CLAIM FORM
Kenneth Keslar II v. Emerus / BHS Thousand Oaks LLC et. al., Case No. 2020-CI-18623
District Court of Texas, 73rd Judicial District, Bexar Country, Texas

IF YOU DO NOT FOLLOW THESE INSTRUCTIONS, YOUR CLAIM COULD BE DELAYED OR REJECTED.

I. INSTRUCTIONS FOR MAKING A CLAIM

TO MAKE A CLAIM FOR A REFUND:

1. **Complete and sign this Claim Form**.
   - Make sure this form is filled out completely and accurately.
   - You must sign and date the RELEASE AND SWORN VERIFICATION STATEMENT (Part IV).

2. **Mail the completed Claim Form and supporting documentation** to the Settlement Administrator at the address shown on the last page of this form, **postmarked no later than September 18, 2023.**

You should include information for each visit for which you are seeking a refund in the Service Information Page included in this Claim Form. If you need additional copies of the Service Information Page or need a new Claim Form, you may contact the Settlement Administrator, RG/2 Claims Administration LLC by phone at 1-866-742-4955 or by email at BaptistEmergencyHospitalSettlement@rg2claims.com.

(NOTE: YOU DO NOT NEED TO COMPLETE THIS FORM TO GET A WRITE-OFF)

II. PATIENT INFORMATION

____
Patient Full Name*

____
Street Address (P.O. BOX ADDRESSES AND POSTAL OFFICE ADDRESSES ARE NOT VALID) *

______________ __ _____-____
City* State* Zip Code*

___-___-____ __-__-____ ______________
Telephone Number Date of Birth* (MM/DD/YYYY)

____
E-mail Address

____
Guardian Full Name* (If Patient Is under the Age of 18)

- Is the person completing and submitting this Claim Form the Patient or Guardian identified above*?

  _Yes

  _No

If no, what is your name and relation to the Patient?

____
Submitter Full Name

____
Submitter Relation to the Patient (*e.g.*, Sibling, Spouse, *etc.*):

(Note: Refund checks will be sent to the mailing address provided on this Claim Form. It is **your** responsibility to send the Settlement Administrator your new contact information, if it changes, to ensure receipt of Refund check and/or further notices.If you prefer to get your refund through electronic payment, please fill out the Claim Form on the website or contact the Settlement Administrator.)

III. SERVICE INFORMATION

Please identify on the following Service Information Page details regarding the Baptist Emergency Hospital (now known as Baptist Neighborhood Hospital), date of service, and bill you received for a BMP (includes CK) and LFT (includes Amylase) laboratory panel tests performed between September 25, 2016 and January 27, 2023. **You must complete a section of the Service Information Page for each date of service for which you are seeking a refund. If you are submitting this Claim Form for more than three dates of service, you may print additional copies of the Service Information section of this Claim Form at www.BaptistEmergencyHospitalSettlement.com.**

NOTE: If you do not know whether the Texas hospital you went to was a Baptist Emergency Hospital, you may call the Settlement Administrator at the following toll-free number: 1-866-742-4955.

Service Information Page

__-__-____
Date of Service* (MM/DD/YYYY)

____
Hospital Name*

____
Hospital Address

__________________ __ _____-____
Hospital City* State Zip Code

The laboratory test panels, performed at this visit, that you are seeking a Refund for (**Check all that apply**):

_ BMP (includes CK)
_ LFT (includes Amylase)

Insurance details

____
Name of Insurance Company

____

Type of Insurance Plan

Bill and payment details (if known)

__-__-____ ______________

Date of the Bill Bill Amount

____

Amount paid (if any)

__-__-_____

Additional Date of Service (MM/DD/YYYY)

____

Hospital Name

____

Hospital Address

_____________________ ____ _____-____

Hospital City State Zip Code

The laboratory test panels, performed at this visit, that you are seeking a Refund for (**Check all that apply**):

_ BMP (includes CK)
_ LFT (includes Amylase)

Insurance details

____

Name of Insurance Company

____

Type of Insurance Plan

Bill and payment details (if known)

