United States District Court for the Northern District of Ohio
Eastern Division

IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION	MDL 2804 Case No. 1:17-md-2804

INSTRUCTIONS FOR SUBMITTING YOUR CLAIM FORM

A Third-Party Payor (TPP) Class Member or an authorized agent for a TPP Class Member may complete this Claim Form. The Notice and Claims Administrator may request supporting documentation in addition to the documentation and information requested below. The Notice and Claims Administrator may reject a claim if the TPP Class Member or its authorized agent does not provide all requested documentation and information in a timely manner. If both a TPP Class Member and its authorized agent submit a Claim Form, the Notice and Claims Administrator will review both and determine which is controlling, as well as the amount of the Claim, giving consideration to the extent to which the claims overlap or supplement one another.

If you are a TPP Class Member submitting a Claim Form on your own behalf, you must provide the information requested in "**Section A – COMPANY OR HEALTH PLAN TPP CLASS MEMBER ONLY**," in addition to the other information requested in this Claim Form.

If you are an **authorized agent** of one or more TPP Class Members, you must provide the information requested in "**Section B – AUTHORIZED AGENT ONLY**," in addition to the other information requested in this Claim Form.

If you are submitting a Claim Form only as an authorized agent of two or more TPP Class Members, you may submit a separate Claim Form for each TPP Class Member OR you may submit a "Consolidated Claim" via a single Claim Form for all such TPP Class Members.

For those Consolidated Claims that are being submitted for multiple TPP Class Members, the filer shall provide **aggregate** information as directed in Sections C or D of this Claim Form, and submit along with this Claim Form a chart identifying the TPP Class Members included in the Consolidated Claim, as directed in Section B. For each TPP Class Member included in the Consolidated Claim, the chart shall provide: (i) the name of the TPP Class Member claimant and (ii) the TPP Class Member's Federal Tax Identification Number (FEIN).

The "TPP Methodology NDCs" and "TPP Methodology ICD Codes" necessary to complete Section C are available at **www.TPPOpioidSettlement.com.**

To qualify to receive a payment from the Settlement, you must complete and submit this Claim Form either on paper or electronically on the Settlement website, **www.TPPOpioidSettlement.com**, and you may need to provide certain requested documentation to substantiate your Claim.

Your failure to complete and submit the Claim Form postmarked (if mailed) or received (if submitted online) on or before **June 20, 2025,** will prevent you from receiving any payment from the Settlement. Submission of this Claim Form does not ensure that you will share in the payments related to the Settlement. If the Notice and Claims Administrator rejects or reduces your Claim, you may invoke the dispute resolution process described on page 7.

MUST BE POSTMARKED ON OR BEFORE, OR SUBMITTED ONLINE BY JUNE 20, 2025

THIRD-PARTY PAYOR CLAIM FORM

Use Blue or Black Ink Only

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR (OR AN AUTHORIZED AGENT) AND NOT INDIVIDUAL CONSUMERS.

- Complete Section A only if you are filing as an individual TPP Class Member.
- Complete Section B only if you are an authorized agent filing on behalf of one or more TPP Class Members.

Section A: Company or Health Plan TPP Class Member Only

TPP Class Member Name

Contact Name

Care of (if applicable)

Street Address

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Tax Identification Number (FEIN)

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since January 1, 1996.

☐ Health Insurance Company/HMO

☐ Self-Insured Employee Health or Pharmacy Benefit Plan

☐ Self-Insured Health & Welfare Fund

☐ Other (Explain)

Section B: Authorized Agent Only

As an authorized agent, please check how your relationship with the TPP Class Member(s) is best described (you may be required to provide documentation demonstrating this relationship):

☐ Third-Party Administrator or Administrative Services Only Provider

☐ Pharmacy Benefit Manager

☐ Other (Explain): _____

Authorized Agent's Company Name

_____

Contact Name

_____

Street Address _____ Floor/Suite _____

City _____ State _____ Zip Code _____

Area Code - Telephone Number _____ Authorized Agent's Tax Identification Number _____

Email Address

_____

Please list the name and FEIN of every TPP Class Member (*i.e.,* Company or Health Plan) for whom you are submitting this Claim Form (attach additional sheets to this Claim Form as necessary). Alternatively, you may submit the requested list of TPP Class Member names and FEINs in an electronic format, such as Excel or a tab-delimited text file. Contact the Notice and Claims Administrator to determine what formats are acceptable. Claim Forms submitted on behalf of two or more TPP Class Members are referred to as Consolidated Claims. In either case, the list shall be maintained as confidential by the Notice and Claims Administrator.

TPP CLASS MEMBER'S NAME	TPP CLASS MEMBER'S FEIN

Section C: TPP Claims Methodology 1 - Transactional Claims Data Available

Recognizing the difficulty of producing (claims or enrollment) data for the early part of the Class Period, we are asking for such data beginning only in 2008. TPP Class Members that are able to access pharmacy and medical transactional claims data from 2008-2024 must utilize the methodology outlined in this Section C to complete this Claim Form.

