



Insurance Authorization Form
Attn: CII BTE Replacement Program

Fax to 877-833-6318

or Mail to Reimbursement Services, 25129 Rye Canyon Loop, Valencia, CA 91355

I - Implant Center Information	
Clinic Name: _____	Physician: _____
Audiologist: _____	Contact Person: _____
II - Patient Information	
Patient Name: _____	Parent Name: _____
Address: _____	
City: _____	State: _____ Zip: _____
Home Phone # (V or TTY?) _____	Date of Birth: _____
Social Security # _____	Sex: _____
Email Address: _____	Implant Date: _____
III - Employer Information	
Employer Name: _____	
Employer Address: _____	
Work Phone (V or TTY?) _____	
IV - Primary Insurance Carrier Information	
Insurance Company Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Phone #: _____	Group Plan #: _____
Member Name: _____	Date of Birth _____
ID #: _____	Relationship to Patient: _____
V - Secondary Carrier Information	
Secondary Insurer Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Secondary Member's Name: _____	ID #: _____
VI - Primary Care Physician Information	
Primary Care Physician Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Phone #: _____	
VII - Authorization	

I authorize Advanced Bionics LLC's Insurance Reimbursement Department to release pertinent information about my medical condition for the purpose of securing health insurance benefits information, authorization, or payment for devices or services.

I will provide a current copy of my **insurance identification card**, policy number and demographic information to Advanced Bionics upon request.

I also **authorize** Advanced Bionics' Insurance Reimbursement Department to act as my representative and on my behalf to secure all authorization necessary from my insurance company regarding a procedure or order involving an Advanced Bionics medical device, including, if necessary, any appeal of a denial of benefit and in billing to my insurance carrier for replacement parts, if necessary.

I understand that I may revoke this authorization at any time by giving my physician or Advanced Bionics LLC a statement to withhold my personal and medical information from hat time forward.

Patient's Name: _____ Patient or Legal Guardian's Signature: _____

Relationship to patient: _____ Date: _____

Reimbursement Services Hotline

877.779.0229 • 877-833-6318 Fax • 800.678.3575 TTY • www.bionicear.com

Disclaimer: Advanced Bionics will endeavor to obtain authorization from your insurance company to reimburse your healthcare provider or Advanced Bionics for services or items covered by an authorization. However, there is no guarantee that we'll receive authorization or payment. The patient or the patient's guardian remain liable for payment of services or goods received except as otherwise provided by law.