PURDUE CLAIM FORM

PURDUE CLAIM DEADLINE: Wednesday, September 30, 2026

Please read the instructions carefully before filling out this Purdue Claim Form (this "Claim Form"). Capitalized terms used herein and not otherwise defined, shall have the meanings ascribed to them in the *Eighteenth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and its Affiliated Debtors* (as modified, amended or supplemented from time to time, the "Plan") [Docket No. 8233] or the Healthcare Provider Trust Distribution Procedures (as modified, amended or supplemented from time to time, the "Healthcare Provider TDP").

Each Holder of a Healthcare Provider Channeled Claim, which includes (i) all Healthcare Provider Claims,[1] and (ii) all Released Claims held by providers of healthcare treatment services or any social services, in their capacity as such, that are not Domestic Governmental Entities, is required to complete and submit this Claim Form in order to be eligible to receive Distributions from the Healthcare Provider Trust.

In this proceeding, "Purdue Opioid" means all natural, semi-synthetic or synthetic chemicals that interact with opioid receptors on nerve cells in the body and brain, and that are approved by the U.S. Food & Drug Administration and listed by the U.S. Drug Enforcement Administration as Schedule II or III drugs pursuant to the federal Controlled Substances Act, 21 U.S.C. § 801 et seq., produced, marketed, or sold by the Debtors as: (i) the following brand name medications: OxyContin®, Hysingla ER®, Butrans®, Dilaudid®, Ryzolt, MS Contin®, MSIR®, Palladone®, DHC Plus®, OxyIR®, or OxyFast®; and (ii) the following generic medications: oxycodone extended-release tablets, buprenorphine transdermal system, hydromorphone immediate-release tablets, hydromorphone oral solution, tramadol extended-release tablets, morphine extended-release tablets, oxycodone immediate-release tablets, oxycodone and acetaminophen tablets (generic to Percocet®), hydrocodone and acetaminophen tablets (generic to Vicodin® or Norco®).

The submission of the completed Claim Form by the Claim Deadline of 5:00 P.M. Central Prevailing Time on Wednesday, September 30, 2026 (the "Claim Deadline") is a prerequisite to eligibility for a Distribution but does not guarantee a Holder of a Healthcare Provider Channeled Claim will be deemed eligible for a Distribution. If a Holder of a Healthcare Provider Channeled Claim is deemed eligible by the Trustee pursuant to the Healthcare Provider TDP to receive Distributions, the information provided in this Claim Form will be used to determine each such Healthcare Provider Authorized Recipient's Distribution from the Healthcare Provider Trust (as defined in the Plan, the "Healthcare Provider Trust"). Holders of Healthcare Provider Channeled Claims may redact information on this Claim Form or any attached documents, as they deem necessary. A Holder of a Healthcare Provider Channeled Claim shall only attach *copies* of any documents that support a Claim and shall not submit original documents; **documents submitted**

[1] Healthcare Provider Claim as defined in the Plan includes, without limitation, (i) the Claims set forth in the approximately 1,030 Proofs of Claim filed by hospitals and the approximately 445 Proofs of Claim filed by other treatment providers (listed in Exhibit "C" of the Plan) and (ii) Claims against the Debtors held by Non-Federal Acute Care Hospitals.

may be destroyed after scanning and will not be returned to the Holder of a Healthcare Provider Channeled Claim.

A person who files a fraudulent Claim on behalf of a Holder of a Healthcare Provider Channeled Claim may, at a minimum, be fined up to $500,000.00, imprisoned for up to 5 years, or both, in accordance with 18 U.S.C. §§ 152, 157. Holders of Healthcare Provider Channeled Claims shall provide the information requested that is, to the best of their knowledge, current and valid as of the date this Claim Form is completed and delivered to the Trustee by such a Holder of a Healthcare Provider Channeled Claim.

Please provide the following information to the Trustee by delivering this completed Claim Form by secure file transfer protocol ("SFTP") as provided at http://www.purduehospitalsettlement.com prior to the Claim Deadline set forth on page 1 of this Claim Form.

