Coloplast

Reimbursement & Benefit Support
HIPAA Authorization Form

If you would like to complete this form electronically, please request a link by calling **(855) 230-7611**
Fax the completed form to **(612) 520-2366** or email to US_MarketAccess@Coloplast.com

Patient Name	Date of Birth
Provider	
Primary Insurance	Primary Insurance Member Number
Secondary Insurance	Secondary Insurance Member Number

Statement of Authorization

I, the undersigned, authorize Coloplast to act as my representative to fulfill the purposes listed on this form.

I authorize the HIPAA covered entities named on this form to discuss and share my Protected Health Information with Coloplast for the purposes described below.

- Request eligibility and coverage from my health plan for the surgical procedure; and send a summary of coverage to my doctor's office
- Request that my health plan reconsider or issue an individual consideration for coverage of the surgical procedure for me, if necessary
- Obtain, share, release and discuss my Protected Health Information
- Ask my health plan to conduct an external review of its decision, if necessary
- File a grievance with my plan regarding its decision not to cover the procedure or its failure to issue a decision about coverage, if necessary
- File a grievance with my local insurance commissioner or other applicable health plan regulator if my health plan fails to honor the request for an external review
- Assist with drafting letters, fill out and send forms necessary to attempt to obtain coverage for the surgical procedure

This Protected Health Information should be discussed and shared with Coloplast:

- All my Protected Health Information relating to any condition, examination, treatment, and hospital confinement in connection with my penile treatment, surgery, and implant.

I understand that I may revoke this Authorization at any time by written request to the parties named on this form.
I understand that my revocation will not apply to information which has already been disclosed pursuant to this Authorization.
If I do not revoke my Authorization, it will expire after one year.

I understand that I am not required to sign this Authorization, and that no healthcare provider may condition treatment, payment, or eligibility for benefits if I choose not to sign this Authorization. However, if I do not sign this Authorization, then Coloplast will not be able to receive my Protected Health Information or provide assistance with any of the purposes described above.

I understand that I may receive a copy of this Authorization by written request to Coloplast.

Signature of Patient or Representative **(Written or DocuSign signature required)**		Date
Representative Name (if Applicable)		
Street Address		
City	State	Zip
Preferred Phone Number		
Email Address (optional)		

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