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: _____

Insurance Services Intake Form (Con't)

PONTO 5 Processors

Qty.	Model
____	Ponto 5 SuperPower
____	Ponto 5 Mini

Ponto Color (choose one)

- ☐ Beige
- ☐ Brown
- ☐ Black
- ☐ Grey
- ☐ Silver White
- ☐ Terracotta

Ponto 5 or Ponto 5 SuperPower, Free Accessory

- ☐ ConnectClip
- ☐ Remote
- ☐ EduMic
- ☐ TV Adapter 3.0

SOFTBAND 5

Size XS/S

Color Options	Unilateral		Bilateral	
COLORS	PART #	QTY	PART #	QTY
Black	227690	____	227702	____
Beige	227693	____	227705	____
Light Blue	227694	____	227706	____
Navy Blue	227696	____	227708	____
Pink	227695	____	227707	____
Dark Brown	227691	____	227703	____
Light Brown	227692	____	227704	____
Red	227697	____	227709	____

Unilateral

Bilateral

SOFTBAND 5

Size M/L

Color Options	Unilateral		Bilateral	
COLORS	PART #	QTY	PART #	QTY
Black	227686	____	227698	____
Beige	227689	____	227701	____
Dark Brown	227687	____	227699	____
Light Brown	227688	____	227700	____

MISCELLANEOUS

PART #	DESCRIPTION	QTY
226779	Connector Pads for Softband 5 (Set of 20)	____
M51177	Ponto Care Kit	____
19900-4000	Pediatric Care Kit	____
173365	Safety Clip	____
M50029	Safety Line	____
173391	SoundConnector	____

RETURN AND EXCHANGE POLICY

Oticon Medical Processors & Accessories can be returned or exchanged within 90 days of the shipment date at no charge. To receive a credit, less shipping, handling and insurance charges, please call 1.888.277.8014 to request a Return for Credit form. The form must be filled out and returned along with the product.

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): _____

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