## Provider Intake Form

Please complete and FAX this form to (877) 833-6318

### 1 - Physician Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone</td>
<td>Fax:</td>
</tr>
<tr>
<td>Surgeon Name</td>
<td>NPI#</td>
</tr>
<tr>
<td>TIN#</td>
<td>License #</td>
</tr>
<tr>
<td>BCBS Provider #</td>
<td>Medicaid Provider #</td>
</tr>
<tr>
<td>Audiolist Name</td>
<td>Phone#</td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td>Center Contact Person</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

### 2 - Cochlear Implant Surgical Facility Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Tax ID#</td>
<td>Phone:</td>
</tr>
<tr>
<td>CMS Provider #</td>
<td>UPIN #:</td>
</tr>
<tr>
<td>BCBS Provider #</td>
<td>Medicaid Provider #</td>
</tr>
</tbody>
</table>

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For Advanced Bionics internal use only  *(To be completed by Insurance Specialist)*

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Specialist</td>
<td>Phone 877-779-0229 Ext_____  Fax 877-833-6318</td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
</tbody>
</table>
We hope that the technology and engineering that went into the design of our implant and external processor serves you or your child for a lifetime. Your implant and sound processor are now registered with AB.

**Warranty Coverage**
AB implants have a 10-year warranty, and external sound processors have a three-year warranty (see packaging for terms and conditions). Additionally, AB offers a One-Time Loss and Damage policy on our sound processors during this three-year period that is detailed on the enclosed certificate. We will contact you when your sound processor warranty is about to expire and outline our programs for extended service contracts.

If your processor is not functioning properly or is lost, stolen or accidentally damaged, please contact your audiologist immediately for instructions on what to do to initiate repair or replacement.

**How to Reach AB Customer Service**
AB Customer Service Representatives are available to assist you Monday through Friday, from 5:00 a.m. to 5:00 p.m. Pacific Time. Emergency service is also available on weekends and holidays. You can reach us in many different ways: Voice: 877.829.0026 / TTY: 800.678.3575 • Web Chat: www.BionicEar.com/support • Email: CustomerService@AdvancedBionics.com

**Shop Online**
For your convenience, our Web Store is available 24/7 for purchasing accessories and spare parts. To begin shopping, visit www.BionicEar.com and follow the instructions for account registration.

**Courtesy Billing Available**
Parts, accessories, and product repair are often covered by health plans under Durable Medical Equipment (DME) coverage. AB will gladly contact your insurance company to determine coverage and pre-authorization requirements. Billing for replacement products does not guarantee reimbursement from your insurance company. Reimbursement varies based on your plan, provisions, and eligibility. In order for us to help you better, please complete the following and return in the attached prepaid envelope.

1. **Insurance Authorization Form:** Please sign, make a copy for your records, and return the original.
   - Provides us with information about your health plan.
   - Allows us to contact your insurance carrier to determine pre-authorization for equipment, and to forward claims and submit bills on your behalf for equipment purchased directly from our Customer Service Department or our Web Store.
   - Health plans requirements can vary. If your health plan requires you to sign additional documentation, we will send that to you only after they confirm it is needed.
2. **Copies of your Insurance Cards** (front and back).
3. **Protocol for Resolving Complaints.** Please keep for your records
   - This notice explains our policy for handling and resolving any Insurance Reimbursement Services complaints from patients.
4. **Satisfaction Survey** (Please complete this brief survey so we can continue to improve our service)
5. **Cochlear Implant Instructions**

To expedite receipt of the completed forms, you may fax them to AB's Insurance Reimbursement Services toll-free fax number at 877.833.6318, or mail them in the enclosed envelope. Please include a copy of all your insurance identification card(s) to assist with your benefit requests. If you have any questions about completing these forms, please contact Insurance Reimbursement Services toll-free at 877.779.0229 or Insurance@AdvancedBionics.com.

Thanks again for choosing to become a member of the Advanced Bionics family!

