

IHCP MEDICAL CLEARANCE AND AUDIOMETRIC TEST

Instructions: 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 Number	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? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain:		
Medical Diagnosis	Hearing Diagnosis	
Has this member worn a hearing aid previously? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, purchase dates	IHCP Purchased?
If member previously owns/wears amplification, give the model and status of the instrument and settings.		
PART II Medical Clearance (to be completed by physician)		
<i>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 below 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:</i>		
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:		
<input type="checkbox"/> I recommend the patient to be fitted for a hearing aid. <input type="checkbox"/> 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 Number	
<i>RE ANSI 1969</i>								
Frequency	500	1000	2000	3000	4000	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: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor						Special Tests:		
Hearing Aid recommended for: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Binaural <input type="checkbox"/> 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 (2) adjacent frequencies on the same ear, or if speech discrimination tests indicate a score of less than 60 percent in either ear, or if hearing loss in one (1) ear is greater than the other ear by 20 decibels (dB) in the pure tone average or 20 percent 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)		
<p><i>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.</i></p> <p><i>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></p> <p><i>"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."</i></p>		
Audiologist/Hearing Aid Dealer's Signature		Date
Indiana License/Registration No.		Date