NC DMA Hearing Aid Services Request for Prior Approval

Recipient Information **DMA-0001**

1. Recipient Last Name:_____ 2. First Name:_____

3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Diagnosis Information

	Diagnosis (code AND description)	Date of Onset	Primary (✓)
1			
2			

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Provider Information

7. Requesting Provider #:_____NPI: ☐ Atypical: ☐ 8. Taxonomy: _____

9. Address: _____ 10. Nine Digit Zip Code: _____

11. Billing Provider # (if different from requesting):_____NPI: ☐ Atypical: ☐ 12. Taxonomy: _____

13. Address: _____ 14. Nine Digit Zip Code: _____

15. Rendering Provider # (if different from billing):_____NPI: ☐ Atypical: ☐ 16. Taxonomy: _____

17. Address: _____ 18. Nine Digit Zip Code: _____

Requester Contact Information Name:_____ Phone #:_____ Ext:_____

Hearing Aid Information

19. New Hearing Aid: ☐ Replacement Hearing Aid: ☐ Repair Hearing Aid: ☐

20. Right Aid: ☐
Manufacturer: _____
Name/Model: _____ Invoice Cost: _____
Type:_____ Other Type: _____
Style: _____ Other Style: _____
Under Warranty? ☐
Reason For Replacement: _____
Original Serial #: _____

21. Left Aid: ☐ Left Aid same as Right except Serial #: ☐
Manufacturer: _____
Name/Model: _____ Invoice Cost: _____
Type:_____ Other Type: _____
Style: _____ Other Style: _____
Under Warranty? ☐
Reason For Replacement: _____
Original Serial #: _____

22. Are you requesting an Ear Mold (EM)? Left EM: ☐ Right EM: ☐ Both: ☐ Total Invoice Cost: _____

23. Are you requesting any Accessories? ☐ Total Invoice Cost: _____ Accessory 1: _____

Accessory 2: _____ Accessory 3: _____ Accessory 4: _____

24. Are you requesting an FM System? New: ☐ Repair: ☐ Replace: ☐ Under Warranty? ☐ Invoice Cost: _____

Transmitter: ☐ Receiver: ☐ Audio Shoe/Boot: ☐ Manufacturer: _____Model: _____

25. Are you requesting any device other than those indicated above? ☐ Invoice Cost: _____

Description: _____

26. Has the patient previously been provided this service? ☐ Date Rendered: _____ Funding Source: _____

Description of Medical Necessity

Requesting Provider's Signature:_____ _____ Date:_____ Fax this form to CSC at: (855) 710-1964

Please attach: Medical clearance, Audiogram, Written Evaluation and Warranty Information