

Timeding loss is more conspicuous than a realing that.

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 and order the replacement hearing aids..
- 4. We will need a letter of medical clearance from your doctor saying that you have lost the hearing aids and need new set and are medically clear to get the hearing aids.
- 5. We will need all the above to process your replacement hearing aids.

Ears in Balance, Inc

31313 Northwestern Hwy, Ste 216, Farmington Hills MI 48334 10501 Telegraph, Suite 100 Taylor, MI 48180 Telephone: (248) 900 EARS (3277)

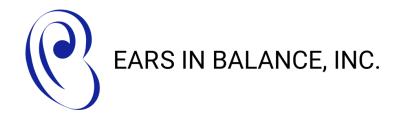
Email: information@earsinbalance.org

Fax: (888) 779 4710

Patient Name:			
Date of Birth:			
Insurance:			
Insurance ID#:			
Date of Incident:			
	Purpose: To file a l	oss & damage claim	
	Circle One: Hearing A	Aid(s): Left / Right / Both	
	Hearing Aid(s) were: I	ost / Damaged / Stolen	
Description of how the	aids were lost or sto	en:	
Description of why rep		eded:	
Patient Signature			
Signature of Notary Pub	lic		
	Name	of Notary Public	
	Date		

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Date:		
To: Physician		
Insurance :		
Re : Name:	ID:	DOB:
0 (" : "	N. II. 1	
Our office is requesting a	Medical clearance for:	to receive new hearing aids within the
5-year frequency due to lo	oss and damage. Per Medicaid gui	delines, the patient is entitled to a replacement set
of hearing aids upon losir	ng or damaging them as well as the	eft after the first year of manufacturer's warranty.
Please write a medical cle	arance for the above patient. You	can use the following sentence:
'Patient has a hea	ring loss and has worn	hearing aids. He/She has lost
them and is seek	ing replacement throug	the Medicaid program. Please
evaluate hearing	and at this time he/she	is medically clear to get
replacement hear	ing aids.'	
Please fax the clearance to	o (888) 779 4701 or email it to <u>infor</u>	mation@earsinbalance.org. Call us at (248) 900 3277
with any questions or clar	rifications.	
Thank you,		
Ears In Balance, Inc		

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REFERRAL AND MEDICAL CLEARANCE

Date of referral:
Patient Name:
Patient Address:
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:
Individual NPI:

Date:	
To whom it may concern,	
I certify that I currently do not have homeow the cost of the replacement hearing aids.	, have lost or damaged hearing aid(s). I vner's/renter's insurance which would cover
Patient Signature	

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Date:	
To whom it may concern,	
Insured Policyholder's Name	_ is currently a policy holder of
homeo	wner's insurance. This policy does not cover the to loss or damage.
requesting that my health insurance caids. I am also aware that my health information. If it is determined that I have	am aware of this policy and I am currently ompany cover the cost of the replacement hearing nsurance company may verify the above stated ave other homeowner's insurance that will cover t disclose that information, I will be responsible for g aids.
Patient Name (print)	Patient Signature
Insurance Rep Name (print)	Insurance Rep Signature

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