



PINAL COUNTY  
Wide open opportunity

PINAL/GILA LONG TERM CARE  
REQUEST FOR REFERRAL  
**COCHLEAR IMPLANTATION**  
PLEASE FAX ALL REQUESTS TO (520) 866-6717

Member Name: \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_\_  
 Medicare A  B  Other Insurance: \_\_\_\_\_  
 Name of Nursing Home/ALF: \_\_\_\_\_  
 EPSDT eligible member? Yes  No  CRS eligible member? Yes  No   
 Service Provider Number: \_\_\_\_\_  
 (AHCCCS# of Provider referred to)  
 Service Provider Name: \_\_\_\_\_  
 (Name of Provider referred to)  
**Service Requested:** \_\_\_\_\_  
 Date of Service: \_\_\_\_\_ Appointment Time: \_\_\_\_\_  
 Diagnosis Code: \_\_\_\_\_  
 Requested CPT Code: \_\_\_\_\_ Est. Cost: \_\_\_\_\_  
**URGENCY STATUS for Cochlear Implantation (see \* for definitions of status):**  
 Standard (Based on members condition – Not to exceed 14 days)  
 Expedited – Urgent (within 3 days)

Please answer the following questions:  
 1. What is the diagnosis related to this request referral? \_\_\_\_\_  
 2. Reason for referral? \_\_\_\_\_  
 \_\_\_\_\_  
 3. What more conservative medical therapy has been tried and failed? \_\_\_\_\_  
 \_\_\_\_\_  
 4. Does member have a diagnosis of bilateral profound sensorineural deafness? Yes  No   
 5. Does member demonstrate the ability to use auditory clues? Yes  No   
 6. Does member have a functioning implant in either ear? Yes  No

**PCP/PCP Designee Signature** \_\_\_\_\_  
**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_  
 PCP Remember: It is your responsibility to assure a copy of this consult/treatment is present in your office/facility medical records

**Please attach the following: (Mandatory)**  
 1. PCP order (if referral form not signed by Physician)  
 2. Current History and Physical  
 3. Progress notes related to request for referral  
 4. Consultation Notes

**\*Standard Authorization Request:** A request for which P/GLTC provides a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request with a possible extension of up to 14 calendar days if the member or provider requests an extension of the P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.

**\*Expedited authorization Request:** A request for which P/GLTC provides a decision to the member as expeditiously as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request with a possible extension of up to 14 days if the member or provider requests an extension or if P/GLTC establishes a need for additional information and delay is in the enrollee's best interest.