Failure to submit a completed copy of this Claim Form and Requisite Claims Data (as described in Item D.7 herein) by the Claim Deadline set forth on page 1 of this Claim Form may disqualify you from receiving a Distribution. Additionally, failure to complete any portion of the Claim Form may result in a reduced Distribution or disqualification from receiving a Distribution.

A. Claimant Information

Please provide the information in Section A.1. if you are submitting a Claim on behalf of an operating entity that owns one or more hospitals/facilities ("Operating Entity") or A.2. if you are submitting a Claim on behalf of a natural person ("Individual").

1. Operating Entity

1. Name of Operating Entity:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Federal Employer Identification Number of Operating Entity:			
4. Claim Number: If you received a Claim Number after you completed your Registration Form, please provide that six-digit Claim Number.			

2. Individual

1. Name of Individual:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Social Security Number:			
4. Phone:			
5. Email:			
By filling out this Claim Form, you are deemed to consent to receipt of this notice by email.			

B. Hospital/Facility Information

Please provide the following information for the Hospital/Facility owned and/or operated by the above referenced Claimant in Section A for which this Claim is filed.

1. Name of Hospital/Facility:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Duration of Ownership:	Date Acquired/Opened	Date Sold/Closed	
4. Number of Staffed Beds[2]:			

[2]The number of beds reported from a hospital's most recent Medicare cost report (W/S S-3, Part I, line 7 column 2). Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long-term, or domiciliary areas of the hospital. Beds in labor room, birthing room, post-anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion

C. Payment Information

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

D. Additional information for Claimants

1. Did you file a Proof of Claim in the Debtors' Chapter 11 Cases on or before July 30, 2020, that included a dollar amount of financial losses in the Purdue bankruptcy?

   ☐ Yes

   ☐ No

   If Yes, please provide the Proof of Claim Number: _____

2. Are you a named plaintiff in any active cause of action against opioids manufacturers, distributors, or pharmacies?

   ☐ Yes

   ☐ No

   a. If Yes, please provide whether the active cause of action is filed (check one):

      ☐ in the MDL Proceeding:

      ☐ in state court:

   b. If Yes, attach a copy of the most recently filed complaint.

3. Funds received from the Healthcare Provider Trust may only be used for specific abatement purposes as set forth in Section 7 of the Healthcare Provider TDP. If the Claimant on whose behalf this Claim has been prepared is allocated a Distribution from the Healthcare Provider Trust, as a condition of receiving the funds, then it will use the funds for one or more specific uses as listed below:

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of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes."

4. Is the hospital/facility listed in Section B above a "Safety Net Hospital"[3] as defined in the CARES ACT?

   ☐ Yes

   ☐ No

   If Yes, please provide proof of such designation.

5. To qualify for a Distribution from the Healthcare Provider Trust, a Holder of a Healthcare Provider Channeled Claim must certify that:

   a. You and/or it adheres to the standard of care for the emergency department, hospital wards and outpatient clinics at the time of any prospective evaluation, diagnosis, and treatment of OUD, including with respect to the applicable standard of care for the treatment of addiction, acute withdrawal and treatment for OUD with medication assisted treatment, AND

   b. You and/or it provides discharge planning and post-discharge care coordination for patients with OUD, including information for appropriate OUD treatment services.

[3] "Safety Net Hospital" has (a) a Medicare Disproportionate Patient Percentage (DPP) of 20.2% or greater; (b) annual uncompensated care (UCC) of at least $25,000 per bed; and (c) profit margin of 3.0% or less.

Do you and/or the hospital/facility listed in Section B above satisfy Item D.5.a. above?

☐ Yes

☐ No

Do you and/or the hospital/facility listed in Section B above satisfy Item D.5.b. above?

