MISSOURI TITLE XIX (MEDICAID) HEARING AID PROGRAM

MO-8811 (Rev. 7/85)

REPORT OF HEARING AID EVALUATION

A. PATIENT IDENTIFICATION

1. PATIENT'S NAME (From Family Services ID Card)	2. Date of Birth	3. Family Services Identification Number

B. PHYSICIAN'S EXAMINATION AND CERTIFICATION

1. PHYSICIAN'S NAME	2. ☐ M.D. ☐ D.O. ☐ Otolaryngologist	3. Physician's Provider No. (if applicable)
4. PHYSICIAN'S ADDRESS		5. Physician's Telephone Number

6. Date of Exam: ______________________ 7. Diagnosis: ______________________

8. Based on your examination, are you aware of any physical or mental condition which would prevent this patient from deriving reasonable benefits from a hearing aid? ______________ If answer is yes, please explain in Comments Section.

9. Are there otologic symptoms or problems that require further evaluation or care? ______________ If yes, please explain in Comments Section.

10. Do you recommend a hearing aid for this patient? __________, R. __________, L. __________, Either __________

11. COMMENTS

12. I CERTIFY THAT THE INFORMATION IN THIS SECTION IS BASED ON MY EXAMINATION OF THIS PATIENT.

____
(SIGNATURE OF PHYSICIAN)

____
(DATE)

C. AUDIOMETRIC TESTING AND CERTIFICATION

1. PROVIDER'S NAME	2. Physician ☐ Audiologist ☐ Hearing Aid Dealer/Fitter ☐	3. Provider's Phone No.	4. Provider's Medicaid No.

In the Following Fields, Note Masked Thresholds and Scores with an Asterisk (E.G., 95*)

5. PURE-TONE THRESHOLDS (db HL, ANSI-1969)

Air Conduction

Hz–	250	500	1000	2000	3000	4000	5000	6000
RE								
LE								

Bone Conduction

RE								
LE								

6. SPEECH THRESHOLDS (db HL FOR SPEECH)

SRT RE: ________dBHL LE: ________dBHL

(Wordlist ______________________: Tape ________ MLV ________)

Most Comfortable Level RE: ________ dBHL LE: ________ dbHL

Discomfort Level RE: ________ dBHL LE: ________ dbHL

7. SPEECH DISCRIMINATION (PERCENT CORRECT)

(Wordlist ______________________: Tape ________ MLV ________)

RE: ________% at ________ dBHL LE: ________% at ________ dBHL

8. DATE OF TESTS

9. RECOMMENDATIONS

10. CERTIFICATION:

a. I CERTIFY THAT I PERFORMED THE TESTS IN THIS SECTION FOR THE PURPOSE OF PRESCRIBING A HEARING AID.

____
(SIGNATURE) (DATE)

b. I CERTIFY THAT I PERFORMED THE TESTS IN THIS SECTION.

____
(SIGNATURE) (DATE)

NOTE: Sign EITHER a. or b. Certification in a. is required if Medicaid is to be billed for the tests.

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D. INSTITUTIONALIZED/NURSING HOME RECIPIENTS ONLY

1. I CERTIFY THAT I INITIATED THE REQUEST FOR A HEARING AID AND AUTHORIZE THE HEARING AID PROVIDER TO RENDER SERVICE TO ME

(SIGNATURE OF PATIENT) (DATE)

2. I CERTIFY THAT THE RECIPIENT INITIATED THE REQUEST FOR A HEARING AID AND THE HEARING AID PROVIDER HAS SECURED MY APPROVAL TO RENDER SERVICE TO THIS PATIENT.

(SIGNATURE OF INSTITUTIONAL ADM.) (DATE)

E. HEARING AID FITTING AND CERTIFICATION

1. PROVIDER'S NAME	2. Provider's Medicaid No.	3. Date of Fitting	4. Ear Fitted L ☐ R ☐	5. Approximate Gain

6. AID FITTED

Style Make: Model: Serial Number:

7. I CERTIFY THAT I PROVIDED THE SERVICES REPORTED IN THIS SECTION.

(SIGNATURE) (DATE)

F. POST FITTING HEARING AID EVALUATION

1 PROVIDER'S NAME	2. PROVIDER'S MEDICAID NO.	3. DATE OF EVALUATION

4. Select and complete a, b, or c.

a. ______ Recommended aid was preferred by the patient using free running speech to evaluate performance.

b ____ Sound field measurements:

Aided SRT = ____ dBHL

Aided speech discrimination = ___% at ________ dBHL.

c. ___ Hearing aid not recommended (Explain in Section G.)

5 I CERTIFY THAT THE AID SPECIFIED IN SECTION E WAS DISPENSED AND THAT REASONABLE AND OPTIONAL BENEFITS WERE DERIVED

SIGNATURE. ____________ DATE: ____________

G. COMMENTS