SunMED Medical Solutions

Start your order online today at SunMEDChoice.com or by submitting this form to SunMED by fax or email Cochlear@sunmedmedical.com
FAX 800-715-5422 | Phone 855-477-4510

Rx This form is a Prescription and Statement of Medical Necessity. All fields are required for insurance approval.

Patient Name: _____ **Date of Birth:** _____
(Last) (First) (M)
Patient Cell # _____ **Patient Home #** _____
Email _____
Patient Address: _____
Alternate Contact Person _____ **Alternate Contact Phone #** _____

Primary Insurance
Name of Insurance: _____ **Effective Date:** _____
Policy # _____ **Group #** _____ **Phone #** _____
Policy Holder (Primary Insured): Self ☐ Other: _____ **DOB:** _____

Secondary Insurance
Name of Insurance: _____ **Effective Date:** _____
Policy # _____ **Group #** _____ **Phone #** _____
Policy Holder (Primary Insured): Self ☐ Other: _____ **DOB:** _____

Battery Type:
☐ **PowerOne Implant Plus P675***
*This battery has a $.40/battery cell upgrade fee
☐ **ZeniPower Mercury Free A675P****
**This battery does not have an upgrade fee
☐ **ZeniPower A312**
**This battery does not have an upgrade fee

Number of Processors Ordering For: ☐ Unilateral (one-side) ☐ Bilateral (two-sided)

You will automatically be enrolled in our Autoship program. Batteries will be shipped every 30 days for Medicaid patients, and every 90 days for all other insurances.
To OPT OUT of this program, please check this box: ☐

Please include a prescription or have your doctor complete the prescription blank below:

Rx MD Name: _____
Address: _____
Phone: _____ **Fax:** _____ **NPI:** _____

On behalf of the patient identified above, I am prescribing disposable batteries that are required to power my patient's external sound processor. The batteries requested are essential to support my patient's lifetime need for their hearing implant technology. My patient uses 1-2 disposable batteries (L8621) per day per treated ear.

QUANTITY: ☐ 90-day supply (180 to 360 batteries) or ☐ 30-day supply (60 to 120 batteries – for Medicaid patients only)
REFILLS: ☐ 3x (90-day supply) or ☐ 11x (30-day Medicaid supply) **LENGTH OF NEED:** 99 (Lifetime)
ICD-10 CODE: ☐ H90.3 ☐ H90.6 ☐ Other: _____

IMPORTANT: Patient chart notes must be submitted that show medical necessity for the batteries.

Physician Signature Required: _____ **Date:** _____