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.

Please be aware that not all employer groups have the same hearing aid coverage.

Section I: PATIENT INFORMATION

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

Section II: PROVIDER INFORMATION

Date Requested:	**Ordering Provider/Physician:**	**Ordering Provider/Physician NPI #:**
Ordering Provider/Physician Contact Person:	**Phone:** ( )	**Facsimile:** ( )

Rendering Provider:	**Rendering Provider NPI #:**	**Rendering Provider Tax ID #:**	**Rendering Provider Address:**
Rendering Provider Contact Person:	**Rendering Provider Phone:** ( )		**Rendering Provider Fax:** ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent	**Requested Date of Service:**
Medical Diagnosis/ICD-10 Code (s):	**Treating Diagnosis/ICD-10 Code (s):**

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. Sophono® Alpha 2™ System, Cochlear™ BAHA® 4 Attract)
5. ☐ Non-implantable, intraoral bone conduction (e.g., SoundBite™ Hearing System)
6. ☐ Semi-Implantable Middle Ear (e.g. Vibrant Soundbridge, Maxum™)
7. ☐ Other (*please specify*): _____

(Please check service being requested.) **QUESTION**	**YES**	**NO**	**COMMENTS/NOTES**
1. Did any of the following conditions cause the patient's hearing loss? *Please check all that apply.* a. ☐ Congenital hearing loss b. ☐ Direct physical trauma affecting the middle ear or inner ear c. ☐ Tumor affecting the middle or inner ear d. ☐ Radiation therapy e. ☐ Infection (e.g. rubella, herpes simplex) resulting in damage to the middle ear or inner ear f. ☐ Side effect of medication (e.g., aminoglycosides, chemotherapy drugs)	☐	☐	
2. Is the hearing loss permanent?	☐	☐	
3. Does hearing testing reveal hearing loss of more than 10dB across at least two frequency ranges?	☐	☐	*Please include copy of hearing testing report.*

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(Please check service being requested.) **QUESTION (*cont'd*)**	YES	NO	COMMENTS/NOTES
4. Is the hearing aid expected to restore equal or greater than 25% of the lost hearing (e.g. if the member has a 10dB loss, 2.5dB or more will be restored)?	☐	☐	
5. Is the hearing loss caused by natural hearing loss associated with age?	☐	☐	
6. Is the hearing loss caused by noise exposure?	☐	☐	
7. Does the patient have conductive hearing loss unresponsive to medical or surgical interventions?	☐	☐	
8. Does the patient have sensorineural hearing loss?	☐	☐	
9. Does the patient have mixed hearing loss?	☐	☐	
10. ☐ **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?	☐	☐	
11. ☐ **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 that precludes the use of a conventional device?	☐	☐	
b. Does the patient have a condition involving chronic middle ear drainage (e.g., dermatitis, severe chronic otitis media) that precludes the use of a conventional device?	☐	☐	
12. ☐ **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 any of the following medical conditions that preclude use of an air conduction aid? *Please check all that apply.* ☐ Chronic otitis externa that is unresolved despite multiple rounds of drug therapy ☐ Eczema or psoriasis affecting the auricle and auditory canal ☐ Allergy to components of air conduction hearing aids that are not included in one of the implants above ☐ Stenotic canal severe enough to preclude use of an air conduction hearing aid ☐ Excessive wax production that cannot be overcome with scheduled treatments ☐ Excessive perspiration that cannot be overcome with scheduled treatments	☐	☐	
d. Does the patient have middle ear disease?	☐	☐	

Additional Comments:

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