



PRIOR APPROVAL REQUEST (Hearing Claims)

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, Telephone: (867) 667-5645, Toll free: 1-800-661-0443, Fax: (867) 667-8740, Website: www.wcb.yk.ca

A - CLINIC INFORMATION

Clinic Address	Date (d/m/y)	
	Clinic Telephone #	Clinic Fax #
	Clinician Name	

B - WORKER INFORMATION

Name	Date of Birth (d/m/y)	Claim Number
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C - USERS

New User Previous User
 Right Left **Invoice Cost Total** _____
 Enclosed: Audiogram (required) Written Report (required)

Comments _____

D - ASSISTIVE LISTENING DEVICES

Please check appropriate boxes	L	R	Invoice Cost
FM System	<input type="checkbox"/>	<input type="checkbox"/>	
Amplified Telephone	<input type="checkbox"/>		
<input type="checkbox"/> Other			

E - 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: \$
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YWCHSB USE ONLY

Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature of Adjudicator _____
Comments _____	

