



# Insurance Authorization Form

Please check the appropriate box as it applies:  New Patient  Pending Order  New Insurance  Other: \_\_\_\_\_

## I. Implant Center Information

Clinic Name: \_\_\_\_\_ Physician Name: \_\_\_\_\_  
Audiologist Name: \_\_\_\_\_ Contact Person Name: \_\_\_\_\_

## II. Patient Information

Patient Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone (indicate V or TTY): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Sex: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Implant Date: \_\_\_\_\_

## III. Employer Information

Employer Name: \_\_\_\_\_ Work Phone (indicate V or TTY): \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## IV. Primary Insurance Carrier Information

Check Health Plan Type (if known):  HMO  PPO  EPO  POS  Medicare  Medicaid  
Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group Plan Number: \_\_\_\_\_ Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## V. Secondary Insurance Carrier Information

Check Health Plan Type:  HMO  PPO  EPO  POS  Medicare  Medicaid  
Insurance Company Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Group Plan Number: \_\_\_\_\_ Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## VI. Primary Care Physician Information

Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## VII. Authorization

I authorize Advanced Bionics Insurance Reimbursement Services 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 AB upon request.

I also authorize AB Insurance Reimbursement Services 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 AB 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 AB 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: \_\_\_\_\_

**Reimbursement Services Hotline (V) 877.779.0229 • (F) 877.833.6318 • (TTY) 800.678.3575 • [www.BionicEar.com](http://www.BionicEar.com)**

AB 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.