Indigenous Services Canada | Services aux Autochtones Canada

CLEAR PRINT

Protected

NIHB HEARING AID AND HEARING AID REPAIR PRIOR APPROVAL FORM

☐ Hearing Devices Initial Request ☐ Hearing Devices Replacement

Section 1: Client Information

Surname:	Given Name(s):	Date of Birth (YYYY/MM/DD):
Client ID #:	Band #:	Sex: M☐ F☐
Address:		Phone #:
City :	Province / Territorv:	Postal Code :

Section 2: Parent/Legal Guardian/Representative (If the client is under 18 months of age and not registered, please provide parent's information.)

Surname:	Given Name(s):	Date of Birth (YYYY/MM/DD):
Client ID #:	Band #:	Phone #:

Section 3: Prescriber Information (PLEASE PRINT)

Name and Title:	License #:
Phone #:	Fax #:
Hearing Test Performed by (Name):	Title:

Section 4: Client Health Information (Please complete this section for new or replacement hearing aid requests)

Diagnosis:	Reason for request:
Date of most recent audiometric test (copy required for new or replacement hearing aids): * Test must be less than 6 months old.	Has the client previously applied for a hearing aid with the Workers Compensation Board? Yes ☐ No ☐ If **yes**, please indicate claim number:
Is the hearing loss the result of an injury? Yes ☐ No ☐ If **yes**, please indicate when and where:	
Has the client previously worked in a noisy environment? Yes ☐ No ☐ If **yes**, type of work and how long:	
Are any of these expenses covered under any other federal, provincial, territorial or private health care plan? Yes ☐ No ☐ If **yes**, provide the details:	

Section 5: Initial Benefit Request, Replacement, and Repair (For new or replacement hearing aids, a copy of the most recent audiometric test (no older than 6 months) must be included for this section to be evaluated. Current hearing aid information must be included for repair and/or replacement requests).

Benefit Code	Description of Benefit	Ear		Unit Cost	Manufacturer Name	Model # or Name & Size	Date of Fitting (for repair only)	Serial No.
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		☐	☐					
		☐	☐					
		☐	☐					
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		☐	☐					

Section 6: Provider Information (PLEASE PRINT)

Name and Title:	Provider #:
Phone #:	Fax #:
I hereby certify that the information provided above is true and complete. The NIHB Program reserves the right to request this form for audit purposes. Provider Signature: Date:	

Privacy statement: The personal information you provide to Indigenous Services Canada (ISC) is governed in accordance with the Privacy Act. We only collect the information needed to administer the NIHB Program. Collection of information for this purpose is authorized by statute. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the Privacy Act. For more information: This personal information collection is described in Info Source, available online at infosource.gc.ca. In addition to protecting your personal information, the Privacy Act gives you the right to request access to and correction of your personal information. For more information, please contact ISC's ATIP Coordinator. Contact information can be found at www.tbs-sct.gc.ca/hgw-cgf/oversight-surveillance/atip-aiprp/coord-eng.asp. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

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