

**MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 PREAUTHORIZATION REQUEST FORM
 AUDIOLOGY SERVICES**

SECTION V - Specific Program Preauthorization Information

Patient Location: Home ___ Nursing Home ___ Hospital Inpatient ___ Discharge Date _____

Address where equipment will be used (if different from Above):

Period of time required:

MFGR	MODEL/PRODUCT	SINGLE UNIT	AMT. PKG
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

Diagnosis and Present Physical Condition _____

Prognosis _____

Treatment Plan _____

Expected Therapeutic Effect _____

SECTION VI (DHMH USE ONLY)

_____ Approved _____ Denied

REASON (S) _____

Medical Consultant's Signature _____

Date _____