Boston Scientific
Advancing science for life™

Patient Authorization for Access to Care Services for the INTRACEPT™ PROCEDURE

Your physician has determined that the Intracept Procedure is medically necessary to treat your condition. To facilitate your access to this treatment, Boston Scientific, Inc. ("BSC"), which manufactures Intracept, is able to provide certain assistance to you regarding insurance coverage and reimbursement.

To do so, BSC will need to use your **Protected Health Information**. This Authorization will allow your healthcare providers, health plans, and health insurers to disclose this information to BSC and its representatives.

BSC provides these services to promote access to the Intracept Procedure. Should you or your physician determine that another course of treatment is more appropriate, BSC will cease all services and notify all involved parties accordingly.

Authorization and Signature

I authorize my physician, physician's practice, any other health care provider, my health plans and health insurers to disclose my Protected Health Information to BSC and its agents and representatives as they request. **Protected Health Information** includes but is not limited to information relating to my medical condition, treatment, care management, health insurance, and medical record. The information will be used for the following purposes:

- To help establish my eligibility for benefits for the Intracept Procedure
- To communicate with me and my healthcare providers, my health plans and my health insurers about my medical care and coverage related to the Intracept Procedure; and
- To facilitate coverage and reimbursement for the Intracept Procedure by my health insurer I

also authorize BSC and its representatives to contact me directly about these issues.

I understand that information disclosed pursuant to this Authorization is subject to re-disclosure by BSC for the purposes set forth above and will no longer be protected by federal privacy laws (the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations).

I understand that: (1) my treatment, payment, enrollment or eligibility for benefits are not conditioned on my signing this Authorization and that I am signing it voluntarily; (2) I am entitled to a copy of this Authorization; (3) BSC does not guarantee that insurance coverage, reimbursement or any other payment will be made. Benefits are determined solely by any applicable health insurer and I am ultimately responsible for the cost of my care; and (4) I may revoke this Authorization at any time by mailing my written request to:

Boston Scientific, Inc.
Attn: VP Health Economics and Reimbursement 7201
Metro Blvd. Suite 300
Edina, MN 55439

but that any revocation will not apply to any information already used or disclosed pursuant to this Authorization. This Authorization automatically expires five (5) years from the date signed below.

Signature: _____ Date: _____

Patient's Printed Name: _____ Patient's DOB: _____

Employer providing insurance coverage (if applicable): _____

Insurer: _____ Group No. _____ Member No. _____

Check the following specialties who have provided treatment for your chronic low back pain:

- ☐ Primary Care
- ☐ Surgeon
- ☐ Pain Medicine
- ☐ Psychology/Social Worker
- ☐ Physical Therapy
- ☐ Chiropractor
- ☐ Aquatic Therapy
- ☐ Massage Therapy

BSC would like to periodically update you on the status of your insurance request via email. Your email address will not be used for any other purpose other than Intracept Patient Access Program activities.

Email: _____

The Intracept Procedure is the only FDA cleared treatment for basivertebral nerve ablation. A positive coverage determination may not apply to other treatment options. A change in therapeutic options by you and your physician may result in you incurring significant out of pocket costs not covered by your insurance.

View Boston Scientific Intracept Intraosseous Nerve Ablation System Indications, Safety, and Warnings at bostonscientific.com/intracept-indications