Prior Authorization Determination Template

Input Conditions:

Service Description: ___Hearing Aids_____

Service Code(s): ____ V5008–V52999 _____

Modifiers: Any ☐ Include ☐ Exclude ☐ List:_____

Patient Information:

Gender: Any ☒ Female ☐ Male ☐

Age: Any ☒ Age Range _____

Program: Any ☒ Include ☐ Exclude ☐
List: _____

Provider Information:

Provider Type: Any ☐ Include ☒ Exclude ☐

List: __Audiologist, Otolaryngologist_____

Provider Specialty: Any ☒ Include ☐ Exclude ☐
List:_____

Place of Service Restrictions:

Any ☐ Inpatient ☐ Outpatient ☐ Office ☒ DME ☐ Lab ☐
Nursing Facility ☐ Telehealth ☐ Ambulatory Surgery ☐ Other ☐

Required Diagnosis: Any ☐

List _____

PA FHIR Coverage Information

Coverage:	PA Required: ☒	PA Not Required: ☐	Not Covered: ☐
May submit PA Request:	Referring ☐	Performing ☒	Either ☐
Documentation Type:	Administrative ☐	Clinical ☐	Both ☒
When submitted:	With PA ☒	With Claim ☐	Retain ☐

Information required to evaluate Prior Authorization Request

Required Clinical Observations / Data

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-
-

Required Assessments

- Audiogram
-
-

Required Evidence (notes, tests, x-rays)

- Report from licensed audiologist
-
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Required Supporting Documentation

- Physician or mid-level practitioner referral
- Certificate of Medical Necessity
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