Hearing Aid Authorization Request

Washington State Health Care Authority

This form is **required** when submitting a request. Please **fax to**: 1-866-668-1214

You must use a typed and completed General Information for Authorization form (13-835) as a cover sheet when faxing.

1 Provider information

Current date

Clinic name

Telephone number

Servicing provider

Name of clinic contact

Billing provider NPI

Fax number

2 Client information

Client name

ProviderOne client ID

3 Service request information

ICD 10 Dx

Description

ICD 10 Dx

Description

Procedure codes requested

Type of request : ☐ Limitation extension ☐ Exception to rule

4 Additional information

Current Audiogram - Please indicate the results of audiogram. Submit copy of audiogram with this form.

Date of audiogram

Hz	Right	Left
1000		
2000		
3000		
4000		
Total		
÷4		

Explain why this authorization request is being submitted (e.g. ETR-requested service is not covered; limitation extension requested; client does not meet program criteria for service; etc.)?:

What is the clinical justification for this request?:

In order to determine medical necessity for hearing aids and supplies, please answer the following questions, then explain below:

1. **Does the client have significant visual deficits or is the client legally blind?** ☐ **Yes** ☐ **No**
2. **Does the client have other disabilities?** ☐ **Yes** ☐ **No**
3. **Does the client have bothersome tinnitus?** ☐ **Yes** ☐ **No**
4. **Does the client have a history of successful hearing aid use previously?** ☐ **Yes** ☐ **No**
   ☐ monaural ☐ binaural
5. **Is the client currently attending school?** ☐ **Yes** ☐ **No**
6. **Is the client currently working?** ☐ **Yes** ☐ **No**
7. **Does the client's hearing loss affect their ability to live safely in the community?** ☐ **Yes** ☐ **No**
8. **Is hearing loss the result of a work-related injury?** ☐ **Yes** ☐ **No**
9. **Has this client already received one or more hearing aids from Medicaid in the past 5 years?** ☐ **Yes** ☐ **No**

Explain answers above. Are there **extenuating circumstances** that you would like us to know about? Explain any functional limitations related to the client's hearing loss:

Continue to page 3 if necessary

Continue to explain your answers to the questions from the previous page if necessary.