Montana Medicaid Hearing Aid Prior Authorization Request Form

Medicaid Member Demographics

First Name

Last Name

Medicaid ID **Birth Date** **Telephone**

1. Does the patient presently have hearing aid(s)? ☐ **Yes** ☐ **No**

   If **Yes**, complete the following related to the hearing aid(s):

Make **Model** **Date Acquired**

Replacement Remarks

2. Does the patient's condition meet the criteria specified in the Montana Medicaid Hearing Aid Services Provider Manual? ☐ **Yes** ☐ **No**
3. Has the patient received a trial use of this item? ☐ **Yes** ☐ **No**
   If **Yes**, for how long:
4. Does the patient have the ability to operate/use this requested item as intended by the item manufacturer? ☐ **Yes** ☐ **No**

I certify that the information contained in this document and its attachments/supporting documents are true, accurate, and complete, to the best of my knowledge.

I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

I further understand my responsibilities, as a condition of participation in the Montana Medicaid Program, to comply with all applicable state and federal statutes, rules, regulations, and policies.

Dispenser Signature _____ **Date** _____

Attachments: This form must be accompanied by copies of supporting documentation to justify the medical need of the requested items. Supporting documentation includes, but is not limited to, the physician's referral for audiological evaluations, audiology report, audiogram and the Certificate of Medical Necessity (CMN).