MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY
Hearing Aid Services (Rev., July 2003)

HEARING AID EVALUATION

Patient Name, Address, Telephone Number, Date of Birth

Medicaid Number

Audiologist Name, Address, Telephone Number

Referring Physician Name, Address, Telephone Number

Date of Evaluation/Referral ________________________

Diagnosis

Date of Audiological Examination

Audiometric Test Results:

	Right Ear	Left Ear
500Hz	___________ /	____________
1000Hz	___________ /	____________
2000Hz	___________ /	____________
3000Hz	___________ /	____________
Total Average	___________ /	____________
PB Max Level	___________ /	____________

Y / N The two-frequency average at 1 KHZ and 2 KHZ is greater than 40 decibels in both ears.

Y / N The two-frequency average at 1 KHZ and 2 KHZ is less than 90 decibels in both ears.

Y / N The two-frequency average at 1 KHZ and 2 KHZ has an interaural difference of less than 15 decibels.

Y / N Word recognition or speech discrimination score is not greater than 20%.

Comments/Recommendations

I certify that I am the audiologist completing the audiological evaluation for the patient identified in this form. I certify that the information contained in this document and its attachments are true, accurate, complete and supported by clinical information in the patients record. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Audiologist Signature ____ **Date** ______/______/______ *(Stamps Are Not Acceptable)*

Attachments: This form must be accompanied by copies of supporting documentation to include, but not limited to the physician=s referral for hearing aid services, diagnostic and evaluation reports. Attachments are necessary for dispenser to request approval of the hearing aid(s) prior to the actual dispensing of the aid(s).

MONTANA
Department of Public Health & Human Services