PRIOR AUTHORIZATION for HEARING AIDS

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490. ***Please be aware that not all employer groups have the same hearing aid coverage criteria or benefit.***

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER INFORMATION

Ordering/Rendering **Provider:**	***Ordering/Rendering*** **Provider Address:**

Provider NPI #:	Provider TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: ***Please check.***

☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent

Requested Date(s) of Service:

From: **To:**

Service (s) Requested: ***Please list all requested services/HCPCS codes regardless of pre-auth requirement. Unlisted codes cannot be pre-authorized.***

Procedure/Service: _____ HCPCS code: _____ ☐ Left ☐ Right ☐ Bilateral ☐ New ☐ Replacement

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A. **Medical Diagnosis/ICD-10 Code (s):**	**B.** **Treating Diagnosis/ICD-10 Code (s):**	**C.** **Type of Hearing Loss:** ***Please check all that apply.***
		1. ☐ Conductive 2. ☐ Mixed 3. ☐ Sensorineural

D. **Does the patient currently own hearing aids?** ☐ Yes ☐ No	**D. 1. Purchase Date:**	**D. 2. Type of Hearing Aid:**	**D. 3. Hearing Aid Condition:**

E. **What type of hearing aid(s) is being requested?** ***Please check all that apply.***

1. ☐ Air Conduction
2. ☐ Bone Conduction
3. ☐ Fully Implantable Middle Ear (e.g., Esteem)
4. ☐ Middle Ear Hearing Aid Device
5. ☐ Non-implantable, intraoral bone conduction (e.g., SoundBite™ Hearing System)
6. ☐ Partially Implantable Magnetic Bone Conduction (e.g., Sophono® Alpha 2™ System)
7. ☐ Other (*please specify*): _____

QUESTION	YES	NO	COMMENTS/NOTES
1. Did the patient have hearing loss that was present at birth?	☐	☐	
1. a. If, "*Yes*", did the patient start receiving treatment/management prior to the age of 18?	☐	☐	
2. Does the patient have a medical condition that caused sudden hearing loss?	☐	☐	
2. a. If, "*Yes*", is the patient receiving ongoing treatment/management of the hearing loss/medical condition?	☐	☐	
3. Does the patient have conductive hearing loss?	☐	☐	
3. a. If, "*Yes*", have all medical and surgical interventions to restore hearing been exhausted?	☐	☐	
4. Is the patient's hearing loss caused by any of the following? ***Please check all that apply.*** a. ☐ Age associated natural hearing loss b. ☐ Exposure to environmental factors c. ☐ Noise exposure d. ☐ Meniere's Disease	☐	☐	
5. Is the patient's hearing loss permanent?	☐	☐	
6. Does hearing testing reveal hearing loss with hearing thresholds of 40 dB or greater at three (3) or more of the following frequencies 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz?	☐	☐	***Please include copy of hearing testing report.***
6. a. If hearing testing reveals hearing loss with hearing thresholds of 40 dB or greater at three or more of the following frequencies 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz *on one side and not the other*, did the opposite side show hearing loss with hearing thresholds of 40 dB or greater at two (2) of the following frequencies 500 Hz, 1000 Hz, 2000 Hz, and 4000 Hz?	☐	☐	
7. Is the hearing aid(s) expected to restore greater than or equal to 25% of the lost hearing?	☐	☐	

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form and medical records to 801-366-7449.