PRESCRIPTION FOR UPGRADE

# HEALTHCARE PROVIDER'S LETTER OF MEDICAL NECESSITY (LMN)

## GENERAL INFORMATION

### RECIPIENT/PATIENT INFORMATION

Name: _____

Address: _____

DOB: _____

Date of Implant: _____

Current Processor: _____

Date of Current Processor Fitting: _____

Implant Side: _____

Delivery Address *(Where should the product be shipped):*

_____

### SUPPLIER/PROVIDER INFORMATION

Cochlear Americas
13059 E. Peakview Ave., Centennial, CO 80111
**Phone:** 800-633-4667 opt 2 **Fax:** 1-866-706-8875
**NPI:** 1336149426 **Tax ID:** 84-0945658

### REQUESTING PROVIDER INFORMATION

Provider: _____

Address: _____

Phone: _____

Fax: _____

NPI: _____

## EQUIPMENT AND SUPPLIES NEEDED

On behalf of the patient identified above, we are submitting this letter to confirm the ongoing medical necessity for this patient of a Cochlear™ external sound processor. This patient's condition has not changed; the patient continues to require the Cochlear external sound processor in order to maintain hearing using a cochlear implant. The item requested is essential to support my patient's lifetime need for their cochlear implant technology to be able to hear. Without it, my patient is unable to hear or achieve any benefit from the cochlear implant. In fact, this patient will continue to need the implant and associated external sound processor(s) for their lifetime. A sound processor continues to be medically necessary for this patient.

**ITEM(S) NEEDED:** _____

**DESCRIPTION OF ITEM ORDERED:** CI External Processor Kit (L8619)

**MAGNET STRENGTH:** ☒ 1/2M ☐ 1M ☐ 2M* ☐ 3M ☐ 4M ☐ 5M **Recommended.*

**# UNITS:** _____

**DIAGNOSIS CODES (ICD-9):** _____

## PHYSICIAN OR AUTHORIZED HEALTHCARE PROVIDER'S ATTESTATION

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

This prescription/order for the external processor ("Device") includes the complete processor kit along with all other accessories and repairs that may be required over the life of the Device and its associated parts to ensure the Device is maintained in proper working order.

Print Name: _____

Signature: _____ Date: _____