

Patient Funding Alternatives LLC

Patient Funding Alternatives LLC as an organization will be represented throughout this document as “Patient Funding Alternatives LLC”, “Patient Funding Alternatives”, “PFA”, or “we”. Our employees or contractors who work directly with individuals will be represented as “Patient Advocacy Specialist”, “patient advocate”, or “PAS”.

Medicaid Premium Assistance

The term "Medicaid Premium Assistance" describes Medicaid-supported programs that help Medicaid eligible individuals and families get reimbursed for commercial or private health insurance. This includes the federally recognized Health Insurance Premium Payment Program (HIPP) as well as other state-specific initiatives such as Health Insurance Buy-In (HIBI), Employer-Sponsored Insurance Assistance, and similar premium support programs. While program names and structures may vary by state, they all fall under the umbrella of "Medicaid Premium Assistance".

To apply for Medicaid Premium Assistance there are required forms you need to sign. Below is a summary of the most common forms which are specific to the state where you and/or your family receive Medicaid benefits. If additional forms are required, your patient advocate will contact you.

Patient Consent Form

This form was created by PFA. By signing it, you acknowledge that you understand the Medicaid Premium Assistance Program is sponsored by the state and that, if accepted, you will continue to receive Medicaid coverage. Additionally, you affirm that the decision to apply for Medicaid Premium Assistance was made independently, without coercion or pressure. You also confirm that you have not received, nor been promised, any gifts or incentives in exchange for applying.

Authorization for PFA

This form was created by PFA. By signing it, you authorize PFA to act on your behalf as your representative in obtaining information about the health insurance plan offered by your employer, COBRA, and the insurance company providing that coverage. If applicable, you also authorize PFA to submit insurance payments to your employer, COBRA administrator, and/or insurance company on your behalf.

Medicaid Premium Assistance Application

This form is part of the HIPP application. By signing it, you acknowledge that you are applying for Medicaid Premium Assistance. If approved, your employer's health insurance plan will serve as your primary coverage, and Medicaid will provide secondary coverage.

Medicaid Premium Assistance Authorization Form

If applicable, a Medicaid Premium Assistance authorization form will be provided for you to sign. By signing it, you authorize Patient Funding Alternatives LLC ("PFA") to act as your representative in communicating with Medicaid Premium Assistance on your application and completing forms required by Medicaid and Medicaid Premium Assistance.

Authorization Form

This form was created by the state from which you receive Medicaid benefits. By signing it, you authorize PFA to act as your representative in communication regarding your application and completing forms required by Medicaid and Medicaid Premium Assistance.

Direct Deposit Form

If applicable, a direct deposit form will be provided for you to sign. By signing it, you authorize the state to use direct deposit for your Medicaid Premium Assistance monthly reimbursements, depositing funds into the account specified on the form. While this form is not required, it is strongly recommended. If you choose this payment option, you must submit either a voided check or a bank letter on official bank letterhead that includes the account number, routing number, and the name of the account holder.

W-9

If applicable, a W-9 form will be provided for you to sign. By signing it, you confirm that the Social Security number and address listed on the form are accurate. This form is not used for tax purposes. The state requires it to establish you as a vendor in their system to issue reimbursement checks.

Medicaid Premium Assistance Acceptance Letter

If applicable, this form will be provided to you upon acceptance. By signing it, you acknowledge that you have been approved for Medicaid Premium Assistance and agree to participate.

Medicaid Premium Assistance Medicaid Form

If applicable, a Medicaid Premium Assistance Medicaid form will be provided for you to sign. By signing it, you acknowledge and authorize HIPP to disenroll you and your dependents from your Medicaid Managed Care and continue with Medicaid Fee-for-Service coverage.

Medicaid Premium Assistance Renewal Application

If applicable, and you sign and/or submit the Medicaid Premium Assistance renewal application and supporting documents, you acknowledge that you are reapplying for Medicaid Premium Assistance.

