



Children and Youth with Special Health Care Needs (CYSHCN)

Hearing Authorization Request Form

Provider's Information

Date of Submission	For Cochlear and BAHA, please see DPH's Appendix 4 Hearing Program Fee Schedule for reimbursement rates and level of frequency. Please note that any order \$3,000 or more can't be shipped directly to the patient's home address. The patient must pick up the order from the audiologist's office completing this form.			
Provider's Name	Name of Clinic	Street Address	City	State
Zip Code	Email Address	Phone #	Fax #	NPI#

Patient's Information

Patient's Last Name	Patient's First Name	DOB	Medicaid #	Wellcare #
Street Address	City	State	Zip Code	Phone #
Service Requested	Diagnosis (ICD Code)			
Justification:				

Cochlear/BAHA Orders

COCHLEAR ORDERS <i>*Refer to current fee schedule for frequency/cost limits</i>	RT/LT	QTY	RT/LT	QTY	ITEM #	COST

BAHA ORDERS <i>*Refer to current fee schedule for frequency/cost limits</i>	RT/LT	QTY	RT/LT	QTY	ITEM #	COST

Vendor Information

Ship to:	Bill to:	Vendor	Vendor Acct #	Purchase Order#
<input type="checkbox"/> Provider <input type="checkbox"/> Patient	<input type="checkbox"/> DPH <input type="checkbox"/> Other			

I certify that I am the authorized provider for the above patient and have reviewed this order to verify the use of the equipment/service is medically necessary for the patient's condition.

Audiologist's Signature	Date:	
DPH Signature	Date:	

Please complete this form in its entirety where it applies and for questions concerning this form or Cochlear/BAHA orders, please contact our main line at (803) 898-0784.



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Instructions for Completing 4475-ENG-DPH

Purpose: This is the standard tool used by external audiology providers to request authorization for Cochlear Implant and/or Bone Anchored Hearing Aid (BAHA) Durable Medical Equipment (DME) provided to CYSHCN clients in accordance with current CYSHCN Appendix 4 Hearing Fee Schedule.

Audience: This tool will be utilized by CYSHCN staff and external audiology providers.

Item-by-Item Instructions:

Audiologist completing the request will:

1. Provider's Information: Enter date request form is submitted. Enter provider's name, clinic (name, street address, city, state, zip code), provider's email address, phone number, fax number, and NPI number.
2. Patient's Information: Enter patient's last name, first name, date of birth, Medicaid number, Wellcare # (if applicable), street address, city, state, zip code, phone number, and other insurance. Select service requested (Cochlear or BAHA). Select Diagnosis and ICD Code. Enter justification as to the need for DME.
3. Cochlear and BAHA Orders: Select requested product. Select ear (right, left). Enter quantity, manufacturer's item number, and cost.
4. Vendor Information: Select shipping recipient (provider or patient). Select bill to (DPH or other). Select vendor. Enter vendor account number. Enter purchase order number.
5. Signature and date by requesting hearing provider.
6. Submit the form to Department of Public Health (DPH) CYSHCN Central Office via email (CYSHCN-Hearing@dph.sc.gov), fax, or mail at the contact information provided.

DPH reviewing the request will:

1. Signature and date by authorizing DPH staff.

Office Mechanics and Filing: This hardcopy form should be completed, scanned into the EHR under Physician Order Image Type and securely stored for three (3) months after scanning. Once the 3-month retention period has been met, and quality review has been completed, an ARM13 destruction request should be submitted and approved prior to disposal of the paper original form. Comprehensive Adult (08498) or Comprehensive Minor (08499) medical record retention applies.