Hearing Aid Assistance Program Audiologist Form

This section must be completed by the facility or audiologist dispensing the hearing aid(s)

APPLICANT INFORMATION

Name: _____Date of Birth:_____

Parent/Guardian Name(s):_____

Address: _____City:_____State:_____Zip:_____

PROVIDER INFORMATION

Facility name: _____

Provider name: _____

Provider NPI (National Provider Identification) #: _____State License #: _____

Phone number: _____ Fax number: _____

MEDICAL EVALUATION

As required by the FDA, a prospective hearing aid user must provide a written statement from a licensed physician that the prospective user has been medically evaluated and is a candidate for a hearing aid(s). A hearing evaluation must occur within 6 months prior to the date of purchase of the hearing aid(s). If 18 years of age or older, the prospective user may waive this requirement provided the prospective user signs a waiver statement. Children (age less than 18 years) are not eligible for a waiver.

I (*audiologist name)* _____will obtain the physician's medical clearance necessary for the hearing aid(s) fitting prior to the fitting.

HEARING EVALUATION

Date of evaluation: _____

Type of loss: (check)

Sensorineural R___ L___	Conductive R___ L___	Mixed R___ L___	Auditory Neuropathy Spectrum Disorder R___ L___

Degree of hearing loss

Mild Hearing Loss:_____ *(20 TO 40dB HL)*	Moderate Hearing Loss:_____ *(40 to 60 dB HL)*
Severe Hearing Loss:_____ *(60 to 80 dB HL)*	Profound hearing loss (including deafness):_____ *(+80 dB HL)*

Diagnosis – Include an explanation of barriers resulting from the diagnosis as it relates to this equipment request

How long is this expected to last? Months_____ Indefinitely_____ Permanently_____

HEARING AID INFORMATION

Has consumer used a hearing aid in the past? Yes___ No___

Approximate age of old hearing aid: _____

EQUIPMENT

Manufacturer name: _____Style/model: _____

Hearing aid for: Right Ear___ Left ear___ Binaural____

Usual and Customary Cost of Equipment

Right ear	Left ear	Binaural

Usual and Customary Cost of Initial Ear Mold

Right ear	Left ear	Binaural

☐ I confirm that I will be doing Real Ear Verification

After evaluating this patient, I certify the need for the dispensing of a hearing aid(s)

Audiologist signature: _____ Date: _____

Upon application approval, the Department of Human Services will provide an authorization with the authorized dollar amount the applicant qualifies for to the provider.

FINANCIAL CONTRIBUTION

- The South Dakota Hearing Aid Assistance Program is the payer of last resort after private health insurance or other third-party resources.
- The program only covers the cost of the hearing aids and initial ear molds. It is the responsibility of the provider to separate out any other applicable costs, including fitting and dispensing fees, which will be the responsibility of the consumer.
- Payment will be made directly to the provider. Prior authorization is required.
- Any applicable copayments are the responsibility of the consumer.