CERTIFICATE OF MEDICAL NECESSITY - HEARING AIDS

DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 581 (8-2016)

Clear Fields

SECTION A - Certification Type/Date

Date	Diagnosis	Initial	Revised
Member Name	Member ID	Birthdate	Age

SECTION B - Information in this Section May Not Be Completed by the Supplier of the Items/Supplies

1. Please attach the required information:
   a. Copy of current Audiogram for both ears, unaided.
   b. Aided Audiogram with one aid and with two (if needed to help verify the medical necessity if one aid or two).
   c. Copy of Baseline Audiogram (to verify progressive hearing loss) if available.

2. What type of hearing aid are you requesting? ☐ Analog ☐ Digital ☐ Right ☐ Left ☐ Binaural

3. Date NDMA purchased a hearing aid for this member (if known):

4. Does recipient own any other hearing aids? ☐ Yes ☐ No	If yes, how many does he/she own?
5. What is the age of hearing aid(s)? Hearing aid #1:	Hearing aid #2:

6. Date and reason member stopped wearing hearing aids if previously worn.

7. Date of last hearing aid replacement.

8a. If the request is for the replacement of hearing aid(s), how does the present equipment not meet the client's hearing needs?

8b. If asking for replacement of lost hearing aid(s), please state what actions will be taken to ensure future loss of replacements.

SECTION C - Narrative Comments

Narrative description of all items, accessories and options ordered.

SECTION D - Physician Signature/Date

Signature	Date	(Signature and Date Stamps are not acceptable)