![Signature]

**Eric Bartolotta**, Director of Customer Service & Reimbursement Services
Insurance Authorization Form

Please check the appropriate box as it applies: ☐ New Patient ☐ Pending Order ☐ New Insurance ☐ Other: ______________________

I. Implant Center Information

Clinic Name: ____________________________________________________________

Physician Name: __________________________________________________________

Audiologist Name: __________________________________________________________

Contact Person Name: ______________________________________________________

II. Patient Information

Patient Name: _____________________________________________________________

Parent Name: _____________________________________________________________

Address: _________________________________________________________________

City: ______________ State: ______ Zip: __________

Home Phone (indicate V or TTY): ___________________________________________

Social Security Number: ________________ Sex: ___________________________

Date of Birth: ________________ Implant Date: ______________________________

Email Address: ___________________________________________________________

III. Employer Information

Employer Name: __________________________________________________________

Work Phone (indicate V or TTY): ___________________________________________

Employer Address: _________________________________________________________

City: ______________ State: ______ Zip: __________

IV. Primary Insurance Carrier Information

Check Health Plan Type (if known): ☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ Medicare ☐ Medicaid

Insurance Company Name: _________________________________________________

Phone: __________________________

Address: _________________________________________________________________

City: ______________ State: ______ Zip: __________

Group Plan Number: ________________ Member Name: _______________________

ID Number: __________________________ Relationship to Patient: ___________________

Date of Birth: ________________

V. Secondary Insurance Carrier Information

Check Health Plan Type: ☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ Medicare ☐ Medicaid

Insurance Company Name: _________________________________________________

Phone: __________________________

Address: _________________________________________________________________

City: ______________ State: ______ Zip: __________

Group Plan Number: ________________ Member Name: _______________________

ID Number: __________________________ Relationship to Patient: ___________________

Date of Birth: ________________

VI. Primary Care Physician Information

Primary Care Physician Name: __________________________

Phone: __________________________

Address: _________________________________________________________________

City: ______________ State: ______ Zip: __________

VII. Authorization

I authorize Advanced Bionics Insurance Reimbursement Services to release pertinent information about my medical condition for the purpose of securing health insurance benefits information, authorization, or payment for devices or services.

I will provide a current copy of my insurance identification card, policy number, and demographic information to AB upon request.

I also authorize AB Insurance Reimbursement Services to act as my representative and on my behalf to secure all authorization necessary from my insurance company regarding a procedure or order involving an AB medical device, including, if necessary, any appeal of a denial of benefit and in billing to my insurance carrier for replacement parts, if necessary.

I understand that I may revoke this authorization at any time by giving my physician or AB a statement to withhold my personal and medical information from that time forward.

Patient’s Name: __________________________ Patient or Legal Guardian’s Signature: __________________________

Relationship to Patient: __________________________ Date: __________________________

Reimbursement Services Hotline (V) 877.779.0229 • (F) 877.833.6318 • (TTY) 800.678.3575 • www.BionicEar.com

AB will endeavor to obtain authorization from your insurance company to reimburse your healthcare provider or Advanced Bionics for services or items covered by an authorization. However, there is no guarantee that we will receive authorization or payment. The patient or the patient’s guardian remain liable for payment of services or goods received except as otherwise provided by law.
Notice of Privacy Practices and Patient Rights

This Notice of Privacy Practices ("Notice") describes how Advanced Bionics¹ may use and disclose protected health information about you and how you can get access to this information. Protected health information means any information that may identify you and that relates to your past, present, or future healthcare treatment, services, or payment.

Treatment, Payment, Healthcare Operations

Treatment
We may use and disclose your health information to provide you with healthcare-related services or products, or we may share your health information with those involved in your health treatment. For example, we may use your health information in order to discuss your cochlear implant with your healthcare provider.

