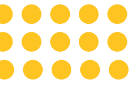
Cochlear Americas



Healthcare Provider's Letter of Medical Necessity (LMN)

General Information

RECIPIENT/PATIENT INFORMATION

Name: ____________________

Address: ____________________

DOB: ____________________

Date of Implant: ____________________

Current Processor: ____________________

Date of Current Processor Fitting: ____________________

Implant Side: ____________________

Delivery Address *(Where should the product be shipped):*

____

SUPPLIER/PROVIDER INFORMATION

Cochlear Americas
13059 E. Peakview Ave., Centennial, CO 80111
Phone: 800-633-4667 opt 2 **Fax:** 1-866-706-8875
NPI: 1336149426 **Tax ID:** 84-0945658

REQUESTING PROVIDER INFORMATION

Provider: ____________________

Address: ____________________

Phone: ____________________

Fax: ____________________

NPI: ____________________

Baha Equipment and Supplies Needed

DESCRIPTION OF ITEM ORDERED: Baha auditory osseointegrated sound processor kit (L8691)
NUMBER OF UNITS: ____________________
DIAGNOSIS CODE (ICD-9) ____________________

Physician or Authorized Healthcare Provider's Attestation

I certify that I am the treating physician or authorized healthcare provider for this patient and have reviewed this order to attest the use of the equipment/supply(ies) is medically necessary for my patient's condition.

This prescription/order for the external processor ("Device") includes the complete processor kit along with all other accessories and repairs that may be required over the life of the Device and its associated parts to ensure the Device is maintained in proper working order.

Print Name: ____________________

Signature: ____________________ Date: ____________________