MEDICAL CLEARANCE AND AUDIOMETRIC TEST FORM

The *Medical Clearance and Audiometric Test Form* must be used for all hearing aid fittings under the Indiana Health Coverage Programs. This form must be completed and carry the proper signature where indicated, before requests will be considered for prior authorization.

PART I Member History

Member's Name	RID	Age
If Institution, Admission Date	Previous Institution	

If unable to independently maintain the member's hearing aid, are there resources available to assist in maintenance?
◯ Yes ◯ No
Explain:

Medical Diagnosis	Hearing Diagnosis

Has this member worn a hearing aid previously? ◯ Yes ◯ No	If so, purchase dates	IHCP Purchased?

If member owns and/or wears or previously owned and/or wore amplification, indicate where the hearing aid is or was worn; include the model and status of the instrument and settings.

PART II Medical Clearance
(to be completed by physician)

A hearing aid will not be approved for a patient prior to that patient's having had a medical examination. Preferably, this examination should be conducted by an otolaryngologist, if available and accessible, but a basic medical survey as indicated in this section can be performed by a licensed physician. All children under 15 years of age must be seen by an otolaryngologist before the hearing aid is fitted. The following minimal assessment is required before the fitting of any hearing aid:

1. Is there any evidence of infection or drainage from either ear?	◯ Yes ◯ No
2. Is there any significant headache, vertigo, dizziness, nausea, or vomiting?	◯ Yes ◯ No
3. Has the hearing loss been sudden in onset?	◯ Yes ◯ No
4. Is the patient able to hear and understand speech at conversational level?	◯ Yes ◯ No
5. Presence of pus in the eardrum?	◯ Yes ◯ No
6. Perforation of the eardrum?	◯ Yes ◯ No
7. Impacted cerumen?	◯ Yes ◯ No
8. Presence of external ear canal infection?	◯ Yes ◯ No
9. The possibility of the complete closure of the ear canal?	◯ Yes ◯ No

Remarks:

I certify that I have examined the patient mentioned above and to my knowledge there is no medical or surgical contraindication to wearing a hearing aid.

Otologic Diagnosis:

◯ I recommend the patient to be fitted for a hearing aid. ◯ I recommend the patient be referred for future medical evaluation.	Signature of Physician	Date

PART III Audiological Assessment
(to be completed by audiologist or otolaryngologist)

Member's Name	Age	RID

RE ANSI 1969

Frequency	500	1000	2000	3000	Speech	Right	Left
Left-Air					SRT		
Left-Bone					Word Recognition (WRS)	/50 dbHL	/50 dbHL
Right-Air					Word Recognition (WRS)	/MCL	/MCL
Right-Bone							

Validity of Test Results: ◯ Good ◯ Fair ◯ Poor Special Tests:

Hearing Aid recommended for: ◯ Left ◯ Right ◯ Binaural ◯ Hearing Aid not recommended

Recommendation information:

Signature (Testing conducted by Audiologist or Otolaryngologist)	Date

If pure tone testing indicates a bone-air gap of 15 decibels (dB) or more for two adjacent frequencies on the same ear, or if speech discrimination tests indicate a score of less than 60% in either ear, or if hearing loss in one ear is greater than the other ear by 20 decibels (dB) in the pure tone average or 20% in the discrimination score, the patient must be referred for further assessment by an otolaryngologist, providing the physician has not already considered these conditions.

PART IV Hearing Aid Evaluation
(to be completed by audiologist or hearing aid dealer)

Ear	Left Aided	Right Aided	Unaided Left	Unaided Right	Binaurally Aided
Make/Model					
SRT					
MCL					
PB Quiet					
PB Noise (+5 S/N)					
PB Level					

Special Conditions:

Signature (Evaluation conducted by Audiologist or Hearing Aid Dealer)	*Date*

PART V Hearing Aid Contract
(to be completed by audiologist or hearing aid dealer)

Should there be complaints from a member, and/or other responsible persons directly interested in the member, as to the user's failure to receive satisfactory benefits from the instruments, the Indiana State Registered Hearing Aid Dealer must attempt to make satisfactory adjustment or follow the recommendation as deemed advisable by the IHCP. Failure to do so may cause payment to be withheld. If payment has been received by the Indiana State Registered Hearing Aid Dealer, the full refund will be made to the contractor.

There is to be no solicitation of IHCP patients, for the purpose of fitting hearing aids. As a general policy, there are to be no replacement hearing aid fittings for IHCP patients where the hearing aid in use is less than five years old.

"I have read the regulations and standards adopted and approved by the IHCP for the fitting and dispensing of hearing aids for IHCP cases and I have followed the procedures provided therein."

Audiologist/Hearing Aid Dealer's Signature	*Indiana License/Registration No.*	*Date*