UIC

PHYSICIAN RECOMMENDATION FOR HEARING AIDS (05.32)

DIVISION OF SPECIALIZED CARE FOR CHILDREN

Child's Name_____

Address_____

_____

City/Zip_____

Birthdate_____

Diagnosis (with ICD Code)_____

_____

I have reviewed the audiological/hearing aid evaluation report of_____

The above named child was examined on (date)_____

1. This patient:

RIGHT EAR	LEFT EAR
☐ Can use amplification ☐ Cannot use amplification	☐ Can use amplification ☐ Cannot use amplification

Reason for Denial _____

Other tests recommended _____

2. Audiologic evaluations should be completed:

☐ Annually ☐ As recommended by Audiologist

Other_____

3. Medication needed_____

_____

4. Other services needed_____

_____

5. I would like to see this child again in_____

6. Bill Attached ☐ Yes ☐ No EOB Attached ☐ Yes ☐ No

_____ _____

Physician's Signature Address

_____ _____

Physician's Printed Name City, State, Zip

_____

Phone

Please return to:

Start Over