SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.548.1224 | 715.221.9588
TTY: 711

Wearable Hearing Aids

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Contact person name (print)	Telephone number	Fax number
Procedure information		
Scheduled date of service (month/day/year) / Requested service/procedure		Procedure code(s)
Diagnosis	Diagnosis code(s)	

Answer all of the following questions.

Is the member 18 years of older ..... ☐ Yes ☐ No

Has the evaluation and prescription for the device been obtained from a licensed audiologist engaged in the practice of hearing aid dispensing ..... ☐ Yes ☐ No

Does the member have one of the following conditions:

- Conductive hearing loss unresponsive to medical or surgical interventions ..... ☐ Yes ☐ No
- Sensorineural hearing loss ..... ☐ Yes ☐ No
- Mixed hearing loss ..... ☐ Yes ☐ No

What device will be ordered:

- Air conduction hearing aid for the treatment of hearing loss ..... ☐ Yes ☐ No

  If yes,

  – behind the ear (BTE) device, for cases of mild to profound hearing loss ..... ☐ Yes ☐ No
  – in the ear (ITE) device, for cases of mild to moderate hearing loss ..... ☐ Yes ☐ No
  – in the ear canal (ITC) device, for all but the most severe hearing loss ..... ☐ Yes ☐ No
  – completely in the canal (CIC) device, for mild to moderate hearing loss ..... ☐ Yes ☐ No
  – contralateral routing of sound (CROS) device, for cases of single-sided hearing loss (i.e. bone conduction of the hearing side is normal) ..... ☐ Yes ☐ No

- Semi-implantable middle ear hearing aid ☐ Yes ☐ No

  If yes,

  – member is age 18 years or older ☐ Yes ☐ No
  – moderate to severe sensorineural hearing loss ☐ Yes ☐ No
  – evidence of a medical condition precluding use of an air conduction hearing aid ☐ Yes ☐ No
- Bone conduction hearing aid ☐ Yes ☐ No

  If yes,

  – malformation of the external or middle ear (e.g. microtic ears, congenital atresia, small ear canals, tumor) ☐ Yes ☐ No
  – conditions involving chronic middle ear drainage (e.g. dermatitis, severe chronic otitis media) ☐ Yes ☐ No
- Any other device ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. Security Health Plan may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:	Security Health Plan Claims Durable Medical Department PO Box 8000 Marshfield, WI 54449-8000 Fax 715.221.9918	**Marshfield Clinic providers route to:** Claims Durable Medical Department Routing location, SHP

If you have any questions, please contact Provider Assistance Line at 1.800.548.1224.

