NC D=" Auditory Implant Sound Processor
Request for Prior Approval

Recipient Information **DMA-0003 (V1.0)**

1. Recipient Last Name:___________________________ 2. First Name:___________________________

3. Recipient ID #____________________ 4. Recipient Date of Birth:_______________ 5. Recipient Gender:_________

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary (✓)
1			
2			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Provider Information

7. Requesting/Billing Provider #:_____________________________________NPI: ☐ Atypical: ☐ 8. Taxonomy: _____________________

9. Address: ____ 10. Nine Digit Zip Code: _________________

Requestor Contact Information

Name:_________________________ Phone #:__________________ Ext:_______ Fax: ____________________

Speech Processor Information

11. Can the speech processor be repaired? ☐ No ☐ Yes 10. Is replacement necessary? ☐ No ☐ Yes

12. Is the replacement or repair necessary for the implant to remain functional? ☐ No ☐ Yes

13. Has the current speech process been repaired? ☐ No ☐ Yes

If Yes: ☐ Left ☐ Right Date(s) of repair: _____________________________________

14. Has this patient received any replacement speech processors since implantation? ☐ No ☐ Yes

If Yes: ☐ Left ☐ Right Date(s) of replacement: ______________________________

15. Has a copy of the physician's signed prescription with complete information regarding the implant system and surgery dates been attached to this request? ☐ No ☐ Yes

16. Has a letter signed by the treating audiologist been attached to this request? ☐ No ☐ Yes

If Yes, the letter MUST include the following information for the request to be processed:

- Audiologist's name, business name, address and phone
- Recipient's name and Medicaid ID number
- Copy of recipient's current Medicaid ID card
- Original surgery date(s): Left Right
- Verification that device is FDA approved
- Specific information regarding repair/replacement parts
- Plan of care and time period during which parts will be used
- Reason for replacement (loss, theft, damage beyond repair, etc)

17. Is the implant in continuous use and meeting the needs of the patient? ☐ No ☐ Yes

Additionally, for Speech Processor Upgrades:

18. Is the recipient's response to the existing speech processor inadequate to the point of interfering with the activities of daily living? ☐ No ☐ Yes If Yes, is substantiating documentation attached? ☐ No ☐ Yes

19. Is the speech processor no longer functional? ☐ No ☐ Yes

20. Can it be replaced with the same model? ☐ No ☐ Yes

Requesting Provider's Signature:____ Date:_______________

Fax this form to: (855) 710-1964