CLAIM INFORMATION DISCLOSURE
(Requestor)

Russell G. Binder v. The Charles Town General Hosp. d/b/a Jefferson Med. Ctr., City Hosp., Inc. d/b/a Berkeley Med. Ctr., West Virginia Univ. Hosp., Inc., West Virginia Univ. Hosp. – East, Inc., Action No. 15-C-530, Circuit Court of Berkley County, West Virginia

—AND—

James F. Smith and John F. Smith, as Co-Executors of the Estate of Donald F. Smith v. Camden-Clark Mem. Hosp. Corp., Action No. 14-C-829, Circuit Court of Wood County, West Virginia

[CLAIM ADMINISTRATOR INFORMATION]

YOU MUST MAIL YOUR CLAIM FORM (WITH ALL SUPPORTING DOCUMENTS IF REQUIRED) BY_____, 2026, TO HAVE YOUR CLAIM REVIEWED.

SECTION A – CLAIMANT INFORMATION

Claimant Name or Business Name:
_____

Claimant ID No. (*see bolded section below*):
_____

Current Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ E-mail Address: _____

Federal Tax Identification Number: _____

IMPORTANT NOTICE: Your Claimant ID Number is located on the lower left-hand side of this page. If you do not see a Claimant ID Number or not have access to your Notice of Settlement Packet, please contact the Claims Administrator at American Legal Claim Services LLC, [Phone/E-Mail] to obtain such information. This information greatly aids in the processing of your claim.

SECTION B – EXCESS COPY CHARGE EXPENSE

Invoice No. (*see bolded section below*):

_____

Hospital Name: _____

Patient Name: _____

Requestor Name: _____

Request Date: _____ Billed Amount _____

Circle: YES or NO_____
Did you represent the Patient?

(CIRCLE WHICH STATEMENT IS ACCURATE- IF ANY)

1. I PAID for the Medical Records and was not reimbursed

   OR

2. I REIMBURSED the Requestor for the Medical Records

IMPORTANT NOTICE: Your Invoice Number(s) has been provided to you in your Notice of Settlement Packet. If you do not have access to your Notice of Settlement Packet, please contact the Claims Administrator at American Legal Claim Services LLC, [Phone/E-Mail] to obtain such information. This information greatly aids in the processing of your claim.

SECTION C - CERTIFICATION

1. If I am completing this Proof of Claim Form, I, or someone on my behalf, (i) between December 1, 2010 to July 5, 2017, sought, in writing, copies of patient's medical records from a WVU Medicine Entity serviced by CIOX and paid CIOX to obtain copies.
2. I am a non-patient making a claim for myself or my company, and I certify that I have not previously been reimbursed by the patient, insurer, CIOX or any other party, either directly or indirectly, for the claim set forth in this Proof of Claim Form.
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. I have not assigned my 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 or company, I have full authority to bind the firm or company.

☐ ***By checking this box, I certify that the information provided on this Claim Form is true and correct to the best of my knowledge.***

_____ _____

Claimant Signature Date

_____

Print Name

If this Claim Form is being submitted on behalf of a **child or person with disability**, or a **deceased Claimant**, please provide documentation showing you have the authority to sign on behalf of the Claimant, such as a Birth Certificate for a child Claimant, a Power of Attorney for a disabled Claimant, or Letters of Administration for a Deceased Claimant.

PROOF OF CLAIM FORM
(Patient)

Russell G. Binder v. The Charles Town General Hosp. d/b/a Jefferson Med. Ctr., City Hosp., Inc. d/b/a Berkeley Med. Ctr., West Virginia Univ. Hosp., Inc., West Virginia Univ. Hosp. – East, Inc., Action No. 15-C-530, Circuit Court of Berkley County, West Virginia

—AND—

James F. Smith and John F. Smith, as Co-Executors of the Estate of Donald F. Smith v. Camden-Clark Mem. Hosp. Corp., Action No. 14-C-829, Circuit Court of Wood County, West Virginia

[CLAIM ADMINISTRATOR INFORMATION]

YOU MUST MAIL YOUR CLAIM FORM (WITH ALL SUPPORTING DOCUMENTS IF REQUIRED) BY_____, 2026, TO HAVE YOUR CLAIM REVIEWED.

SECTION A – CLAIMANT INFORMATION

Claimant Name or Business Name:
_____

Claimant ID No. _____

Current Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ E-mail Address: _____

Social Security Number: XXX-XX-_____

IMPORTANT NOTICE: Your Claimant ID Number is located on the lower left-hand side of this page. If you do not see a Claimant ID Number or not have access to your Notice of Settlement Packet, please contact the Claims Administrator at American Legal Claim Services LLC, [Phone/E-Mail] to obtain such information. This information greatly aids in the processing of your claim.

SECTION B – EXCESS COPY CHARGE EXPENSE

Invoice No. (*see bolded section below*):

_____

Hospital Name: _____

Patient Name: _____

Requestor Name: _____

Request Date: _____ Billed Amount _____

Circle: Yes or No
Were you represented by the Requestor?

(CIRCLE WHICH STATEMENT IS ACCURATE- IF ANY)

1. I PAID for the Medical Records and was not reimbursed

Or

2. I REIMBURSED the Requestor for the Medical Records

IMPORTANT NOTICE: Your Invoice Number(s) has been provided to you in your Notice of Settlement Packet. If you do not have access to your Notice of Settlement Packet, please contact the Claims Administrator at American Legal Claim Services LLC, [Phone/E-Mail] to obtain such information. This information greatly aids in the processing of your claim.

SECTION C - CERTIFICATION

1. If I am completing this Proof of Claim Form, I, or someone on my behalf, (i) between December 1, 2010 to July 5, 2017, sought, in writing, copies of my medical records from a WVU Medicine Entity serviced by CIOX and paid CIOX to obtain copies.
2. I am a patient or a patient making a claim on behalf of myself, I certify that I have not already been reimbursed by my counsel, CIOX or any other party, either directly or indirectly, for the claim set forth in this Proof of Claim.
3. I have not previously entered into a settlement for the claim set forth in this Proof of Claim Form.
4. I have not assigned my 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.

☐ ***By checking this box, I certify that the information provided on this Claim Form is true and correct to the best of my knowledge.***

_____ _____

Claimant Signature (or signature of Claimant's Representative if Claimant is a Minor, is Incapacitated or is Deceased) Date

_____

Print Name

If this Claim Form is being submitted on behalf of a **child or person with disability**, or a **deceased Claimant**, please provide documentation showing you have the authority to sign on behalf of the Claimant, such as a Birth Certificate for a child Claimant, a Power of Attorney for a disabled Claimant, or Letters of Administration for a Deceased Claimant.