BlueCross BlueShield
Federal Employee Program®

Federal Employee Program® and Postal Hearing Aid Prior Approval Request Form

Please complete this form when requesting prior approval for hearing aid devices or services. Prior Approval is also required when Medicare or other insurance is primary. Failure to obtain any necessary authorizations may result in a denial of benefits. Please allow up to 15 days for a determination.

This form shouldn't be used for Utilization Management requests such as inpatient, hospice care, skilled nursing, residential treatment, or applied behavior analysis (ABA) therapy.

Hearing Aid devices must be FDA approved and prescribed/ordered by a licensed provider based on documented hearing loss. Prior Approval must be submitted within 6 months of the prescription/order. Any approval will be valid for 6 months from the date of the prescription/order.

For new hearing aid requests, please submit the following:

- Copy of the prescription/order for hearing aids
- Any records documenting the decibel loss if not included on the prescription/order
- Comprehensive audiometric testing or other age-appropriate testing - including date, type of testing, and results that demonstrates greater than 26 dB hearing loss (HL)
- The name of the hearing aid being considered for purchase

For replacement hearing aid requests, please submit the following:

- Copy of the prescription/order for hearing aids
- Any records documenting the decibel loss if not included on the prescription/order
- The name of the hearing aid being considered for purchase or recommendation for the type of replacement device
- Member's history of hearing aid use
- Pertinent medical history, description of functional status, relevant prior treatment information
- Comprehensive audiometric testing: date, type of testing and results that demonstrates the hearing loss and need for a replacement hearing aid
- Documentation showing significant change in hearing that requires a different hearing aid (at least a 15 dB change in at least one frequency between 500 and 4000 Hz)

Date Submitted: _____/_____/_____ Pages attached (include cover and/or form): _____

Contact Name: _____

Contact Phone #: (_____)_____-_____ Contact Fax #: (_____) _____ - _____

Member Name: _____

Member ID Number: _____ Date of Birth: _____/_____/_____

Prescribing/Ordering provider information below:

Prescribing/Ordering Provider: _____

Phone #: (_____) _____-_____ Fax #: (_____)_____-_____

Address: _____

City: _____ State:_____ ZIP:_____

FEP/PSHB Utilization Management Guidelines can be accessed online at https://www.fepblue.org/legal/utilization-guidelines

Please return this completed form to:

BlueCross BlueShield of Tennessee
Predetermination/ODM
1 Cameron Hill Circle, STE 0014
Chattanooga, TN 37402-0014

You may also fax this completed form to **(423) 591-9091** or submit through your MyBlue account on **fepblue.org**. If you have any questions, please contact BlueCross BlueShield of Tennessee FEP Customer Service at **1-800-572-1003** or Postal Customer Service at **1-866-780-7742**, Monday through Friday, 8 a.m. to 6 p.m. (ET).

Please note: Final reimbursement determinations are based on member eligibility at the time of service, medical necessity criteria, applicable member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and FEP/PSHB Medical Policy.

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