



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

Recipient Information

DMA-0003 (V1.1)

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 (<input checked="" type="checkbox"/>)
1			
2			

Payer Information

6. The payer for this service is: _____	Medicaid: <input type="checkbox"/>
-----------------------------------------	------------------------------------

Provider Information

7. Requesting/Billing Provider #: _____	NPI: <input type="checkbox"/>	Atypical: <input type="checkbox"/>	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? <input type="checkbox"/> No <input type="checkbox"/> Yes	10. Is replacement necessary? <input type="checkbox"/> No <input type="checkbox"/> Yes
12. Is the replacement or repair necessary for the implant to remain functional? <input type="checkbox"/> No <input type="checkbox"/> Yes	
13. Has the current speech process been repaired? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If Yes: <input type="checkbox"/> Left <input type="checkbox"/> Right Date(s) of repair: _____	
14. Has this patient received any replacement speech processors since implantation? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If Yes: <input type="checkbox"/> Left <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	
16. Has a letter signed by the treating audiologist been attached to this request? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<u>Additionally, for Speech Processor Upgrades:</u>	
18. Is the recipient's response to the existing speech processor inadequate to the point of interfering with the activities of daily living? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If Yes, is substantiating documentation attached? <input type="checkbox"/> No <input type="checkbox"/> Yes	
19. Is the speech processor no longer functional? <input type="checkbox"/> No <input type="checkbox"/> Yes	
20. Can it be replaced with the same model? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Requesting Provider's Signature: _____ Date: _____

Fax this form to: (855) 710-1964