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).