PURDUE PERSONAL INJURY TRUST ("PURDUE PI TRUST")

ATTN: EDGAR C. GENTLE, III, ESQ., CLAIMS ADMINISTRATOR
PURDUE PI TRUST
P.O. Box 361930
Hoover, Alabama 35236-1930
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This package contains four documents which are outlined below:

1. **NOTICE OF DEADLINE FOR PERSONAL INJURY CLAIMANTS TO SUBMIT FORMS AND EVIDENCE TO DETERMINE ELIGIBILITY TO RECEIVE PAYMENT FROM THE PERSONAL INJURY TRUST**

2. **NON-NAS PI CLAIM FORM** - To be completed by a Holder of a Claim for personal injury(ies) that arose from the Injured Party's own use of qualifying prescribed opioids.

3. **NAS CLAIM FORM** - To be completed by a Holder of a Claim for a Child with Neonatal Abstinence Syndrome (NAS) personal injury claims.

4. Table listing Proofs of Claim filed by your Firm.

Please review the documents in their entirety to ensure that you are submitting the correct PI Claim Form and Required Information for a Claim on behalf of your Client(s).

As noted throughout the documents, the completed, applicable PI Claim Form along with the Required Information must be submitted to ensure that they are **received by the Claims Administrator on or before July 28, 2025, at 11:59 p.m. Eastern Time.**

Law firms representing more than one Claimant, should visit the Law Firm Bulk Submittal tab on the https://www.purduepitrust.com website for additional information regarding bulk submittal of claims for multiple, represented Claimants.

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re:	**Chapter 11**
PURDUE PHARMA L.P., *et al.*,	**Case No. 19-23649**
Debtors[1]	**(Jointly Administered)**

NOTICE OF DEADLINE FOR PERSONAL INJURY CLAIMANTS TO SUBMIT FORMS AND EVIDENCE TO DETERMINE ELIGIBILITY TO RECEIVE PAYMENT FROM THE PERSONAL INJURY TRUST

You are receiving this package because you are an individual who filed a proof of claim asserting a personal injury claim in Purdue's bankruptcy cases. This package contains important documents that you need to review and prepare responses for to preserve your ability to recover money in Purdue's bankruptcy.

There was a hearing before the bankruptcy court on April 10, 2025. At that hearing, the court approved procedures for gathering information for personal injury claimants to get paid. This is the next step in the process on the way to getting personal injury claimants paid. Even though you filed a proof of claim, you still need to provide additional information in order to determine if you are eligible to be paid. Enclosed are forms for you to provide this information, which you must submit so that your form is received no later than **July 28, 2025, at 11:59 p.m. (Eastern Time)**.

The information you submit will be reviewed by the claims administrator for personal injury claims. On April 15, 2025, the court appointed Ed Gentle as the claims administrator in these cases. He and his team will review the form and other information you submit. If he or his team have questions, they will contact you for additional information.

As you will see, this package contains two different types of claim forms. The first thing you need to do is choose which form applies to you. One is for holders of claims relating to children with neonatal abstinence syndrome (called NAS personal injury claims), and one is for holders of other personal injury claims that are not NAS personal injury claims (called non-NAS personal injury claims). **You must fill out the form that applies to your claim.**

Each form also lists the requirements you must meet in order to be eligible to receive a payment. You also must submit certain proof that is set out in each form. If you already submitted

[1] The Debtors in these cases, along with the last four digits of each Debtor's registration number in the applicable jurisdiction, are as follows: Purdue Pharma L.P. (7484), Purdue Pharma Inc. (7486), Purdue Transdermal Technologies L.P. (1868), Purdue Pharma Manufacturing L.P. (3821), Purdue Pharmaceuticals L.P. (0034), Imbrium Therapeutics L.P. (8810), Adlon Therapeutics L.P. (6745), Greenfield BioVentures L.P. (6150), Seven Seas Hill Corp. (4591), Ophir Green Corp. (4594), Purdue Pharma of Puerto Rico (3925), Avrio Health L.P. (4140), Purdue Pharmaceutical Products L.P. (3902), Purdue Neuroscience Company (4712), Nayatt Cove Lifescience Inc. (7805), Button Land L.P. (7502), Rhodes Associates L.P. (N/A), Paul Land Inc. (7425), Quidnick Land L.P. (7584), Rhodes Pharmaceuticals L.P. (6166), Rhodes Technologies (7143), UDF LP (0495), SVC Pharma LP (5717) and SVC Pharma Inc. (4014). The Debtors' corporate headquarters is located at One Stamford Forum, 201 Tresser Boulevard, Stamford, CT 06901.

this proof along with your proof of claim, you do not have to resubmit the same proof. But it is very important that you review the form to make sure that the proof you submitted meets the requirements in the form.

It is very important that you read the entire form you are submitting and follow the instructions. If you do not fill out the form and submit it by **July 28, 2025, at 11:59 p.m. (Eastern Time**), you may be at risk of losing your right to receive any payment. **You must fill out the form even if you have filed a proof of claim.**

If you do not submit the form and all the required information by **July 28, 2025, at 11:59 p.m. (Eastern Time),** your claim may be objected to, denied, or disallowed.

The deadline to submit forms and the required evidence to the claims administrator is July 28, 2025, at 11:59 p.m. (Eastern Time). If you do not submit your form and required information so that it is received by July 28, 2025, at 11:59 p.m. (Eastern Time), you may lose your right to receive any payment, even if you timely filed a proof of claim in Purdue's bankruptcy.

There are 3 ways to submit the form and the other required information:

- ELECTRONICALLY

  At http://www.purduepitrust.com
  You can also access the PI Trust Website using the following QR code:

  or

  By e-mail to purduepitrust@purduepitrust.com

- U.S. POSTAL SERVICE MAIL:

  Purdue PI Trust
  P.O. Box 361930
  Hoover, Alabama 35236-1930

- FACSIMILE:

  Facsimile to 205-716-2364
  Attn: Purdue PI Trustee

If you have any questions regarding submitting your form, please contact the claims administrator:

Ed Gentle, Esq.
PI Claims Administrator
Purdue PI Trust
P.O. Box 361930
Hoover, Alabama 35236-1930
Telephone: 855-637-5538
purduepitrust@purduepitrust.com

For questions regarding the chapter 11 cases generally, you may contact the advisors to the Official Committee of Unsecured Creditors:

Akin Gump Strauss Hauer & Feld LLP
Purdue Claims Information
One Bryant Park
New York, NY 10036
purduecreditorinfo@akingump.com

Dated: May 29, 2025

NON-NAS PI CLAIM FORM

To be completed by the Holder of a Claim for personal injury that arose from the Injured Party's own use of qualifying prescribed opioids.

