



Application

Cochlear Implant Program

Applicant Information

Applicant Name _____
First MI Last

SS#: _____ Birth date: _____ Gender: Male ___ Female ___

Does the applicant currently have one implant? Yes No
 Age first implant received _____

Parent/Guardian Name(s): _____

Address _____

City, State, Zip _____

County _____ Email Address _____

Primary Phone _____ Secondary Phone _____

Medical Candidacy

Has the applicant been medically recommended for cochlear implant(s) by a Cochlear Implant surgeon?
 Yes No *If no, you may submit your application, but this step will need to be completed before an eligibility determination can be made*

Is the applicant recommended for one or two implants? _____

Date of Surgery (if known) _____

Center Name _____

Center Address _____
Mailing Address City State Zip Code

Center Contact Person _____

Phone _____ Email Address _____

Health Insurance

Is the applicant covered under any Health Insurance Plan? Yes No

Policy Holder: _____ Identification No. _____ Group No. _____

Name of Insurance: _____ Phone: _____

Address: _____

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 health insurance has denied coverage, has an appeal been filed? Yes No

If an appeal has been filed, please attach correspondence regarding the results

Does the applicant have Medicaid coverage? Yes No

Has Medicaid approved or denied coverage for the requested services? Approved Denied

Please attach relevant correspondence to or from Medicaid regarding approval or denial of coverage including documentation pertaining to appeals filed.

Expenses not covered or not payable for some reason other than the deductible and coinsurance provisions in the health insurance plan are not eligible.

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 (or Applicant Signature if over 18)

Date

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