NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Medicaid and Long-Term Care

Physician's Report on Hearing Loss

Patient Name	Age of Patient

HISTORY

Is there a history of?

☐ Dementia/Alzheimer's ☐ Severe Arthritis ☐ Chronic Middle Ear Pathology
☐ Visual Impairment ☐ Cognitive/Development Concerns

Does the patient wear glasses?

○ Yes ○ No

Other handicapping/medical conditions

Does the patient have the cognitive ability to use a hearing aid (remembers when to wear hearing aid, how and when to change batteries, and how to care for a hearing aid? ○ Yes ○ No

Are there support services available as needed? ○ Yes ○ No

Does the patient have adequate manual dexterity to use a hearing aid.? (Can place and remove HA, replace batteries, adjust hearing aid).

☐ Yes ☐ No

If no, does patient have access to support services for these functions? ○ Yes ○ No

Living arrangements

☐ Lives alone at home ☐ Lives at home with assistance ☐ Nursing facility ☐ Other

TO THE PHYSICIAN

The individual named above is a recipient of assistance. Medical findings on this form will be used in determining the need and advisability of providing a hearing aid.

PHYSICIAN'S EXAMINATION

Positive ear, nose and throat findings:

Diagnosis:

Do you feel a hearing aid will help this patient? ○ Yes ○ No

Recommendations and/or comments:

Date of Examination	Physician's NPI number	
Typed Name of Physician		**Sign Here** _____ Signature of Examining Physician

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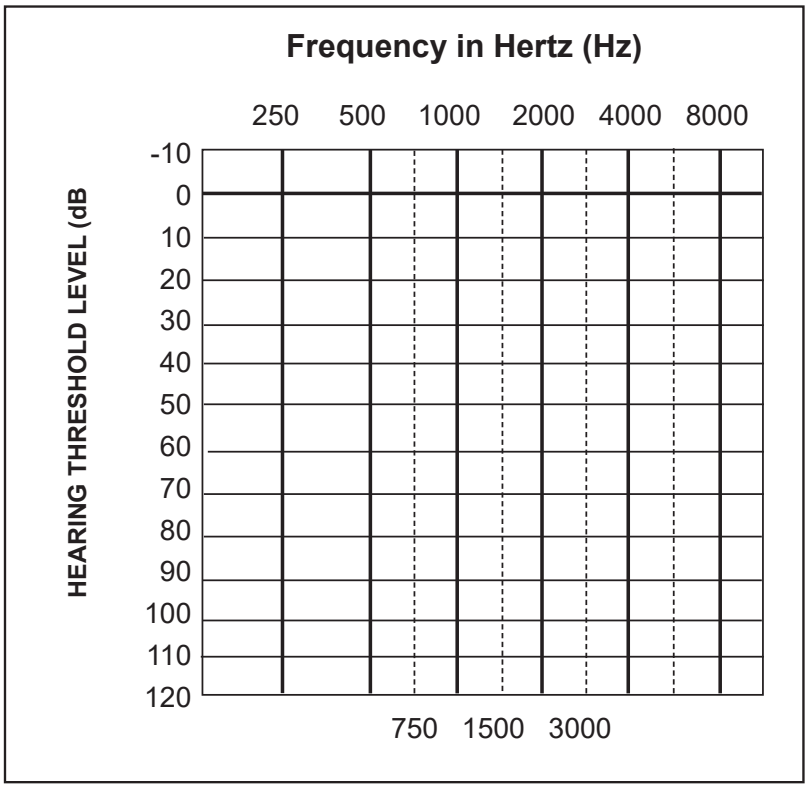
(DO NOT USE previous version 3/12)

HEARING EVALUATION

Patient Name	Medicaid ID	Age of Patient	Test Date	Name of Tester

Stability of Hearing Loss	Previous HA Use	HA Style	Age of HA	Reason for Replacement
☐ Stable ☐ Progressive ☐ Fluctuating	○ Yes ○ No			

Complete this chart by hand



Ear	SRT	Word Recognition	
HL	%		
Right			
Left			

Additional Test Results/Comments:

Hearing Aid Recommended

Ear	Manufacturer	Model	Style	Technology	Warranty (years)	Loss & Damage (years)	Approx. Invoice Cost (each)
			☐ BTE ☐ ITE				
			☐ BTE ☐ ITE				

Provider Name:	Phone Number:	Email Address:
NPI:	Taxonomy:	9-digit zip code: