Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

Explanation of Necessity for Hearing Aids

CONSUMER INFORMATION

Consumer name: _____ Consumer Medicaid ID #: _____
Consumer address: _____ Date of birth: _____/_____/_____
Age: _____

PROVIDER INFORMATION

Provider name: _____
Provider Medicaid ID#: _____ Provider NPI #: _____
Provider contact person: _____
Phone number: _____ Fax number: _____

I. MEDICAL EVALUATION

Check the appropriate box(es).

Etiology of Loss:

Cochlear damage	☐ R	☐ L
Otitis media	☐ R	☐ L
Otosclerosis	☐ R	☐ L
Congenital	☐ R	☐ L
Other_____	☐ R	☐ L

Patient History:

Family history of hearing loss?	☐ Yes	☐ No
Voice affected?	☐ Yes	☐ No
Legally blind?	☐ Yes	☐ No

Comments:

I have medically evaluated this consumer's hearing loss and he/she is a candidate for a hearing aid(s) in the:

☐ Right ear only ☐ Left ear only ☐ Either ear ☐ Binaural

Physician signature: _____ Date: ____/____/_____

II. HEARING EVALUATION

Date tested: ____/____/_____ Tested by: (check) ☐ ENT ☐ Audiologist ☐ Hearing aid specialist
Name: _____
Address:

Type of Loss: (check)

Sensorineural	☐ R	☐ L
Conductive	☐ R	☐ L
Mixed	☐ R	☐ L

Pure Tone Air Conduction

	250	500	1000	2000	3000	4000	6000	8000	HZ
RE									
LE									

Masking: (check) ☐ Yes ☐ No

Pure Tone Bone Conduction

	500	1000	2000	4000

Masking: (check) ☐ Yes ☐ No

Kansas Department of Health and Environment
Division of Health Care Finance

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II. HEARING EVALUATION continued

SPEECH RECEPTION THRESHOLD (Check how obtained)
MLV_____ Tape Recording _____ Disc Recording _____
Air conduction: RE _____ LE _____ MCL RE _____ LE _____
Masking: (check) ☐ Yes ☐ No UCL RE _____ LE _____

SPECH DISCRIMINATION (Check how obtained)
MLV_____ Tape Recording _____ Disc Recording _____

Word Recognition
RE _____% LE _____% Test(s) used: _____
Masking: (check) ☐ Yes ☐ No

Specialist signature: _____ Date: ____/____/_____

Provider Medicaid ID #: _____

Comments:

III. CERTIFICATION FOR DISPENSING OF HEARING AID

(Must be signed by the person who performed the hearing evaluation in Section II.)

Verification for fitting: (check) ☐ ENT ☐ Audiologist ☐ Hearing aid specialist

Hearing aid for: (check) ☐ Right ear ☐ Left ear ☐ Binaural

Hearing Aid Evaluation:

Preferred style of hearing aid(s): (check) ☐ ITE ☐ BTE ☐ Body Aid ☐ Cros ☐ BiCros ☐ Optic

After evaluating this person, I certify the need for the dispensing of a hearing aid(s).

Specialist signature: _____ Date: ____/____/_____

Provider Medicaid ID #: _____

If fitting binaural aids, test must include the consumer's speech reception thresholds and speech discrimination ability under:
1) Standard listening conditions using earphones
2) Listening with a monaural fitting and listening with a binaural fitting
Please attach appropriate documentation.

(***NOTE:*** If requesting binaural aids for consumers over 21, please note if consumer is legally blind, has occupational requirements for binaural listening or previous use of binaural aids. This information must be attached or appear on this form to be considered for prior authorization.)

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IV. FINAL FITTING

Has consumer used a hearing aid in the past? (check) ☐ Yes ☐ No

If yes, list brand and model (if known): _____

Approximate age of old hearing aid: _____

New Hearing Aid

Manufacturer name: _____ Style/model: _____

Hearing aid specification: BTE, Optic or Body type: ITE Gain _____dB Output _____dB
Matrix: _____ _____ _____

Dispenser signature: _____ Date: ____/____/_____

Provider Medicaid ID #_____

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY WILL RESULT IN THE RETURN OF THE PRIOR AUTHORIZATION REQUEST.

CONSUMER INSTRUCTIONS FOR FORM COMPLETION

SECTION I. A physician must complete this section.

SECTION II. An ENT, certified audiologist, or hearing aid specialist must complete this section.

SECTION III. An ENT, certified audiologist, or hearing aid specialist must complete this section.

SECTION IV. The provider who dispenses the hearing aid must complete this section.

Completed form should be faxed to 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.
If this request is not received within 15 working days, PA will be denied.