Patient consent form

Powered by PRIA Healthcare Management LLC

Disclosure

Purpose of disclosure: I hereby give my consent for PRIA Healthcare Management LLC (PRIA) to use and disclose protected health information (PHI) to seek coverage and payment for the **mild and/or OptaBlate BVN procedure**. This authorization is made in connection with my pre-certification/prior authorization, appeal of both pre- and post-service claims, grievance, and/or independent review for the **mild and/or OptaBlate BVN procedure**.

Method of disclosure: Disclosure may occur via secure email, fax, mail, or other secure methods.

Patient name (first and last name)	**Date of birth** (mm/dd/yyyy)
Phone number	**Email address**

Patient authorization to use and disclose health information

- I understand that I must complete this authorization form before I can receive assistance from PRIA, an appointed Authorized Representative whose services include assisting patients in obtaining coverage for the **mild and/or OptaBlate BVN procedure** through pre-certification/prior authorization, appeal, grievance, or independent review of insurance benefits. As part of this process, PRIA will need to obtain, review, use, and disclose my Personal Information as described below.
- I understand that this authorization is voluntary and that my treatment and health insurance enrollment or eligibility will not be affected if I refuse to sign this form but if I do not sign this Authorization, PRIA cannot receive Personal Information about me and cannot provide me with assistance in obtaining coverage for the **mild and/or OptaBlate BVN** procedure.

Purpose of disclosure

- I authorize my healthcare providers and health plans to disclose my Personal Information to PRIA for the purposes described below. I authorize PRIA to request and receive my Personal Information from my healthcare provider and health plans and use and disclose my Personal Information as needed for the purposes described below and attempt by any reasonable means of communication to seek insurance benefit and/or other coverage approval either through prior authorization/pre-certification, appeal or independent review. I am willingly providing authorization for PRIA to receive and request information, whether in written or oral form to assist in my pre-certification/prior authorization, appeal, grievance, and/or independent review request related to insurance benefits and/or coverage for the **mild and/or OptaBlate BVN procedure**.

My personal information may be disclosed to PRIA for the following purposes

- Confirming my eligibility for this appeal program.
- Communicating with my healthcare providers or health plans to seek insurance benefit or other coverage approval on my behalf.
- Completing my pre-certification/prior authorization, or to appeal a denied claim for the **mild and/or OptaBlate BVN procedure**.

Information that may be shared

- Personal information about me may contain my name, date of birth, contact information, demographic, and financial information, information created by other persons or entities including medical, pharmacy, and health care program information, and my health care information (which may include name and contact information of my health care provider, my future and current medical condition, medical procedures performed, location where the procedure was performed, treatment and medications prescribed, and insurance coverage eligibility information). This information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. PRIA agrees to protect my information by using and disclosing it only for the purposes described herein or as required by law.

Important notes about the appeal process

- I understand PRIA has not provided me with any guarantees or assurances that I am eligible for this program or, in the event I am eligible, I acknowledge that I have not been promised any specific outcome to my appeal and that this appeal may ultimately be denied or not processed by the payor.
- While I understand there are no costs for me to participate in this appeal program, some health care providers or other entities may require payment for copying medical records and if I want those records to be part of my appeal package, I will be directly responsible for paying those providers.
- I understand that the purpose of this appeal is to gain insurance approval for the **mild and/or OptaBlate BVN procedure** and this appeal will not address the amount of payment which the payor is required to render any health care provider or facility in the event I am approved.

Revoking your authorization

- I understand that even if the **mild and/or OptaBlate BVN procedure** is approved, I will likely have personal financial responsibility to pay for services which are not covered by my insurance and I will have personal financial responsibility for any co-payments, coinsurance, deductibles, etc.
- I understand that I may change my mind and cancel (revoke) this authorization at any time by contacting PRIA in writing at PRIA Healthcare Management, 30 Batterson Park Rd, Suite 120, Farmington, CT 06032 or sending an email to strykerIVS@PRIAhealthcare.com
- Cancellation of this authorization will not apply to information that has already been released based upon this authorization. On written request, I may receive a copy of this form after I sign it. I understand this authorization will expire one year from the date entered below or upon conclusion of my appeal and/or independent review process, whichever is later.

Patient name (first and last name)

Patient signature | **Date of signature**

The following section is not part of the HIPAA Authorization but designates PRIA as my Authorized Representative for insurance purposes: I hereby appoint PRIA Healthcare Management and its employees/contractors to be my Authorized Representative for purposes of seeking coverage and payment for the **mild and/or OptaBlate BVN procedure.** I give permission for PRIA to do the following on my behalf:

- Request, gather, work and sign any and all required documents needed for the **mild and/or OptaBlate BVN procedure** appeals process.
- Attempt by any means of communication to seek insurance benefit and/or other coverage approval either through prior authorization/pre-certification, appeal, and/or independent review.
- Speak on my behalf to insurance companies and providers.
- I understand that this appointment is voluntary. I may, at any time, request in writing to have this appointment revoked by contacting PRIA at PRIA Healthcare Management, 30 Batterson Park Rd, Suite 120, Farmington, CT 06032 or sending an email to strykerIVS@PRIAhealthcare.com
- Cancellation of this appointment will not apply to information that has already been released based upon this appointment.
- PRIA accepts this appointment as Authorized Representative and is a service whose purpose is to assist patients in obtaining coverage through pre-certification/prior authorization, appeal, grievance, and/or independent review of insurance benefits.

Patient name (first and last name)

Patient signature | **Date of signature**

This authorization will expire one year from the date entered above or upon conclusion of my appeal and/or IRO process, whatever is later.