For the TPP Class Member(s) on whose behalf you are submitting this Claim Form, please provide the following information or utilize the forms for both individual and Consolidated Claims provided by the Notice and Claims Administrator at **www.TPPOpioidSettlement.com**.

i. By state, *on an aggregated basis for entities filing Consolidated Claims*, identify: the total dollar amount paid or reimbursed by the TPP Class Member(s) for the TPP Methodology NDCs from January 1, 2008 to September 3, 2024.

ii. By state, *on an aggregated basis for entities filing Consolidated Claims*, identify the number of member-years with an opioid use disorder (OUD) diagnosis based on the TPP Methodology ICD Codes from January 1, 2008 to September 3, 2024. Member-years with OUD diagnosis is the sum of the number of unique individuals with an OUD diagnosis within each year, totaled for the most recent 17 years of the damage period. (For example, if you had 10 people per year with OUD in each year for 5 years, that would equal 50 member-years with OUD diagnosis.)

iii. By state, *on an aggregated basis for entities filing Consolidated Claims*, identify the number of Covered Lives* as of January 1, 2024.

iv. The TPP Claim amounts for TPP Class Members that provide the information identified above in this Section C will be calculated as follows:

   a. The estimated medical cost of OUD ($XX,XXX) will be multiplied by the number of member-years with OUD identified in Section C.ii.; and

   b. The dollar value provided in Section C.i. will be combined with the dollar value derived in Section C.iv.a.

*"Covered Lives" means the number of enrollees or beneficiaries covered by the TPP.

What should I do if I have transactional data available for some years but not others?

You **must** follow Methodology 1 outlined in Section C to complete the Claim Form for **all** the years between January 1, 2008 to September 3, 2024 for which you have transactional data available. You may use Methodology 2 outlined in Section D to complete the Claim Form for any remaining years for which you do not have transactional data available.

Please note, if you use Methodology 2 to submit a Claim Form for years that you have or could obtain data for, your entire claim may be rejected.

State	Total Dollar Amount Paid	Member-Years with OUD Diagnosis	Covered Lives as of January 1, 2024

Section D: TPP Claims Methodology 2 - Transactional Claims Data Unavailable

A TPP Class Member that is unable to access pharmacy and medical transactional claims data from 2008 – 2024, as necessary to complete Section C above, should utilize the methodology outlined in this Section D to complete this Claim Form. TPP Class Members electing to utilize TPP Methodology 2 must attest below that they do not have access to the necessary transactional claims data for completing TPP Methodology 1.

For each TPP Class Member on whose behalf you are submitting this Claim Form, and on an *aggregated basis for entities filing Consolidated Claims*, list the number of Covered Lives* for each year in the applicable group of states. Spreadsheet templates of this chart are also available on the Settlement website for both individual and Consolidated Claims, **www.TPPOpioidSettlement.com**.

The Notice and Claims Administrator may request documents or other information from you to support your response below regarding your membership.

*"Covered Lives" means the number of enrollees or beneficiaries covered by the TPP.

	Group 1: AK, AZ, CA, CO, GA, HI, ID, IL, MN, NV, NM, NY, SC, TX, UT, VT, VA, WA, WY Covered Lives	**Group 2: CT, IN, KS, LA, MD, MI, MS, MT, NE, NH, NC, ND, OR, SD, WI Covered Lives**	**Group 3: AL, AR, DE, DC, FL, IA, KY, ME, MA, MO, NJ, OH, OK, PA, RI, TN, WV Covered Lives**
2008			
2009			
2010			
2011			
2012			
2013			
2014			
2015			
2016			
2017			
2018			
2019			
2020			
2021			
2022			
2023			
2024			

If you are unable to break down the number of covered lives by state, please complete the chart below with the number of covered lives by year. You may receive less than you may have otherwise been eligible for in accordance with the Plan of Allocation.

	All States Covered Lives
2008	
2009	
2010	
2011	
2012	
2013	
2014	
2015	
2016	
2017	
2018	
2019	
2020	
2021	
2022	
2023	
2024	

For TPP Class Members electing to utilize TPP Methodology 2: After all Claims have been filed, the Notice and Claims Administrator will calculate an average dollar value per covered life, based on all TPP information accumulated from submissions pursuant to Section C. The Notice and Claims Administrator will apply this average dollar value to the information provided above in this Section D.

Section E: Proof of Payment and Disputes Regarding Claim Amounts

Please provide as much of the information requested above as possible. **If you submitted pharmacy transaction data supporting your claim in *In re McKinsey & Co., Inc. National Prescription Opiate Consultant Litigation*, No. 21-md-02996-CRB pending in the United States District Court for the Northern District of California, you do not need to submit transaction data with this claim, but you still must submit this claim form**. If you did not make a claim in *In re McKinsey*, or did not submit pharmacy transaction data in that case, pharmacy transaction data supporting the claims identified in Section C above is mandatory for Section C.i. amounts of $300,000 or more, although the Notice and Claims Administrator may also require pharmacy transaction data for claims of less than $300,000, so keep related transaction data and any other claim documentation supporting your Claim (e.g., invoices) in case the Notice and Claims Administrator requests it later. If the Section C.i. amount is less than $300,000, you should still provide the pharmacy transaction data with your Claim submission if you can if you did not do so in your *In re McKinsey* claim.

