Saskatchewan Workers' Compensation Board

Health Care Services
Email: askwcb@wcbsask.com
Web: www.wcbsask.com/care-providers

200 - 1881 Scarth Street
Regina, Saskatchewan
Canada S4P 4L1
Tel: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll-free fax: 1.888.844.7773

MCARE

WCB claim number: _____

Clinic #: _____ **Provider #:** _____ **PHN:** _____

Tel: _____ **Fax:** _____ **D.O.B:** _____ **Tel:** _____

Employer name: _____

Clinic name, address and postal code:

Worker's name, address and postal code:

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/YYYY) Model/Style: _____

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

- ☐ L or ☐ R – Improper amplification for hearing loss
- ☐ L or ☐ R – Improper fit resulting in feedback
- ☐ L or ☐ R – Significant change in hearing (20 dB at 3 or more frequencies (500-4,000 Hz)
- ☐ L or ☐ R – Hearing aid style is inappropriate (e.g., dexterity)
- ☐ L 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 – SELECT ONE OPTION

☐ SK Hearing Aid Plan fee schedule: Code 202 - Fee $

☐ WCB fee schedule for non-HAP providers: Code 202 - Manufacturer's price $ _____ (not to exceed $900) + 10% handing 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:** _____

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

MCARE

☐ Approved ☐ Denied

Date: _____ **Case Manager:** _____ **Tel:** _____

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/YYYY) Warranty expiry date: _____ (DD/MM/YYYY)

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 (DD/MM/YYYY), type of repair type and cost.

Date: _____ Repair type: _____ Cost: _____
Date: _____ Repair type: _____ Cost: _____
Date: _____ 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:

D. WCB INVOICING

- ☐ SK Hearing Aid Plan fee schedule (please itemize)
- ☐ WCB fee schedule (please itemize using WCB fee codes and descriptors on the invoice)

Care provider signature: _____ **Date:** _____

E. WCB RESPONSE

☐ Approved ☐ Denied

Date: _____ **Case Manager:** _____ **Tel:** _____