☐ Yes

☐ No

6. Did the hospital/facility listed in Section B timely file a Claim to the Trustee (or its agents or representatives) in either the *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. David Sackler, et al.,* Case No. 1:25-cv-01010 in the United States District Court for the District of New Mexico or the *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. Johnson & Johnson, et al.*, Case No. 1:23-cv-00903-KWR-JFR in the United States District Court for the District of New Mexico?

   ☐ Yes

   ☐ No

   a. If Yes, to the best of your knowledge, did you provide all of the Requisite Claims Data from January 1, 2015 through December 31, 2020, and wish to utilize the Requisite Claims Data previously provided for this Healthcare Provider Channeled Claim and hospital/facility noted in Section B above?

      ☐ Yes

      ☐ No

      If Yes to D.6.a., then proceed to Item D.8.

If No to Item D.6 or D.6.a, then proceed to Item D.7.

7. For all inpatient and outpatient discharges during the period January 1, 2015, to December 31, 2020, from you and/or the hospital/facility listed in Section B above, please provide to the SFTP the following data in CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File to be used in connection with the calculation of financial damages. **An example of the data formatting is set forth in Exhibit A**. **This data should be in a separate CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File for each Holder of a Healthcare Provider Channeled Claim**. Physician office visits and non-acute care visits should **NOT** be included in data provided.

For the CSV (Comma Delimited) Electronic File or Pipe Delimited Electronic Text File, please include in the file name the name of the Holder of a Healthcare Provider Channeled Claim, City and State where located and date range of data provided, for example, PhoenixGeneral-Phoenix-AZ-Jan09-Dec12.csv. If more than one file is provided due to size limitation, each file name will be the same with only the date range of the data provided changing e.g., PhoenixGeneral-Phoenix-AZ-Jan13-Dec20.csv.

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

To the extent that hospital/facility listed above utilizes a coding system for any columns/data fields, please provide an index to explain the contents of any column/data field to the SFTP provided by the Trustee. For example, the Patient Type data provided includes a 1, 2, or 3 and these respective contents are 1=Inpatient, 2=Outpatient, 3=Emergency.

If sending the requested data in a CSV (Comma Delimited) Electronic File, please also ensure that all columns/data fields that may contain commas are updated so that such columns/data fields are placed in quotations when populating the CSV (Comma Delimited) Electronic File. The columns/data fields that often contain commas include, but are not limited to, Attending Physician Name, DRG and ICD Diagnosis Code Descriptions.

Once the CSV (Comma Delimited) or Pipe Delimited Electronic Text File is prepared, **please review the data VERY CAREFULLY** to confirm the data in each column contains the applicable data for that respective column's data field description. For example, payment amounts (Total Payments) should not be shown in the DRG Code column/data field, ICD Diagnosis Code column/data field should not be blank or designed null for a patient visit without an explanation, etc. This will require, that in conducting your review that you "reality test" your data before submission to ensure that it does not contain obvious errors and inconsistencies. **After submission of the Registration Form, each Holder of a Healthcare Provider Channeled Claim will be provided a secure portal (SFTP) by the Trustee (or its agents or representatives) to upload an executed BAA (as described in Section D.8 of this Claim Form) and then upload this Requisite Claims Data to the SFTP.**

Requisite Claims Data		
Column	**Data Fields**	**Definitions and Clarifications**
a.	**Name**	Name of hospital/facility for which data is provided.
b.	**Address**	Address of hospital/facility for which data is provided.
c.	**City**	City of hospital/facility for which data is provided.
d.	**State**	State of hospital/facility for which data is provided.
e.	**Zip**	Zip of hospital/facility for which data is provided.
f.	**CMS Certification Number**	Center for Medicare & Medicaid Services Certification Number – Formerly known as the Medicare Provider Number. This should be a six-digit Medicare certification number for which the data is provided.
g.	**Patient Medical Record #**	
h.	**Patient Account #**	
i.	**Payor Financial Class Description**	e.g., Blue Cross, Medicaid, Self Pay, etc.
j.	**Patient Type**	e.g., Inpatient or Outpatient. Hospital related clinics or physician office visits should NOT be included in data provided.
k.	**Custom Patient Type**	e.g., Inpatient Psych, Outpatient Single Visit, Surgery, Lab, etc. Hospital related clinics or physician office visits should NOT be included in data provided.
l.	**Date of Admission**	
m.	**Date of Discharge**	
n.	**Length of Stay (days)**	
o.	**Admission Type Description**	e.g., Emergency, Reservation, Reference Lab, etc.

