Hearing Aid Prescription/Clearance Form

This form is **required** for those with asymmetrical hearing loss, for those in select health plans, or as determined by the hearing professional. By requesting your physician to complete this form, you authorize him/her to forward it to *hi HealthInnovations*.

Physicians

Please submit this form to indicate that this individual may be considered a candidate for hearing aids. The FDA only allows physicians to sign this form. Nurse practitioners, physician assistants, audiologists and doctorates of audiology cannot sign this form.

Patient Name _____ **Phone** _____

DOB _____

I have evaluated this individual within the last six months, and he/she may be considered a candidate for hearing aid(s).

Physician Name (Print) _____

Physician Signature _____

Physician Phone Number _____

Date_____

Dx. Code (select one):

- ☐ H90.3 – Sensorineural hearing loss, bilateral, both ears
- ☐ H90.41 – Sensorineural hearing loss, unilateral, right ear
- ☐ H90.42 – Sensorineural hearing loss, unilateral, left ear
- ☐ Other: _____

Physician office stamp (if available):

Return to *hi Healthinnovations*: **FAX** 877-955-4336 **Mail**: P.O. Box 356, Minneapolis, MN 55440