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ACADEMY OF AUDIOLOGY

## Audiology Prior Authorization Request – Hearing Aids

### Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member/Subscriber ID: \_\_\_\_\_ Insurance Plan  
Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

### Provider Information

Audiologist Name: \_\_\_\_\_ Practice/Clinic  
Name: \_\_\_\_\_

NPI #: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

### Request Type

Initial Authorization     Renewal     Replacement

### Diagnosis Information

ICD-10 Code(s): \_\_\_\_\_

Onset/Duration of Hearing Loss: \_\_\_\_\_

### Clinical Justification / Summary of Findings

See attached audiogram and supporting documentation

Date of Hearing Evaluation: \_\_\_\_\_

Pure Tone Average (PTA): Right Ear: \_\_\_\_\_ dB Left Ear: \_\_\_\_\_ dB

Speech Recognition Scores: Right Ear: \_\_\_\_\_ % Left Ear: \_\_\_\_\_ %

Functional Impact:  Difficulty understanding speech in quiet     Difficulty in  
noise     Other: \_\_\_\_\_

Medical Clearance:  ENT evaluation completed Date: \_\_\_\_\_

Contraindications ruled out

## Recommended Treatment Plan

Device Type:  BTE  RIC  ITE  ITC  CIC  Rechargeable  Other: \_\_\_\_\_

Laterality:  Mon-aural (Right)  Mon-aural (Left)  Binaural

Manufacturer/Model: \_\_\_\_\_

Estimated Cost per Device: \$\_\_\_\_\_ Total Estimated Cost: \$\_\_\_\_\_

Fitting/Follow-up Visits Included:  Yes  No

## Medical Necessity Statement

The patient has a documented, permanent hearing loss that significantly impairs communication ability and daily function. Hearing aids are medically necessary to improve hearing thresholds, speech understanding, and overall quality of life. Without amplification, the patient demonstrates significant difficulty communicating in personal, educational, or occupational settings. Amplification is expected to provide measurable improvement in speech perception and communication ability.

Attachments (required)

- Audiogram
- Medical clearance (if required)
- Quote or invoice for device(s)
- Clinical notes supporting hearing aid need
- Prior trial results (if applicable)

## Signatures

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient/Guardian Signature (if required): \_\_\_\_\_

Date: \_\_\_\_\_