CERTIFICATE OF MEDICAL NECESSITY - HEARING AIDS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 581 (12-2023)

Clear Fields

SECTION A - Certification Type/Date

Date	Diagnosis	Initial	Revised	
Member Name	Member ID		Birthdate	Age

SECTION B - To be completed by the Physician/Practitioner

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 of one aid or two).
   c. Copy of Baseline Audiogram (to verify progressive hearing loss) if available.

2. What type of hearing aid is being requested?
   ☐ Analog ☐ Digital ☐ Right ☐ Left ☐ Binaural

3. Date ND Medicaid purchased a hearing aid for this member (if known)

4. Does the member own any other hearing aids?
   ☐ Yes - Specify how many he/she owns: ☐ No

5. What is the age of the hearing aid #1? | What is the age of the hearing aid #2?

6. Date and reason member stopped wearing hearing aid(s) (if previously worn)

7. Date of Last Hearing Aid Replacement

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

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

SECTION C - Narrative Descriptions

Narrative description of ALL items, accessories, and options ordered.

SECTION D - Physician/Practitioner Signature/Date

Signature	Date

** (Signature/Date Stamps are not acceptable)