Payment
We may use or disclose your health information to bill and collect payment for the healthcare-related services or products that we provide to you. This includes determining eligibility or coverage, billing for services rendered, and collections. Unless you have asked that we not bill your insurer or health plan, we may complete a claim form that contains your health information to obtain payment from your insurer or health plan.

Healthcare Operations
We may use or disclose your health information for the purposes of AB healthcare operations, which are activities that support AB normal business operations. For example, we may use your health information to process the healthcare products you have ordered.

There are some services provided through contracts with business associates. We may give limited access to your health information to our business associates so they can perform services to support our business. Our business associates are required by contract to safeguard your health information.

Disclosures that may be made without Your Authorization
There are situations in which we are permitted by law to disclose or use your health information without your written authorization. These situations include:

- When required or permitted by law to do so, such as reporting your health information to law enforcement officials, court officials, or government agencies, such as the FDA.
- When ordered by authorized public health officials for the purpose of carrying out public health activities, such as to report product problems or exposure to a communicable disease.
- When the use/disclosure relates to victims of abuse, neglect, or domestic violence.
- When the use/disclosure is for health oversight activities, such as by written request of a state/federal government agency performing management audits, financial audits, and program monitoring.
- When the use/disclosure is for judicial and administrative proceedings, such as in response to an order of a court.
- When the use/disclosure is for law enforcement purposes, such as reporting certain types of wounds or injuries, or if there is a good faith belief that the disclosure is necessary to prevent or lessen a serious, imminent threat to the safety of a person or the public.
- When the use/disclosure is related to death, such as disclosing your health information to coroners, medical examiner and funeral directors so they can carry out their duties related to your death.
- When the use/disclosure is related to cadaveric organ, eye, or tissue donation purposes.
- When the use/disclosure relates to military, national security, or incarceration/law enforcement custody purposes. We may disclose information about you for military activities, national security and intelligence activities, and for protective services to the President of the United States. We may disclose information about you to a correctional institution having lawful custody of you.
- When the use/disclosure relates to workers' compensation. We may disclose your health information as authorized by and to the extent necessary to comply with the laws related to workers' compensation or other similar programs established by law.
- When the use/disclosure relates to certain research purposes. For example, in limited circumstances, we may disclose your information to researchers preparing a research protocol or if an institutional review board determines authorization is not necessary.

¹ For purposes of the HIPAA Privacy Rule, AB is defined as those components/units that act as direct suppliers of healthcare products (for example, cables) to patients, and certain units that support the supplier function, for example, finance.
For other uses and disclosures, we will ask you for your written authorization before disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. Please submit your written revocation to the Privacy Officer at the address below. However, any revocation will not apply to disclosures or uses already made or taken in reliance on the authorization.

Your Rights Under Federal Privacy Regulations. The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create certain rights that you may exercise regarding your health information.

You have the right to inspect and copy your protected health information. If you request copies, we will charge you a reasonable fee for copies. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to laws that prohibit access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for your notification purposes as described in this Notice of Privacy Practices. Your request must be in writing, state the specific restriction requested and to whom you want the restriction to apply. Advanced Bionics will consider such requests, but is not required to agree to them.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information was not created by this organization and is not available for inspection because of an appropriate denial or if the information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your health information record. If we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made, and tell others that we now have the correct information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Requests must be made in writing to the person listed below.

Complaints
If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd, CS-24-04
Baltimore, MD 21244

Question and Contact Person for Requests
If you have any questions, or want to make a request pursuant to the rights described above, please contact:

HIPAA Compliance Officer
Advanced Bionics, LLC
28515 Westinghouse Place
Valencia, CA 91355
Email: HIPAA@AdvancedBionics.com

This notice is effective on the following date: January 3, 2008

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Revision Date: 12/09/09
Protocol for Resolving Complaints

The patient has the right to freely voice grievances regarding Advanced Bionics' Reimbursement Services without fear of reprisal or unreasonable interruption of services. AB maintains a complaint tracking system that records the patient's name, address, telephone number, and health insurance claim number, a summary of the complaint, the date it was received, the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

All complaints will be handled in a professional manner. All logged complaints will be investigated, acted upon, and responded to in writing or by telephone by a manager within a reasonable amount of time after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to the Chief Executive Officer of the company.

