

SERVICE PROVIDER REPORT (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 - PAYMENT INFORMATION

Date (d/m/y)		Date of Fitting (d/m/y) (will be considered the anniversary date for replacement)	
Clinic Address	Clinic Telephone #	Clinic Fax #	
	Clinician Name		

B - WORKER INFORMATION

Name	Date of Birth	Claim Number
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C - SERVICE DETAILS

Type of Service	Date of Service (d/m/y)	Description	R	L	Total Cost
Hearing assessment		\$75 once every four years	—	—	
Hearing assessment		\$45 once every year	—	—	
H. Aid fitting fee		\$475 per aid once every four years	<input type="checkbox"/>	<input type="checkbox"/>	
H. Aid post fitting (enclose print out of verification measures)		\$75 once every four years	<input type="checkbox"/>	<input type="checkbox"/>	
H. Aid re-adjustment		\$25 once a year	<input type="checkbox"/>	<input type="checkbox"/>	
H. Aid performance		\$25 once a year	<input type="checkbox"/>	<input type="checkbox"/>	
H. Aid return fee		\$50 per aid	<input type="checkbox"/>	<input type="checkbox"/>	
Assistive listening device fitting fee		\$100 once a year	—	—	
In house repair		\$20 three times per year/per aid	<input type="checkbox"/>	<input type="checkbox"/>	
Out of office repair		\$75 per aid once a year	<input type="checkbox"/>	<input type="checkbox"/>	
Ear impressions		\$30 per ear once a year	<input type="checkbox"/>	<input type="checkbox"/>	

Attach manufacturer's invoice for reimbursement for hearing aids and assistive listening devices

Product	R	L	Manufacturer Cost	Total Cost
Hearing aid(s)	<input type="checkbox"/>	<input type="checkbox"/>		
Manufacturer repair	<input type="checkbox"/>	<input type="checkbox"/>		
Ear molds	<input type="checkbox"/>	<input type="checkbox"/>		
Infrared TV system	<input type="checkbox"/>			
FM system	<input type="checkbox"/>			
Telephone	<input type="checkbox"/>			
Other	<input type="checkbox"/>			
			Total Cost: \$	

D - SERVICE PROVIDER

Comments _____ _____ _____
I hereby certify that I have rendered the above goods and/or services to the client named above.
Signature of Clinician _____