



POWERED BY THE AMERICAN 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: _____