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-10) 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

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: _____

_____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____