of the payment.

Account Name: ____

Account Type (Checking/Savings): ______________________________

Bank ACH Routing Number (9 Digits): ___________________________

Account Number (Up to 16 Digits): _____________________________

(Claim Form 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 HOSPITAL/FACILITY NET SETTLEMENT FUND

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

☐ **WIRE TRANSFER**
(For payment amounts of $250,000 or more; there may be a fee of up to $100 for this payment method.)

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 1-3 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.*

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**
(For payment amounts $10,000 or less; there are <u>no</u> fees associated with this payment method.)

The PayPal payment will be issued to the Health Care System or Health Care Facility identified on the first page. Be sure that the email address below is for the PayPal account to which funds are to be paid. There is no charge to receive a PayPal payment and no fees will be deducted from your award.

Email Address Associated with PayPal Account: ____

☐ **VENMO**
(For payment amounts $10,000 or less; there are <u>no</u> fees associated with this payment method.)

The Venmo payment will be issued to Health Care System or Health Care Facility 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. There is no charge to receive a Venmo payment and no fees will be deducted from your award.

Email Address Associated with Venmo Account: ____

Phone Number Associated with Venmo Account: ____

(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 HOSPITAL/FACILITY NET SETTLEMENT FUND

☐ **VIRTUAL MASTERCARD**
(For payment amounts $10,000 or less; there are no fees associated with this payment method.)

The Virtual Mastercard will be issued to the Health Care System or Health Care Facility identified on the first page. Be sure that the email address below is for the Health Care System or Health Care Facility. There is no charge to receive a Virtual Mastercard payment and no fees will be deducted from your award.

Email Address: ____

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

Enter the Tax Identification Number of the Claimant whose name will appear on any check and related Form-1099.	*Tax Identification Number (TIN)*

By signing this Claim Form, I certify that:

1. The number shown on this form above is the correct Tax 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 D required to avoid backup withholding.

Signature of Claimant	*Date*

Any Claim Form submitted online or postmarked after July 29, 2025 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.**
- **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 26443, Richmond, VA 23261.

If you have any questions, please contact the Settlement Notice Administrator by telephone at (888) 452-3095 or by email at Administrator@BCBSProviderSettlement.com.

RIDER FOR HEALTH CARE SYSTEMS AND HEALTH CARE FACILITIES

Health Care System or Health Care Facility Name	
Name and Title of Person Filing	*Phone Number*
Email Address of Person Filing	

List of Health Care Facilities and Key Information For EACH Health Care Facility for Whom You Are Submitting Claims
(Please attach additional pages of this form, if necessary)

Health Care Facility Name:

Health Care Facility Type		
Business Address 1	*Business Address 2*	
Business City	*Business State*	*Business Zip Code*
Billing National Provider Identifier (NPI)	*Billing Tax ID Number (TIN)*	
First Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)	*Last Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)*	
Does Facility Provide Inpatient Services (IP), Outpatient Services (OP) or Both?	*Time Period for Which Claimant is Submitting Claim on behalf of Health Care Facility (Format: MM/DD/YYYY to MM/DD/YYYY)*	

If you selected Option B ("Alternative Method"), complete the Estimated Allowed Amounts from 7/24/2008 through 10/4/2024, including information for each year, Inpatient Services, and Outpatient Services.
If you selected Option A ("Default Method"), you do not need to complete the Estimated Allowed Amounts below.

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Inpatient Services (IP)									
Outpatient Services (OP)									
	2017	2018	2019	2020	2021	2022	2023	2024	
Inpatient Services (IP)									
Outpatient Services (OP)									

To add information for more Health Care Facilities, 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 Health Care Facility. 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.

List of Health Care Facilities and Key Information For EACH Health Care Facility for Whom You Are Submitting Claims
(Please attach additional pages of this form, if necessary)

Health Care Facility Name:

Health Care Facility Type

Business Address 1

Business Address 2

Business City

Business State

Business Zip Code

Billing National Provider Identifier (NPI)

Billing Tax ID Number (TIN)

First Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)

Last Date of Service During Period from 7/24/2008 to 10/4/2024 (Format: MM/DD/YYYY)

Does Facility Provide Inpatient Services (IP), Outpatient Services (OP) or Both?

Time Period for Which Claimant is Submitting Claim on behalf of Health Care Facility (Format: MM/DD/YYYY to MM/DD/YYYY)

If you selected Option B (“Alternative Method”), complete the Estimated Allowed Amounts from 7/24/2008 through 10/4/2024, including information for each year, Inpatient Services, and Outpatient Services. If you selected Option A (“Default Method”), you do not need to complete the Estimated Allowed Amounts below.

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Inpatient Services (IP)									
Outpatient Services (OP)									
	2017	2018	2019	2020	2021	2022	2023	2024	
Inpatient Services (IP)									
Outpatient Services (OP)									

To add information for more Health Care Facilities, you may print and use extra copies of this page as many times as needed to submit information for each Health Care Facility. 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.