EARS IN BALANCE, INC.

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 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

EARS IN BALANCE, INC.

Patient Name: _____

Date of Birth: _____

Insurance: _____

Insurance ID#: _____

Date of Incident: _____

Purpose: To file a loss & damage claim

Circle One: Hearing Aid(s): Left / Right / Both

Hearing Aid(s) were: 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

_____Name of Notary Public

_____ Date

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EARS IN BALANCE, INC.

Date:

To: Physician

Insurance : _____

Re : Name: _____ ID: _____ DOB: _____

Our office is requesting a Medical clearance for: _____ to receive new hearing aids within the 5-year frequency due to loss and damage. Per Medicaid guidelines, the patient is entitled to a replacement set of hearing aids upon losing or damaging them as well as theft after the first year of manufacturer's warranty.

Please write a medical clearance for the above patient. You can use the following sentence:

'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 information@earsinbalance.org. Call us at (248) 900 3277 with any questions or clarifications.

Thank you,

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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: _____

EARS IN BALANCE, INC.

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

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EARS IN BALANCE, INC.

Date: _____

To whom it may concern,

_____ is currently a policy holder of
Insured Policyholder's Name

_____ 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

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