NON-NAS PI CLAIM FORM
FOR PURDUE PI TRUST DISTRIBUTION PROCEDURES

Eligibility and Claim Requirements:

In order to be eligible for a Distribution[1] from the Purdue PI Trust (the "**PI Trust**") for a Non-NAS PI Channeled Claim, a claimant will, among other things, be required to:

a) Hold such Non-NAS PI Channeled Claim against one or more Debtors;
b) Provide proof demonstrating usage prior to the September 15, 2019, Petition Date of a qualifying prescribed opioid listed in Exhibit C to the TDP and also listed here on Pages 9 and 10 of this Form (a "**Qualifying Opioid**"); and
c) Have timely filed an individual personal injury Proof of Claim for such Non-NAS PI Channeled Claim against one or more Debtors in the Chapter 11 Cases.

Each Holder of a Non-NAS PI Claim seeking an Award from the PI Trust must complete, sign, and submit the following documents so that they are **received on or before July 28, 2025, at 11:59 p.m. (Eastern Time)** (the "**PI Claims Deadline**"):

a) This Non-NAS PI Claim Form;
b) The applicable HIPAA consent form on Pages 11 and 12 of this Form; and
c) To the extent the Non-NAS PI Channeled Claim concerns the injuries of a decedent of the Holder of such Claim, the Heirship Declaration, which can be found on the Purdue PI Trust website at https://www.purduepitrust.com, or valid estate documents authorizing the Holder of the Claim to act on behalf of the decedent's estate.

FAILURE TO SUBMIT THIS NON-NAS PI CLAIM FORM ALONG WITH THE REQUIRED INFORMATION OUTLINED UNDER THE ELIGIBILITY SECTION ABOVE BY JULY 28, 2025, AT 11:59 P.M. (EASTERN TIME) MAY RESULT IN THE NON-NAS PI CLAIM POTENTIALLY BEING THE SUBJECT OF AN OBJECTION, DISALLOWANCE, OR DENIAL AND NOT RECEIVING ANY DISTRIBUTION.

THE NON-NAS PI TDP AND ANY FORMS REFERENCED IN THIS NON-NAS PI CLAIM FORM CAN BE REVIEWED, DOWNLOADED AND PRINTED ON THE PI TRUST WEBSITE AT HTTPS://WWW.PURDUEPITRUST.COM.[2]

[1] Capitalized terms used but not defined herein have the meanings ascribed to them in Thirteenth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and Its Affiliated Debtors [ECF No. 7306] (the "**Plan**"), the Purdue PI Trust Distribution Procedures for Non-NAS PI Channeled Claims (the "**Non-NAS PI TDP**"), or the PI Trust Agreement, as applicable.

[2] The Non-NAS PI TDP that is currently on the PI Trust Website is substantially complete but may have minor revisions. The Non-NAS PI TDP will be filed with the Bankruptcy Court as part of the Plan Supplement and will be considered by the Bankruptcy Court for approval at the hearing to consider confirmation of the Debtors' Plan on a date to be scheduled.

Instructions for Non-NAS PI Claim Form Submission:

Only one Non-NAS PI Claim Form in addition to the Required Information should be submitted by or on behalf of a Holder of a Non-NAS PI Claim, even if the Claim of such Holder is for multiple injuries to that same Holder (for example, addiction, overdose, jail, etc.).

If the Holder of a Non-NAS PI Claim holds Non-NAS PI Claims for or on behalf of more than one opioid user, then a separate PI Claim Form for each opioid user in addition to the Required Information should be submitted.

Follow the instructions in each section carefully to ensure that this Non-NAS PI Claim Form is submitted correctly. Any section of the Non-NAS PI Claim Form that does not pertain to your Claim should be left blank.

Submitting this Non-NAS PI Claim Form does not guarantee that your Non-NAS PI Claim will be Allowed or that you will receive payment from the PI Trust.

It is the responsibility of the Holder of the Non-NAS PI Claim or its representative to submit this Non-NAS PI Claim Form along with the Required Information (i.e., the HIPAA Form *AND* the required proof demonstrating usage of a Qualifying Opioid prior to the September 15, 2019 Petition Date as outlined in the Non-NAS PI TDP and below) by the PI Claims Deadline.

If the Non-NAS PI Claim arises from the use of opioids by a deceased Person, then a Death Certificate along with either the Heirship Declaration or valid estate documents (for example, letters testamentary or letters of administration) authorizing the Holder of such Claim to act on behalf of the Decedent's estate must be submitted as well.

This Non-NAS PI Claim Form along with the Required Information can be completed and submitted online at https://www.purduepitrust.com or by sending such completed Form and Required Information by:

(i) e-mail to purduepitrust@purduepitrust.com,

(ii) mail to Purdue PI Trust, P.O. Box 361930, Hoover, Alabama, 35236-1930, or

(iii) fax to 205-716-2364.

Law firms representing more than one PI Claimant, should visit the Law Firm Bulk Submittal tab on the https://www.purduepitrust.com website for additional information regarding submittal of claims for multiple, represented PI Claimants.

PLEASE PRINT ALL INFORMATION CLEARLY AS THE INFORMATION PROVIDED WILL BE USED TO BOTH EVALUATE YOUR CLAIM AND CONTACT YOU.

PART ONE: PERSONAL INFORMATION OF PI CLAIMANT

Please fill out only **one** of the following sections (Section 1.A **or** 1.B).

Section 1.A – Claim for a Living Injured Party

Complete this Section **only** if you are (i) the Holder of a Non-NAS PI Claim arising from **your own use of opioids or** (ii) the representative of **another living Person who used opioids.**

Name of PI Claimant: _____
First Middle Last

Date of Birth of PI Claimant: _____/_____/_____
DD MM YYYY

Current Address of PI Claimant: _____
Street Address

_____
City State Zip

Full Social Security Number of PI Claimant:
(or Taxpayer ID or Social Insurance Number) _____

Kroll/Prime Clerk Proof of Claim Number(s) in Purdue's Chapter 11 Cases: _____

Name of Representative:
(if applicable, i.e., if you are the representative of the opioid user) _____
First Middle Last

Legal Authority for Representative:
(if applicable) _____
(e.g., Power of Attorney, Legal Guardian, Conservator, etc.)