Portal Access, Employer Sponsored Insurance Benefit Enrollment Forms, Coordination of Benefits Forms, Birth Certificates

If applicable, you authorize PFA to assist you in creating and accessing the necessary portals, including your Employer Benefits portal, Commercial Insurance portal, Medicaid portal, and COBRA portal. You also authorize PFA to help you complete and sign employer-sponsored insurance benefit enrollment forms and/or Coordination of Benefits forms if required. Additionally, if applicable, PFA may assist you in ordering birth certificates for you and/or your dependents. The requirement of these forms and documents is determined by your employer or insurance carrier to complete enrollment in employer-sponsored insurance.

Medicaid Premium Assistance Program Form(s)

If applicable, a form will be provided by Medicaid Premium Assistance to update family demographic information, update address information, process a stop payment, and/or additional updates Medicaid Premium Assistance requires to maintain your eligibility on the program.

As previously explained, we will request your address, employer's name, Social Security Number, and other necessary information to complete the required forms.

Please sign the Patient Choice Form. By signing electronically, you authorize PFA to apply your signature from the Patient Choice Form to the forms referenced above. PFA will only use your signature for those specific forms. If additional forms are required during the application, enrollment, or renewal process, you authorize PFA to process the required forms with your collected signature.



Patient Funding Alternatives LLC

PATIENT CHOICE ACKNOWLEDGEMENT

- I am currently, or have recently been, a patient or the guardian of a patient at a healthcare facility partnered with Patient Funding Alternatives LLC.
- I know and agree that my employer offers me the opportunity to participate in its group medical, dental, and/or vision insurance and that I must pay a portion of the premium to participate in that group medical, dental, and/or vision insurance.
- I understand that Medicaid Premium Assistance exists in the state where my family and/or I receive Medicaid benefits from and that I can apply to participate in that Program.
- I understand that Patient Funding Alternatives LLC is available to help me apply to for Medicaid Premium Assistance.
- Patient Funding Alternatives LLC has provided a clear explanation of how Medicaid Premium Assistance works, and I confirm that I understand the process. If my application is accepted and approved by Medicaid Premium Assistance, they will reimburse the portion of the employee's premium—set by the employer—that is considered cost-effective by the state.
- I agree, understand, and acknowledge that I do not need to change my health insurance coverage, namely Medicaid, and I am not required to apply for Medicaid Premium Assistance.
- I acknowledge, understand, and agree that if my application for this program is approved, my employer-sponsored insurance will serve as my primary coverage, while Medicaid will act as secondary coverage. In cases where my employer offers multiple medical, dental, and/or vision plans, Medicaid Premium Assistance will determine which plan(s) are considered cost-effective.
- I agree, understand, and acknowledge that I am choosing of my own free will to apply for Medicaid Premium Assistance.
- I agree and acknowledge that I have received no gift, money, or other benefit resulting from my choice to apply to the Program. I agree, understand, and acknowledge that whether I apply to the Program or not and whether I am accepted in the Program or not, that I have the right to select any provider for my health care needs.
- I acknowledge, understand, and agree that I am only eligible to apply for Medicaid Premium Assistance in the state where me and/or my family's Medicaid benefits are issued. I hereby give my consent for the completion and submission of all forms and documentation required by the state for participation in the Medicaid Premium Assistance program.
- I understand that PFA may request access to medical records from my healthcare providers to support my participation in Medicaid Premium Assistance. This may include clinical notes, laboratory results, radiology and pathology reports, billing records, consultation notes, and referrals. PFA may also request information about upcoming medical appointments if necessary for program coordination. I authorize PFA to communicate with its

designated staff members regarding my health information as necessary to support my participation in Medicaid Premium Assistance.

- By signing this agreement, you agree to receive voice calls at the mobile phone number you provided from Patient Funding Alternatives related to enrollment in benefits, account information, account notifications, reminders of appointments, scheduling, and set calls. You acknowledge and agree that these voice calls may be placed using an automatic telephone dialing system and/or a prerecorded/artificial voice. Consent is not required to receive any services. We will not share your phone number with any third parties for marketing purposes.

SMS Communication Consent

Mobile Number: _____

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By checking this box, you agree to receive SMS messages from Patient Funding Alternatives related to account information, account notifications, reminders of appointments, scheduling, and set calls. You may reply STOP to opt-out at any time. Reply to HELP for assistance. Messages and data rates may apply. Message frequency will vary.

