Instructions for Needs Processing

The sharing turnaround time is between 14 and 60 days, depending on the receipt of all required information and whether your bills go through negotiation. If your Needs Processing Form is correct and complete, and there are no ongoing financial negotiations with providers, your Need will normally be shared the next sharing period. Sedera processes shareable Needs on a weekly basis.

Please make sure all bills contain the following:

a. Name, address, and phone number of medical provider
b. Name of patient (Sedera Member or Dependent)
c. Date(s) of service
d. Description of services provided
e. Total charge, discount/adjustment amount (if applicable), and other related payments you have made (if applicable)
f. Account number if available

Please Note: The above information is required for bills to be accepted for sharing. Bills that merely give amounts or codes may not be accepted.

Up-Front Payments
If a payment was made up-front, please make sure you ask the provider for a detailed invoice to submit along with proof of payment.

Paying with Insurance
Please include proof of payments made by other agencies such as Medicare, Medicaid, Workers Compensation or other insurance, if applicable.

BIll Negotiation
Please keep in mind that we will attempt to negotiate any bills that have a balance greater than $500 that do not already have a significant self-pay discount.

Change of Address
If your mailing address has changed since you joined Sedera, please ask the Health Plan Administrator in your company for a Change Request Form in order to ensure that your Needs request will be received without delay.

Submitting Your Needs Processing Form
Scan and email your completed Needs Processing Form, Medical Information Release Form and supporting documents to Sedera at needs@sedera.com. Needs Processing Form, Medical Information Release Form and supporting documents can also be mailed to Sedera Health, P.O. Box 90489, Austin, TX 78709-0489.

Needs Processing Form

This form should be completed when a member has a medical cost(s) exceeding their IUA (Initial Unshareable Amount) and wish to submit a Need to Sedera Health for Medical Cost Sharing. ***Please note:*** If your Needs Processing Form is correct and complete, and there are no ongoing financial negotiations with providers, your need will normally be shared the next sharing period.

Contact Information

Primary Member: _____

Member ID Number: _____

Work Phone: _____

Mailing Address: _____

Employer: _____

Membership Effective Date: ____ / _____ / _____

Cell Phone: _____

City: _____ State: _____ Zip: _____

Patient Information *(If not the Primary Member)*

Name: _____

Phone Number: _____

Relationship to Primary Member: _____

Email:

_____

Required Information for MCS

Description of injury, illness, or symptoms *(Please be specific)*:

_____

_____

_____

_____

Date of symptom onset or first related provider visit: ____ / _____ / _____

Medical Need includes *(Check all that apply)*:

- ❑ Emergency Room
- ❑ Hospitalization
- ❑ Outpatient Surgery
- ❑ Family Doctor
- ❑ Specialist
- ❑ Medication
- ❑ Lab Work
- ❑ Diagnostic Imaging

❑ Other *(Please specify)* _____

The Medical condition is a result of (check one):

- ❑ Work-Related Injury
- ❑ Non-Work Related Injury
- ❑ Illness
- ❑ Pregnancy *(Due Date: ____ / _____ / _____)*

Member Need Confirmation

Please Note: This Section must be completed by Primary Member.

1. Did the patient have symptoms or receive treatment for this condition prior to the membership start date? **Yes / No**
2. Is any of the requested need eligible for coverage by an insurance company or government agency including Medicare or Medicaid? **Yes / No**
3. Will a state or private agency pay any portion of this need? **Yes / No**
4. Will Workers Compensation pay any portion of this need? **Yes / No**

Acknowledgement of Terms

I understand and agree that any money I may receive from other Sedera members is given to help with a medical need that is shareable according to the Sedera Guidelines and for no other purpose. Also, I agree that any changes in my need that results in extra money coming to me, will be set aside and returned to Sedera. I further clarify that the information I am providing in this Medical Needs Processing Form is accurate and true. I understand that failure to provide accurate, truthful information or failure to use the money only for shareable medical bills will be a violation of the members trust and grounds for termination of my membership.

Signature: _____ Date: _____

Sedera Medical Release Authorization

Contact Information

Patient's Name: _____ Phone Number: _____

Social Security Number: _____ Date of Birth: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Terms and Acknowledgement

As a member of Sedera Health, I (signer below) hereby authorize any medical practitioner, hospital, facility, insurance company or any other person or entity that has my medical records or knowledge of my medical history and/or the dependent's listed herein, to release such information upon request to Sedera Health and/or its agent, The Karis Group, Inc., for the purpose of The Karis Group communicating on my or the dependent's behalf. This release shall be limited to the medical bills or incident(s) I have specifically requested or authorized Sedera Health and/or The Karis Group to negotiate or assist me with. I hereby grant permission to Sedera Health and/or The Karis Group, Inc. to discuss any and all medical related information with any medical practitioner, hospital, facility, insurance company or any other agency that has my medical records or knowledge of my medical need or the dependent's listed herein for the purpose of The Karis Group communicating on my or the dependent's behalf.

As a member of Sedera Health, I (signer below) hereby authorize any medical practitioner, hospital, facility, insurance company or any other person or entity that has my medical records or knowledge of my medical history and/or the dependent's listed herein, to release such information upon request to Sedera Health and/or its agent, The Karis Group, Inc., for the purpose of The Karis Group communicating on my or the dependent's behalf. This release shall be limited to the medical bills or incident(s) I have specifically requested or authorized Sedera Health and/or The Karis Group to negotiate or assist me with. I hereby grant permission to Sedera Health and/or The Karis Group, Inc. to discuss any and all medical related information with any medical practitioner, hospital, facility, insurance company or any other agency that has my medical records or knowledge of my medical need or the dependent's listed herein for the purpose of The Karis Group communicating on my or the dependent's behalf.

I understand that:

- I may revoke this medical information release at any time, in writing, but the release shall remain validuntil
- revoked or upon the expiration of one (1) year after the release is executed, whichever occurs first.
- This release may include medical records of treatment for physical and/or emotional illness, except psychotherapy notes, including treatment of alcohol or drug abuse.
- The Karis Group, Inc. will maintain the privacy of any information obtained and will not disclose such
- information to any other person or entity except as necessary to effectuate service or by express written permission by me.
- A copy of this form, including a facsimile or scan, may be used in place of the original.
- I acknowledge that I have read and understand this Medical Information Release Authorization. Further, I authorize the disclosure of my or the dependent's protected health information in accordance with the terms in this Authorization.

Patient's Name (Print): _____

Signature: _____ Date: _____

Signature of Parent/Legal Guardian if Patient is a Minor: _____

Optional: If it is necessary for someone other than your spouse to discuss your medical bills or finances with The Karis Group, please provide the individual's name below to appoint and authorize them to act as your personal representative for this limited purpose: _____ ("Personal Representative").