NIHB HEARING AID AND HEARING AID REPAIR PRIOR APPROVAL REQUEST FORM

PA#: **DATE:**

Section 1: Client Information

Client's Surname:		Date of Birth: (DD/MM/YY)
Given Name(s):		Sex: M ☐ F ☐
Band #:	Family #:	Client ID#:
Client Address: Client Phone No.: ( )		

Section 2: Background Information (Please complete this section for new or replacement hearing aid requests)

Date of most recent audiometric test (copy required for new or replacement hearing aids):
Has the client ever worked in a noisy environment? Yes ☐ No ☐ If **yes**, type of work and how long.
Is the hearing loss the result of an injury? Yes ☐ No ☐ If **yes**, please indicate when and where:
Has the client ever applied with WCB? Yes ☐ No ☐ If **yes**, please indicate claim number:
Are any of these expenses covered under any other public or private health care plan: Yes ☐ No ☐

Section 3: Initial Benefit Requests, Replacements, and Repairs (for new or replacement hearing aids, a copy of the most recent audiometric test must be included for this section to be evaluated. Current hearing aid information must be included for repair and/or replacement requests).

Benefit Code	Description of Benefit	L Ear	R Ear	Unit Cost	Manufacturer Name	Model No. or Name	Date of Fitting	Serial No.

Reason for request:

Section 4: Provider information

Provider Name:	Provider #:
Provider Address:	
Telephone #:	Fax#:
I hereby certify that the above information is true and complete.	
Provider Signature:	Date:

Secion 5: Decision

If not approved, reason for Denial: