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 **You**:

- ☐ Reimbursement Support Services Intake From (Page 1)
- ☐ Notice of Privacy Practices (Page 4)
- ☐ Patient Acknowledgements and Waivers (Page 5)
- ☐ Copy of Insurance Card(s) (clear/enlarged copies of the front & back)

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 6)
- ☐ Other Clinical Supporting Documentation (i.e. Audiogram(s), Hearing tests, etc.)

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.

Oticon Medical Reimbursement Support Services Intake Form

Return this completed and signed form to:
Oticon Medical, 580 Howard Avenue, Somerset, NJ 08873
Phone: 1.855.400.9761 | Fax: 1.732.568.7130 | reimbursement@oticonmedical.com

To be completed by You/Patient

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Gender: M ☐ F ☐

Address/City/State/Zip: _____

Phone: _____ Alternate Phone: _____

Patient's Parent/Legal Guardian or Authorized Contact Person: _____

Emergency Contact (Required): _____

Relationship to the patient: _____ Phone: _____

Side(s) Implanted: Right: ☐ Left: ☐ Date of Original Implant: Right: _____ Left: _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Company Name: _____ Insurance Company Phone: _____

Member ID: _____ Group ID: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____

Type of Insurance Plan: ☐ PPO ☐ POS ☐ Medicare ☐ Medicaid ☐ Other: _____

Secondary Insurance:

Insurance Company Name: _____ Insurance Company Phone: _____

Member ID: _____ Group ID: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Subscriber Employer: _____

Type of Insurance Plan: ☐ PPO ☐ POS ☐ Medicare ☐ Medicaid ☐ Other: _____

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
- ☐ Email: _____

INSURANCE INFORMATION

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

Diagnosis: _____ ICD-10 Diagnosis Code(s): _____

- ☐ L8691: Auditory osseointegrated device, external sound processor, replacement (Ponto Sound Processor)
- ☐ L8692: Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment
- ☐ L7510: Repair of prosthetic device, repair or replace minor parts
- ☐ L8621: Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement each
- ☐ L9900: Orthotic and prosthetic supply, accessory, and/or service component of another hcpcs "I" code
- ☐ Other _____

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

Oticon Medical LLC may NOT complete this section.

SECTION A

Date of Physician's Examination: _____ Date of Original Implants: _____

Estimated Length of Need (# of months): _____ 1-99 (99 = Lifetime)

ICD-9 Diagnosis Code(s): _____

SECTION B

1. Narrative description of items ordered: _____
   Processor, Replacement, HCPCS code: _____
2. Oticon Medical Charge: $_____
3. 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: _____

Notice of Privacy Practices

To be completed by You/Patient

Our Responsibilites

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

Effective Date of this Notice: February 01, 2017

Please complete this Acknowledgement and return it to Oticon Medical's Reimbursement Department either via fax to 732.568.7130 or by mail to 580 Howard Avenue, Somerset, NJ 08873.

ACKNOWLEDGEMENT

I hereby acknowledge receipt of Oticon Medical's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

If the Patient is a minor child or dependent:

Parent or Legal Guardian Printed Name: _____ Date: _____

Relationship to the Patient: _____

Patient Acknowledgements and Waivers

To be completed by You/Patient

Assignment of Benefits

For Medicare Beneficiaries:
I understand that Medicare pays for sound processor implants and related surgical services under certain conditions. I understand that Oticon Medical will inform me in advance as to whether it expects Medicare to approve or deny coverage for the services I am seeking given my medical condition and other circumstances. I also understand that I may elect to receive a service from Oticon Medical, even if Oticon Medical believes that coverage by Medicare is unlikely.

If I receive sound processor implants and/or related services from Oticon Medical, by signing this form, I authorize and assign Oticon Medical the right to pursue and receive payment from Medicare, as well as the right to pursue all administrative appeals and litigation, and any other causes of action as necessary to pursue payment. I understand that even if Medicare pays Oticon Medical for the service provided to me, I may be responsible for a deductible, coinsurance, copayment, or other payment amount under the Medicare program rules. I understand that Oticon Medical may bill me for that amount, and I assume responsibility for its payment in full. I also understand that if I receive a service that Medicare does cover under any circumstances, or for which Medicare denies payment because of my medical condition and/or other circumstances, I may be billed by Oticon Medical for the cost of the services rendered to me and I assume responsibility for payment of the billed amount in full. I also understand that if Medicare denies payment for a service I have received, I have the right to appeal that determination.

For All Other Beneficiaries:
I authorize and assign Oticon Medical the right to pursue and receive payment from my insurance carrier, as well as the right to pursue all administrative appeals and litigation, and any other causes of action as necessary to pursue payment related to my receipt of sound processor implants and/or related services from Oticon Medical.

Financial Liability

I understand that if my health insurance does not provide coverage for, or denies payment for, any of the services provided to me, Oticon Medical may bill me for those services, unless doing so would be prohibited by state or federal law, and I assume responsibility for payment of the billed amount in full. I also hereby transfer and assign to Oticon the proceeds of any claim, proceeding, suit and/or action for damages payable to me, my representative or my estate, up to the cost of those services provided to me by Oticon Medical not covered by my health insurance.

I certify that the financial and insurance information I supplied is correct and that I have been informed of my financial obligations.

Use of Information

I understand that my signature on this form gives Oticon Medical the authority to use and/or release my protected health information for treatment, payment and health care operations and as further set forth in the Notice of Privacy Practices. I have received a copy of patient handouts that include the notice of privacy practices (requires signature), description of services – including how to contact the company and how to file a grievance or complaint, patient bill of rights and responsibilities and Medicare supplier standards.

I certify that I have read these documents/policies and my signature indicates my understanding and consent.

Patient Name: _____

Patient's Signature: _____ Date: _____

If the Patient is a minor child or dependent:

Parent or Legal Guardian Signature: _____

Relationship to the Patient: _____ Date: _____

Letter of Medical Necessity
Equipment and Supplies

To be completed by ENT/Doctor

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) Implanted: Right ☐ Left ☐ Date(s) of Original Implant: Right _____ Left _____

Current Processor(s): _____ Date Current Processor(s) Originally Fit: _____

ICD-10 Diagnosis Code(s): _____

Equipment and Supplies Needed: Please provide a narrative description of the patient's condition and confirmation of medical necessity in space below:

Select	Qty.	Description
☐	_____	L8691: Auditory osseointegrated device, external sound processor, replacement (Ponto sound processor)
☐	_____	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)
☐	_____	L8621: Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each

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: _____

Signature (including credentials): _____

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