CLAIM FORM

Claim Deadline: March 4, 2025

Please read the instructions carefully before filling out this Claim Form (this "Claim Form"). Capitalized terms not otherwise defined shall have the meanings ascribed to them in the Acute Care Hospital Class Action Settlement Agreements[1] (the "Settlement Agreements") in *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. Johnson & Johnson, et al.*, Case No. 1:23-cv-00903-KWR-JFR (D.N.M.) available on the settlement website at www.acutecarehospitalsettlement.com. Each entity making a Claim ("Claimant") must submit a separate Claim Form.

To be eligible to make a Claim, the Claimant must fall within one or more of the following categories:

(1) Claimant is an Acute Care Hospital in the United States that treated patients diagnosed with opioid use disorder and/or other opioid-related conditions from January 1, 2009, through October 30, 2024, and is not owned or operated by a federal, state, county, parish, city, or other municipal government. To be considered an Acute Care Hospital under the Settlement Agreements, Claimant must (a) provide medical care and other related services for surgery, acute medical conditions or injuries for a period of treatment time that is, on average, less than 25 days; and (b) either (i) appear as either active or inactive in the American Hospital Directory® as a "short term acute care" hospital or a "critical access" hospital or (ii) have an emergency department that is subject to the Emergency Medical Treatment and Labor Act ("EMTALA");

(2) Claimant is listed on Exhibit A to the Acute Care Hospital Class Action Settlement Agreement for which it is submitting a Claim; and/or

(3) Claimant is one of the Plaintiffs in the Other Actions listed on Exhibit B to the Acute Care Hospital Class Action Settlement Agreement for which it is submitting a Claim.

Exhibits A and B to each Settlement Agreement are non-exhaustive lists and do not purport to identify all members of the Settlement Class for that particular Settlement.[2] A Class Member may be eligible to make a Claim for one or more Settlements.

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

[1] "Acute Care Hospital Class Action Settlement Agreements" refers collectively to the Distributor Class Action Settlement Agreement with Acute Care Hospitals dated September 26, 2024, the Janssen Class Action Settlement Agreement with Acute Care Hospitals dated September 27, 2024, the Teva Defendants Class Action Settlement Agreement with Acute Care Hospitals dated September 30, 2024, and the Allergan Defendants Class Action Settlement Agreement with Acute Care Hospitals dated October 1, 2024 available at www.acutecarehospitalsettlement.com.

[2] Inclusion of an entity on Exhibit A and/or as a Plaintiff in the Other Actions listed on Exhibit B to a particular Settlement does not determine whether that entity is eligible for any other Settlement.

Settlement Agreement.[3] A Claimant may be ineligible for recovery under one or more Settlement Agreement(s), but still be eligible for recovery under other Settlement Agreements if it meets the eligibility criteria for those other Settlement Agreements.

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

The submission of this Claim Form by the Claim deadline of 5:00 p.m., Central Standard Time, on **March 4, 2025**, (the "Claim Deadline") is a prerequisite to eligibility for an Allocated Amount but does not guarantee that a Class Member will be deemed eligible to receive an Allocated Amount. If a Class Member is deemed eligible to receive an Allocated Amount, the information provided in this Claim Form will be used to determine each such Allocated Amount. Class Members may redact information on this Claim Form or any attached documents as they deem necessary, although redactions may impact the Notice and Claims Administrators' determinations as to eligibility or the Allocated Amount. A Class Member shall only submit through the secure file transfer protocol ("SFTP") link *copies* of any documents that support a claim and shall not mail or transmit hard copies or original documents; documents submitted may be destroyed after scanning and will not be returned to the Class Member.

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

[3] Exclusion of a Claimant from one Settlement Agreement on this basis does not necessarily prevent a Claimant from being eligible for the other Settlement Agreements identified in Footnote 1.

