**PROOF OF CLAIM**
**Instructions**

***Marc Browne and Terri Adley, individually and on behalf of all others similarly situated v. Ciox Health, LLC*, Case No. 4:19-cv-00667, pending in the United States District Court for the Eastern District of Texas, Sherman Division.**

If you are reviewing this Proof of Claim Form, you probably received and reviewed a "Notice of Pendency of Class Action and Proposed Settlement," which more fully explains this Action and the terms of the tentative Settlement among the Parties therein. ***You may obtain a list of potentially eligible invoice(s) (including invoice number, invoice date, patient name, name of the Texas Hospital or Texas Clinic, and amount paid) from the Claims Administrator to assist in completing this Proof of Claim Form. For each potentially eligible invoice, you must submit a separate Proof of Claim Form.***

For you or your client(s) to be eligible to receive a settlement payment, you or your client(s) must be part of either Settlement Subclass A or Settlement Subclass B and must not have excluded yourself/themselves from the Settlement Class. If your client(s) reimbursed you for the Disputed Fee Amount through settlement proceeds or otherwise, your client(s) is the Settlement Class Member. If you were not reimbursed by your client(s) for the Disputed Fee Amount, then you are the Settlement Class Member. Whether for yourself or for your client(s), you must submit a separate Proof of Claim Form for each potentially eligible invoice.

The Disputed Fee Amount is the total dollar amount paid more than the total applicable Electronic Rate in connection with a Qualifying Clinic Request or Qualifying Hospital Request, as these terms are defined in the Settlement Agreement. The Electronic Rate means the applicable Clinic Electronic Rate as set in accordance with the Texas Administrative Code, 22 TAC §165.2 and/or the applicable Hospital Electronic Rate as set in accordance with Health and Safety Code, §241.154(e). The applicable Clinic Electronic Rate and Hospital Electronic Rate effective at various time periods are further defined in the Settlement Agreement.

> ***Settlement Subclass A*** includes all Persons who, on one or more occasions during the Class Period: (i) sought copies of medical records from a Texas Clinic(s) or Texas Hospital(s), or had the copies of medical records requested by some other Person pursuant to their authorization, (ii) specifically requested, in the applicable request letter, that the copies of medical records be delivered in electronic format, (iii) were charged more than the applicable Electronic Rate, (iv) subsequently paid Ciox more than the applicable Electronic Rate, and (v) were not reimbursed by Ciox for the Disputed Fee Amount.
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> ***Settlement Subclass B*** includes means all Persons who, on one or more occasions during the Class Period (i) sought copies of medical records from a Texas Clinic(s) or Texas Hospital(s), or had the copies of medical records requested by some other Person pursuant to their authorization, (ii) did not request, in the applicable request letter, that the copies of medical records be delivered in electronic format, but otherwise received electronic copies of the medical records via the Ciox eDelivery Portal pursuant to their registration for the same, (iii) were charged more than the applicable Electronic Rate, (iv) subsequently paid Ciox more than the applicable Electronic Rate, and (v) were not reimbursed by Ciox for the Disputed Fee Amount.
>
> Excluded from the Settlement Class are (i) Ciox, any predecessor, subsidiary, sister and/or merged companies, and all of the present or past directors, and officers of Ciox, (ii) any and all Persons that paid for the requested copies of medical records pursuant to a specific pricing agreement or rate different from the applicable Electronic Rate, and (iii) the Judge signing the Final Approval Order and Judgment, or any judge or justices who considers the Action on appeal or remand (if applicable) and the current spouse and all other persons within the third degree of consanguinity to such judges/justices.

Please review the Notice and Settlement Agreement carefully before filling out this form. Capitalized terms are defined in the Settlement Agreement.

As set forth in the Notice, for you or your client(s) to be eligible to receive a settlement payment, you or your client(s) must complete all required portions of this Proof of Claim Form for each potentially eligible invoice. This Proof of Claim Form must be completed, signed, and submitted electronically via the Settlement Webpage, www.cioxtexasclasssettlement.com, ***no later than November 23, 2022***, or mailed to the Claims Administrator at: Browne v. Ciox Health, c/o Settlement Administrator, PO Box 23489, Jacksonville, FL 32241, **postmarked no later than November 23, 2022**.

If you have any questions about completing this Proof of Claim Form, you may contact the Claims Administrator: by calling 1-800-641-9107 or emailing info@cioxtexasclasssettlement.com, or contact Class Counsel: The Jeeves Law Group, P.A., 2132 Central Avenue, St. Petersburg, FL 33712, cioxsettlement@jeeveslawgroup.com. ***Do not contact the Court, Ciox or Defense Counsel for advice or information about this Settlement***.

It is your responsibility to make sure that your Proof of Claim Form(s) is timely received. The Parties and their attorneys cannot assume responsibility for Proof of Claim Forms that are not received. You should keep a copy of your completed Proof of Claim Forms for your records. **Proof of Claim Forms that do not comply with all requirements herein shall be deemed invalid**.

