Nevro Corp. • 1800 Bridge Parkway • Redwood City, CA 94065 USA • 650-251-0005

Patient Assistance and Donation Policy Application

Physician Application Form

Implanting Institution Name: _____

Implanting Institution Address: _____

_____

Contact person: _____

Contact telephone: _____

Contact email: _____

Institution Federal Tax ID: _____

Requesting Physician Name: _____

Patient Name: _____

Patient DOB: _____/ _____/_____

Patient Need: _____

Procedure(s) to be performed: _____

Product name and quantity: _____

Once completed, please send Physician Application Form, Physician Certification, Patient Certification, and Facility Certification to: PatientAssistance@nevro.com

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Physician Certification

By checking the box below, I, the undersigned, as a representative of the requesting institution, certify that to the best of my knowledge the following statements are true with respect to this request:

- The product will be used by an entity that has the resources necessary to safely support the medical procedure and by a healthcare professional who has been trained and educated on the use of the product.
- Requestor has used his/her independent medical judgement to determine that the implant is medically necessary for an indication that is consistent with FDA labelling for the product.
- If the product requested requires ongoing support (e.g. product programming), the patient will have access to such necessary medical support even if s/he is unable to pay for it.
- The product will be used only on the indigent patient named in this request; the patient named in the request does not have coverage under any federal, state, or private health insurance program; product charges will not be billed to the patient or a third party; and services and facilities will be provided at no charge (unless it is lawful and appropriate under local law to charge a nominal facility and/or service fee to cover costs).
- Requestor will comply with Nevro procedures and/or local requirements regarding product tracking, product complaints, and return of explanted product.
- Requestor has not solicited the donation in exchange for his/her agreement to purchase, use, order, or recommend Nevro products. Should this request be approved, requestor also certifies that the donation has not been offered to requestor in exchange for past or future purchase, use, order, or recommendation of Nevro products.

Printed Name: _____

Signature: _____

Date: _____/ _____/_____

Once completed, please email to PatientAssistance@nevro.com

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Patient Certification

Patient Information

First Name (Legal):_____ MI:_____ Last Name:_____

Gender:_____ Marital Status:_____

Phone Number:_____

Email Address:_____

Social Security Number:_____

Date of Birth:_____/ _____/_____

Mailing Address:_____

City: _____ State: _____ Zip Code: _____

Income Information

Salary/Wages: $_____ Disability: $_____ Social Security: $_____

Alimony/Child Support: $_____ Pension/Retirement: $_____

Unemployment/Work Comp: $_____

Number of people in household (including yourself, spouse if married, anyone claimed as tax dependent who is also required to file their own tax return): _____

Total Gross Monthly Income: $_____

Patient Certification

- I certify that I do not have the ability to pay for the device requested by my licensed prescriber and that all information provided in the above sections is accurate and complete. I understand that Nevro's Patient Assistance Program ("Program") is entitled at any time to request verification of any such information which I agree to provide from me, my employer, and/or my insurer. I understand that if approved, I am not eligible to, and I certify that I will not, seek reimbursement for the device requested by my physician from any government program or third party. I understand that if my physician's request is approved, my physician will manage my device and procedure, and must submit a new Patient Assistance Product Donation Application if I should need a replacement device in the future.

- I authorize my physician to provide Protected Health Information ("PHI") (as such term is defined in the Health Insurance Portability and Accountability Act ("HIPAA") and regulations there under, as well as other state or federally protected person al information) to the Program or third parties engaged, as required to assist Nevro in administering the Program. I understand that as part of that process, the Program may disclose my PHI to Centers for Medicare & Medicaid Services ("CMS") (and/or CMS's authorized vendor) for the purpose of verifying my Medicare Part D enrollment status and disclosing my enrollment in the Program with my Medicare Part D plan. I understand that my PHI will consist of my name, address, Social Security number, income, prescription for the

device, financial documents and insurance records and will be used for purposes of determining my eligibility to participate in the Program. I further understand that if my PHI is incomplete or my completed PHI does not allow me to participate in the Program that I may be notified of such. I understand that upon the furnishing of my PHI to the Program, my PHI may not be subject to all of the protections and safeguards provided by HIPAA or other federal and state privacy laws. This authorization will extend for as long as I participate in the Program and will thereafter expire. I may revoke this authorization at any time by providing written notice to Nevro at the address set forth above. My revocation will become effective on the date my written notice is received and processed at the Program. If I revoke my authorization, I understand this means I may no longer be able to receive assistance from the Program. I understand that the Program reserves the right at any time and without notice to me to modify and/or discontinue any or all of the Program, including modification of eligibility criteria, and immediate termination of assistance provided by the Program.

Signature (If patient is unable to sign, an agent may sign on patient's behalf and signed, notarized Power of Attorney must be included):

_____

Date: _____/ _____/_____

When completed, please return to your physician for submission to Nevro.

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Facility Certification

Hospital or Facility Representative Certification of Free Health Care

Note

A signed copy of this Certificate is required for any requests submitted to Nevro for a Patient Assistance Product Donation. Please upload or email this completed Certificate with the rest of the Patient Assistance Product Donation application materials.

By checking the box below, I, the undersigned, certify that the hospital or facility identified in this request form, will not bill the patient named in this request form, Medicare, Medicaid, any insurer, or any other individual or third party payor for any hospital or facility services and products, including any products donated by Nevro, related to the patient and procedure listed in the Nevro Patient Assistance Product Donation Request Form.

Additional Information

Organization name: _____

Your name: _____

Title: _____

Phone number, including area code: _____

Signature: _____

Date: _____/ _____/_____

When completed, return to requesting physician or email directly to PatientAssistance@nevro.com

If you have any questions about this form, please contact Nevro at PatientAssistance@nevro.com