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

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

A. Claimant Information

Please provide the information in Section A for the Claimant:

1. Name of Acute Care Hospital:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Duration of Ownership:	Date Acquired/Opened	Date Sold/Closed	
4. Number of Staffed Beds[4]:			
5. Name of Operating Entity:			
6. Federal Employer Identification Number of Operating Entity:	_____ - _____		
7. Claimant Number: If you received a Claimant Number after you completed your Registration Form, please provide that four-digit Claimant Number.	_____		

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

B. Contact Information

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

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

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

C. Attorney Information

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

Yes ☐

No ☐

If yes, please provide your attorney's name, phone number, mailing address, and email:

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

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

Yes ☐

No ☐

D. W-9 Form

If Yes was selected in Section C.2, please complete a W-9 Form for the law firm identified in Section C of this Claim Form and return it with this Claim Form. If not working with an attorney or if No was selected in Section C.2, please complete the W-9 Form attached hereto and return it with this Claim Form for the Claimant identified in Section A of this Claim Form.

E. Payment Information

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

F. Additional information for Claimants seeking calculated amounts (non-Quick-Pay option)

If you wish to claim an Allocated Amount on the basis of a calculated amount, and not the Quick-Pay option as defined in the Registration Form and Plan of Allocation, you must complete this Section F, including submission of all of the data identified in Item 8 below.[5] **Failure to provide claims data for the entire time period from January 1, 2015 through December 31, 2020 may result in a reduction in Operational Impact, as defined in the Plan of Allocation.**

1. Have you, as of the date of the completion of this Claim Form, provided to the Notice and Claims Administrators all of the requisite claims data relating thereto (as described in Item 8 below) to the best of your knowledge?[6] ☐ Yes ☐ No

2. Are you a named plaintiff in any active cause of action against opioid manufacturers, distributors, or pharmacies? ☐ Yes ☐ No

    a. If yes, please indicate whether the active cause of action is pending (check one below and provide the case number):
        i. in the Multidistrict Litigation, Case No. 1:17-md-2804: ☐
        ii. in federal court: ☐ Case Number: _____
        iii. in state court: ☐ Case Number: _____

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

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

[6] A Claimant who previously timely filed a Claim to the Hospital Trust in the Chapter 11 case of Mallinckrodt plc, et al., No. 20-12522 in the United States Bankruptcy Court for the District of Delaware that contained all of the requisite claims data from January 1, 2015 through December 31, 2020 and was approved for an allocation need not complete Item 8 below.

3. Does the Acute Care Hospital listed above fall within one or more of the following categories?
☐ Yes ☐ No

   a. An Acute Care Hospital in the United States that treated patients diagnosed with opioid use disorder and/or other opioid-related conditions from January 1, 2009, through October 30, 2024, and is not owned or operated by a federal, state, county, parish, city, or other municipal government that (i) provides medical care and other related services for surgery, acute medical conditions, or injuries for a period of treatment time that is, on average, less than 25 days; and (ii) either (a) appears as active or inactive in the American Hospital Directory® as a "short term acute care" hospital or a "critical access" hospital or (b) includes an emergency department that is subject to the Emergency Medical Treatment and Labor Act ("EMTALA");

   b. an entity listed on Exhibit A to the Acute Care Hospital Settlement Agreements for which it is submitting a claim; and/or

   c. a Plaintiff in the Other Actions listed on Exhibit B to the Acute Care Hospital Settlement Agreements for which it is submitting a claim.

