

PRIOR AUTHORIZATION FOR OUT-OF-NETWORK SERVICES

Patient Information

Today's Date	
Patient DOB Month / Day / Year	
Patient Name	
Patient's Member ID	

Out-of-Network Provider

Provider Name	
Clinic Name	
NPI Number	
W-9 Address	
Federal Tax ID Number	
City State Zip	
Clinic Contact Name	
Telephone Number	

Out-of-Network Facility

Provider Name	
Clinic Name	
NPI Number	
W-9 Address	
Federal Tax ID Number	
City State Zip	
Clinic Contact Name	
Telephone Number	

Prior Authorization Information

Services:	CPT Code(s)/HCPCS Code(s)
1. Hearing Screening	92557, 92550
2. Advanced Testing	
3. Hearing Screening, Consult & Dispensing of Hearing Aids	
4. Diagnosis ICD-10 Code(s) and/or secondary conditions	



This referral request is valid for a maximum of _____ visits from _____ through _____

Have you attempted to find an in-network 20/20 Hearing Care Provider? ____ Yes ____ No

Has the patient seen this out-of-network provider in the past? ____ Yes ____ No

If so, when was the last visit? / (month/year) _____


Summary of in-network specialists this patient has seen related to above diagnosis:

Explain why the requested services can only be provided by this out-of-network provider.

Please secure with the following password: Hear123# and email to:

care@2020hearingnetwork.com for authorization to provide hearing services.



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(815) 301-8260 (eFAX)

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