Pred Form Guidelines This form is used for audiologists to prior authorize hearing aids.

Step	Action
1	**Verify eligibility and benefits** to make sure that your patient is covered and the services are covered. Log onto www.bcbsmt.com and register to view benefits, claims, and eligibility information or call 1-800-447-7828. To be considered for coverage, members must be enrolled in HMK on the date of the prior authorization request, the date the hearing aid is dispensed, and when additional hearing aid services are required.
2	An audiologist assessment, audiogram report, audiologist recommendation (all completed within the past six months), a copy of the medical evaluation by ear, nose, and throat (ENT) specialist and final medical clearance documentation from the referring medical provider must be attached.
3	Complete the Prior Authorization Request - Hearing Aids.

Provider Participation Notice

Healthy Montana Kids (HMK) members are required to use HMK participating providers when seeking medical treatment, and all providers involved with this procedure must be HMK participating providers. Call Blue Cross and Blue Shield of Montana at 1-800-447-7828 and ask for Network Services, to enroll in the network prior to rendering services or to inquire about whether the provider to whom you are referring an HMK member is an enrolled HMK participating provider.

BlueCross BlueShield of Montana

MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services

Internal Use Only

PRED
(Work Item Type)

Predetermination Request – Hearing Aids

FAX: 855-610-5684, ATTN: Predetermination
To check status of a Predetermination, call 855-699-9907

Member Name:	Member ID:	Member Group ID:	Member Date of Birth:
Audiologist Name:	Audiologist NPI Number:	Audiologist Phone: Audiologist Fax:	
Referring Physician Name:	Referring Physician NPI Number:	Hearing Aid Request Date:	

1. Is this request for new hearing aid(s) or a replacement hearing aid(s) needed *due to a change in patient condition*? If no, go to Section 2. If yes, complete the information below and attach audiologist assessment, audiogram report, and audiologist recommendation. A copy of the medical evaluation by ear, nose and throat (ENT) specialist must be provided.

HCPCS Code	Description (new)	Manufacturer	Model Number	Estimated Cost

Manufacturer (current)	Model	Date Acquired

2. Is this a request for replacement hearing aid(s) *due to loss or damage*? If no, go to Section 3.

   NOTE: Members are responsible for costs of repair or replacement if equipment was purposely or negligently destroyed or damaged. If yes, answer the following questions or attach supporting documentation:

Replacement reason:

Is the equipment under warranty? Yes ☐ No ☐ How old is the equipment? _____
Is item repairable? Yes ☐ No ☐ Estimated cost of repair? _____

Manufacturer (current)	Model	Date Acquired

3. Is this a hearing aid repair? Yes ☐ No ☐ If yes, answer the following questions or attach supporting documentation.
   Is equipment under warranty? Yes ☐ No ☐ How old is the equipment? _____
   Estimated cost of repair? _____

Manufacturer (current)	Model	Date Acquired

Fax: 855-610-5684, ATTN: Predetermination **or**
Or Mail: Utilization Management Department
Blue Cross and Blue Shield of Montana
PO Box 4309
Helena, MT 59604

NOTE: Do not mail form if already faxed.

To Be Completed By BCBSMT ☐ Approved - Authorization Number: _____

☐ Denied

Comments:

Reviewed by: _____ Date: _____

Prior authorization approves the medical necessity and appropriateness of the services requested. The determination for payment of claims is made when the claim is received. The claim is subject to the terms and limitations of the member's benefit plan, including applicable copayments. Prior authorization is only honored if the member is enrolled in HMK at the time services are rendered. HMK participating providers accept the HMK allowance as payment in full as specified in the provider agreement. HMK participating providers agree to bill the HMK member only for applicable copayments and for noncovered services the HMK member has agreed to pay in writing in advance of receiving services.

Hearing aid manufacturer's invoice must be submitted with the claim.

Blue Cross and Blue Shield of Montana complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Montana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Montana:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Montana has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

The HELP Plan is administered by Blue Cross and Blue Shield of Montana, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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To request auxiliary aids and services, including materials in alternative formats, please call 1-877-233-7055.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-710-6984 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-710-6984 (TTY: 711)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-710-6984 (TTY: 711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم:711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-710-6984 (TTY: 711).

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-710-6984 (телетайп: 711).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-710-6984 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-710-6984 (TTY: 711).