Advanced Bionics, LLC
28515 Westinghouse Place
Valencia, CA. 91355
Toll-Free 877.779.0229
Insurance@AdvancedBionics.com
<table>
<thead>
<tr>
<th>Access, Delivery and Service</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Equipment/Supplies was delivered in a timely manner.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Equipment/supplies was ready for patient use upon delivery.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Received and understood instructions on proper application and use of equipment/supplies.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Feel confident to operate/use equipment/supplies.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Received info on my Rights &amp; Responsibilities, complaint process, billing, contact numbers, and reasons to notify the equipment/supply company.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Response to my questions, problems, concerns were addressed in a timely manner.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7. Satisfied with the equipment or supplies.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8. Satisfied with the service. Would recommend to others.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Comments: ____________________________________________________________

______________________________________________________________

Signature: ____________________________________ Date: __________________

Please return to Advanced Bionics: 661.362.7795 Fax or insurance@AdvancedBionics.com

Advanced Bionics • 28515 Westinghouse Place • Valencia, CA 91355 USA
877. 829.0026 in US and Canada • 800. 678.3575 TTY • 661. 362.1400 • 661. 362.1500 (Fax) • AdvancedBionics.com
Cochlear Implant Instructions

Dear Patient,

Advanced Bionics would like to ensure you’ve received all information regarding your Cochlear Implant System. This information is generally provided by your audiologist upon your initial stimulation session. If you have not yet received this information or instructions, you should contact your audiologist or center. If you’re unable to obtain this information from your audiologist or center, please contact us at the number below for assistance.

✓ Privacy Notice
✓ Patient Rights & Responsibilities
✓ Medicare Supplier Standards (if applicable)
✓ Complaint Process
✓ Cleaning & Maintenance of your Cochlear Implant equipment
✓ Instructions for use of your Advanced Bionics Cochlear Implant System
✓ Services provided by Advanced Bionics
✓ Warranty Information

Your signature below is an acknowledgement that you have received and reviewed instructions for your Cochlear implant.

_________________________________________  ___________________________________________  ____________
Print Name  Signature  Date

Please return to Advanced Bionics: 877.833.6318 Fax or insurance@AdvancedBionics.com

Advanced Bionics • 28515 Westinghouse Place • Valencia, CA 91355 USA
877.829.0026 in US and Canada • 800.678.3575 TTY • 661.362.1400 • 661.362.1500 (Fax) • AdvancedBionics.com
Please include a copy of your insurance card

(Front and Back)

This is your employer health plan Identification Card. Present it to the provider of health care when you or your eligible dependents receive services. See your certificate(s) or booklet(s) for a description of the benefits, terms, conditions, limitations, and exclusions of coverage. When submitting invoices always include your member number from the face of this card. Possession or use of this card does not guarantee payment.

WestPoint Pharmacy (BIN 610053)  
2477 NurseLine  
(600) 799-2541  
(600) 700-9105

BlueCard® Provider Access  
(800) 810-BLUE  
For all providers nationwide, please submit claims to your local Blue Cross and/or Blue Shield Plan. To ensure prompt claim processing, please include the 3-digit alpha prefix that precedes the patient's identification number listed on the front of this card.

For Pre-Authorization or Pre-Service Review Providers Call: (800) 274-7787

Aetna Medicare is the trade name of Blue Cross of California, an Independent Licensee of the Blue Cross Association.

Please return to Advanced Bionics: 661.362.7795 Fax or insurance@AdvancedBionics.com

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877.829.0026 in US and Canada • 800.678.3575 TTY • 661.362.1400 • 661.362.1500 (Fax) • AdvancedBionics.com