

Background

Your physician has identified you as a potential candidate for the DETOUR™ System. The DETOUR System provides a novel solution via a Percutaneous Transmural Arterial Bypass (PTAB) approach to effectively and durably treat long femoropopliteal lesions.

To assist you in determining your insurance coverage for the DETOUR System, you may choose to enroll in the Reimbursement Support Center, which is administered by Endologix through its contractor PRO-Spectus.

Scope, Use and Disclosure of Your Health Information

If you choose to sign this Authorization, you authorize your healthcare providers, your health insurance company, the requesting/treating provider, and the facility at which you are treated to disclose to Endologix, and its respective affiliates, agents, and contracted third parties, including, but not limited to Reimbursement Support Center (administered via PRO-Spectus), (collectively, "Companies") your protected health information ("PHI"), for the purposes described below. This PHI includes all of your medical records related to your possible treatment with the DETOUR System, as well as information related to your treatment and insurance coverage (for example, your name, address, phone number, email address, or information about your medical condition or status).

Examples of how your information maybe used and/or disclosed if you execute this Authorization, include, but are not limited to, the following:

- To enroll you in the "Reimbursement Support Center," a support resource designed to assist with questions as well as provide assistance regarding insurance;
- To help verify or coordinate insurance coverage or otherwise obtain payment for your treatment with the DETOUR System procedure;
- To provide updates regarding the status of your insurance coverage, including reasons for any insurance denial to your healthcare provider and Endologix, specifically including Endologix's field representatives;
- To provide you with educational information related to the DETOUR System procedure or similar products that may be of interest to you, including disease awareness and management programs;
- To provide you with support related to the DETOUR System;
- To communicate with your healthcare provider or you regarding the status of your DETOUR System procedure; and
- In conducting quality assurance, surveys and other business activities in connection with the DETOUR System procedure;
- To collect information related to the DETOUR System, with assistance of coordination of care, obtain reimbursement details for the DETOUR System and demonstrate the safety and efficiency of the DETOUR System.

Authorization

I authorize the Reimbursement Support Center to receive and share my PHI on my behalf and release to a payor (insurance company), provider and/or a treating facility.

I understand that the Companies may contact me by mail, email, text, telephone, and/or any alternative communication method ("Communications") that I request for the purposes described in this Authorization.

I understand that Endologix may pay companies to provide some of these communications to me.

I understand that my healthcare providers, insurance company, providers, and/or treating facility may receive remuneration in exchange for reimbursement services and/or therapy support services provided to me.

I understand that I am not required to sign this Authorization as a condition to receive treatment with Endologix products or reimbursement for treatment; enrolling in a health plan; or establishing eligibility for benefits. However, I also understand that by refusing to sign this Authorization, I will not be able to enroll in or receive certain services provided by the Reimbursement Support Center.

I understand that I may refuse to sign this Authorization.

I understand that I should keep a copy of the executed Authorization for my records.

I understand that I may revoke this Authorization at any time by notifying Endologix in writing at the following address:

Reimbursement Support Center
c/o Endologix Customer Care
2 Musick
Irvine, CA 92618

I understand that the revocation of this authorization will be effective upon actual receipt of my letter by Endologix at the above address. Revoking this authorization will end my consent to further disclosure of my PHI to Endologix and the Companies. If I revoke this authorization, it will not have any effect on any actions taken by the Companies before the revocation.

I understand that the PHI disclosed pursuant to this authorization may be subject to re-disclosure by the recipient(s), because it may no longer be protected by federal privacy regulations, including HIPAA.

This Authorization expires five (5) years from the date this Authorization is signed (unless a shorter period is required by law).

By executing this authorization, I certify that I

- (1) have read this authorization;
- (2) understand the Scope and Uses and Disclosure of Your PHI; and
- (3) authorize the use and disclosure of my protected health information as described above.

PLEASE COMPLETE THIS FORM:

Questions? Call (888)605-0658

Patient Signature

Date

Patient Name Printed

Email

Address (Street, City, State, Zip)

Personal Representative Signature

Relationship to Patient

Including the Authority for status as Personal Representative

Representative Name Printed

SEND COMPLETED FORM TO:



DETOUR@PTABACCESS.com

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(888)570-0498