Application

Cochlear Implant Processor Upgrade

Applicant Information

Applicant Name:_____
First *MI* *Last*

SS#:_____ Birth date: _____ Gender: Male____ Female____

Does the applicant have unilateral or bilateral implants? Unilateral ☐ Bilateral ☐

Has the applicant utilized this program in the past for initial implant or an upgrade? Yes ☐ No ☐
If yes, year of last application _____

Parent/Guardian Name(s): _____

Address:_____

City, State, Zip:_____

County:_____ Email Address: _____

Primary Phone: _____ Secondary Phone:_____

Health Insurance

Is the applicant covered under any health insurance plan? Yes ☐ No ☐ Medicaid ☐

Has coverage been approved or denied for the requested services? Approved ☐ Denied ☐
If coverage has been approved, please include documentation pertaining to out-of-pocket expenses such as deductibles, co-payments, and coverage limits
If coverage has been denied, please include documentation pertaining to denial including reason for denial

If coverage has been denied, has an appeal been filed? Yes ☐ No ☐
If an appeal has been filed, please attach correspondence regarding the results

No amounts are payable by the telecommunication fund for the deaf for any portion of the cost of covered services listed in 46:30:08:03 covered by a health insurance plan or otherwise covered under another plan of insurance. The telecommunication fund for the deaf shall be secondary to any other insurance covering or providing reimbursement for the cochlear implant surgery, device, initial mapping and follow-up mapping.

I declare and affirm that the information included in this application and additional information as required by the cochlear implant program is true and correct to the best of my knowledge and ability. I also acknowledge it is my responsibility to report any significant changes that could affect eligibility for the Cochlear Implant Program.

_____ _____
Parent or Guardian Signature Date

Estimated Fees

This section must be completed by the facility performing the upgrade services

Please provide information 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 after the applicant's health insurance (if applicable) and all other benefits have been paid out. Please include a fax number and/or email address where prior authorization should be sent.

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

Address:_____

City, State, Zip Code:_____

Phone:_____ Fax:_____

Email:_____

Processor Upgrade Estimated Cost

Device Name/Brand:_____

Single Processor Cost:_____

Second Processor Cost (if applicable):_____

Please include a completed W9 with this form

Submit application and supporting documentation to:

Shayna Remund
Division of Rehabilitation Services
1310 Main Ave S, Suite 102
Brookings, SD 57006
Phone: 605-688-4224
Fax: 605-688-5497
Shayna.Remund@state.sd.us