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 Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

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

Section II: PROVIDER INFORMATION

Date Requested:		Service Provider Name:
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date of Service:**
Primary Diagnosis/ICD-10 Code:	**Secondary Diagnosis/ICD-10 Code:**

Service (s) Requested: *Please list all requested services/CPT codes regardless of pre-auth requirement.*

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

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

B. What type of hearing aid is being requested?

1. ☐ Air Conduction
2. ☐ Bone Conduction
3. ☐ Fully Implantable Middle Ear (e.g., Esteem)
4. ☐ Partially Implantable Magnetic Bone Conduction (e.g., SoundBite™ Hearing System)
5. ☐ Non-implantable, intraoral bone conduction (e.g. Sophono® Alpha 2™ System, Cochlear™ BAHA® 4 Attract)
6. ☐ Semi-Implantable Middle Ear (e.g. Vibrant Soundbridge, Maxum™)

(Please check device being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
1. Does the patient have conductive hearing loss unresponsive to medical or surgical interventions?	☐	☐	
2. Does the patient have sensorineural hearing loss?	☐	☐	
3. Does the patient have mixed hearing loss?	☐	☐	
4. ☐ **Air Conduction Hearing Aid:** a. Is "Behind the Ear" (BTE) device being requested because the patient has mild to profound hearing loss?	☐	☐	
b. Is "In the Ear" (ITE) or "Completely in the Canal" (CIC) device being requested because the patient has mild to moderate hearing loss?	☐	☐	
c. Is "In the Ear Canal" (ITC) device being requested because the patient has the most severe hearing loss?	☐	☐	
d. Is "On the Body" hearing aid being requested because the patient has severe or profound hearing loss?	☐	☐	
e. Is "Contralateral Routing of Sound" (CROS) device being requested because the patient has single-side hearing loss?	☐	☐	
6. ☐ **Bone Conduction Hearing Aid:** a. Does the patient have malformation of the external or middle ear (e.g., microtic ears, congenital atresia, small ear canals) or chronic middle ear drainage (e.g., dermatitis, severe chronic otitis media) that precludes the use of a conventional device?	☐	☐	
7. ☐ **Semi-Implantable Middle Ear Hearing Aid:** a. Is the patient 18 years or older?	☐	☐	
b. Does the patient have moderate to severe sensorineural hearing loss?	☐	☐	
c. Does the patient have evidence of a medical condition precluding use of an air conduction aid?	☐	☐	
d. Does the patient have middle ear disease?	☐	☐	

Additional Comments:

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