



**Utilization Management**  
**Phone: 1-877-284-0102      Fax: 1-800-510-2162**

**Durable Medical Equipment – Cochlear Implant Precertification Review**

Date: \_\_\_\_\_ Reference #: \_\_\_\_\_ (provided after initial review)  
*A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call Healthlink at 1-877-284-0102.*

**Provider Information**

Agency Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_  
 ID Number: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**Ordering Physician Information**

Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 TIN: \_\_\_\_\_

**Clinical Information**

Primary Diagnosis: \_\_\_\_\_  
 Diagnosis (ICD-9) Code: \_\_\_\_\_  
 Type of Hearing Loss: \_\_\_\_\_  
 Hearing Threshold Measurements: \_\_\_\_\_

What level hearing loss does this patient have (i.e. mild, profound, etc.)? \_\_\_\_\_

- Is hearing loss related to a meningitis infection?     YES     NO
- Is this patient able to use a conventional hearing device?     YES     NO
- Are the auditory nerve and acoustic areas of the central auditory pathway free of lesions?     YES     NO
- Does the patient have any middle ear infections, otitis media, or any other infections of the ear currently?     YES     NO

If yes, please explain: \_\_\_\_\_

Can the auditory cranial nerve be stimulated?     YES     NO

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Is the patient able and willing to participate in cochlear rehabilitation?  YES  NO

**Next Generation Upgrade Requests**

Are all components of the current cochlear implant functional?  YES  NO

Is the lack of functionality of the unit affecting daily activities?  YES  NO

If yes, please explain: \_\_\_\_\_

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**Provider Contact Information**

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_