OMS Insurance Support

Surgical procedure authorization request

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01 Professional Services to be Authorized

Group Name: _____ Group Tax ID: _____

Surgeon Name: _____ Surgeon NPI: _____

Primary Diagnosis Code & Description: _____

CPT Code(s) & Description of Procedure: _____

Surgery Date (if scheduled): _____ or Date Range Request _____ to _____

02 Facility Services to be Authorized

Facility Name: _____ Tax ID: _____

Type:

☐ Outpatient ☐ Inpatient ☐ Surgery Center NPI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

HCPCS Code(s) & Description of Procedure: _____

Device to Be Implanted:

☐ Cochlear Implant ☐ Hybrid Implant ☐ ABI ☐ Baha Connect ☐ Baha Attract ☐ Osia

# of Units: _____ ☐ Left Ear ☐ Right Ear ☐ Bilateral Other: _____

03 Patient Information

Patient Name (first, last, middle): _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Preferred Communication Method: ☐ Phone ☐ Email

04 Insurance Information

Primary Insurance Company: _____ Member ID: _____

Group Number: _____ Employer: _____

Provider Relations Phone#: _____

Name of Subscriber (if different than Patient): _____ Subscriber SSN: _____

05 Secondary Insurance Information (If Applicable)

Secondary Insurance Company: _____ Member ID: _____

Group Number: _____ Employer: _____

Provider Relations Phone#: _____

Name of Subscriber (if different than Patient): _____ Subscriber SSN:_____

For any questions regarding the above information, please contact OMS at 866 433 4876; via email at OMS@cochlear.com; or fax 303 799 4353.

06 Submitting Provider Contact 1

Contact Name: _____

Contact Email: _____ Contact Phone: _____

07 Submitting Provider Contact 2

Contact Name: _____

Contact Email: _____ Contact Phone: _____

OMS Insurance Support Checklist

Requests with missing information will not be processed

☐ Completed Surgical Procedure Authorization Request Form

☐ Copy of front and back of patient's health insurance card(s)

☐ Patient Authorization for Release of Patient Health Information Form (Candidate signature required)

☐ Patient Authorization to Provide Insurance Support Services Form (Candidate signature required)

☐ Letter of Medical Necessity signed by the doctor

- Patient's diagnosis
- Severity and etiology of hearing loss
- Treatments tried and failed (including prior hearing aid use)
- Explain why the implant system is the recommended treatment option

☐ Patient's medical records applicable to hearing health, including audiograms

☐ Copy of health plan's denial letter (appeals only)

Please send your completed predetermination or appeal assistance requests to OMS@cochlear.com or via fax 303 799 4353.

For any questions regarding the above required information, please contact OMS at 866 433 4876

866 433 4876
OMS@cochlear.com
www.cochlear.us/ReimbursementHub

CAM-HE-015_F ISS4 FEB23

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OMS Insurance Support

Patient authorization to provide insurance support services

I hereby authorize Otologic Management Services Insurance Support (a department of Cochlear Americas, referred to herein as "OMS") to assist me in my efforts to obtain insurance preauthorization from my Insurer and/or employer self-funded plan ("Insurer") for the surgical implantation of a Cochlear™ implant systems (referred to herein as an "Implant") for myself, my child or dependent.

I understand that OMS will use good faith efforts to help me obtain insurance coverage from my Insurer(s) for the Implant and surgical procedure; however, OMS cannot guarantee favorable results. OMS's assistance may include assisting me with the preauthorization process, as well as the written appeals processes if preauthorization is denied.

I hereby authorize OMS to act on my behalf in order to provide the insurance support services described herein. Absent my express direction, OMS is hereby authorized to deal with my physician and Insurer in whatever manner OMS, in its reasonable judgment, considers appropriate for the purposes described in this Authorization. **I hereby agree not to hold OMS liable for any and all services rendered in good faith.**

I hereby authorize my Insurer and/or employer to provide OMS with my Insurance Booklet, Summary Plan Description, Insurance Plan and any other relevant insurance documents (collectively, "Plan Documents"). I will complete the attached Patient Medical Records Release Form and provide a copy to my physician(s) in order to authorize them to release any necessary medical information to OMS. I hereby authorize OMS to provide my physician with copies of all correspondence relating to insurance coverage of the Implant and surgical procedure.

