

Dear Doctor:

Cochlear Americas is pleased to offer your facility participation in our insurance pre-authorization/pre-determination of benefits program. We hope this service will facilitate the insurance pre-authorization process for your cochlear implant and/or auditory osseointegrated implant (Baha) program and patients. **We offer this service at no charge.**

In order to enact this program, we will need to obtain information about your center and about each implant patient you identify. Please fill out the attached questionnaire and return them to me as soon as possible. Once an implant patient is identified it will be necessary for us to receive a copy of insurance card, and an authorization permitting us to pursue reimbursement on their behalf. For any implant patients you identify, we suggest that you explain the role of Otologic Management Services and obtain their signature on the enclosed "Authorization to Provide Services" and the "Authorization for Release of Health Information". This information will then be forwarded to us along with the completed "OMS Patient Information Form". Copies of any correspondence you have on hand from the patients relating to insurance coverage must be forwarded promptly to us.

Otologic Management Services will comply with any special instructions provided. Upon request, all correspondence will be copied to you for the patient's records.

The following information must be received prior to commencement of the pre-authorization program:

1. Center information form
2. A copy of this letter with signed agreement on page 2

If you have already identified an implant patient, the following information must be received prior to our seeking pre-authorization from their insurance company:

1. Signed Authorization to Provider Services form and Authorization For Release of Health Information form
2. Patient information form
3. Copy of insurance card
4. Medical records, including tests, consults, H&P and medical history

Please make copies of the enclosed Notice Of Privacy Practices and give one to each patient that will be utilizing the OMS services. This notice is for the patient to keep.

Other information may be required, as we deem necessary. After receipt of this information, we will then begin the pre-authorization process. This process will be pursued until we are satisfied that we have secured the maximum level of authorization allowable by the patient's insurance policy. This amount may be limited to the insurance carriers provisions for usual, reasonable and customary fee schedule.

We reserve the right to use professional judgment in determining when the appeal process for pre-authorization of insurance benefits is exhausted. If we determine that coverage is unavailable or inadequate and your center wants to continue to challenge the decisions, you will be responsible for doing so on your own. It is agreed that neither your patient nor yourself will hold Otologic Management Services liable for services rendered in good faith.

It is assumed that if a positive pre-authorization is obtained and the patient has been determined to be an appropriate candidate, both audiological and physiologically, surgery will be scheduled in a timely manner. It is also understood that an extended period of time between authorization and surgery may necessitate a reconfirmation of benefits. OMS will not be responsible for obtaining the pre-certification required by the various carriers. Pre-certification is usually the responsibility of the surgeon's office or the hospital-admitting department.

We look forward to working with you. We feel confident that this service will ease the stress and time commitment necessary to obtain positive insurance authorization for your cochlear implant and Baha patients. Please feel free to contact me with any questions or concerns you may have regarding this matter.

If you wish to proceed with this program on the terms outlined above, please sign a copy of this letter in the space indicated on this page and return to OMS Insurance Support.

Enclosures

Accepted and Agreed:

Please print provider's name above

By (Authorized Signature)

Name and title of person signing

Date