**BIGSTONE HEALTH COMMISSION**

Bigstone Health Benefits Medical Supplies and Equipment
Hearing Aid and Hearing Aid Repair Prior Approval Form

BIGSTONE HEALTH COMMISSION PROTECTED WHEN COMPLETED

**Section 1: Patient Information**

| | | |
|---|---|---|
| Patient Name: | | Date of Birth: |
| Patient Address: | | Sex: M ☐ F ☐ |
| Telephone #: | PHN #: | Client ID #: |

**Section 2: Prescriber Information**

| | |
|---|---|
| Prescriber's Name: | License #: |
| Telephone #: | Fax#: |

**Section 3: Client Health Information**

| | | |
|---|---|---|
| Diagnosis: | Reason for request: | |
| Explanation of benefit requirement and specific details of item to be provided:<br><br>Date of most recent audiometric test: | | |
| Is the benefit requested due to the result of an injury: | YES ☐ NO ☐ | If yes, please complete the following: |
| Where did the injury occur:<br>Home: ☐ Work: ☐ Other: ☐ | When did the injury occur?<br>Has the client ever worked in a noisy environment? | |
| Are any of these expenses covered under any other public or private health care plan: | Yes ☐ No ☐ | |

**Section 4: Equipment or Supplies requested**

| Description of benefit \| Left or Right \| Manufacturer and Model \| Serial No. | Benefit Code | Qty | Cost |
|---|---|---|---|
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**Section 5: Provider Information**

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|---|---|
| Provider Name: | Provider Number: |
| Telephone#: | Fax#: |
| I hereby certify that the information is true and complete:<br><br>Provider Signature: | Date: |



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|---|---|
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PLEASE SUBMIT WITH DATED AUDIOGRAM