Address of Representative: _____
Street Address

_____
City State Zip

Section 1.B – Claim for a Deceased Injured Party

Complete this Section **only** if you are (i) the Holder of a Non-NAS PI Claim arising from the **use of opioids by a deceased Person that is your Decedent** or (ii) completing this Non-NAS PI Claim Form as such Holder's representative.

Name of Deceased Person Who Used Opioids:

_____
First Middle Last

Date of Birth of Deceased Person Who Used Opioids:

_____/_____/_____
DD MM YYYY

Date of Death:

_____/_____/_____
DD MM YYYY

Full Social Security Number of Deceased Person Who Used Opioids: (or Taxpayer ID or Social Insurance Number)

_____

Kroll/Prime Clerk Proof of Claim Number(s) in Purdue's Chapter 11 Cases:

_____

Name of PI Claimant Submitting This PI Claim Form on Behalf of Deceased Person Who Used Opioids:

_____
First Middle Last

Address of PI Claimant Submitting This PI Claim Form on Behalf of Deceased Person Who Used Opioids:

_____
Street Address

_____
City State Zip

Relationship to Deceased Person Who Used Opioids:

_____
(must be the court appointed representative of the deceased Person's estate or the Decedent's legal heir as per the intestate statute of the state or domicile of the Decedent at the time of the Decedent's death, i.e. parent, sibling, child, spouse, etc.)

Name of Representative: (if applicable)

_____
First Middle Last

Legal Authority for Representative: (if applicable)

_____
(e.g., Power of Attorney, Legal Guardian, Conservator, etc.)

Address of Representative:

_____
Street Address

_____
City State Zip

PART TWO: PRESCRIBED MEDICATIONS

Identify the name brand and/or generic Qualifying Opioid(s) listed below that was **prescribed** and used by you or the opioid user on whose behalf you are submitting this Non-NAS PI Claim. ***A list of Qualifying Opioids along with their NDC Labeler and Drug Prefix can be found on pages 9 and 10 of this Form.***

OxyContin	☐	MS Contin	☐	DHC Plus	☐	Morphine Sulfate	☐
OxyFast	☐	Dilaudid	☐	MSIR	☐	Hydromorphone	☐
OxyIR	☐	Hysingla ER	☐	Palladone	☐	Oxycodone CR/ER	☐
		Butrans	☐	Ryzolt	☐		

Other Brand Name or Generic Opioid - list name(s) below:

_____ _____

_____ _____

_____ _____

Date of first use of the Qualifying Opioid(s) identified above: _____

Evidence of the prescription(s) demonstrating usage of a Qualifying Opioid prior to the September 15, 2019 Petition Date as outlined below and in the Non-NAS PI TDP MUST be submitted with this Non-NAS PI Claim Form by the PI Claims Deadline, unless you previously submitted such evidence as part of your Proof of Claim in the Debtors' Chapter 11 Cases. Failure to do so will result in the Non-NAS PI Claim being deficient as outlined in the Non-NAS PI TDP and may be the subject of an objection, disallowance, or denial.

TYPES OF EVIDENCE REQUIRED FOR QUALIFYING OPIOIDS

Each Holder of a Non-NAS PI Channeled Claim must provide any of the following documentation listed below in (a) – (e) demonstrating (i) a prescription that sets forth the name of the Holder of the Non-NAS PI Channeled Claim (or its decedent, if applicable), for (ii) an opioid that is a Qualifying Opioid by providing one of the following pieces of evidence with its Non-NAS PI Claim Form so as to be received by the Claims Administrator on or before the PI Claims Deadline, unless such documentation was previously submitted with a Proof of Claim that was timely filed by the Holder of the Non-NAS PI Channeled Claim in the Debtors' Chapter 11 Cases:

a) Pharmacy prescription records;
b) Other prescription records, including without limitation:
    (i) A visit note in which the prescribing physician listed a prescription for a Qualifying Opioid; or
    (ii) A signed prescription from a doctor for a prescribed Qualifying Opioid;
c) A historical reference to a prescribed Qualifying Opioid, including but not limited to:[3]
    (i) A reference in contemporaneous medical records to historical use of a prescribed Qualifying Opioid;
    (ii) A reference in contemporaneous substance abuse/rehabilitation/mental health records to historical use of a prescribed Qualifying Opioid;
    (iii) A reference in contemporaneous law enforcement records to historical use of a prescribed Qualifying Opioid; or
    (iv) A reference in contemporaneous family law or other legal proceeding records to historical use of a prescribed Qualifying Opioid;

[3] The record containing the historical reference must have been created prior to September 15, 2019.

PART TWO: PRESCRIBED MEDICATIONS (CONTINUED)

d) A photograph of the prescription bottle or packaging of a Qualified Opioid with the date of the prescription as well as the name of Holder of the Non-NAS PI Channeled Claim (or its Decedent, if applicable), listed as the patient on the prescription bottle or packaging.

e) Documentation indicating that the Holder of the Non-NAS PI Channeled Claim (of its decedent, if applicable) had at least one prescription for a Qualifying Opioid supplied prior to the September 15, 2019 Petition Date through customer loyalty programs, patient assistance programs ("PAPs") or copay assistance programs provided by the Debtors or one of their successors.

PART THREE: TIER DESIGNATION

Please check the tier that applies to the Non-NAS PI Claim. ONLY CHECK ONE. Please refer to the Non-NAS PI TDP for full definitions and qualifying criteria.

☐ **Tier 1:** You can demonstrate use of a Qualifying Opioid **equal to or greater than six (6) months** (does not have to be consecutive use) for a period prior to September 15, 2019.

OR

☐ **Tier 2:** You can demonstrate use of a Qualifying Opioid for **less than six (6) months** for a period prior to September 15, 2019.

PART FOUR: MEDICAL LIENS

Section 4.A: Did any insurance company pay for medical treatment for the opioid-related personal injuries that gave rise to the Non-NAS PI Claim? Yes: _____ No:_____

Section 4.B: In the last twenty (20) years, were you or the opioid user on whose behalf you are submitting this Non-NAS PI Claim Form eligible for coverage by any of the following?

