



Hearing Loss – Request for Funding

WCB claim number: _____

Workers' name: _____ Provincial Health Number: _____

Worker's address: _____ Postal code: _____ Date of birth: _____ (DD/MM/YY)

Clinic name: _____ Clinic number: _____ Provider number: _____

Clinic address: _____ Postal code: _____ Phone: _____ Fax: _____

Employer name: _____

PART I – REQUEST FOR FUNDING OF NEW OR REPLACEMENT HEARING AIDS

A. Hearing aid replacement request (to be completed where worker has a current hearing aid)

Purchase date of current hearing aids: _____ (DD/MM/YY) Model/style: _____

Reasons to replace current hearing aid(s). Check appropriate boxes:

- L and/or R Improper amplification for hearing loss
- L and/or R Improper fit resulting in feedback
- L and/or R Significant change in hearing (20 dB at 3 or more frequencies (500-4,000 Hz)
- L and/or R Hearing aid style is inappropriate (e.g., dexterity)
- L and/or R Repair is no longer cost effective (manufacturer estimated cost of repair:\$ _____)

Other (please explain): _____

B. Description of new hearing aid request

	Manufacturer/Model	Style	Warranty period (>3yrs)
Left ear			
Right ear			

Attach manufacturer's document stamped "not for payment" with invoice.

C. WCB invoicing

Code 202 - Manufacturer's price \$ _____ (not to exceed \$900) + 10% handling fee _____ + \$525 for fitting and first-year visits + handling and shipping fees within the warranty period = \$ _____ per hearing aid.

Is the worker choosing to upgrade to a mid-range or premium model? Yes No

If yes, is the worker aware that the WCB will only pay the fee to a maximum of \$1,515 and includes follow up and service fees for the first year as per the WCB fee schedule? Yes No

Care provider signature: _____ Date: _____ (DD/MM/YY)

Worker signature: _____

Worker signature required if the worker upgrades hearing aid and agrees to pay any additional fees to the hearing instrument provider.



D. WCB RESPONSE

Approved Denied

Date: _____ Case Manager: _____ Phone: _____

PART 2 – REQUEST FOR REPAIRS OR HEARING AID SUPPLIES

A. Request for funding for repair (WCB fee code 205 – billable only after the warranty has expired)

Purchase date of current hearing aid(s): _____ (DD/MM/YY) Warranty expiry date: _____ (DD/MM/YY)

Authorization for repair requested for:

- Hearing aid 3 to 4 years old and repair exceeds \$300
- Hearing aid greater than 4 years old
- Hearing aid between 3 and 4 years old and has been repaired within the last 12 months

Expected cost: \$ _____

Repair history – List date(s) of repair, repair type and cost.

Date: _____ (DD/MM/YY) Repair type: _____ Cost: _____

Date: _____ (DD/MM/YY) Repair type: _____ Cost: _____

Date: _____ (DD/MM/YY) Repair type: _____ Cost: _____

Description of repairs for hearing aid(s):

Code 205 – Explain what needs to be repaired and the steps taken to resolve the issues (e.g., inadequate gain available or feedback/static).

B. Request for supplies for hearing aids

- Receiver is required after warranty expired
- Ear molds (WCB fee code 215) exceeding one mold per ear every 2 years

Expected cost: \$ _____

C. Request for funding for servicing of hearing aid (WCB fee code 214 – only billable after the first year that the WCB prepaid.)

Authorization requested for a visit exceeding the prepaid 2 visits per year. This visit will be # _____ this year.

Reason for additional service visit over 2 per year:

Care provider signature: _____ Date: _____ (DD/MM/YY)

D. WCB response

Approved Denied

Date: _____ Case Manager: _____ Phone: _____