p.	**Discharge Disposition Description**	e.g., Discharge Home, Nursing Home, Expired, etc.
q.	**Patient Date of Birth**	
r.	**Patient Age at Discharge**	
s.	**Patient Gender**	
t.	**Patient Race**	
u.	**Patient City**	
v.	**Patient State**	
w.	**Patient Zip Code**	
x.	**Attending Physician Name**	
y.	**Total Charges**	
z.	**Total Payments**	Total Payments should only contain actual payments received (e.g., insurance/self-pay). It should NOT include adjustments, bad debt, write-offs or contractual adjustments.
aa.	**DRG Code**	Diagnosis Related Group (DRG) code for each inpatient visit/discharge.
ab.	**DRG Code Description**	DRG Code description for the above DRG Code.
ac.	**All ICD Diagnosis Code**	All International Classification of Disease (ICD) diagnosis codes (ICD-9 or ICD-10, as applicable) associated with each patient visit/discharge. Note: In most instances there should be multiple ICD codes for a patient visit/discharge. Each of these ICD Diagnosis Codes related to each patient's visit should NOT be listed in multiple columns but rather each ICD Code should be listed in the same single column with each ICD Code shown on separate rows within the same single column. See Exhibit A.

ad.	**ICD Diagnosis Code Descriptions**	ICD Diagnosis Code descriptions for the above ICD Diagnosis Codes.
ae.	**ICD Diagnosis Code Priority**	Indicate whether each ICD Diagnosis Code is a Primary, Secondary, Tertiary, etc. diagnosis. These categories must be expressed in terms of a numerical code such as 1=Primary, 2=Secondary, 3=Tertiary, etc. ADD "Location of Service (LOS) or Place of Service (POS) as i.e., Office, Home, Telehealth, etc.
af.	**Mom's MRN - If applicable**	This field pertains only to Healthcare Provider Channeled Claims that deliver newborn babies or have a neonatal unit. If this visit/charge is for a birth mother, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a baby, then this field should contain the mother's MRN so that there can be a mother/baby link associated therewith.
ag.	**Baby's MRN - If applicable**	This field pertains only to Healthcare Provider Channeled Claims that deliver newborn babies or have a neonatal unit. If this visit/charge is for a baby, then this field should be blank as it would be the same MRN as the patient reported in #g above. However, if this visit/charge pertains to a birth mother, then this field should contain the Baby's MRN so that there can be a mother/baby link associated therewith.
ah.	**Place of Service Code (s)**	Two-digit Place of Service Code (s) associated with each patient visit/discharge.
ai.	**Place of Service Name**	Place of Service Name for the Place of Service Code i.e., Inpatient Hospital, Emergency Room – Hospital

8. Please execute and submit a Business Associate and Confidentiality Agreement ("BAA"), which is a fillable PDF that can be downloaded from www.purduehospitalsettlement.com, for the Operating Entity or Individual listed in Section A above, to Cherry Bekaert Advisory, LLC (formerly known as Legier & Company, apac) via the SFTP. This BAA is not subject to revision or update.