I understand that OMS may discontinue providing me with insurance support services if I do not provide reasonable cooperation or for any other reason in OMS's sole discretion.

I understand that I may discontinue OMS's insurance support services at any time by notifying OMS in writing, any notices under this Authorization are to be sent to OMS via email OMS@cochlear.com. Notice shall be effective upon OMS's receipt of such notice.

I understand and agree that OMS will have no further obligation to me if OMS determines, in its sole judgment, that all reasonable avenues for obtaining the necessary coverage from my Insurer have been exhausted.

I understand that neither Cochlear nor OMS will pursue litigation against my Insurer on my behalf in the event of denial or for any other reason and that any legal advice should be obtained separately on my own accord.

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

Patient's printed name (or authorized representative of patient): _____

Signature of Patient (or Authorized Representative):_____

Relationship to Patient (If requester is not the patient): _____

Date: _____

866 433 4876
OMS@cochlear.com
www.cochlear.com/us

CAM-HE-014_F ISS3 FEB23

OMS Insurance Support

Authorization for release of patient health information

Cochlear®
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I authorize the disclosure of patient health information of the individual named below:

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Medical facility that records are requested from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Records to be disclosed to: OMS Insurance Support | **Email:** OMS@cochlear.com
Phone: 866 433 4876 | **Fax:** 303 799 4353

Purpose of this Request: Insurance preauthorization and verification support

Type of Records Requested:

- All medical records related to the above mentioned patient's hearing loss, and/or
- Treatment Summary

This request does NOT include a request for any patient records other than those types listed above.
OMS specifically requests that no other patient records be provided.

This authorization is valid for 1 year from the date of this authorization OR until (insert date) _____

I understand that:

- My right to health care treatment is not conditioned on this Authorization.
- With the exception of when a disclosure has already been made in reliance on my prior authorization, I understand that I may cancel this Authorization at any time by submitting a written request to the OMS Insurance Support email or fax provided above.
- Release of HIV-related information, mental health related care or substance abuse diagnosis and treatment information requires additional authorization.

Printed Name of Patient (or Authorized Representative): _____

Signature of Patient (or Authorized Representative):_____

Date: _____

Relationship to Patient (If requester is not the patient): _____


866 433 4876
OMS@cochlear.com
www.cochlear.com/us

CAM-HE-012_F ISS6 FEB23

COCHLEAR AMERICAS NOTICE OF PRIVACY PRACTICES
Effective August 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Throughout this notice, the words "we," and "us," mean Cochlear Americas and its Otologic Management Services ("OMS") department. "You" refers to anyone who receives health care services or products from us. "Health information" means any oral, written or recorded information, that we create or receive relating to your past, present or future health or health care payment.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION. We are required by law to give you this Notice explaining that we use and disclose your health information for the following purposes:

- **Treatment.** We will use your health information to provide you with health care services, products. We may share your health information with health care professionals who are involved in your care and who are part of the entity providing your care.
- **Treatment Alternatives.** We will use your information to provide you with health care treatment alternatives.
- **Payment.** We may use and disclose health information about you so that we can bill any applicable payors or programs for your health care services or products. If your insurer or health plan requires prior approval or other notice in order to determine whether they will pay for those services or products, we may disclose your health information to them—unless you have asked that we not bill your insurer or plan.
- **Health Care Operations.** We may use and disclose information about you within Cochlear Americas to manage and improve our business. This includes quality assessment activities, licensing and accreditation activities, obtaining legal and accounting services, and business planning and management. Other people and companies who are not employees or affiliates of Cochlear Americas may help us run our business. These people and/or companies are our "business associates." We may give them limited access to your health information to do what we have hired them to do and they agree to safeguard your information.
- **Individuals Involved in Your Care.** If you agree, we may give certain health information about you to a friend or family member involved in your care or obtaining payment related to your care. If you cannot agree because of incapacity or emergency circumstances, we may disclose your health information as necessary if we determine that it is in your best interest, based on our professional judgment.
- **Research.** We will not use or disclose health information that identifies you for research purposes unless you agree in writing or the use or disclosure complies with applicable law and a privacy board or institutional review board approves the arrangement.