Please answer the question by writing **"Yes" or "No" next to each insurance provider name** and provide the requested information as to each. If any insurance carrier who provided coverage is not listed below, please fill in that carrier's information at the bottom of the chart. You may submit the information on additional paper, if needed, in order to provide all of the information requested.

Insurance Provider	Yes or No	Address, Phone & Policy Number	Policy Holder and Dates of Coverage
Medicare		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Medicaid		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____

PART FOUR: MEDICAL LIENS (CONTINUED)			
Tricare		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
VA		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Champus		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Private (1) List insurance provider name below: _____ _____		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Private (2) List insurance provider name below: _____ _____		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____

PART FIVE: SIGNATURE

This Non-NAS PI Claim Form must be signed by the Holder of the Non-NAS PI Claim or its Representative or Counsel of Record.

Name of person who is signing this Form: _____

E-mail address of person who is signing this Form: _____

Phone Number of person who is signing this Form: _____

IF SIGNING AS THE HOLDER OF THE NON-NAS PI CLAIM OR AS HIS/HER REPRESENTATIVE:

I declare under penalty of perjury that the representations made, and the information provided, on this Non-NAS PI Claim Form, are true, correct, and complete to the best of my knowledge.

_____

Signature of Holder of Non-NAS PI Claim
(or signature of Representative Completing This Form on Behalf of Such Holder)

IF SIGNING AS COUNSEL OF RECORD:

I, _____, Counsel for the Holder of the Non-NAS PI Claim or its representative PI Claimant, hereby swear under penalty of perjury that the information contained herein is true and accurate to the best of my knowledge made after conducting due diligence, and that this Non-NAS PI Claim Form is being filed with the consent of my client, or the authority to file on my client's behalf under applicable law, and/or with appropriate power of attorney.

_____

Signature of Counsel of Record to Holder of Non-NAS PI Claim or Its Representative

CONFIRMATION OF SUBMISSION OF REQUIRED PROOF OF USAGE OF A PRESCRIBED QUALIFYING OPIOID (Please check one):

☐ I am including with my submission of this Non-NAS PI Claim Form the required evidence of a Qualifying Opioid prescription(s) as required under PART TWO above and as required in the Non-NAS PI TDP;

OR

☐ I previously submitted with my Proof of Claim filed in the Debtors' Chapter 11 Cases the required evidence of a Qualifying Opioid prescription(s) as required under PART TWO above and as required in the Non-NAS PI TDP.[4]

As stated above in PART TWO, evidence of the prescription(s) demonstrating usage of a Qualifying Opioid prior to the September 15, 2019 Petition Date as outlined in the Non-NAS PI TDP must be submitted WITH THIS NON-NAS PI CLAIM FORM by the PI Claims Deadline unless the PI Claimant previously submitted such evidence with its Proof of Claim filed in the Debtors' Chapter 11 Cases. Failure to do so will result in the Non-NAS PI Claim being deficient as outlined in the Non-NAS PI TDP and may be the subject of an objection, disallowance, or denial.

[4] The Claims Administrator will verify whether such required evidence is on Kroll's database.

QUALIFYING OPIOIDS FOR
PURDUE PI TRUST DISTRIBUTION PROCEDURES
FOR NON-NAS PI CHANNELED CLAIMS

Drug Name	NDC Labeler and Drug Prefix	Drug Name	NDC Labeler and Drug Prefix
OxyContin	59011-410-[5]	Dilaudid	76045-010-
OxyContin	59011-415-	Dilaudid	0074-2414-
OxyContin	59011-420-	Dilaudid	0074-2415-
OxyContin	59011-430-	Dilaudid	0074-2416-
OxyContin	59011-440-	Dilaudid	0074-2426-
OxyContin	59011-460-	Dilaudid	0074-2451-
OxyContin	59011-480-	Dilaudid	0074-2452-
OxyContin	59011-0100-	OxyIR	59011-0201-
OxyContin	59011-0103-	OxyFast	59011-0225-
OxyContin	59011-0105-	MSIR	00034-0518-
OxyContin	59011-0107-	MSIR	00034-0519-
OxyContin	59011-0109-	MSIR	00034-0521-
OxyContin	43063-0244-	MSIR	00034-0522-
OxyContin	43063-0245-	MSIR	00034-0523-
OxyContin	43063-0246-	Palladone	59011-0312-
OxyContin	43063-0354-	Palladone	59011-0313-
Butrans	59011-750-	Palladone	59011-0314-
Butrans	59011-751-	Palladone	59011-0315-
Butrans	59011-752-	Buprenorphine	42858-353-
Butrans	59011-757-	Buprenorphine	42858-493-
Butrans	59011-758-	Buprenorphine	42858-501-
Hysingla ER	59011-271-	Buprenorphine	42858-502-
Hysingla ER	59011-272-	Buprenorphine	42858-586-
Hysingla ER	59011-273-	Buprenorphine	42858-750-
Hysingla ER	59011-274-	Buprenorphine	42858-839-
Hysingla ER	59011-275-	Hydromorphone Hydrochloride	42858-301-
Hysingla ER	59011-276-	Hydromorphone Hydrochloride	42858-302-
Hysingla ER	59011-277-	Hydromorphone Hydrochloride	42858-303-
MS Contin	42858-515-	Hydromorphone Hydrochloride	42858-304-
MS Contin	42858-631-	Morphine Sulfate	42858-801-
MS Contin	42858-760-	Morphine Sulfate	42858-802-
MS Contin	42858-799-	Morphine Sulfate	42858-803-
MS Contin	42858-900-	Morphine Sulfate	42858-804-
MS Contin	00034-0513-	Morphine Sulfate	42858-805-
MS Contin	00034-0514-	Morphine Sulfate	0904-6557-
MS Contin	00034-0515-	Morphine Sulfate	0904-6558-
MS Contin	00034-0516-	Morphine Sulfate	0904-6559-
MS Contin	00034-0517-	Morphine Sulfate	35356-833-
MS Contin	16590-884-	Morphine Sulfate	35356-836-
Dilaudid	42858-122-	Morphine Sulfate	35356-838-
Dilaudid	42858-234-	Morphine Sulfate	42858-801-
Dilaudid	42858-338-	Morphine Sulfate	42858-802-
Dilaudid	42858-416-	Morphine Sulfate	42858-803-
Dilaudid	76045-009-	Morphine Sulfate	42858-810-

[5] Pharmacies may include an additional "0" in the second segment of NDC Labeler and Drug Prefixes, such that, in respect of eight digit NDC Labeler and Drug Prefixes listed herein (for example, 59011-410-), a pharmacy record may include a "0" as a ninth digit (for example, 59011-0410).