**IMPORTANT INSTRUCTIONS: The "Claimant" to be identified below is the person to whom the settlement payment will be made if the Proof of Claim is validated. A Claimant may be a Patient or his/her personal representative, or any Non-Patient requestor, depending upon who ultimately paid the potentially eligible invoice. The Claimant and the person submitting this Claim may or may not be the same. Only one settlement payment will be made per invoice. In the event of a Claim by more than one individual or entity for an invoice, the Claims Administrator will determine who shall receive the payment.**

**To assist in the review of the Claim, please submit a copy of the request letter sent to the Texas Hospital or Texas Clinic in connection with the potentially eligible invoice.**

**This Proof of Claim Form can be filled out electronically at the Settlement Webpage: www.cioxtexasclasssettlement.com. Submitting the Proof of Claim Form via the Settlement Webpage will speed up processing and save you the cost of postage.**

**United States District Court**
**Eastern District of Texas, Sherman Division**

In re: *Browne, et al. v. Ciox Health, LLC*
Case No. 4:19-cv-00667

## PROOF OF CLAIM FORM

Instructions: **You must complete all three sections for your claim to be valid. Fields marked with an asterisk (*) are required. Please print legibly.**

### SECTION I – CLAIMANT INFORMATION

Notice ID (from Postcard Notice):

Firm Name (if applicable):

First Name* / Middle Initial:

Last Name*:

Mailing Address*:

City*, State* and Zip*:

Email Address*:

Daytime Phone*: – –

Alternate Phone: – –

### SECTION II – CLAIM/PATIENT INFORMATION

Select which statement applies to your claim.* *(Select exactly one.)*

- ☐ I AM A *NON-PATIENT* (i.e., ATTORNEY, LAW FIRM, RECORDS REQUESTING COMPANY, OR INSURANCE COMPANY) SEEKING RECOVERY FOR *MYSELF*.
- ☐ I AM A *NON-PATIENT* SEEKING RECOVERY FOR THE *PATIENT*.
- ☐ I AM A PATIENT SEEKING RECOVERY FOR *MYSELF*.

Patient First Name* / Middle Initial:

Patient Last Name*:

Last 4 digits of Patient's SSN:

Person who requested records:

Relationship to Patient:

Texas Hospital or Clinic:

Invoice Number:

Amount Charged: $ , .

*Mark exactly one of the following choices to complete the statement below, as applicable to the invoice listed in Section II above. Marking both will invalidate this Proof of Claim.

**Between September 13, 2015, and July 26, 2022, I requested copies of medical records from a Texas Hospital or Texas Clinic, and:**

- ☐ I specifically requested, in the request letter, that the copies of medical records be delivered in electronic format.
- ☐ I did not request, in the request letter, that the copies of medical records be delivered in electronic format, but I received electronic copies of medical records via the Ciox eDelivery Portal.

**To assist in the review of the Claim, please attach a copy of the request letter sent to the Texas Hospital or Texas Clinic in connection with the potentially eligible invoice.**

Indicate how you want to be paid if your claim is validated. *(Select exactly one.)*

- ☐ Paper check made payable to the name and address indicated in **Section I – Claimant Information** above.
- ☐ Paper check made payable to the following payee:

Payee Name:

Mailing Address:

City, State and Zip:

- ☐ Electronic Mastercard
- ☐ PayPal
- ☐ Venmo
- ☐ Zelle

For payment via electronic Mastercard, PayPal, Venmo, or Zelle, indicate the email, phone, or username associated with the account in the field below. Please print legibly. **If no payment selection is made, or the account information is invalid or illegible, payment will be made via paper check to the Claimant indicated in Section I**.

*For Administrator Use – Do Not Mark Below Line*

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*Docket* *Received* *Postmarked*

## SECTION III – ATTESTATION

1. If I am completing this Proof of Claim Form, I, or someone on my behalf, either (i) specifically requested, in the request letter, that copies of medical records be delivered in electronic format, or (ii) did not request, in the request letter, that copies of medical records be delivered in electronic format but received electronic copies of medical records via the Ciox eDelivery Portal.
2. If I am a non-patient making a claim for myself, I certify that I have not previously been reimbursed by my client, Ciox or any other party, either directly or indirectly, for the claim set forth in this Proof of Claim Form. If I am a non-patient making a claim for a patient, I certify that I have been reimbursed by the patient for the claim set forth in this Proof of Claim Form and, to the best of my knowledge, the patient has not already been reimbursed by Ciox or any other party, either directly or indirectly, for the claim set forth in this Proof of Claim Form. If I am a patient making a claim on behalf of myself, I certify that I have not already been reimbursed by Ciox or any other party, either directly or indirectly, for the claim set forth in this Proof of Claim.
3. Neither I nor the patient, as applicable, has previously entered into a settlement for the claim set forth in this Proof of Claim Form.
4. Neither I nor the patient, as applicable, has assigned my/their claim to any person or been reimbursed by any other person, and to my knowledge no other person has submitted a Proof of Claim Form related to this claim.
5. I understand that the claim in this Proof of Claim Form may be audited for veracity and accuracy. I agree to provide in a timely manner any additional necessary information within my possession as requested by the Claims Administrator to validate this claim, and I understand that this claim may be rejected if I fail to respond to a request by the Claims Administrator for additional information.
6. If I am completing this form on behalf of a firm, I have full authority to bind the firm.

☐ ***By checking this box, I certify under penalty of perjury that the information provided on this Claim Form is true and correct.***

____________________ *Date*

____________________ *Signature*

____________________ *Title*

____________________ *Firm Name*

***For Administrator Use – Do Not Mark Below Line***

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*Docket* *Received* *Postmarked*