__-__-____ ________

Date of the Bill Bill Amount

______

Amount paid (if any)

__-__-____

Additional Date of Service (MM/DD/YYYY)

____

Hospital Name

____
Hospital Address

_______________ __ _____-____
Hospital City State Zip Code

The laboratory test panels, performed at this visit, that you are seeking a Refund for (**Check all that apply**):

_ BMP (includes CK)
_ LFT (includes Amylase)

Insurance details

____
Name of Insurance Company

____
Type of Insurance Plan

Bill and payment details (if known)

__-__-____ ________
Date of the Bill Bill Amount

______
Amount paid (if any)

IV. RELEASE AND SWORN VERIFICATION STATEMENT

PLEASE READ THE BELOW CAREFULLY AS IT WILL AFFECT YOUR LEGAL RIGHTS.

With full awareness and understanding of this release, I hereby acknowledge I have received the Notice of Settlement ("Notice"). I submit this Claim Form to participate in the settlement reached in this Lawsuit, and submit to the jurisdiction of the District Court of Texas, 76th District, Bexar County, with respect to my claim asserted herein, and for purposes of enforcing the release of claims stated in this Claim Form and in the Notice. I further agree and acknowledge that I am bound by the terms of the Order and Judgment that may be entered by the Court in this Lawsuit, and the terms of the Settlement Agreement, including the release of claims set forth therein.

I, ____________________________________, (**PRINT PATIENT NAME OR GUARDIAN NAME IF PATIENT IS UNDER THE AGE OF 18**), swear under penalty of perjury of the laws of Texas that the information I have supplied in this Claim Form is accurate, truthful, and complete in all respects. I understand that the above information will be reviewed and verified by a representative from the Settlement Administrator, and that I may be contacted for more information, if needed. I understand that my claim will be reviewed by the Settlement Administrator and may be approved or denied, and pursuant to the Texas Medical Records Privacy Act and the Health Insurance Portability and Accountability Act ("HIPAA"), I consent to and authorize the Settlement Administrator, the Defendants, and the Parties' counsel to review my billing records and any related

medical information on the billing records for the purpose of determining whether or not I am entitled to a Refund.

___________________________________ ____________________

Patient Signature* (Or Guardian If Patient Is Under the Age of 18) Date

You do NOT need to submit any medical records with this Claim Form. If you do include medical information, you expressly acknowledge that it may be reviewed by the Parties' counsel and/or the Settlement Administrator and consent to such review.

An asterisk (*) indicates that it is a mandatory field and if left incomplete, can lead to rejection or delay in processing your claim form.

V. MAILING INSTRUCTIONS

Please mail your completed claim form no later than September 18, 2023 to:

By U.S. Mail:
Baptist Emergency Hospital Settlement
c/o RG/2 Claims Administration LLC
P.O. Box 59479
Philadelphia, PA 19102-9479

YOU ARE STRONGLY ENCOURAGED TO KEEP A COPY OF YOUR COMPLETED CLAIM FORM FOR YOUR RECORDS AND TO ENSURE CONFIRMATION OF DELIVERY USING A TRACKING ENABLED METHOD OF MAIL (E.G., USPS PROOF OF MAILING) OR BY CALLING THE SETTLEMENT ADMINISTRATOR AT 877-522-0019. NEITHER DEFENDANTS (NOR ANY OF THEIR SUBSIDIARIES OR AFFILIATES), PLAINTIFF, THEIR ATTORNEYS, NOR THE SETTLEMENT ADMINISTRATOR ARE RESPONSIBLE FOR LOST, MISDIRECTED, OR DELAYED MAIL SHIPMENTS.

VI. WHAT HAPPENS NEXT?

When your Claim Form is received, it will be reviewed and processed by the Settlement Administrator to determine if you are eligible and have satisfied the requirements for a Refund. If your Claim Form has a defect, and that is curable, the Settlement Administrator will contact you and give you a chance to fix the defect. If you are deemed eligible for a Refund, it will be processed in a reasonable amount of time, as approved by the Court.