DOCUMENTATION FOR AUTHORIZATION OF HEARING AIDS

To be filled out by a licensed clinician and submitted with the TAR

1. Name of Patient: _____ Medi-Cal ID#: _____
2. Age_____ Sex: _____ DOB: _____ Examination Date: _____
3. Diagnosis (Otological):_____ Place of Exam: _____
4. Hearing loss: AS _____ AD _____ Onset _____
5. Has the patient ever worn a hearing aid? YES ____ NO _____
   If Yes, Patient has worn a hearing aid for _____ years on the _____ ear.
6. If the request is to replace a current hearing aid, please clarify why a new hearing aid is needed at this time:

   _____

   _____

   _____

   _____
7. The patient has had a complete examination of the ear, nose and throat by me and the patient has the requisite psychological and physical well-being to successfully wear and care for a hearing aid. YES ____ NO ____
8. The audiological evaluation was performed by me _____, or by a licensed audiologist _____under my personal supervision.
9. SIGNATURE: _____ MD/ DO/ NP/ PA

   Name: _____

   Address: _____

   City/State/Zip: _____