Oticon Medical Insurance Support Services

Oticon Medical Insurance Services 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.

Checklist to be completed by the **ENT and Audiologist:**
(please note that Physicians and Audiologists are familiar with these forms and the documentation that is needed)

- ☐ Insurance Services Intake Form (Pages 2 & 3)
- ☐ Letter of Medical Necessity - must be signed by ENT (Page 4)
- ☐ Relevant, Recent Clinical Notes (can be from ENT or Audiologist visit)
- ☐ Proof of Delivery and Survey (to be returned after approval and shipment)

Please be sure to complete most recent Audiogram or ABR and sign the applicable Letter of Medical Necessity (Please refer to Page 4)
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: 888.683.8736
Email: InsuranceServices@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 note that additional documentation will be required from the patient. For the full list of documents, please go to www.oticonmedical.com/us/bone-conduction/new-to-bone-conduction/getting-a-ponto/insurance-support. Please feel free to contact us if you have any questions or need assistance.

For your convenience, these forms are also available on our website allowing you to complete and submit electronically. Please visit www.oticonmedical.com/us under Insurance Support.

Insurance Services Intake Form

Return this completed and signed form to:
Oticon Medical, 580 Howard Avenue, Somerset, NJ 08873
Phone: 1.855.400.9761 | Fax: 888.683.8736 | InsuranceServices@oticonmedical.com

To be completed by ENT/Physician

PHYSICIAN INFORMATION

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

Physician: _____ Office Contact: _____
Address/City/State/Zip: _____
Phone: _____ Fax: _____
TIN: _____ NPI: _____
Email: _____

AUDIOLOGIST INFORMATION

☐ **Ship to Clinic** *(please use shipping address if shipping to clinic)* ☐ **Ship to Patient**

Account Number:_____
Audiologist: _____ Office Contact: _____
Address/City/State/Zip: _____
Phone: _____ Fax: _____
TIN: _____ NPI: _____
Email: _____

PATIENT INFORMATION

☐ Patient Name: _____
☐ Patient Phone Number: _____
☐ Patient Email: _____

Qty.	Model
____	Ponto 3 SuperPower
____	Ponto 5 Mini

Side (P3SP only)
☐ Right
☐ Left

Ponto 5 Mini, Free Accessory
☐ ConnectClip
☐ Remote
☐ EduMic

Ponto 3SP Free Accessory
☐ Streamer – Blk
☐ Streamer – White
☐ 3rd Year Repair

Softband
☐ Bilateral
☐ Unilateral

Softband Color (choose one)
☐ Beige ☐ Yellow ☐ Cerise ☐ Turquoise
☐ Brown ☐ Purple ☐ Blue ☐ Indigo
☐ Black ☐ Pink ☐ Navy
☐ Grey ☐ Red ☐ Green

Ponto Color (choose one)
☐ Beige ☐ Silver White
☐ Brown ☐ Pure White (P3)
☐ Black ☐ Terracotta (P5 only)
☐ Grey

Insurance Services Intake Form

To be completed by ENT/Physician

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: 1.732.868.6949
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 without 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.

Physician Name: _____ Date: _____

Physician Signature (including credentials): _____

20-90202 19900-9132/12.6.21

oticon MEDICAL

oticon MEDICAL | Because sound matters

Dear Ponto Customer,

Thank you for selecting the Ponto System – Oticon Medical's proven bone anchored hearing system that offers great sound quality in a user-friendly and discreet design.

Because Oticon Medical is an accredited provider for the Medicare program and we have billed your insurance for your device, we are required to provide you with the enclosed documents, listed below:

- Assignment of Benefit/Proof of Delivery document/Plan of Service document
- Patient Satisfaction Survey

It is imperative that as part of this process Oticon Medical confirms that your device has indeed been delivered to you for your use. If we do not receive confirmation from you that you have received your device, you may be responsible for the full cost of the item. Therefore, we request that you please take a moment to review, complete and return the following documents to our offices in the enclosed postage-paid envelope:

- Assignment of Benefit/Proof of Delivery/Plan of Service document
- Patient Satisfaction Survey

We greatly appreciate your cooperation with our request. If you have any questions, please contact Oticon Medical's Reimbursement team at 855.400.9761.

Thank you in advance,

Oticon Medical LLC
Reimbursement Department

Oticon Medical, LLC
580 Howard Avenue
Somerset, NJ 08873
USA

Phone: 1-855-400-9761
Fax: 1-732-568-7130
Email: reimbursement@oticonmedical.com
www.oticonmedical.com

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ASSIGNMENT OF BENEFIT/PROOF OF DELIVERY/PLAN OF SERVICE

I hereby assign medical benefits I am entitled to; I authorize and direct my insurance carriers, including Medicare, private insurance and any other health/medical plan, to issue payment checks directly to Oticon Medical for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Patient Name: _____

Patient's Signature:_____ Date: _____

I, _____ certify that I have received the services/product agreed to through
(Patient Name)
Oticon Medical as listed on the included shipping document and have read and understood the user manual and the warranty information.

I understand that I may view company marketing materials and information on the company's scope of services at the company website: https://www.oticonmedical.com.

Expected outcomes: The patient will be provided the product(s) to comply with the physician's prescription. The patient will use the product(s) as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

Patient Name: _____

Patient's Signature:_____ Date: _____

Oticon Medical, LLC
580 Howard Avenue
Somerset, NJ 08873
USA

Phone: 1-855-400-9761
Fax: 1-732-568-7130
Email: reimbursement@oticonmedical.com
www.oticonmedical.com

Thank you for selecting the Ponto System – Oticon Medical's proven bone-anchored hearing system that offers great sound quality in a user-friendly and discreet design.

Please take a few moments to complete the below Patient Satisfaction Survey as your opinion relative to your experiences with our company and product are of great value to Oticon Medical. Your feedback will be used as we continuously work to improve upon the services we provide. Upon completion, this document can be returned to Oticon Medical along with the Assignment of Benefit/Proof of Delivery/Plan of Service document in the enclosed postage-paid envelope.

1. How satisfied are you with the Oticon Medical billing services?

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
☐	☐	☐	☐	☐

2. Please respond to the following statements regarding your interactions with Oticon Medical representatives:

The representative was courteous on the phone.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

The representative was knowledgeable and explained the process clearly.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

All of my questions and/or issues were answered to my satisfaction.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

The representative was available to speak with me when I called and any messages were returned in a timely manner.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

3. Based on the features and benefits of the product/Ponto sound processor you received, how satisfied are you with the product?

Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
☐	☐	☐	☐	☐

The next two questions are optional to answer. If you do answer, your responses may be used for marketing purposes. Your personal information will not be disclosed in any way.

4. I would recommend Oticon Medical to others.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

5. How did you hear about Oticon Medical?

Physician/Audiologist	Friend	Internet Search	Oticon Medical Website	Other
☐	☐	☐	☐	☐

If you'd like to bring any additional comments that were not addressed in this survey to our attention, please do so in the space below:

_____

_____

14339 / 12.6.21

Phone: 1-855-400-9761 | Fax: 1-732-568-7130 | www.oticonmedical.com/us

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