Cochlear™ Baha® 6 Max Sound Processor

**Letter of Medical Necessity & Prescription for Services - Obsolete**

Patient Name:

Date of Birth:

Implant Date:

Diagnosis Code: SELECT DX CODE

 Date Last Seen By Physician (If Applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RE: Predetermination/Preauthorization of Benefits for a Cochlear™ BAHA® Sound Processor**

This letter concerns the patient above, to whom we provide audiological/otolaryngological services. My patient’s current sound processor is out of the manufacturer’s warranty. The manufacturer has deemed the patient’s current processor as obsolete and is unable to repair or provide replacement parts.

SELECT BILATERAL/UNILATERAL

[*ADD IN REASON FOR REPLACEMENT-Please update with your own verbiage*](#_top) *Ex: Does the patient’s sound processor have any kind of damage or intermittency? Ex: The patient’s sound processor is non-functional and the patient is currently out of sound. Or this patient’s sound processor is experiencing intermittency which is leaving my patient without consistent sound. This poses significant safety concern and reduces the patient’s quality of life.*

The CochlearBaha 6 Max Sound Processor (L8691 Processor, L9900/L8694 Actuator Unit) is necessary for safe, effective and uninterrupted use of my patient’s Baha implant and is needed to support their Baha implant technology. Without it, my patient is unable to achieve the benefits of their hearing implant.

My patient will continue to need the Baha implant and external sound processor for their lifetime.

The Baha 6 Max Sound Processor comes with a two-year manufacturer’s warranty that will cover repairs. My patient currently has a Cochlear brand processor and the replacement should be purchased from them:

Cochlear Americas

10350 Park Meadows Drive

Lone Tree, CO 80124

Phone: (800) 633-4667

If you have questions or need additional information, please feel free to contact me at

Insert Clinic Name and Address

AUDIOLOGIST SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_