

**FORWARDHEALTH
 PRIOR AUTHORIZATION REQUEST / HEARING INSTRUMENT
 AND AUDIOLOGICAL SERVICES (PA/HIAS2)**

Providers may submit prior authorization (PA) requests with attachments to ForwardHealth by fax at (608) 221-8616 or by mail to ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Hearing Instrument and Audiological Services (PA/HIAS2) Completion Instructions, F-11021A.

SECTION I — PROVIDER INFORMATION

1. Name — Provider	4. Address — Provider (Street, City, State, ZIP+4 Code)
2. National Provider Identifier	
3. Telephone Number — Provider	

SECTION II — MEMBER INFORMATION

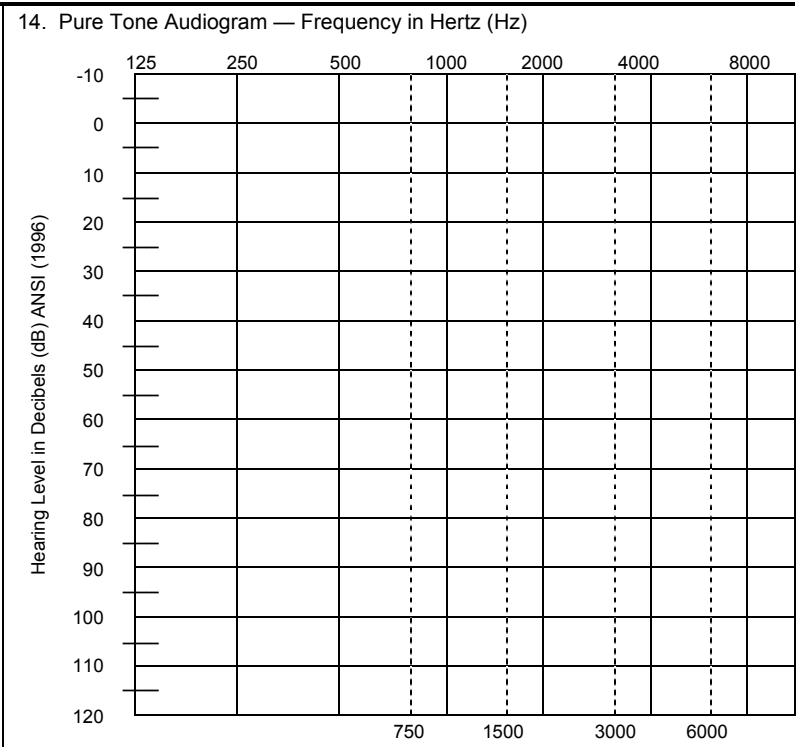
5. Name — Member (Last, First, Middle Initial)	6. Date of Birth — Member	
7. Member Identification Number	8. Gender — Member <input type="checkbox"/> Male <input type="checkbox"/> Female	9. Has the Member Ever Used a Hearing Instrument? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Describe Prior Hearing Instrument Use	11. Testing Date	12. Test Reliability (Check One) <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

SECTION III — DOCUMENTATION

13.

						Legend							
		Air		Bone									
Ear	Un-masked	Masked	Un-masked	Masked	NR								
Right	o - o	Δ - Δ	<	[↙								
Left	x - x	□ - □	>]	↘								

SPEECH AUDIOMETRY	R	L	SF
Threshold (SRT or SDT)			
Word recognition in quiet			
Word recognition in noise			
Uncomfortable level (dB-HL)			
Most comfortable level (dB-HL)			



15. Additional Audiometric Studies and Results, Pertinent Social Background, Other Relevant Information (Use an Attachment if Necessary)

16. Recommendations for a Hearing Instrument (use an attachment if necessary)

Ear (Check One) Left Right Both Ear Mold Style _____ Hearing Aid Style _____

Describe Electroacoustic Specifications Ear Mold Left Right Both

Special Modifications _____

17. SIGNATURE — Requesting Provider	18. Name — Requesting Provider (Print)	19. Provider Type (Check One) <input type="checkbox"/> Audiologist <input type="checkbox"/> Hearing Instrument Specialist	20. Date Signed
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