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

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

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

Signature: _____

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

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

Name (First, Middle, Last): _____

Title: _____

Hospital/Facility: _____

Address: _____

_____

Contact phone: _____

Email: _____

Data Request Example
EXHIBIT A

	A	B	C	D	E	F	G	H	I	J
1	**Hospital Name**	**Hospital Address**	**Hospital City**	**Hospital State**	**Hospital Zip**	**CMS Certification Number**	**Patient Medical Record #**	**Patient Account #**	**Payor Financial Class Description**	**Patient Type**
2	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient
3	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient
4	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12345	Blue Cross	Inpatient
5	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12346	Blue Cross	Outpatient
6	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	101	A12346	Blue Cross	Outpatient
7	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	999	A12399	Blue Cross	Outpatient
8	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	102	A12356	Medicare	Inpatient
9	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	102	A12356	Medicare	Inpatient
10	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
11	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
12	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
13	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
14	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12367	Champus	Inpatient
15	ABC Hospital	123 Main Street	Shelbyville	US State	12345	123456	103	A12368	Champus	Emergency
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Data Request Example
EXHIBIT A

	K	L	M	N	O	P	Q	R	S
1	**Custom Patient Type**	**Date of Admission**	**Date of Discharge**	**Length of Stay**	**Admission Type Description**	**Discharge Disposition Description**	**Patient Date of Birth**	**Patient Age**	**Patient Gender**
2	Lab	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
3	Lab	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
4	Lab	5/6/2016	5/8/2016	2	Transfer	Discharge Home	4/1/1980	36	Female
5	OB	2/28/2017	3/1/2017	1	O/P Obersvation	Discharge Home	4/1/1980	36	Female
6	OB	2/28/2017	3/1/2017	1	O/P Obersvation	Discharge Home	4/1/1980	36	Female
7	Nursery	2/28/2017	2/28/2017	1	O/P Obersvation	Discharge Home	2/28/2017	0	Female
8	Lab	4/15/2016	4/18/2016	3	Transfer	Discharge Home	1/1/1955	61	Male
9	Lab	4/15/2016	4/18/2016	3	Transfer	Discharge Home	1/1/1955	61	Male
10	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
11	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
12	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
13	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
14	Lab	12/7/2016	12/10/2016	3	Reservation	Home w/ Health Serv	2/1/1975	41	Female
15	ER	7/4/2017	7/4/2017	1	Emergency	Discharge Home	2/1/1975	42	Female
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There is only one column for ICD Code. Therefore, each patient stay must be replicated as many times as necessary to provide all of the ICD Codes associated with the stay. For example, a patient stay with five ICD Codes would be listed in five rows (e.g., the 12/10/2016 stay of patient 103).

Data Request Example
EXHIBIT A

	T	U	V	W	X	Y	Z	AA	AB	AC
1	**Patient Race**	**Patient City**	**Patient State**	**Patient Zip Code**	**Attending Physician Name**	**Total Charges**	**Total Payments**	**DRG Code**	**DRG Code Description**	**ICD Diagnosis Code**
2	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	B974
3	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	B998
4	African American	Shelbyville	US State	12345	Smith, Jane	$1,000.00	$350.00	181	Respiratory Neoplasms w CC	F1110
5	African American	Shelbyville	US State	12345	Doe, John	$500.00	$125.00			G459
6	African American	Shelbyville	US State	12345	Doe, John	$500.00	$125.00			A419
7	African American	Shelbyville	US State	12345	Doe, John	$600.00	$125.00	795	Normal Newborn	L22
8	Caucasian	Shelbyville	US State	12345	Smith, Jane	$2,000.00	$725.00	603	Cellulitis w/o MCC	Z431
9	Caucasian	Shelbyville	US State	12345	Smith, Jane	$2,000.00	$725.00	603	Cellulitis w/o MCC	T148
10	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	E861
11	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	J209
12	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	Z041
13	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	T1491
14	African American	Springfield	US State	12367	Smith, Jane	$5,000.00	$1,500.00	539	Osteomyelitis w MCC	N179
15	African American	Springfield	US State	12367	Doe, John	$1,000.00	$200.00			F1199
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There is only one column for ICD Code. Therefore, each patient stay must be replicated as many times as necessary to provide all of the ICD Codes associated with the stay. For example, a patient stay with five ICD Codes would be listed in five rows (e.g., the 12/10/2016 stay of patient 103).

Data Request Example
EXHIBIT A

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