

Insurance Authorization Form

Please complete and FAX this form to 877-833-6318

Please check one of the following reasons for submission of this form:

Insurance Update Pending Order New Patient OTHER: _____

I - Implant Center Information	
Clinic Name: _____	CI Surgeon: _____
Audiologist: _____	Contact Person: _____
Audiologist Phone #: _____	Contact Number: _____
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(s): _____
III - Employer Information	
Employer Name: _____	
Employer Address: _____	
Work Phone (V or TTY?): _____	
IV - Primary Health Plan Information	
Check Health Plan Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID	
Primary Health plan Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Phone #: _____	Group Plan #: _____
Member Name: _____	Date of Birth: _____
ID #: _____	Relationship to Patient: _____
V - Secondary Health Plan Information	
Secondary Health plan Name: _____	Phone #: _____
Address: _____	
City: _____	State: _____ Zip: _____
Secondary Member's Name: _____	ID #: _____
VI - Primary Care Physician Information (required for HMO members)	
Primary Care Physician Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Phone #: _____	
VII - Authorization	

I authorize Advanced Bionics Corporation's Reimbursement Services 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' Reimbursement Services Department to act as my representative and on my behalf to secure all authorization necessary from my health plan 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 health plan for replacement parts, if necessary.

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

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

Relationship to patient: _____ Date: _____

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 remains liable for payment of services or goods received except as otherwise provided by law.