Drug Name	NDC Labeler and Drug Prefix
Morphine Sulfate	42858-811-
Morphine Sulfate	42858-812-
Morphine Sulfate	61919-966-
Morphine Sulfate	67296-1561-
Morphine Sulfate	68084-157-
Morphine Sulfate	68084-158-
Morphine Sulfate	16590-966-
Oxycodone Hydrochloride	0406-0595-
Oxycodone Hydrochloride	0093-0031-
Oxycodone Hydrochloride	0093-0032-
Oxycodone Hydrochloride	0093-0033-
Oxycodone Hydrochloride	0093-5731-
Oxycodone Hydrochloride	0093-5732-
Oxycodone Hydrochloride	0093-5733-
Oxycodone Hydrochloride	0093-5734-
Oxycodone Hydrochloride	0115-1556-
Oxycodone Hydrochloride	0115-1557-
Oxycodone Hydrochloride	0115-1558-
Oxycodone Hydrochloride	0115-1559-
Oxycodone Hydrochloride	0115-1560-
Oxycodone Hydrochloride	0115-1561-
Oxycodone Hydrochloride	0115-1562-
Oxycodone Hydrochloride	0591-2693-
Oxycodone Hydrochloride	0591-2708-
Oxycodone Hydrochloride	0591-3503-
Oxycodone Hydrochloride	0781-5703-
Oxycodone Hydrochloride	0781-5726-
Oxycodone Hydrochloride	0781-5767-
Oxycodone Hydrochloride	0781-5785-
Oxycodone Hydrochloride	10702-801-
Oxycodone Hydrochloride	10702-803-
Oxycodone Hydrochloride	42858-001-
Oxycodone Hydrochloride	42858-002-
Oxycodone Hydrochloride	42858-003-
Oxycodone Hydrochloride	42858-004-
Oxycodone Hydrochloride	42858-005-
Oxycodone Hydrochloride	49884-136-
Oxycodone Hydrochloride	49884-137-
Oxycodone Hydrochloride	49884-138-
Oxycodone Hydrochloride	49884-197-
Oxycodone Hydrochloride	60505-3537-
Oxycodone Hydrochloride	60505-3538-
Oxycodone Hydrochloride	60505-3539-
Oxycodone Hydrochloride	60505-3540-
Oxycodone Hydrochloride	60951-0702-
Oxycodone Hydrochloride	60951-0703-
Oxycodone Hydrochloride	60951-0705-
Oxycodone Hydrochloride	60951-0710-
Oxycodone Hydrochloride	67296-1376-
Oxycodone Hydrochloride	67296-1560-
Oxycodone Hydrochloride	68774-0161-
Oxycodone Hydrochloride	68774-0162-
Oxycodone Hydrochloride	68774-0163-
Oxycodone Hydrochloride	68774-0164-
Oxycodone Hydrochloride	00093-0024-
Oxycodone Hydrochloride	00093-0031-
Oxycodone Hydrochloride	00093-0032-
Oxycodone Hydrochloride	00093-0033-
Oxycodone Hydrochloride	00115-1644-
Oxycodone Hydrochloride	00172-6354-
Oxycodone Hydrochloride	00172-6355-
Oxycodone Hydrochloride	00172-6356-
Oxycodone Hydrochloride	00172-6357-
Oxycodone Hydrochloride	00591-3501-
Oxycodone Hydrochloride	00591-3502-
Oxycodone Hydrochloride	00591-3503-
Oxycodone Hydrochloride	00591-3504-
Oxycodone Hydrochloride	52152-0408-
Oxycodone Hydrochloride	52152-0409-
Oxycodone Hydrochloride	52152-0410-
Oxycodone Hydrochloride	52152-0411-
Oxycodone Hydrochloride	63304-400-
Oxycodone Hydrochloride	63304-401-
Hydrocodone Bitartrate/Acetaminophen	42858-040-
Hydrocodone Bitartrate/Acetaminophen	42858-139-
Hydrocodone Bitartrate/Acetaminophen	42858-201-
Hydrocodone Bitartrate/Acetaminophen	42858-202-
Hydrocodone Bitartrate/Acetaminophen	42858-203-
Hydrocodone Bitartrate/Acetaminophen	42858-238-
Oxycodone/Acetaminophen	42858-102-
Oxycodone/Acetaminophen	42858-103-
Oxycodone/Acetaminophen	42858-104-

HIPAA RELEASE FORM FOR
PURDUE PI TRUST DISTRIBUTION PROCEDURES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Injured Party Name: _____ Date: _____

Injured Party Date of Birth: _____ Soc Sec #: _____

1. The following individuals or organizations are authorized to disclose my health records to the parties specified below in section #4:

_____
_____
_____
_____
_____

(Note: Please list the names of your medical care providers and your health insurance providers that may have records relevant to the resolution of your PI Claim. If you are unsure of the exact legal name of your medical providers and health insurance providers, you can leave this blank, and we will complete it for you with the understanding that you authorize all relevant parties):

2. The type and amount of information to be used or disclosed is as follows:

The entire record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies, for the following dates:

Dates of Services - From:_____ To: _____

(Note: List the date range for which the medical providers and insurance companies above may have records relevant to the resolution of your PI Claim. If you are unsure of the exact dates, then leave this blank, and we will complete this section for you with the understanding that you authorize all relevant date ranges).

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse.

4. The health information may be disclosed to and used by the following individual and/or organization:
    a. Purdue Personal Injury Trust
    b. Edgar C. Gentle, III., of Gentle, Turner & Benson, LLC, as the Trustee and Claims Administrator of the Purdue Personal Injury Trust
    c. Med Lien Solutions

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 10 years after the date that I sign it.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and forego a recovery under the Purdue Pharma L.P. PI Trust Distribution Procedures for Non-NAS or NAS PI Channeled Claims. I understand that no organization may condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules or HIPAA. If I have questions about disclosure of my health information, I can contact the parties listed above in section #4.

