



Certification of Hearing Status

Cochlear Implant Program

Applicant Name: _____ Birth Date: _____
First MI Last

Parent/Guardian(s): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Email: _____

This certification must be completed by a Cochlear Implant Surgeon specializing in otology

Verification of Hearing Status

An evaluation shows that the applicant meets the following eligibility requirements:

- Has a severe to profound hearing loss
 - Is medically recommended for a cochlear implant
- “Profound hearing loss” a hearing impairment of 91dBHL or more
 “Severe hearing loss” a hearing impairment of 71dBHL to 90 dBHL

Name: _____ Title: _____
(Please type or print)

Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

It is my professional opinion that the applicant identified above has a severe to profound hearing loss and is medically recommended for a cochlear implant

Signature: _____ Date: _____

Estimated Fees

Provider(s) please submit the following estimate information for the cost of cochlear implant surgery – including hospitalization, anesthesiology, surgery fees, etc. – cost of devices, and cost of initial and follow-up mapping.

Implant Surgery Estimated Costs

Medical Center Fees:	Facility Name:
	Fax Number:
Surgical Services Fees:	Facility Name:
	Fax Number:
Hospitalization for Surgery Fees:	Facility Name:
	Fax Number:

Cochlear Implant Device Estimated Cost

Device Name / Brand:	Single Device Cost:
Facility Name:	Second Device Cost (if applicable):
Fax Number:	

Mapping Estimated Costs

Cost of Initial Mapping:	Facility Name:
Cost of Follow-up Mapping:	
Anticipated Number of Follow-up Mapping:	
	Fax Number:

***Facility Name** is the name of the facility that prior authorization should be assigned to and to whom payments should be made. The Department of Human Services will pay the facility directly upon receipt of completed health insurance claim form. Please include a fax number where prior authorization can be sent.

Please include a completed W9 with this form for all facilities

Submit completed form and W9(s) to:

SD Department of Human Services

ATTN: Shayna Remund

1310 Main Ave S, Suite 102

Brookings, SD 57006

Shayna.Remund@state.sd.us

FAX: 605-688-5497

PHONE: 605-688-4224