Attachment 3: Prior Authorization Request for Bone Conduction Hearing Device(s)

Acronyms Used: CCS (California Children's Services), SAR (Service Authorization Request), ENT (Ear, Nose, and Throat), NPI (National Provider Identifier), BCHD-SW (Bone Conduction Hearing Device Surface Worn), Date of Birth (DOB)

General Instructions:

1. The CCS Program requires prior authorization of the SAR for the types of devices and supplies associated with this NL. Prior authorization of SAR(s) is not a guarantee for claim payments.
2. The SAR must be submitted by completing the Prior Authorization Request Form and documentation that serves to validate Medical Necessity of the requested item(s) and service(s).
3. If surgical implantation is involved, submitted documentation must also specify medical clearance for anesthesia and surgery.
4. Prior Authorization requests accompanied by incomplete or inadequate documentation may be denied by CCS Program.

Document Checklist for SAR Prior Authorization

Type of Document	(Mark all applicabe)
Completed "Prior Authorization Request Form for Bone Conduction Hearing Device(s)" (pages 2-3 of this attachment)	☐
Report(s) from CCS-paneled Audiologist	☐
Reports containing results of audiometric testing, including Bone Conduction thresholds in both ears	☐
Reports containing results of audiometric testing, including Air Conduction threshold in affected ear(s)	☐
Prescription for device signed by CCS-paneled ENT Specialist Physician	☐
Report(s) from CCS-paneled ENT Specialist Physician	☐
Other relevant reports (e.g., written explanation for device loss)	☐
Catalog page listing price of the device or component(s) (if available)	☐

Prior Authorization Request for Bone Conduction Hearing Device(s)
Beneficiary and Provider Information

CCS Beneficiary Information

Beneficiary's First Name: _____

CCS Beneficiary's Last Name: _____ Middle Initial: _____

DOB: (MM/DD/YYYY): _____

CCS Number: _____

CCS County: _____

Date of Request: (MM/DD/YYYY):

CCS-Paneled Provider Information

Audiologist First Name: _____

Audiologist Last Name: _____ Middle Initial: _____

NPI Number: _____

Practice Address: _____ City: _____

State: _____ Zip Code: _____

Phone Number: _____

ENT Specialist First Name: _____

ENT Specialist Last Name: _____ Middle Initial: _____

NPI Number: _____

Practice Address: _____ City: _____

State: _____ Zip Code: _____

Phone Number: _____

Prior Authorization Request for Bone Conduction Hearing Device(s)
Request Information

Request for	
☐ New device(s)	☐ Replacement device(s)
Side (if requesting devices for bilateral use, please mark both sides)	
☐ Left side	☐ Right side
Device	**Details (including manufacturer and specific model)**
☐ Bone Conduction Hearing Device (what is BCHD-SW)	
☐ Bone Conduction Hearing Device used in conjunction with surgically inserted component(s) (BCHD-SI)	
Surgical Procedure(s)	**HCPCS or CPT code(s)**
☐ Surgical insertion of BCHD-SI component(s)	
Additional Notes (describe rationale for device use or replacement)	