



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 plans and health insurers to disclose my personal health information, including, but not limited to, information relating to my medical condition, treatment, care management, health insurance, medical record, and all information provided on this form (“Protected Health Information”), to, SI-BONE, and their respective representatives, agents, and contractors for the following purposes: (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 iFuse Implant System. I also authorize SI-BONE and their representatives to contact me directly about these issues. I understand that any of my Protected Health Information disclosed under this Authorization may no longer be protected by federal privacy law and may be re-disclosed by SI-BONE. I understand that I may refuse to sign this Authorization and that my treatment, payment, enrollment or eligibility for benefits are not conditioned on my signing 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, ATTN: PICS 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 five (5) years from the date signed below.

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 Number: _____

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

Patient email I _____ 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. 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.