Additionally, we may use or disclose your health information, without your authorization, for the following purposes:

- as authorized by and to the extent necessary to comply with workers' compensation or similar laws;
- for public health activities, as permitted or required by law, such as preventing or controlling disease and reporting suspected abuse or neglect;
- to a health oversight agency for audits, investigations, inspections, and licensure activities;
- to a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, witness, or missing person or as required by law;
- to a court or party in litigation in response to a valid court or administrative order;
- to a coroner or funeral director as permitted or required by law to identify a deceased person or otherwise as necessary to carry out their duties;
- if you are an inmate of a correctional institution, to the institution as necessary for your health and the health and safety of other individuals;
- for military, national security or lawful intelligence activities; or
- as otherwise as permitted or required by law.

Uses and disclosures of your health information, other than those described above, will be made only with your written authorization. You may revoke that authorization in writing at any time, but we cannot take back any disclosures we already made in reliance on a previous authorization.

YOUR RIGHTS TO YOUR HEALTH INFORMATION. You have the following rights regarding the health information we maintain about you:

- **Right to Inspect and Copy.** With some exceptions, you have the right to inspect and request a copy of your records if we have or use those records and they include health information about you.
- **Right to Amend.** If you feel that a record containing your health information is incorrect or incomplete, you may ask us to amend the information. You must tell us why you think the information is wrong or incomplete. We may deny your request if (among other reasons) the information was not created by us; is not included in your medical, billing or other records used to make decisions about your care; or is otherwise accurate and complete.
- **Right to an Accounting of Disclosures.** With limited exceptions, you have the right to request a written accounting of every disclosure of your health information we have made for up to six years prior to your request, other than disclosures to you, disclosures authorized by you in writing, and disclosures for treatment, payment and health care operations as described in this Notice. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003.
- **Right to Receive a Breach Notification.** If a breach involving your health information occurs, you have the right to be notified of the circumstances.
- **Right to Authorize Marketing Communications or Sale of Health Information**. In instances where we may receive financial remuneration in exchange for making a communication about a health-related product or sale of your health information, you have the right to be notified and specifically provide or deny authorization of this use or disclosure.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, health care operations, or to assist others' involvement in your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. In your request, you must tell us (1) what information you want to limit; (2) whether and how you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse). You have the right to restrict disclosures of your protected health information to a health plan if you pay out of pocket in full for the item or service.
- **Right to Request Confidential Communications.** You have the right to request that we communicate health information about you in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To pursue any of the above listed rights, you must submit your request in writing to our Privacy Officer, at the address listed at the end of this Notice. Your request should indicate in what form you want the reply (for example, on paper or by e-mail). We reserve the right to charge you for copying and providing further information in response to your request. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

OUR LEGAL DUTIES AND RIGHTS. We are required by law to protect the privacy of your health information and to provide this Notice about our legal duties and health information practices. We will comply with this Notice. We reserve the right to change our health information practices and the terms of this Notice. We reserve the right to make the changed Notice effective for health information we already have about you as well as any information we receive after the change. The Notice will contain an effective date on the first page, in the top left-hand corner. We will post a copy of the current Notice on our website, www.cochlear.com.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at the address listed immediately below. You may also file a complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights, HIPAA Complaint Division, 7500 Security Blvd., C5-24-04, Baltimore, MD 21244. For information on how to file, call 1-800-368-1019. All complaints must be submitted in writing. You will not be penalized for filing a complaint**.**

If you have any questions please contact our Privacy Officer, by writing to Cochlear Privacy Officer, 10350 Park Meadows Drive, Lone Tree CO 80124.