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

5. Has the Acute Care Hospital listed above produced claims data (as described in Item 8 below herein) to the Settling Defendants, for the cause of action noted in Item 2(a) above?
☐ Yes ☐ No

6. Has the Acute Care Hospital listed above actively engaged in discovery, for the cause of action, if any, noted in Item 2(a) above? ☐ Yes ☐ No

   If yes, please indicate below those activities in which the Acute Care Hospital has actively engaged[7]:

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

   b. Supplied hospital financial documents, policies and procedures, custodial emails, dispensing and discharge prescription data in response to requests by Settling Defendants or orders of a court? ☐ Yes ☐ No

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

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

d. Propounded discovery to Settling Defendants? ☐ Yes ☐ No

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

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

7. Did the Acute Care Hospital listed above have a court-ordered trial date, for the cause of action, if any, noted in Item 2(a) above?
☐ Yes ☐ No

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

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

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

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

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

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

Once the CSV (Comma Delimited) or Pipe-Delimited Electronic Text File is prepared, **please review the data VERY CAREFULLY** to confirm the data in each column contains the applicable data for that respective column's data field description. For example, payment amounts (Total Payments) should not be shown in the DRG Code column/data field or ICD Diagnosis Code column/data field should not be blank or designated null for a patient visit without an explanation, etc. In conducting your review, this will require that you "reality test" your data before submission to ensure that it does not contain obvious errors and inconsistencies. **Each Class Member will be provided a secure portal by the Notice and Claims Administrators to upload an executed Business Associate Agreement ("BAA") with Cherry Bekaert Advisory, LLC (formerly known as Legier & Company, apac), and upload this requisite claims data to the secure portal.**

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

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

Column	Data Fields	Definitions and Clarifications
		same single column with each ICD diagnosis code shown on separate rows within the same single column. See Exhibit A.
ad.	**ICD Diagnosis Code Descriptions**	Provide ICD diagnosis code descriptions for the above ICD diagnosis codes.
ae.	**ICD Diagnosis Code Priority**	Provide whether each ICD diagnosis code is a Primary, Secondary, Tertiary, etc. diagnosis. These categories must be expressed in terms of a numerical code such as 1=Primary, 2=Secondary, 3=Tertiary, etc.
af.	**Mother's MRN (if applicable)**	This field pertains only to Acute Care Hospitals that deliver newborn babies or have a neonatal unit. If this visit/charge is for a birth mother, then this field should be blank as it would be the same MRN as the patient reported in row g. above. However, if this visit/charge pertains to a baby, then this field should contain the mother's MRN so that there can be a mother/baby link associated therewith.
ag.	**Baby's MRN (if applicable)**	This field pertains only to Acute Care Hospitals that deliver newborn babies or have a neonatal unit. If this visit/charge is for a baby, then this field should be blank as it would be the same MRN as the patient reported in row g. above. However, if this visit/charge pertains to a birth mother, then this field should contain the Baby's MRN so that there can be a mother/baby link associated therewith.

G. Certification

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

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

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

1. **Distributor Class Action Settlement Agreement with Acute Care Hospitals**
   ☐ YES ☐ NO
2. **Janssen Class Action Settlement Agreement with Acute Care Hospitals**
   ☐ YES ☐ NO
3. **Teva Defendants Class Action Settlement Agreement with Acute Care Hospitals**
   ☐ YES ☐ NO
4. **Allergan Defendants Class Action Settlement Agreement with Acute Care Hospitals**
   ☐ YES ☐ NO

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

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

Signature: _____

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

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

Name (First Middle Last): _____

Title: _____

Acute Care Hospital: _____

Address: _____

_____

_____

Contact Phone: _____

Email: _____

Data Request Example
EXHIBIT A

	A	B	C	D	E	F	G	H	I	J
1	**Hospital Name**	**Hospital Address**	**Hospital City**	**Hospital State**	**Hospital Zip**	**CMS Certification Number**	**Patient Medical Record #**	**Patient Account #**	**Payor Financial Class Description**	**Patient Type**
2	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient
3	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient
4	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient
5	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12346	Blue Cross	Outpatient
6	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12346	Blue Cross	Outpatient
7	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	999	A12399	Blue Cross	Outpatient
8	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	102	A12356	Medicare	Inpatient
9	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	102	A12356	Medicare	Inpatient
10	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
11	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
12	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
13	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
14	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
15	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12368	Champus	Emergency
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										