☐ Check this box if you provided data with your claim form in *In re McKinsey* and would like the Notice and Claims Administrator to append this same data to this claim form.

While not required to be submitted along with your initial Claim Form, please also retain all medical transaction data supporting your Section C.ii. amounts in case the Notice and Claims Administrator requests it later.

If, after an audit of your Claim, the Notice and Claims Administrator still has questions about your Claim and you have not provided sufficient substantiation of your Claim, the Notice and Claims Administrator may reject your Claim.

If the Notice and Claims Administrator rejects or reduces your Claim and you believe the rejection or reduction is in error, you may contact the Notice and Claims Administrator to request further review. If the dispute concerning your Claim cannot be resolved by the Notice and Claims Administrator and Settlement Class Counsel, you may request that the Court review your Claim.

Section F: Certification

I/We have read and am/are familiar with the contents of the Instructions accompanying this Claim Form. I/We certify that the information I/we have set forth in the above Claim Form and in any documents attached by me/us are true, correct, and complete to the best of my/our knowledge. I/We certify that I/we, or the TPP Class Member(s) I/we represent:

a. During the period January 1, 1996 to September 3, 2024, (i) paid and/or were reimbursed for any or all of the opioid prescription drugs identified in the TPP Methodology NDCs (which were manufactured, marketed, sold, distributed, or dispensed by any of the Defendants and/or Opioid Supply Chain Members), for purposes other than resale, **and/or** (ii) paid or incurred costs for treatment related to the misuse, addiction, and/or overdose of opioid drugs, as identified in the TPP Methodology ICD Codes, on behalf of individual beneficiaries, insureds, and/or members; and

b. Is not one of the following excluded parties: (1) all federal governmental entities and all state and local governmental entities whose claims have been released by a prior settlement with the Settling Distributors; (2) Pharmacy Benefit Managers ("PBMs"); (3) consumers; (4) fully insured plan sponsors; (5) Excluded Insurers (Aetna, Anthem, Cigna, Humana, and UnitedHealth), including all related entities (other than Medicare Part C and Part D plans and Medicaid MCO plans which are included in the Class); (6) Settling Distributors and their subsidiaries, affiliates, and controlled persons; (7) officers, directors, agents, servants, or employees of any Settling Distributor, and the immediate family members of any such persons; (8) persons and entities named as Defendants in any of the actions centralized in MDL No. 2804; and (9) anyone that excluded themselves from the TPP Class.

I/We further certify that I/we have provided all of the information requested above to the extent I/we have it.

I/We further certify that to the extent I/we am/are submitting this Claim Form pursuant to Section D, TPP Claims Methodology 2, above, I/we do not reasonably have access to the transactional claims data necessary to complete and submit this Claim Form pursuant to Section C, TPP Methodology 1.

To the extent I/we have been given authority to submit this Claim Form by one or more TPP Class Members on their behalf, and accordingly am/are submitting this Claim Form in the capacity of an authorized agent with authority to submit it, and to the extent I/we have been authorized to receive on behalf of the TPP Class Member(s) any and all amounts that may be allocated to them from the Settlement Fund, I/we certify that such authority has been properly vested in me/us and that I/we will fulfill all duties I/we may owe the TPP Class Member(s). If amounts from the Net Settlement Fund are distributed to me/us and a TPP Class Member later claims that I/we did not have the authority to claim and/or receive such amounts on its behalf, I/we and/or my/our employer will hold the Class, Settlement Class Counsel, Settling Distributors, and the Notice and Claims Administrator harmless with respect to any claims made by the TPP Class Member.

I/We further certify that that I/we, or the TPP Class Member(s) I/we represent, have authority to release all Released Claims on behalf of the TPP Class Member(s) and all other entities who are Releasors by virtue of their relationship or association with it/them.

I/We hereby submit to the jurisdiction of the United States District Court for the Northern District of Ohio for all purposes connected with this Claim Form, including resolution of disputes relating to this Claim Form. I/We acknowledge that any false information or representations contained herein may subject me/us to sanctions, including the possibility of criminal prosecution. I/We agree to supplement this Claim Form by furnishing documentary backup for the information provided herein, upon request of the Notice and Claims Administrator.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Claim Form was executed this _____ day of _____ 2025.

Signature	Position/Title

Print Name	Date

Mail the completed Claim Form to the address below, postmarked on or before **June 20, 2025**, or submit the information online at the Settlement website below by that date:

In re National Prescription Opiate Litigation
c/o A.B. Data, Ltd.
P.O. Box 173026
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-411-4860
Website: www.TPPOpioidSettlement.com
Email: info@TPPOpioidSettlement.com

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form. Attach or upload any required documentation supporting your claim.
2. Keep a copy of your Claim Form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Claim Form, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.
4. If you move and/or your name changes, please send your new address and/or your new name or contact information to the Notice and Claims Administrator at info@TPPOpioidSettlement.com or via U.S. Mail at the address listed above.