Patient Consent Form

The purpose of this form is to authorize Argenta Advisors, Inc. (Argenta) to help you attempt to obtain insurance coverage for PET imaging with PYLARIFY® (piflufolastat F 18) injection. It allows Argenta to act on your behalf and to take certain actions that are described below for the purpose of attempting to obtain insurance coverage. It also allows your health plan(s) to communicate with Argenta, although your health plan may also require that you sign its form as well.

___________________________ _____________________________

Member (Patient) Name Date of Birth

I want to and hereby allow Argenta Advisors, Inc. to be my Designated Authorized Representative.
I request and authorize my representative to perform the following for me:

- Request that my health plan(s) review my eligibility for coverage of the product and(or) service
- Request that my health plan(s) reconsider or issue an individual consideration for coverage of the surgical procedure for me, if necessary
- Obtain, share, release, and discuss protected health information (PHI) about me and my health care
- Ask my health plan(s) to conduct an external review of its decision, if necessary
- File a grievance with my plan(s) 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 if my health plan(s) fails to honor the request for an external review
- Assist with drafting letters, complete and send forms necessary to attempt to obtain coverage for the product and/or service

I allow and hereby authorize my health plan(s), in its decision letter and in connection to the processing of my request for predetermination of coverage, reconsideration of predetermination of coverage, appeal, grievance, or independent external medical review, to communicate with my Designated Authorized Representative concerning the following:

> All medical and financial information contained in my insurance file related to any condition, examination, treatment, and hospital confinement in connection with the determination that is being appealed.

I understand that I can revoke permission for my Designated Authorized Representative to act on my behalf at any time. Otherwise, this authorization is valid for a period of one year or for the duration of the appeal.

_____________________________________ _______________________________

Member or Legal Representative's Signature Date

_____________________________________ _______________________________

Legal Representative's Name (if applicable) Member's Daytime Phone Number

_____________________________________ _______________________________

Member's Street Address Member's Evening Phone Number

_____________________________________ ________________________________

Member's City, State, Zip Member's Email Address (optional