Data Request Example
EXHIBIT A

	K	L	M	N	O	P	Q	R	S
1	**Custom Patient Type**	**Date of Admission**	**Date of Discharge**	**Length of Stay**	**Admission Type Description**	**Discharge Disposition Description**	**Patient Date of Birth**	**Patient Age**	**Patient Gender**
2	Lab	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
3	Lab	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
4	Lab	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
5	OB	2/28/2017	3/1/2017	1	O/P Obersvation	Discharge Home	4/1/1980	36	Female
6	OB	2/28/2017	3/1/2017	1	O/P Obersvation	Discharge Home	4/1/1980	36	Female
7	Nursery	2/28/2017	2/28/2017	1	O/P Obersvation	Discharge Home	2/28/2017	0	Female
8	Lab	4/15/2016	4/18/2016	3	Transfer	Discharge Home	1/1/1955	61	Male
9	Lab	4/15/2016	4/18/2016	3	Transfer	Discharge Home	1/1/1955	61	Male
10	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
11	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
12	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
13	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
14	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
15	ER	7/4/2017	7/4/2017	1	Emergency	Discharge Home	2/1/1975	42	Female
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									

There is only one column for ICD Code. Therefore, each patient stay must be replicated as many times as necessary to provide all of the ICD Codes associated with the stay. For example, a patient stay with five ICD Codes would be listed in five rows (e.g., the 12/10/2016 stay of patient 103).

Data Request Example
EXHIBIT A

	T	U	V	W	X	Y	Z	AA	AB	AC
1	**Patient Race**	**Patient City**	**Patient State**	**Patient Zip Code**	**Attending Physician Name**	**Total Charges**	**Total Payments**	**DRG Code**	**DRG Code Description**	**ICD Diagnosis Code**
2	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	B974
3	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	B998
4	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	F1110
5	African American	Shelbyville	US State	12345	Doe, John	$500.00	$125.00			G459
6	African American	Shelbyville	US State	12345	Doe, John	$500.00	$125.00			A419
7	African American	Shelbyville	US State	12345	Doe, John	$600.00	$125.00	795	Normal Newborn	L22
8	Caucasian	Shelbyville	US State	12345	Smith, Jane	$2,000.00	$725.00	603	Cellulitis w/o MCC	Z431
9	Caucasian	Shelbyville	US State	12345	Smith, Jane	$2,000.00	$725.00	603	Cellulitis w/o MCC	T148
10	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	E861
11	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	J209
12	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	Z041
13	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	T1491
14	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	N179
15	African American	Springfield	US State	12367	Doe, John	$1,000.00	$200.00			F1199
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										

There is only one column for ICD Code. Therefore, each patient stay must be replicated as many times as necessary to provide all of the ICD Codes associated with the stay. For example, a patient stay with five ICD Codes would be listed in five rows (e.g., the 12/10/2016 stay of patient 103).

Data Request Example
EXHIBIT A

	AD	AE	AF	AG
1	**ICD Diagnosis Code Description**	**ICD Diagnosis Code Priority**	**Mom's Medical Record #**	**Baby's Medical Record #**
2	Respiratory syncytial virus as the cause of diseases classified elsewhere	1		999
3	Other infectious disease	3		999
4	Opioid Abuse - Uncomplicated	2		999
5	Transient Cerebral Ischemic Attack - Unspecified	2		999
6	Sepsis - Unspecified Organism	1		999
7	Diaper Dermatitis	1	101	
8	Encounter For Attention To Gastrostomy	1		
9	Other Injury Of Unspecified Body Region	2		
10	Hypovolemia	1		
11	Acute Bronchitis - Unspecified	2		
12	Encounter for examination and observation following transport accident	3		
13	Suicide attempt	4		
14	Acute Kidney Failure - Unspecified	5		
15	Opioid Use - Unspecified With Unspecified Opioid-Induced Disorder	1		
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31