HEALTHCARE PROVIDER'S ORDER FOR COCHLEAR IMPLANT SUPPLIES

GENERAL INFORMATION

PATIENT NAME, ADDRESS, AND PHONE NUMBER	SUPPLIER NAME, ADDRESS, PHONE, NPI
	ADVANCED BIONICS, LLC 12740 SAN FERNANDO ROAD SYLMAR, CA 91342-3828
PHONE: DOB: ____/_____/_____	PHONE: 800-678-2575 NPI: 1841479573

EQUIPMENT AND SUPPLIES NEEDED		**PROVIDER'S NAME, ADDRESS, PHONE, & NPI (Please complete below.)**
Replacement equipment, supplies, and accessories related to supporting my patient's cochlear implant device. The item(s) requested support the lifetime of my patient's cochlear implant technology. Without it, my patient is unable to hear or achieve any benefit from the cochlear implant. List item(s) needed:		PHONE: NPI:

DIAGNOSIS (-ES) AND LENGTH OF NEED (PLEASE COMPLETE.)

EST. LENGTH OF NEED :	DIAGNOSIS CODES (ICD-9):
☐ Lifetime ☐ Other, please specify: _____	☐ 389.10: Sensorineural hearing loss, unspecified ☐ 389.18: Sensorineural hearing loss of combined types. ☐ Other: (Please state.) _____

PHYSICIAN OR AUTHORIZED HEALTHCARE PROVIDER'S ATTESTATION (PLEASE SIGN.)

I certify that I am the treating physician or authorized healthcare provider for this patient and have reviewed this order to certify the use of the equipment/supply (ies) is medically necessary for my patient's condition.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____