

HEALTHCARE PROVIDER'S ORDER FOR COCHLEAR IMPLANT SUPPLIES

GENERAL INFORMATION	
PATIENT NAME, ADDRESS, AND PHONE NUMBER PHONE: _____ DOB: ____/____/____	SUPPLIER NAME, ADDRESS, PHONE, NPI ADVANCED BIONICS, LLC 12740 SAN FERNANDO ROAD SYLMAR, CA 91342-3828 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 : <input type="checkbox"/> Lifetime <input type="checkbox"/> Other, please specify: _____	DIAGNOSIS CODES (ICD-9): <input type="checkbox"/> 389.10: Sensorineural hearing loss, unspecified <input type="checkbox"/> 389.18: Sensorineural hearing loss of combined types. <input type="checkbox"/> 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: _____	