WellFirst Health

Hearing Aid(s) Authorization Form- Optional
Fax completed form to:
608-252-0863

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION		
Provider Name:		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:	Specialty:	

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Specialty:		

REQUEST INFORMATION		
Date (s) of Service:	Diagnosis Code(s):	ICD Code(s):
CPT Codes and Description:		
# of Visits	3rd Party liability:	☐ W/C ☐ MVA ☐ Other

Hearing Level Assessment

Left Ear (X)

Hz	dB level
500	
1000	
2000	
3000	
4000	
Total	

Right Ear (0)

Hz	dB level
500	
1000	
2000	
3000	
4000	
Total	

Form Submitted By:		
Name:	Phone:	Fax:

For further information on hearing aids, Please see the WellFirst Health medical policy, Hearing Aids at www.wellfirstbenefits.com/

The optional completed form can be faxed to: 608-252-0863
If you have any questions regarding the services or form, Please contact Customer Service at 866-514-4194 Requests to non-plan providers must be approved prior to obtaining services.