

ALABAMA MEDICAID AGENCY

AUTHORIZATION FOR COCHLEAR IMPLANTS

Recipient Name _____ Medicaid Number _____

Address _____ Diagnosis _____

EPSDT Screen Yes
Referral Attached

Referring Physician _____ *(Must be attached for authorization to be granted)*

Recipient's Age *(must be chronological age 2 to 21 year of age)*: _____

Recipient has profound (>90dBHL) sensorineural hearing loss bilaterally and minimal speech perception under best aided conditions.

Recipient has obtained minimal or no benefit from a hearing (a vibrotactile) aid as demonstrated by failure to improve on age appropriate closed-set work identification task. *Appropriate amplification and rehabilitation for a minimum six-month trial period was conducted to assess the potential for aided benefit.*

The recipient does not have any medical or radiological contraindications, and is otologically stable and free of active middle ear disease prior to cochlear implantation.

Families/caregivers and possible candidates are well motivated.

Education has been conducted to ensure parental understand of the benefits and limitations of the device, appropriate expectations, commitment to the development of auditory and verbal skills, dedication to the child's therapeutic program and the ability to adequately care for the external equipment.

I certify that the recipient meets the criteria indicated above and the information is true and accurate.

Surgeon's Signature

Date

Surgeon's Name (Printed or Typed)

(_____) _____
Surgeon's Telephone Number

Mailing Address of Surgeon

Surgeon's Medicaid Provider Number

City, State, Zip Code + 4