_____ _____

Patient or Legal Representative Date

_____

Relationship to Patient (If signed by Legal Representative)

NAS CLAIM FORM

To be completed by the Holder of a Claim for a Child with Neonatal Abstinence Syndrome (NAS) personal injury claims.

NAS CLAIM FORM
FOR PURDUE NAS PI TRUST DISTRIBUTION PROCEDURES

Eligibility and Claim Requirements:

In order to be eligible for a Distribution[1] from the Purdue PI Trust (the "**PI Trust**") for a NAS PI Channeled Claim, a claimant will, among other things, be required to:

a) Hold a NAS PI Channeled Claim against one or more Debtors;

b) Have timely filed individual personal injury Proof of Claim for such NAS PI Channeled Claim against one or more Debtors in the Chapter 11 Cases;

c) Submit the required proof demonstrating a diagnosis by a licensed medical provider of a medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement or treatment medication, including but not limited to the condition known as neonatal abstinence syndrome ("**NAS**").

Important Note: If you provided the required documentation in connection with (i) the *Mallinckrodt plc* (Case No. 20-12522) (Bankr. D. Del.) bankruptcy, (ii) the *Endo International plc* (Case No. 22-22549) (Bankr. S.D.N.Y.) bankruptcy, or (iii) your Proof of Claim that was filed in the Debtors' Chapter 11 Cases, you do not need to resubmit the required documentation, but shall provide the PI Claims Administrator with a statement (or if filing in bulk by the Firm, with a list) confirming the previously filed Claim(s) for the PI Claims Administrator to review;

Additionally, each Holder of a NAS PI Claim seeking an Award from the PI Trust must complete, sign, and submit the following documents so that they are **received on or before July 28, 2025** ("**Claims Deadline**"):[2]

a) This NAS PI Claim Form (the "**NAS Claim Form**");

b) The applicable HIPAA consent form found on pages 13 and 14 of this NAS Claim Form;

c) To the extent the NAS PI Channeled Claim concerns the injuries of a decedent of the Holder of such Claim, the Heirship Declaration, which can be found on the Purdue PI Trust website at purduepitrust.com, or valid estate documents authorizing the Holder of the Claim to act on behalf of the decedent's estate; and

d) For Holders of NAS PI Claims that are minors, a Proxy Form found on pages 10 through 12 of this NAS Claim Form, which can also be found in Exhibit D of the NAS PI TDP.

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[1] Capitalized terms used but not defined herein have the meanings ascribed to them in the NAS Personal Injury Trust Distribution Procedures ("**NAS PI TDP**") or, if not defined therein, then the meanings ascribed to them in the Thirteenth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and Its Affiliated Debtors (the "**Plan**"). The most recent versions of the NAS PI TDP and the Plan can be found at http://www.purduepitrust.com.

[2] Parties that previously filed claims and provided the required documentation in connection with (i) the Mallinckrodt plc (Case No. 20-12522) (Bankr. D. Del.) bankruptcy, ((ii) the Endo International plc (Case No. 22-22549) (Bankr. S.D.N.Y.) bankruptcy, or (iii) your Proof of Claim that was filed in the Debtors' Chapter 11 Cases do not need to provide further documentation, except as set forth herein. In the event of law firms with a large inventory doing bulk uploads, the PI Trustee shall establish procedures for bulk attestations.

FAILURE TO TIMELY SUBMIT THIS NAS CLAIM FORM ALONG WITH THE REQUIRED INFORMATION OUTLINED UNDER THE ELIGIBILITY SECTION ABOVE BY JULY 28, 2025, IN ACCORDANCE WITH THE NAS PI TDP MAY RESULT IN THE NAS PI CLAIM BEING DEEMED A DISPUTED CLAIM THAT WILL BE THE SUBJECT OF AN OBJECTION.

THE NAS PI TDP AND ANY FORMS REFERENCED IN THIS NAS CLAIM FORM CAN BE FOUND ON THE PI TRUST WEBSITE AT HTTP://WWW.PURDUEPITRUST.COM.[3]

Instructions for NAS Claim Form Submission:

If you represent the interests of an NAS Child and are seeking to recover money from the PI Trust on account of that NAS Child's NAS PI Channeled Claim(s), you must complete this NAS Claim Form and return the form as instructed below. If you do not complete the form, you MAY NOT qualify to receive funds on behalf of the NAS PI Claimant you represent, and your NAS PI Claim may be the subject of an objection, disallowance or a denial.

If you believe that the NAS Child you represent holds multiple NAS PI Channeled Claims against the Debtors on account of multiple injuries, you should submit only one NAS Claim Form.

If you represent the interests of more than one NAS Child, you must file a NAS Claim Form on behalf of each individual NAS Child. YOU CANNOT file one NAS Claim Form on behalf of multiple children.

Please follow the instructions of each section carefully to ensure that the NAS Claim Form is submitted correctly. Except as otherwise indicated, all words shall be given their ordinary meaning. Submitting this NAS Claim Form does not guarantee that your NAS PI Claim will be Allowed or that you will receive payment from the PI Trust.

It is the responsibility of the Holder of the NAS PI Claim or its representative to submit this NAS Claim Form along with the Required Information (i.e. the HIPAA Form *AND* Evidence demonstrating a diagnosis by a licensed medical provider or a medical, physical, cognitive, or emotional condition resulting from intrauterine exposure, to either opioids or opioid replacement/treatment medication as outlined in the NAS PI TDP) by the Claims Deadline.

If the NAS PI Claim is filed on behalf of an individual who is a minor, then a Proxy Form and supporting documentation, if required, authorizing the person to act on behalf of the Minor must be submitted as well.

[3] The NAS PI TDP that is currently on the PI Trust Website is substantially complete but will likely have changes. An updated NAS PI TDP will be filed with the Bankruptcy Court as part of the Plan Supplement and will be considered by the Bankruptcy Court for approval at the hearing to consider confirmation of the Debtors' Plan of Reorganization, on a date to be scheduled.

This NAS Claim Form along with the Required Information can be completed and submitted online at https://www.purduepitrust.com or by sending such completed Claim Form and Required Information by:

(i) e-mail to purduepitrust@purduepitrust.com,

(ii) mail to Purdue PI Trust, P.O. Box 361930, Hoover, Alabama, 35236-1930, or

(iii) fax to 205-716-2364.

