SI-BONE®

PATIENT AUTHORIZATION FORM FOR IFUSE IMPLANT SYSTEM®

Your physician has determined that surgery using the iFuse Implant System (iFuse) is medically necessary to treat your sacroiliac joint dysfunction. SI-BONE can provide certain assistance consisting of education and training to you and your physician regarding insurance coverage and reimbursement. We provide this program in order to facilitate your access to treatment with iFuse by providing training and education to patients and health care professionals on insurance company policies and procedures such as those relating to obtaining prior authorization and appeals of denied claims for reimbursement for the iFuse Implant System.

In order to provide assistance, SI-BONE will need to use your Protected Health Information (as defined below) to share it with your health plan. This authorization will allow your healthcare providers, health plans, and health insurers that maintain your Personal Health Information to disclose this information to us.

Authorization and Signature

By signing this Authorization, I authorize my physician, physician's practice, any other health care provider, my health plan(s) and health insurer(s) to disclose my Protected Health Information to SI-BONE. This Protected Health Information may include, but not be limited to:

(i) MEDICAL RECORDS: Hospital records, chart and notes; laboratory records and reports; physical therapy records; doctors and nurse's notes; all correspondence of any kind; psychiatric and psychological records, reports, tests and test results, x-ray films and reports; and any and all other records which pertain to my medical care, treatment history and prognosis;

(ii) INSURANCE/BILLING RECORDS: Any and all communications, notes, billing statements, claim forms, Explanation of Benefits, or other documents to/from insurance companies, self-insured plans, TPAs, claims administrators, Plan Sponsors, Plan Administrators, utilization review companies or other third-party payers involved with evaluating, adjusting, processing or paying my claim(s) for insurance benefits, whether pre-service or post-service in nature; and

(iii) Any other records relating to my medical condition, treatment, care management, health insurance that SI-BONE, and their respective representatives, agents and contractors may need for the purposes described in this Authorization ("Protected Health Information").

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information.

The purpose of this Authorization is (1) to help establish my eligibility for benefits; (2) to communicate with my health care providers and me about my medical care; and (3) to facilitate coverage and reimbursement by my health insurer for my procedure using the iFuse Implant System. I also authorize SI-BONE, to contact me directly about these issues.

I understand that this Authorization is voluntary.

I understand that my Protected Health Information may be subject to re-disclosure by SI-BONE, and their representatives and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that the covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. I understand that I am entitled to a copy of this Authorization.

I understand that I may cancel this Authorization at any time by mailing a letter requesting such cancellation to SI-BONE, Inc., ATTN: LEGAL DEPT at 471 El Camino Real, Suite 101, Santa Clara, CA 95050, but that this cancellation will not apply to any information already used or disclosed through this Authorization. This Authorization expires the earlier of either (i) five (5) years from the date signed below or (ii) two (2) years from the date on which I receive authorization for the iFuse Implant System.

In addition, I hereby request and authorize SI-BONE to communicate with_____ (name of individual) who is my_____(relationship, *e.g.*, spouse, partner, son, daughter) regarding the information described in this Authorization.

I understand that SI-BONE does not guarantee that insurance coverage, reimbursement or any other payment will be made and that I am responsible for the cost of my care. I agree that a copy of this form may be treated as a signed original.

Signature: _____ Date: _____

Patient Printed Name: _____ Patient Phone:_____

☐ Yes ☐ No If I am unavailable, I authorize leaving a message at this phone number via voicemail or text.

Patient email: _____Patient Date of Birth: _____

Surgeon Name _____ ____

If you are signing this authorization as a personal representative of the person to receive a procedure using iFuse, please state your relationship (e.g., “mother,” “father,” “legal guardian”):

Relationship:_____Printed Name: _____

Please fax signed form to 844-602-4619 or email to pics@si-bone.com

For questions, please call SI-BONE toll-free at 1-800-710-8511

The iFuse Implant System® is intended for sacroiliac joint fusion for conditions including sacroiliac joint dysfunction that is a direct result of sacroiliac joint disruption and degenerative sacroiliitis. This includes conditions whose symptoms began during pregnancy or in the peripartum period and have persisted postpartum for more than six months. The iFuse Implant System is also intended for sacroiliac fusion to augment immobilization and stabilization of the sacroiliac joint in skeletally mature patients undergoing sacropelvic fixation as a part of a lumbar or thoracolumbar fusion. There are potential risks associated with the iFuse Implant System. It may not be appropriate for all patients and all patients may not benefit. For information about the risks, talk to your doctor and visit: www.si-bone.com/risks

SI-BONE does not guarantee that the assistance provided will result in coverage or reimbursement. The assistance is not legal advice or official payor guidance, and it is not intended to increase or maximize reimbursement. Health care providers are solely responsible for complying with Medicare and other payor rules and requirements as well as for the information submitted with all claims and appeals. Before any claims or appeals are submitted, health care providers should review official payor instructions and requirements and confirm the accuracy of their coding or billing practices. It is the responsibility of the health care provider to choose the most appropriate code to describe the services and treatment provided to the patient, to do so with independent judgment, and to document such in the patient’s medical record.