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

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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: Fax Number:	Second Device Cost (if applicable):

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