

## Review Request for Cochlear and Auditory Brainstem Implants

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

<b>Policy Last Review Date: 05/21/09</b>	<b>Policy Effective Date: 07/15/09</b>	<b>Provider Tool Effective Date: 8/10/09</b>
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

**Please check all that apply to the member:**

**Cochlear Implants**

- Request is for unilateral cochlear implantation
- Request is for bilateral cochlear implantation
- Request is for an FDA-approved single channel cochlear implant
- Request is for an FDA-approved multi-channel cochlear implant
- Request is for an upgrade for existing implant/component for a next generation device
- Member is 12 months of age or older
- Member has bilateral severe to profound pre- or postlingual hearing loss (sensorineural deafness) defined as a hearing threshold of 70 decibels (dB) or greater.
- Member cannot benefit from conventional hearing devices
- Member is free from lesions in the auditory nerve and acoustic areas of the central auditory pathway (nervous system)
- Member is free from otitis media or other active middle ear infections
- Member's auditory cranial nerve can be stimulated
- Member is able to participate in a post-cochlear rehabilitation program
- Member's response to existing component is inadequate to the point of interfering with activities of daily living
- Components of current device are no longer functional.
- Request is for a smaller profile component
- Request is to switch from a body-worn, external sound processor to a behind-the-ear (BTE) model
- Other: \_\_\_\_\_

**Auditory Brain Stem Implants**

- Request is for an FDA-approved auditory brainstem implant (ABI)
- Request is for an upgrade for an existing implant for a next generation device
- Member is 12 years of age or older
- Member has Neurofibromatosis Type II
- Member was rendered deaf due to bilateral resection of neurofibromas of the auditory nerve (e.g. neurofibromatosis or von Recklinghausen's disease)
- Member's response to existing component is inadequate to the point of interfering with activities of daily living
- Components of current device are no longer functional.
- Request is for a smaller profile component
- Request is to switch from a body-worn, external sound processor to a behind-the-ear (BTE) model
- Other: \_\_\_\_\_

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This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: \_\_\_\_\_
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

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Name and Title of Provider or Provider Representative  
Completing Form (Please Print)\*

Date

**\* The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**