

Medtronic Australasia Pty Ltd

ABN 47 001 162 661
2 Alma Road Macquarie Park
NSW 2113 Australia

Medtronic New Zealand Ltd

NZBN 9429000102308 Level 3 – Building 5,
Central Park Corporate Centre 666 Great
South Road Penrose, Auckland 1051 New
Zealand

**Valiant Navion™ Thoracic Stent
Graft System**

**SAFE-N Limited Warranty Claim
Form**

**Patient or Provider Unreimbursed
Medical Expenses**

SYNTAX

Patient Full Name: _____ Telephone: _____

Patient Address: _____

Suburb: _____ State: _____ Post Code: _____

Patient Date of Birth: _____

Private Health Insurer (PHI): _____ Membership Number: _____

Name of Person Filing Out Form (if not Patient): _____ Telephone: _____

Relationship to Patient: Spouse Child Healthcare Provider Other: (Describe): _____

If you are a family or non-family member authorized by and assisting the patient on their behalf, please have the patient complete and sign an **Authorization for Patient Caregiver** form, attached.

Status of Insurance (check as applies):

- I am submitting expenses (e.g., co-pays, coinsurance, or deductibles) that are not covered by health insurance.
- My claim was denied by my Private Health Insurer.
- I am a public patient.
- Other: (describe): _____

If you are uninsured, please complete and sign an **Uninsured Status Verification Form**.

I am seeking reimbursement for the following types of medical expenses (check all that apply):

- Additional Imaging or Uninsured Reintervention Other (describe below)
Imaging

If selecting additional imaging, I certify that I have received my routine, annual imaging and have not sought reimbursement for expenses related to the same from Medtronic.

If you selected "other" above, please describe the type of medical expense you are requesting be reimbursed: _____

Enclosed are the medical bills and insurance documents relating to my claim for reimbursement of unreimbursed medical expenses that are directly related to the Valiant Navion recall:

Medtronic may disclose sensitive health information to a related body corporate subject to the FDA jurisdiction for public health purposes related to the quality, safety, or effectiveness of an FDA-regulated product. Additional limitations may apply. Reimbursements are subject to review and approval. To the extent allowable by law, the SAFE-N Limited Warranty is limited to its express terms. The SAFE-N Limited Warranty is voluntary and does not constitute a representation, judgment, admission, or assumption of liability by Medtronic with respect to imaging, reintervention, and/or utilized thoracic stent graft systems. No action taken by Medtronic in connection with the Voluntary Product Recall, including this SAFE-N Limited Warranty, shall be construed as an admission of any fault or liability whatsoever to the patient, doctor, health care professional, or to any third party. Medtronic makes no representation with respect to any potential impact of reimbursements on a patient's eligibility to participate in a Health Savings Account or other tax-favored health plan; please consult with a tax advisor as necessary. All rights reserved.

| Physician/Facility Name (include Provider Number if possible) | Date of Procedure | Type of Procedure | Amount Billed | Amount Paid by Medicare or Insurance | Unpaid Balance |
|---|-------------------|-------------------|---------------|--------------------------------------|----------------|
| | | | | | |
| TOTALS: | | | | | |

Please refer to the [Valiant Navion patient website](#) to verify what qualifies for reimbursement. Additional limitations may apply. Reimbursements and credits are subject to review and approval. Further Information may be requested at a later date. For Unreimbursed Medical Expenses, required documentation is as follows:

| | Required Documentation |
|---|---|
| All patients | <ul style="list-style-type: none"> For reintervention, documentation of a diagnosis of recall-related observations or determination by a physician that reintervention is in the patient's best interests* For more than once per 12-month period imaging, documentation of physician orders for more than twice annual monitoring, or, if the patient is uninsured, an Uninsured Status Verification Form |
| Patient insured , procedure allowed, patient has copay | <ul style="list-style-type: none"> A copy of the Patient's Statement of Claim and Benefits (SOC), which must include: <ul style="list-style-type: none"> Medical insurance overview of billing received Defines patient's final out of pocket responsibility (what the patient owes) Note that medical expenses incurred in this setting may entail two separate bills: one from a physician or imaging group and one from the facility. Both expenses are reimbursable. |
| Patient insured , procedure denied | <ul style="list-style-type: none"> If insured with coverage denied, a copy of the insurance denial, which may appear on the SOC. Denial of pre-approval will not be considered. Reimbursement requires submitting the bill to insurance for the care once performed, along with documentation of its denial. |
| Patient uninsured | <ul style="list-style-type: none"> Itemized final medical bills, which must include: <ul style="list-style-type: none"> A detailed list of all charges related to the date(s) of service to include the total amount Clearly defines patient's final out of pocket responsibility (what the patient owes) A "summary of charges" will not be considered Completed Uninsured Status Verification Form |
| Patient paid expenses | <ul style="list-style-type: none"> If patient paid the medical provider's bills, proof of payment |

* Documentation may consist of medical records or a physician statement and is not required where observations were confirmed by Syntactx core lab.

I certify that the statements and information contained above are true, accurate, and complete. I certify that the above expenses were incurred by me, have not been reimbursed or are not reimbursable by any other insurance or benefit, are expenses related to coverage that has been denied or that I am uninsured.

Patient's or Authorized Person's Signature: _____ Date: _____

Within 90 days of the Imaging, Reintervention, or Treatment Date:
E-mail Completed Warranty Form to: SAFE-N-Reimburse@syntactx.com

Mailing or facsimile submission is also available at:

Syntactx
RE: SAFE-N Project
4 World Trade Center
150 Greenwich Street, 44th Floor
New York, New York, 10007
Facsimile: 1 (800) 342-1401

Please allow between 45-60 days for processing any reimbursement request. Syntactx may need to contact you directly to obtain additional verification or information before payment may be processed. Payments for medical expenses will either be via electronic funds transfer or via U.S. Mail to the patient's primary mailing address indicated on their patient account. Please consult your financial and tax advisor regarding any reporting obligation for tax purposes.

For questions, contact Medtronic through Syntactx at the SAFE-N reimbursement helpline: AU: 1800 512 149, NZ: 0800 444 248 or email: SAFE-N-Reimburse@syntactx.com.

Medtronic may disclose sensitive health information to a related body corporate subject to the FDA jurisdiction for public health purposes related to the quality, safety, or effectiveness of an FDA-regulated product. Additional limitations may apply. Reimbursements are subject to review and approval. To the extent allowable by law, the SAFE-N Limited Warranty is limited to its express terms. The SAFE-N Limited Warranty is voluntary and does not constitute a representation, judgment, admission, or assumption of liability by Medtronic with respect to imaging, reintervention, and/or utilized thoracic stent graft systems. No action taken by Medtronic in connection with the Voluntary Product Recall, including this SAFE-N Limited Warranty, shall be construed as an admission of any fault or liability whatsoever to the patient, doctor, health care professional, or to any third party. Medtronic makes no representation with respect to any potential impact of reimbursements on a patient's eligibility to participate in a Health Savings Account or other tax-favored health plan; please consult with a tax advisor as necessary. All rights reserved.