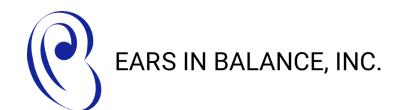


A hearing loss is more conspicuous than a Hearing-Aid.

## GUIDELINES FOR REPLACING LOST OR DAMAGED HEARING AIDS FOR MEDICAID

- 1. Get a notarized letter stating how you lost the hearing aid and the reason you seek replacement
- 2. We will need a proof that your home or any other insurance will not replace hearing aids
- 3. Once you have all these documents, please schedule an appointment with Ears In Balance for a new hearing test.
- 5. We will need all the above to process your replacement hearing aids.

Ears in Balance, Inc



Patient Name:	
Date of Birth:	
Insurance:	
Insurance ID#:	
Date of Incident:	
Purpose: To file	e a loss & damage claim
Circle One: Heari	ng Aid(s): Left / Right / Both
Hearing Aid(s) we	re: Lost / Damaged / Stolen
Description of how the aids were lost or	stolen:
Description of why replacement aids are	needed:
Patient Signature	-
Signature of Notary Public	_
Na	me of Notary Public
Dat	e
	vy, Ste 216, Farmington Hills MI 48334
	oh, Suite 100 Taylor, MI 48180 Iephone: (248) 900 EARS (3277)
	mation@earsinbalance.org
Fax	к : (888) 779 4710



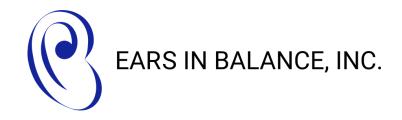
Date:		
To: Physician		
Insurance :		
Re : Name:	ID:	DOB:

'Patient has a hearing loss and has worn hearing aids. He/She has lost them and is seeking replacement through the Medicaid program. Please evaluate hearing and at this time he/she is medically clear to get replacement hearing aids.'

Please fax the clearance to (888) 779 4701 or email it to <u>information@earsinbalance.org</u>. Call us at (248) 900 3277 with any questions or clarifications.

Thank you,

Ears In Balance, Inc



## REFERRAL AND MEDICAL CLEARANCE

Date of referral:

Patient Name:

Date of Birth:

Medicaid ID:

To: Ears in Balance, Inc

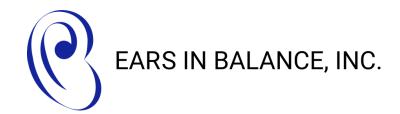
The above patient was seen by me, and it is determined that she/he has a hearing. loss which cannot be treated medically. At this time, she/he may be best suited. for hearing aids which will help her/him in communication and hearing. Referring patient to your office for further evaluation

The patient is medically clear for hearing aids.

Please do not hesitate to call my office with any questions.

**Physician Signature:** 

Physician Name: NPI:



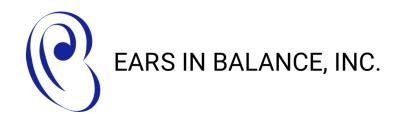
Date: \_\_\_\_\_

To whom it may concern,

I \_\_\_\_\_\_, have lost or damaged hearing aid(s). I certify that I currently do not have homeowner's/renter's insurance which would cover the cost of the replacement hearing aids.

I am requesting that my insurance cover the cost of replacement hearing aids in full at this time. I am aware that my health insurance company may verify the above stated information. If they determine that I have homeowner's or renter's insurance policy which will cover the cost of my replacement hearing aids, at that time I will be responsible to pay the cost in full.

Patient Signature



Date: \_\_\_\_\_

To whom it may concern,

Insured Policyholder's Name is currently a policy holder of

\_\_\_\_\_ homeowner's insurance. This policy does not cover the cost of replacement hearing aids due to loss or damage.

I \_\_\_\_\_\_\_ am aware of this policy and I am currently requesting that my health insurance company cover the cost of the replacement hearing aids. I am also aware that my health insurance company may verify the above stated information. If it is determined that I have other homeowner's insurance that will cover replacement hearing aids and I do not disclose that information, I will be responsible for the full cost of the replacement hearing aids.

Patient Name (print)

Patient Signature

Insurance Rep Name (print)

Insurance Rep Signature