Law firms representing more than one NAS PI Claimant, should visit the Law Firm Bulk Submittal tab on the https://www.purduepitrust.com website for additional information regarding submittal of claims for multiple, represented NAS PI Claimants.

PLEASE PRINT ALL INFORMATION CLEARLY AS THE INFORMATION PROVIDED WILL BE USED TO BOTH EVALUATE YOUR CLAIM AND CONTACT YOU.

PART ONE: PERSONAL INFORMATION OF NAS PI CLAIMANT AND HIS/HER REPRESENTATIVE

Section 1.A – Fill out the information of the NAS Child below:

NAS Child's Name: _____
First Middle Last

NAS Child's Date of Birth: _____/_____/_____
DD MM YYYY

NAS Child's Date of Death: (if applicable) _____/_____/_____
DD MM YYYY

NAS Child's Current Address:
_____
Street Address
_____
City State Zip

NAS Child's Full Social Security Number: (or Taxpayer ID or Social Insurance Number) _____

Kroll/Prime Clerk Proof of Claim Number(s) in Purdue's Chapter 11 Cases: _____

Section 1.B – Fill out your information below:

Your Name: _____
First Middle Last

Your Date of Birth: _____/_____/_____
DD MM YYYY

Your Address:
_____
Street Address
_____
City State Zip

Section 1.B – Fill out your information below: (continued)

Your Social Security Number: (or Taxpayer ID or Social Insurance Number) _____

Relationship to NAS Child: _____
(Natural/Birth Parent, Adoptive Parent, Legal Guardian, or Other Custodian)

Name of Your Representative: (if applicable) _____
First Middle Last

Legal Authority for Representative: (if applicable) _____
(e.g., Power of Attorney, Legal Guardian, Conservator, etc.)

Address of Representative:

Street Address

City State Zip

PART TWO: MEDICAL PROVIDER INFORMATION

Section 2.A: This section concerns licensed medical providers who have diagnosed the NAS Child with any medical, physical, cognitive or emotional condition resulting from his/her intrauterine exposure to opioids or opioid replacement or treatment medication(s). The diagnoses may include, but are not limited to, the condition known as neonatal abstinence syndrome ("**NAS**"). Fill out and provide the following information, if known:

Name of Licensed Medical Provider	Address	City	State	Zip	Date of Diagnosis

PART TWO: MEDICAL PROVIDER INFORMATION (CONTINUED)

Section 2.B: Even if you do not know the information sought in Section 2.A, **please include with your submission of this NAS Claim Form Competent Evidence that a licensed medical provider has diagnosed the NAS PI Claimant with any medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement or treatment medication(s).** The diagnoses may include, but are not limited to, the condition known as NAS. The diagnosis can be made by any licensed medical professional, specifically including physicians, nurses, physician assistants, mental health counselors or therapists, or professionals at a rehabilitation center. Evidence can include, among other things, medical records evidencing that the NAS Child had a NAS diagnosis, including post-natal treatment for symptoms caused by opioid exposure, symptoms of post-natal withdrawal from opioids, medical scoring for NAS or NOWS which is positive or indicates fetal opioid exposure, a positive toxicology screen of the birth mother or infant for opioids or opioid-weaning drugs, or medical evidence of maternal opioid use.

Section 2.C: Was the NAS Child born in a medical facility? If so:

Name of the Facility where the NAS Child was born: _____

Location (city and state) where NAS Child was born: _____

PART THREE: MEDICAL LIENS

Section 3.A: Did any insurance company pay for medical treatment for the NAS Child's opioid-related injuries? Yes: _____ No:_____

Section 3.B: In the last 20 years, was the NAS Child eligible for coverage by any of the following providers?

Please answer the question above by writing "Yes" or "No" next to each insurance provider name and provide the requested information as to each. If any insurance carrier who provided coverage to the NAS Child is not listed below, please fill in that provider's name and information at the bottom of the chart**.** You may submit the information on additional paper, if needed, in order to provide all of the information requested.

Insurance Provider	Yes or No	Address, Phone & Policy Number	Policy Holder and Dates of Coverage
Medicare		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____

PART THREE: MEDICAL LIENS (CONTINUED)			
Medicaid		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Tricare		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
VA		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Champus		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Private (1) List insurance provider name below: _____ _____		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____

PART THREE: MEDICAL LIENS (CONTINUED)

Private (2) List insurance provider name below: _____ _____		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____

PART FOUR: SIGNATURE

This NAS Claim Form must be signed by the Holder of the NAS Claim or its Representative or Counsel of Record.

NAS Child's Name: _____

NAS Child's E-mail (if any): _____

NAS Child's Phone Number (if any): _____

Name of the person signing this Form: _____

E-mail address of the person signing this Form: _____

Phone Number of the person signing this Form: _____

IF SIGNING AS THE NAS PI CLAIMANT OR INDIVIDUAL ACTING ON BEHALF OF THE NAS PI CLAIMANT:

I declare under penalty of perjury that the representations made and the information provided on this NAS Claim Form are true, correct and complete to the best of my knowledge.

_____

Signature of Holder of NAS PI Claim
(or signature of Representative Completing this Form on Behalf of such Holder)

IF SIGNING AS COUNSEL OF RECORD:

I, _____, Counsel for the Holder of the NAS PI Claim or his/her Personal Representative, hereby swear under penalty of perjury that the information contained herein is true and accurate to the best of my knowledge made after conducting due diligence, and that this NAS Claim Form is being filed with the consent of my client, or the authority to file on my client's behalf under applicable law and/or with appropriate power of attorney.

