OMS Insurance Support

Surgical procedure authorization request

Cochlear®
Hear now. And always

01 Professional Services to be Authorized

Group Name: _____ Group Tax ID: _____

Surgeon Name: _____ Surgeon NPI: _____

Primary Diagnosis Code & Description: _____

CPT Code(s) & Description of Procedure: _____

Surgery Date (if scheduled): _____ or Date Range Request _____ to _____

02 Facility Services to be Authorized

Facility Name: _____ Tax ID: _____

Type:

☐ Outpatient ☐ Inpatient ☐ Surgery Center NPI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

HCPCS Code(s) & Description of Procedure: _____

Device to Be Implanted:

☐ Cochlear Implant ☐ Hybrid Implant ☐ ABI ☐ Baha Connect ☐ Baha Attract ☐ Osia ☐ Vistafix

# of Units: _____ ☐ Left Ear ☐ Right Ear ☐ Bilateral Other: _____

03 Patient Information

Patient Name (first, last, middle): _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Preferred Communication Method: ☐ Phone ☐ Email

04 Insurance Information

Primary Insurance Company: _____ Member ID: _____

Group Number: _____ Employer: _____

Provider Relations Phone#: _____

Name of Subscriber (if different than Patient): _____ Subscriber SSN: _____

05 Secondary Insurance Information (If Applicable)

Secondary Insurance Company: _____ Member ID: _____

Group Number: _____ Employer: _____

Provider Relations Phone#: _____

Name of Subscriber (if different than Patient): _____ Subscriber SSN:_____

For any questions regarding the above information, please contact OMS at 800 633 4667 option 4; via email at OMS@cochlear.com; or fax 303 524 6765.

06 Submitting Provider Contact 1

Contact Name: _____

Contact Email: _____ Contact Phone: _____

07 Submitting Provider Contact 2

Contact Name: _____

Contact Email: _____ Contact Phone: _____

OMS Insurance Support Checklist

Requests with missing information will not be processed

☐ Completed Surgical Procedure Authorization Request Form

☐ Copy of front and back of patient's health insurance card(s)

☐ Patient Authorization for Release of Patient Health Information Form (Candidate signature required)

☐ Patient Authorization to Provide Insurance Support Services Form (Candidate signature required)

☐ Letter of Medical Necessity signed by the doctor

- Patient's diagnosis
- Severity and etiology of hearing loss
- Treatments tried and failed (including prior hearing aid use)
- Explain why the implant system is the recommended treatment option

☐ Patient's medical records applicable to hearing health, including audiograms

☐ Copy of health plan's denial letter (appeals only)

Please send your completed predetermination or appeal assistance requests to OMS@cochlear.com or via fax 303 524 6765.

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800 633 4667
OMS@cochlear.com
www.cochlear.com/us

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