P.O. Box 90489 | Austin, Texas 78709-0489
Sedera Toll-Free 1-855-973-3372 | M-F 9AM – 5PM CST
Fax: 512-236-5147| email: needs@sedera.com

Instructions for Needs Processing

The most common delays in processing needs are due to incomplete information.

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 payments you've made (if applicable)
f. Account number, if available.

Note: Bills that merely give amounts or codes may not be accepted.

If payment was made up-front, please make sure you ask the provider for a detailed invoice to submit along with your receipt. Receipts alone will not be accepted.

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

It is not necessary to wait until you have met the $500 Initial Unsharable Amount (IUA) to submit bills.

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

You can also contact your Member Advisor for assistance in obtaining self-pay pricing for any upcoming procedures or surgeries. Call 1-855-973-3372 or email memberservices@sedera.com.

If your mailing address has changed since you joined Sedera, please ask your HR representative for a Change Request Form in order to ensure that your needs request will be received without delay.

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

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Needs Processing Form

Primary Member: _____ Employer:_____

Mailing Address: _____ City _____ State _____ Zip _____

Cell/Mobile # _____ Work # _____

Patient and Contact Information:

Patient Name: _____ Preferred phone #:_____

Preferred Email: _____

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

_____

_____

_____

Required: Date of initial visit or onset of symptoms:_____

Medical need includes (check all that apply):

☐ Emergency Room ☐ Hospitalization ☐ Outpatient Surgery ☐ Family Doctor ☐ Specialist

☐ Medication ☐ Lab work ☐ Diagnostic imaging ☐ Other _____

Medical condition is a result of (check one):

☐ Injury (work-related) ☐ Injury (non work related) ☐ Illness ☐ Pregnancy (Due Date:_____)

Medical Condition is (check one):

☐ Acute/Short-term ☐ Chronic/Long-term ☐ Undiagnosed ☐ Fully Recovered

Member Need Confirmation - <u>Must be completed</u>

Y N Did the patient have symptoms or receive treatment for this condition prior to the membership start date?

Y N Will any other entity pay any portion of this Need, including an insurance company, Medicare, Medicaid, Worker's Compensation, a state agency, or private agency?

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

Patient's Name			
Mailing Address		City	
State		Zip	
SSN		DOB	

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 valid until
- 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.

Signature	Signature of Parent/Legal Guardian if Patient is a Minor
Patient's Name	Date

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").

Return via mail or fax to:
P. O. Box 90489, Austin, Texas 78709-0489
Ph. 855.973.3372 Fax: 512.276-6734