

Otologic Management Service (OMS)

AUTHORIZATION TO PROVIDE SERVICES

I hereby authorize Otologic Management Services (a division of Cochlear Americas, which is referred to herein as "OMS") to assist me, at no charge for OMS's services, in my efforts to obtain insurance pre-authorization from my commercial health insurance plan or employer self-funded plan ("Insurer") for the surgical implantation of a cochlear implant or a Baha auditory osseointegrated implant system ("Implant") for myself or my child or dependent. An Implant is a prosthetic device implanted in the skull that assists in hearing restoration.

OMS will use good faith efforts to help me attempt to obtain coverage from my Insurer(s) for the Implant and surgical procedure, but OMS does not guarantee favorable results. OMS's assistance may include assisting me with the pre-authorization process up to and through available written appeals processes, if the pre-authorization is denied. If OMS determines in its judgment that it has exhausted reasonable avenues for obtaining coverage for me from my Insurer, OMS will have no further obligation to me. I understand that I must engage legal counsel if I desire to pursue litigation or any other review of my Insurer's denial during or beyond the written appeals processes.

I understand that OMS may act on my behalf, and, subject to the limits set forth herein, I may instruct OMS regarding how I would like OMS to proceed with my Insurer in obtaining coverage of the Implant. If I do not specifically direct OMS, OMS is hereby deemed authorized to deal with my physician and Insurer in whatever manner OMS, in its judgment, considers appropriate for the purposes described in this Authorization.

Upon occasion, OMS may consult outside attorneys to assist OMS with the written appeals process. If OMS retains outside attorneys to assist, the outside attorneys will send me a letter explaining that they represent only OMS and do not in any way represent me. I understand that OMS's outside attorneys will not represent me personally in this process and will not be available to represent me in litigation or appeals.

I authorize my employer and/or Insurer to provide OMS and/or its outside attorneys with my insurance booklet, Summary Plan Description, and insurance plan (collectively, "Plan Documents"). I will complete the attached Patient Medical Records Release Form and provide it to my physicians to authorize them to release necessary medical information to OMS and/or its outside attorneys. I agree to cooperate with OMS in all aspects of its efforts, including without limitation, in obtaining the necessary (a) Plan Documents from my insurance company and/or employer; and (b) medical information from my physician(s). I authorize OMS and its outside attorneys to provide my physician with copies of all correspondence it has relating to coverage for the Implant. OMS may discontinue this service if I do not reasonably cooperate with OMS or for any other reason, and will provide me with written or email notice of any necessary termination of OMS's assistance.

I may discontinue this service at any time by notifying OMS in writing, by letter or email. Any notices under this Authorization are to be sent to OMS, c/o Cochlear Americas, 13059 E. Peakview Ave, Centennial, CO 80111 or to reimbursement@cochlear.com.

By my signature (or authorized signature) below, I understand and agree to the provisions of this Authorization and acknowledge receiving Cochlear's Notice of Privacy Practices.

Patient Name

Patient's Signature

If Patient is a minor child or dependent:

Parent or Legal Guardian printed name

Parent's or Legal Guardian's signature

Date

Email address