Oticon Medical Reimbursement Support Services

Oticon Medical Reimbursement Support Team is here to make the process simple and easy for you and your hospital or clinic. We will work with you to do everything from verification of benefits to submitting the paperwork to insurance providers to request and receive pre-authorization for the procedure. We do this in a confidential and private manner to protect your healthcare information at every step of the process.

This enclosed packet has everything to need to get the process started:

Checklist to be completed by your **ENT/Doctor**:
(please note that ENT/Doctors are familiar with these forms and the documentation that is needed)

- ☐ Reimbursement Support Services Intake From (Pages 2 & 3)
- ☐ Letter of Necessity (Page 4)
- ☐ Other Clinical Supporting Documentation (i.e. Audiogram(s), Hearing tests, etc.)

Please be sure to complete and sign the applicable Letter of Medical Necessity (not included; please refer to separate packet)
Once you have completed all the documents listed above, please send via mail or fax as listed below:

Oticon Medical
580 Howard Avenue
Somerset, New Jersey 08873
Phone: 1.855.400.9761
Fax: 1.732.568.7130
Email: reimbursement@oticonmedical.com

If any of these documents are missing, we will not be able to begin the process. So please be sure you send ALL of these documents completed. Please feel free to contact us if you have any questions or need assistance.

Reimbursement Support Services Intake Form

To be completed by ENT/Doctor

PHYSICIAN INFORMATION

Must be completed by Physician and/or clinic's representative

Physician: _____ Office Contact: _____

Address/City/State/Zip: _____

Phone: _____ Fax: _____

TIN: _____ NPI: _____

Email: _____

AUDIOLOGIST INFORMATION

Audiologist: _____ Office Contact: _____

Address/City/State/Zip: _____

Phone: _____ Fax: _____

TIN: _____ NPI: _____

Email: _____

SERVICE REQUESTED

- ☐ Repair Authorization
- ☐ Prior Authorization Request for Surgery
- ☐ Prior Authorization Request for Equipment and Supplies

Model	**Qty.**	**Side** (P3 Only)		**Color**		**Free Accessory**		**Softband**	
Ponto 4	____	Right	☐	Beige	☐	ConnectClip (P4)	☐	Bilateral	☐
Ponto 3	____	Left	☒	Brown	☐	Remote (P4)	☐	Unilateral	☒
Ponto 3 Power	____			Black	☐	Streamer – Blk (P3)	☐	Color: _____	
Ponto 3 Super Power	____			Silver White	☐	Streamer – White (P3)	☐		
				Grey	☐	3rd Year Repair (P3)	☒		
				Terracotta (P4)	☐				
				Pure White (P3)	☒				

Reimbursement Support Services Intake Form

To be completed by ENT/Doctor

PROCEDURES INFORMATION

Required for Surgical Prior Authorization Requests Only

Facility Name: _____

Address/City/State/Zip: _____

Phone: _____ Surgery Date: _____

TIN: _____ NPI: _____

ICD-10 Diagnosis Code(s): _____ Surgical Codes*: _____

**Include Applicable CPT Procedure and HCPCS Codes*

Place of service:

☐ Inpatient ☐ Outpatient ☐ ASC

Side of implant:

☐ Left ☒ Right ☒ Bilateral

MEDICAL INFORMATION

Initial requests only; for Medicare and Medicaid patients only. Oticon Medical LLC may NOT complete this section.

SECTION A

Date of Physician's Examination (must be within the last 6 months for surgery requests) : _____

ICD-10 Diagnosis Code(s): _____

SECTION B

1. Narrative description of items ordered: _____

   Processor, Replacement, HCPCS code: _____

   Oticon Medical Charge: $ _____

   Medicare DMEPOS Fee Schedule: $_____

SECTION C

I certify that I am the treating physician identified in Section A of this document. I have received Sections A, B and C of this document including the charges for items ordered. Any statement on my letterhead attached hereto has been reviewed and signed by me.
I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Physician's Signature: _____ Date: _____

Letter of Medically Necessary Equipment and Supplies

Must be completed by ordering Physician

Supplier/Provider Information

Oticon Medical LLC
580 Howard Avenue
Somerset, NJ 08873

Phone: 1.888.277.8014
Fax: 1.732.568.7130
NPI: 1861728479
Tax ID: 80-0400458

Requesting/Ordering Provider

Provider: _____

Address: _____

Phone: _____

Fax: _____

NPI: _____

Patient: _____ Date of Birth: _____

Address: _____

Side(s) to be Implanted (new requests only; please check applicable side for Softband requests): Right ☐ Left ☐

Date(s) of Original Implant (replacement/upgrade request only): Right _____ Left _____

Current Processor(s) (replacement/upgrade request only): _____

Date Current Processor(s) Originally Fit (replacement/upgrade request only): _____

ICD-10 Diagnosis Code(s): _____

Equipment and Supplies Needed: Please provide brief description of the device ordered:

Select	Qty.	Description	Select	Qty.	Description
☐	____	**L8691**: Auditory osseointegrated device, external sound processor, replacement (Ponto sound processor)	☐	____	**L8694**: Auditory osseointegrated device, transducer/ actuator, replacement only, each
☐	____	**L8692**: Auditory osseointegrated device, external sound processor, used with osseointegration, body worn, includes headband or other means of external attachment (Ponto sound processor and softband)	☐	____	**L9900**: Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS "L" code (misc.)
☐	____	**L8621**: Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each	☐	____	**L7510**: Repair of prosthetic device, repair or replace minor parts
☐	____	**L8690**: Auditory osseointegrated device, includes all internal and external components	☐	____	**69714**: Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

Estimated Length of Need

☐ Lifetime ☐ Other: _____

Signature

I certify that I am the treating physician or authorized health care provider for this patient and have reviewed this order to certify the use of the equipment/supply is medically necessary for my patient's condition.

Patient Name: _____ Date: _____

Physician Signature (including credentials): _____

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