Print Form

Health Canada / Santé Canada

Health Canada Protected

NIHB HEARING AID AND HEARING AID REPAIR PRIOR APPROVAL FORM

Section 1: Client Information

Surname:		Date of Birth: (YYYY/MM/DD)	
Given Name(s):		Sex: M ☐ F ☐	
Street Address:		City:	
Province/Territory:		Postal Code:	
Client ID #:	[OR] Band #:	Family #:	

Section 2: Parent/ Legal Guardian/ Representative

If client is under one year of age and not registered, please provide parent's information.

Surname:		Given Name:		Date of Birth: (YYYY/MM/DD)	
Client ID#:		[OR] Band #:		Family #:	

Section 3: Prescriber Information (PLEASE PRINT)

Name and Title:		License / Billing #:	
Telephone #:		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 ever applied for a hearing aid with WCB? 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 ever 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 ☐	

Section 5: Initial Benefit Requests, Replacements, and Repairs (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.
		L	R					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					
		☐	☐					

Section 6: Provider Information

Name and Title:		Provider #:	
Telephone #:		Fax #:	

Section 7: Hearing Aid and Hearing Aid Repair Confirmation

Please complete this section after prior approval is obtained and the client has been fit with the hearing aid. Fax this form with a copy of the manufacturer's invoice to the Health Canada regional office.

Prior Approval Number:		Date of Service: (YYYY/MM/DD)	
I hereby certify that the information provided above is true and complete, and that the above-named client has received and is satisfied with the equipment and instruction and the equipment dispensed and fitting is appropriate to meet the client's needs. I will provide appropriate follow-up during the warranty period. The NIHB Program reserves the right to request this form for audit purposes.			
Provider Signature:		Date:	

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Privacy statement

MS&E providers are required to comply with the NIHB Program's Privacy Code. The code can be found on the Health Canada Web site at: http://www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_priv/2005_code/index-eng.php