# Hearing Aid Prior Authorization Request Form

COMMUNITY HEALTH PLAN of Washington™
MEDICARE ADVANTAGE

**For expedited processing for both Apple Health/Medicaid and Medicare Advantage Plans please submit Prior Authorization requests via the Care Management Portal at www.chpw.org/submitcare.**

Alternately, you can fax Prior Authorization requests to the appropriate number below:

**For Apple Health/Medicaid:**

Prior Authorizations requests may be faxed to:
**206-613-8873**

Please call Customer Service to verify eligibility & benefits:
**1-800-440-1561**
**Monday through Friday**
**8 a.m.-5 p.m.**

**For Medicare Advantage Plans:**

Prior Authorizations requests may be faxed to:
**206-652-7065**

Please call Customer Service to verify eligibility & benefits:
**1-800-942-0247**
**7 days a week**
**8 a.m.-8 p.m.**

- A complete list of services requiring Prior Authorization may be found at **www.chpw.org**
- **With your submitted form, please attach supporting clinical documentation.**
- Incomplete forms and requests without clinical information will delay processing
- A Prior Authorization is not a guarantee of payment; Payment is subject to member eligibility and benefits at the time of service

**ORDERING PROVIDER INFORMATION**

| First Name: | Last Name: | Contact Phone #: | Contact Fax #: |
|---|---|---|---|
| | | | |

Contact Person at this office:

☐ Ordering provider is PCP
PCP's Clinic Name:

☐ Ordering provider is Specialist
Specialty:

**PATIENT INFORMATION**

| First Name: | Last Name: | MI: | Date of Birth: |
|---|---|---|---|
| | | | |

CHPW Member ID:

☐ Patient Retro Enrolled with CHPW

Retro Enrolled Date:

**SERVICE PROVIDED BY**

| First Name: | Last Name: | Address: |
|---|---|---|
| | | |

☐ Participating
☐ Non-Participating

Tax ID:
NPI:

Specialty:

Contact Phone #:

Contact Fax #:

☐ Inpatient ☐ Outpatient

Please indicate **CLINICAL** urgency of request: ☐ Routine ☐ Urgent

Diagnosis: Primary: Code (_____) Description: _____

Secondary: Code (_____) Description: _____

Date of Service:

Services being requested:

CPT/HCPCS #1_____ Description:_____

CPT/HCPCS #2_____ Description:_____

CPT/HCPCS #3_____ Description: _____

☐ New request ☐ Extension

Request*

#Visits:_____ Duration: _____

*Last Date of service if an extension _____

**ADDITIONAL INFORMATION REQUIRED:** Please indicate the result of the most current Audiogram

Date of Audiogram:

| HZ | RIGHT | LEFT |
|---|---|---|
| 1000 | | |
| 2000 | | |
| 3000 | | |
| 4000 | | |
| TOTAL | | |
| ÷ 4 | | |