EARS IN BALANCE, INC.

A hearing loss is more conspicuous than a Hearing-Aid.

GUIDELINES FOR REPLACING LOST OR DAMAGED HEARING AIDS FOR MEDICAID

1. Get a notarized letter stating how you lost the hearing aid and the reason you seek replacement

2. We will need proof that your home or any other insurance will not replace hearing aids

3. Once you have all these documents, please schedule an appointment with Ears In Balance for a new hearing test.

4. We will need a letter of medical clearance from your doctor saying that you have lost the hearing aids and need a new set and are medically clear to get the hearing aids. They will need to sign and date the attached form.

5. We will need all the above to process your replacement hearing aids.

Ears in Balance, Inc

31313 Northwestern Hwy, Ste 216, Farmington Hills MI 48334
10501 Telegraph, Suite 100 Taylor, MI 48180
Telephone: (248) 900 EARS (3277)
Email: information@earsinbalance.org
Fax : (888) 779 4701

EARS IN BALANCE, INC

Patient Name: _____

Date of Birth: _____

Insurance: _____

Insurance ID#: _____

Date of Incident: _____

Purpose: To file a loss & damage claim

Circle One: Hearing Aid(s): Left / Right / Both

Hearing Aid(s) were: Lost / Damaged / Stolen

Description of how the aids were lost or stolen:

_____
_____
_____
_____
_____
_____
_____

Description of why replacement aids are needed:

_____
_____
_____
_____
_____
_____

_____
Patient Signature

_____
Signature of Notary Public

_____Name of Notary Public

_____ Date

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EARS IN BALANCE, INC.

Date:

To: Physician

Re : Name: DOB:

Our office is requesting a medical clearance for this patient to receive new hearing aids within the 5-year frequency due to loss and damage. Per Medicaid guidelines, the patient is entitled to a replacement set of hearing aids upon losing or damaging them as well as theft after the first year of manufacturer's warranty.

Please sign the attached medical clearance which is formatted to the Medicaid Language

Please fax the clearance to (888) 779 4701 or email it to information@earsinbalance.org. Call us on (248) 900 3277 with any questions or clarifications.

Thank you,

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REFERRAL AND MEDICAL CLEARANCE

Date of referral:

Patient Name:

Date of Birth:

Address:

Medicaid ID:

To: Ears in Balance, Inc/Rajashree Natarajan AUD CCC-A

The above patient lost their current hearing aids. They have a hearing loss which cannot be treated medically. The patient needs replacement hearing aids and is medically cleared for it.

If the patient gets hearing aids, I also authorize batteries, earmolds and supplies to be given as needed to this patient as long as they are in possession of the hearing aids.

Please do not hesitate to call my office with any questions.

Physician Signature: _____

Physician Name: _____

Individual NPI: _____

EARS IN BALANCE, INC

Date: _____

To whom it may concern,

_____ is currently a policy holder of
Insured Policyholder's Name

_____ homeowner's insurance. This policy does not cover the cost of replacement hearing aids due to loss or damage.

I _____ am aware of this policy and I am currently requesting that my health insurance company cover the cost of the replacement hearing aids. I am also aware that my health insurance company may verify the above stated information. If it is determined that I have other homeowner's insurance that will cover replacement hearing aids and I do not disclose that information, I will be responsible for the full cost of the replacement hearing aids.

_____ _____
Patient Name (print) Patient Signature

_____ _____
Insurance Rep Name (print) Insurance Rep Signature

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EARS IN BALANCE, INC

Date: _____

To whom it may concern,

I _____, have lost or damaged hearing aid(s). I certify that I currently do not have homeowner's/renter's insurance which would cover the cost of the replacement hearing aids.

I am requesting that my insurance cover the cost of replacement hearing aids in full at this time. I am aware that my health insurance company may verify the above stated information. If they determine that I have homeowner's or renter's insurance policy which will cover the cost of my replacement hearing aids, at that time I will be responsible to pay the cost in full.

_____
Patient Signature

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