SMS Terms and Conditions

SMS for Consent Communication

We will not share your phone number with any third parties for marketing purposes.

Types of SMS Communications

If you opt in to receive messages from Patient Funding Alternatives, you may receive texts about account information, account notifications, reminders of appointments, scheduling, and set calls. Standard message rates may apply.

Message Frequency

You may receive approximately 5 SMS messages per month. Message frequency may vary.

Carrier Charges

Message and data rates may apply based on your mobile carrier and location.

Opt-In Methods

You can opt in by submitting the following form to your assigned Patient Advocate:

<https://insidepfa.com/wp-content/uploads/2026/03/PFA-Communication-Consent-Form.pdf>

Opt-Out Instructions

You may opt out at any time by replying STOP to any message. To resume receiving texts, reply START.

Help

If you need assistance, reply HELP or contact us at (866) 591-8864.

Disclosures

- Message frequency may vary.
- Message and data rates may apply.
- Reply STOP to cancel.
- Reply HELP for assistance.

Privacy Policy

You may view our Privacy Policy and Terms of Service here: <https://insidepfa.com/privacy-policy/>

Print Name: _____

Signature: _____

Date: _____

Patient Funding Alternatives LLC Authorized Representative Designation

Patient Funding Alternatives LLC

Patient Funding Alternatives LLC as an organization will be represented throughout this document as “Patient Funding Alternatives LLC”, “Patient Funding Alternatives”, “PFA”, or “we”. Our employees or contractors who work directly with individuals will be represented as “Patient Advocacy Specialist”, “patient advocate”, or “PAS”.

How PFA can help you?

You may choose an authorized representative to help you get health care coverage through programs offered by an Insurer, Employer, COBRA administrator, or your Employer's Third-Party Administrator. You can do this by filling out this form (the Authorized Representative Designation Form) or a sufficiently similar designation document. You can sign for yourself, and for any of your dependent children under the age of 18 for whom you are the custodial parent. You are not required to have a representative to apply for or receive benefits as outlined by the Patient Funding Alternatives LLC designated representative.

Who can help me?

An authorized representative can be a friend, a family member, a relative or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. None of the following: Insurer, Employer, COBRA Administrator or the Employer's Third-Party Administrator will choose an authorized representative for you. You must designate in writing using this form by filling out Section I, Part A, the person or organization to whom you want to be your authorized representative. Your authorized representative will fill out Section I, Part B.

What can an authorized representative do?

An authorized representative may fill out your Medicaid Premium Assistance application and/or eligibility review forms; give proof of information reported on these forms; report changes in income, address or other circumstances; obtain copies of your insurer, Employer, COBRA administrator or Employer Third Party Administrator enrollment notices; obtain copies of your commercial and/or Medicaid insurance cards; enroll you and/or your dependents onto Employer Sponsored Insurance; and act on your behalf in all other matters related to this application with the state, the Insurer, Employer, COBRA administrator or the Employer's Third Party Administrator.

How does an authorized representative designation end?

If you no longer wish PFA to act as your Authorized Representative, please contact your patient advocate. You may also send a notarized letter to:

Patient Funding Alternatives LLC
500 Unicorn Park Drive STE 200
Woburn, MA 01801.

SECTION I: Authorized representative designation

Part A: to be filled out by the employee/policy holder.

Print Employee/Policy holder's Name: _____

Employee/Policy holder's email address: _____

By providing your email address, you authorize PFA to communicate with you electronically on all matters related to this consent form. It will also be considered a voluntary Opt-In to comply with state regulations, including the GDPR, which require businesses to obtain explicit opt-in consent before sending emails to individuals.

I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Employee/Policy holder's signature:

Date:

Part B: to be filled out by the authorized representative.

Part B: Patient Funding Alternatives LLC

I certify on behalf of the organization set forth below that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by the Employer, Insurer, COBRA Administrator or the Employer's Third-Party Administrator.

I, the provider, staff member, or volunteer of the organization set forth below completing this form, certify on behalf of myself and on behalf of the organization I represent that any staff members acting on behalf of Patient Funding Alternatives LLC in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F 42 C.F.R 447.10 and 45 C.F.R 155.260(f).

Authorized Representative's printed name (organization):

Patient Funding Alternatives LLC