_____

Signature of Counsel of Record to Holder of NAS PI Claim or Its Representative

PART FOUR: SIGNATURE

CONFIRMATION OF SUBMISSION OF REQUIRED PROOF (Please check one):

I am including the required evidence that demonstrates that a licensed medical provider has diagnosed the NAS PI Claimant with any medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement or treatment medication(s), as required under PART TWO above in my submission of this Claim: **Yes: _____ No: _____**

Did you previously file a NAS PI Claim with the Mallinckrodt plc (Case No. 20-12522) (Bankr. Del.) bankruptcy NAS Personal Injury Trust (the "**MNK NAS PI Trust**") or the Endo International plc (Case No. 22-22549) (Bankr. SDNY) bankruptcy NAS Personal Injury Trust (the "**Endo NAS PI Trust**"), or you previously provided evidence that demonstrates that a licensed medical provider has diagnosed the NAS PI Claimant with any medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement treatment medication(s) with a Proof of Claim that was filed in the Debtors' Chapter 11 Cases?
Yes: _____ No: _____

If you answered yes above to filing a NAS PI Claim in the MNK NAS PI Trust or the Endo NAS PI Trust, please indicate which one you filed with:

MNK NAS PI Trust **Yes: _____ No: _____**
Endo NAS PI Trust **Yes: _____ No: _____**

REMINDER: Unless as stated above, evidence demonstrating that a licensed medical provider has diagnosed the NAS PI Claimant with any medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement or treatment medication(s), as outlined in the NAS PI TDP MUST BE SUBMITTED WITH THIS NAS CLAIM FORM by the Claims Deadline. Failure to do so will result in the NAS PI Claim being deficient as outlined in the NAS PI TDP and may be the subject of an objection, disallowance or denial.

PURDUE PROXY FORM NAS MINOR CLAIMANTS

PART ONE: PERSONAL INFORMATION OF NAS CHILD AND THEIR PROXY

NAS Child Information (Fill out the information for the NAS Child)

NAS Child's Name: _____
First Middle Last

NAS Child's Date of Birth: _____/_____/_____
DD MM YYYY

NAS Child's Current Address: _____
Street Address

_____
City State Zip

NAS Child's Full Social Security Number: (or Taxpayer ID or Social Insurance Number) _____

Proxy Information (Fill out this information as the Purported Proxy of the NAS Child, if applicable)

Proxy's Name: _____
First Middle Last

Proxy's Relationship to the Minor Claimant: _____
Custodial Parent (Natural/Birth/Adoptive), Legal Guardian, or Other Custodian

Proxy's Date of Birth: _____/_____/_____
DD MM YYYY

Proxy's Address: _____
Street Address

_____
City State Zip

Proxy's Social Security Number: (or Taxpayer ID or Social Insurance Number) _____

Proxy's Phone Number: _____

PART TWO: PROXY TYPE (you must supply the following evidence to the Trust)

ONLY SELECT ONE: Please **check** the one section that applies to you, **fill out** the information included and **provide** the **required** information and evidence, if applicable

☐

I Am A Custodial Parent

Please **fill out** this section if you are the **custodial parent** of a NAS Child.

I, _____, am the Custodial Parent (biological mother/father with whom the child currently lives) of the NAS Child, _____.

I declare, under penalty of perjury, that the representations made and the information provided on this Proxy form are true, correct, and complete to the best of my knowledge.

Signature of the Purported Proxy acting on behalf of the NAS Child:

_____

Print Name: _____ Date: _____

☐

I Am A Court Appointed Legal Guardian

Please **fill out** this section and **provide the applicable order** if you are the **legal guardian** of a Minor Claimant.

I, _____, have been appointed by the court as the guardian of the NAS Child, _____, and am providing the order appointing me as the legal guardian of the NAS Child.

I declare, under penalty of perjury, that the representations made and the information provided on this Proxy form are true, correct, and complete to the best of my knowledge.

Signature of the Purported Proxy acting on behalf of the NAS Child:

_____

Print Name: _____ Date: _____

☐ **I am providing custody and care for the NAS Child, but I am neither the Custodial Parent nor the Court Appointed Legal Guardian.**

Please **fill out** this section and **provide the applicable statements and/or records** if you are **providing custody and care for the NAS Child but are neither the custodial parent nor the court appointed legal guardian** of the NAS Child.

I, _____, am providing custody and care to the NAS Child, _____.

I have been providing custody and care to the NAS Child since _____ (date).

My relationship with the NAS Child is:

_____

The circumstances around the provisions and care of the NAS Child are:

_____

_____

_____

I am providing the statements and/or records marked below as a form of evidence to the Trust to support my statement under penalty of perjury: **(select one)**

_____ Records/statements from the NAS Child's school or childcare provider

_____ Records/statements from my landlord or property manager

_____ Records/statements from the placement agency which put the NAS Child in my care

_____ Records/statements from a governmental social services agency

_____ Records/statements from Indian tribe officials

_____ Records/statements from my employer

_____ Records/statements from NAS Child's medical/healthcare provider

I declare, under penalty of perjury, that the representations made and the information provided on this Proxy form are true, correct, and complete to the best of my knowledge.

Signature of the Purported Proxy acting on behalf of the NAS Child:

_____

Print Name: _____ Date: _____

HIPAA RELEASE FORM FOR
PURDUE PI TRUST DISTRIBUTION PROCEDURES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Injured Party Name: _____ Date: _____

Injured Party Date of Birth: _____ Soc Sec #: _____

1. The following individuals or organizations are authorized to disclose my health records to the parties specified below in section #4:

_____
_____
_____
_____
_____

(Note: Please list the names of your medical care providers and your health insurance providers that may have records relevant to the resolution of your NAS PI Claim. If you are unsure of the exact legal name of your medical providers and health insurance providers, you can leave this blank, and we will complete it for you with the understanding that you authorize all relevant parties):

2. The type and amount of information to be used or disclosed is as follows:

The entire record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies, for the following dates:

Dates of Services - From:_____ To: _____

(Note: List the date range for which the medical providers and insurance companies above may have records relevant to the resolution of your PI Claim. If you are unsure of the exact dates, then leave this blank, and we will complete this section for you with the understanding that you authorize all relevant date ranges).

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse.

4. The health information may be disclosed to and used by the following individual and/or organization:
    a. Purdue Personal Injury Trust
    b. Edgar C. Gentle, III., of Gentle, Turner & Benson, LLC, as the Trustee and Claims Administrator of the Purdue Personal Injury Trust
    c. Med Lien Solutions

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 10 years after the date that I sign it.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and forego a recovery under the Purdue Pharma L.P. PI Trust Distribution Procedures for Non-NAS or NAS PI Channeled Claims. I understand that no organization may condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules or HIPAA. If I have questions about disclosure of my health information, I can contact the parties listed above in section #4.

_____ _____

Patient or Legal Representative Date

_____

Relationship to Patient (If signed by Legal Representative)

<u>Important</u>

Proofs of Claim filed by your Firm:

Claim Number	Name
12345	John Smith
23456	Jane Jones