Medical Assistance Division

Income Support Division

HEARING AID EVALUATION INFORMATION FOR MEDICAID PRIOR APPROVAL

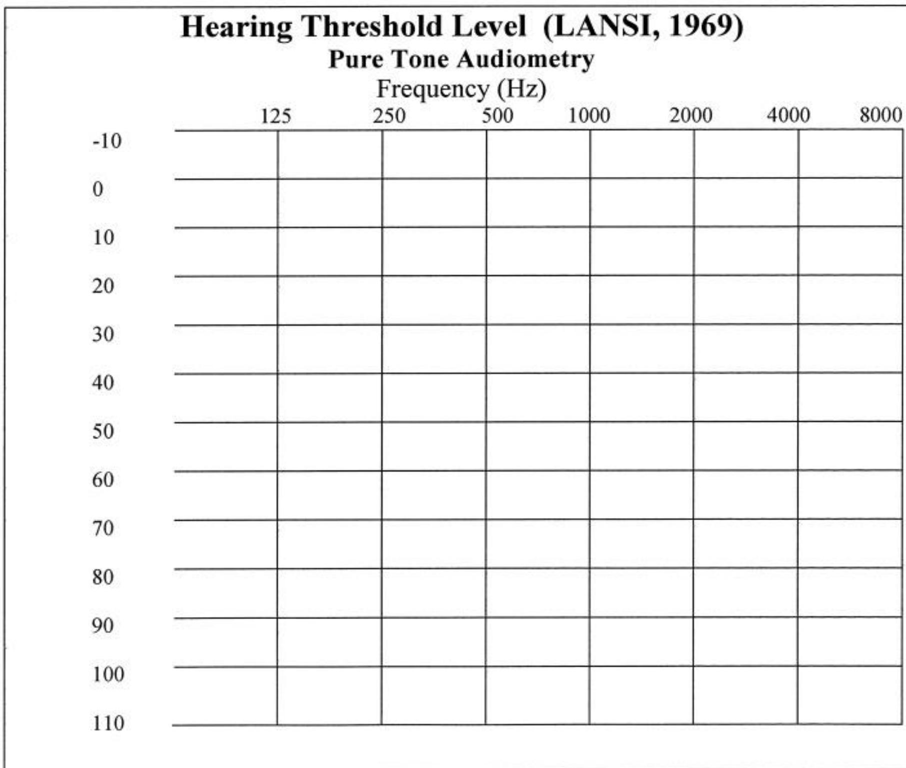
Date | |	Recipient Name	
Medicaid Number		Date of Birth | |
Examiner		

PREVIOUS HEARING AID USE

Previously worn hearing aids? ☐ Yes ☐ No
Number of years worn:
Purchase Date:
Purchased by Medicaid? ☐ Yes ☐ No
Condition of current aid:
Is recipient in a nursing home? ☐ Yes ☐ No (If YES, attach necessary documentation)

REASON FOR NEW HEARING AID

Initial Instrument:
Lost:
Stolen:
Beyond Repair:
Other:
Chief Complaint and History:
Document procedure used to determine benefit for recommended aid:



Speech Audiometry

	Threshold		Discrimination	
			In Quiet	In Noise
	SRT	SAT	SL %	SN %
Left Ear				
Right Ear				
Binaual				
Unaided Sound Field				
Aided Sound Field				

Dispensing Provider
NPI Number
Taxonomy

Audiogram Code	Air Conduction/Bone Conduction					Sound Field	Could Not Test	Did Not Test
No Response	Ear	Un-Masked	Masked	Un-Masked	Masked			
↙	R	O	△	>	⊐	S	CNT	DNT
	L	X	□	<	⊏			

PLOT AIDED RESULTS

MEDICAL RELEASE SIGNATURE

Signature- (Signature stamp not acceptable)	DATE SIGNED		
	Mo.	Dy.	Yr.

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