



Prior Approval Request

A. Worker Information

Name:	Date of birth:
Claim number:	
Address:	

B. Clinic Information

Billing Date:	Date :
Clinic:	
Service Provider Name:	
Telephone:	Fax:

C. New User Enclosed : **Audiogram** (required) **Written Report** (required)

D. Previous User

Reasons to Replace Hearing Aids(s) <i>Please check appropriate boxes</i>	L	R	
Inadequate gain available	<input type="checkbox"/>	<input type="checkbox"/>	
Improper fit resulting in feedback	<input type="checkbox"/>	<input type="checkbox"/>	
Significant change in hearing (>20dB at three or more frequencies)	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing aid style inappropriate (e.g. dexterity, acoustical needs)	<input type="checkbox"/>	<input type="checkbox"/>	
Repair is no longer cost effective	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other:			
Enclosed: <input type="checkbox"/> Audiogram (required) <input type="checkbox"/> Real ear measures (required)			
Comments:			

E. Assistive Listening Devices

Please check appropriate boxes	L	R	
FM system	<input type="checkbox"/>	<input type="checkbox"/>	
Amplified Telephone	<input type="checkbox"/>		
<input type="checkbox"/> Other:			

F. Cost Sharing

I agree that since the hearing aid(s) or ALD cost more than what YWCHSB will fund, I will solely be responsible for the additional cost .	
Signature of worker:	
YWCHSB amount: \$	Client amount \$
YWCHSB use only	
Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No Signature of adjudicator:	