Hearing aid replacement and/or clinical exception request form

for use by

audiologists/physicians and hearing instrument specialists

Replacement and clinical exceptions may be considered in certain conditions. Please refer to the replacement and clinical exception documents on our website.

Please select hearing aid(s) from the hearing aid selection list, which is available on the TELUS Health provider portal.

All hearing aid replacement requests during the five-year period must be accompanied by all supporting documentation, which confirms the persons' need for a new hearing aid.

For lost, stolen or damaged hearing device(s), the patient must submit the *Declaration of lost, stolen or damaged hearing devices form* (10570A) for WSIB consideration of replacement.

Clinical exceptions and prescriptions require an audiologist and/or physician signature with the *Hearing assessment form* (3275A).

For more information about the provision, replacement or repair of hearing devices, see Operational Policy Manual (OPM) document #17-07-04, Hearing Devices.

You can submit the completed form at wsib.ca/submit. If you don't have access to our website, you can also mail your completed form to us.

WSIB Ontario | Hearing aid replacement and/or clinical exception request form

Claim number

Visit wsib.ca/submit to submit this form and supporting documents.

This form is to be completed by audiologists/physicians and hearing instrument specialists. Please read the instructions page before completion.

Hearing health care practitioner information		
Clinic name	Clinic phone number	WSIB provider number
Clinic address		Phone number
Hearing health care practitioner/physician name		Registration number

Patient information		
Last name	First name	Date of birth (dd-mmm-yyyy)
Home address		Phone number

Please indicate your request:

☐ Hearing aid(s) replacement	**Please complete Section A (Submit audiologist and/or physician prescription and the *Hearing assessment form*).**
☐ Lost, stolen or damaged hearing aid(s)	**Please complete Section B.**
☐ Clinical exception	**Please complete Section C (Submit audiologist and/or physician prescription and the *Hearing assessment form*).**

Section A: Hearing aid(s) replacement

☐ I have attached supporting medical documentation. ☐ I have attached the *Hearing assessment form*. ☐ I have attached the prescription.

Reason for replacement request:

☐ R ☐ L Change in hearing

☐ R ☐ L Change in ability to operate hearing aid(s)

☐ R ☐ L Fitting issues

☐ R ☐ L Change in work duties and environment

☐ R ☐ L Other:

Please indicate the following information for the current and requested replacement hearing aid(s):

	Ear (R/L)	Model	Serial number	Original dispense date
Current hearing aid(s):				

	Ear (R/L)	Manufacturer	Model	Product code	Price
Requested replacement:					

For replacement only: please provide clinical rationale to support the replacement request (please attach supporting medical documentation).

Email accessibility@wsib.on.ca if you need a different format or accommodation. Disponible en français.

Section B: Lost, stolen or damaged hearing aid(s)

1.	☐ Yes	☐ No	Is the lost, stolen or damaged hearing aid(s) still within the manufacturers lost and damaged warranty period?
2.	☐ Yes	☐ No	Has the manufacturer warranty been used for a prior lost, stolen or damaged hearing aid? If yes, please provide supporting documentation.
3.	☐ Yes	☐ No	Has the manufacturer tested the hearing aid? If yes, provide supporting documentation and the date of testing:
4.	☐ Yes	☐ No	Is the original hearing aid(s) discontinued? If yes, please provide the manufacturer-recommended similar replacement(s). If no, please provide a copy of the prescription and *Hearing assessment form*.

Please indicate the following information for the current and requested replacement hearing aid(s):

	Ear (R/L)	Model	Serial number	Original dispense date
Current hearing aid(s):				

	Ear (R/L)	Manufacturer	Model	Product code	Price
Requested replacement:					

☐ I have included the manufacturer's invoice/report/supporting documentation with this form (i.e., manufacturer invoices and estimate of repair).

For lost, stolen or damaged only: please provide a full explanation of how the patient's hearing aid(s) were lost, stolen or damaged:

Section C: Clinical exception request

☐ **Initial request** ☐ **Replacement request**

☐ I have attached supporting medical documentation.

☐ I have attached the *Hearing assessment form*.

☐ I have attached the prescription.

Please indicate the following information for the current and requested replacement hearing aid(s):

	Ear (R/L)	Manufacturer	Model	Product code	Price
Initial hearing aid(s):					

	Ear (R/L)	Model	Serial number	Original dispense date
Current hearing aid(s):				

	Ear (R/L)	Manufacturer	Model	Product code	Price
Requested replacement:					

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Claim number

For clinical exception only: please provide clinical rationale to support the need for an exception-level hearing aid(s):

Health care practitioner/physician declaration and signature

By signing below: I understand that it is an offence to deliberately make a false statement to the Workplace Safety Insurance Board; and I declare that all of the information provided above is true.

Audiologist name	Audiologist signature	Date (dd-mmm-yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

Physician name	Physician signature	Date (dd-mmm-yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

Hearing instrument specialist name	Hearing instrument specialist signature	Date (dd-mmm-yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.

Patient acknowledgement and signature

By signing below, I acknowledge and understand that my hearing health care provider is seeking approval from the WSIB on my behalf to request hearing aid(s) for the reasons stated above.

Name	Signature	Date (dd-mmm-yyyy)

☐ Check this box if you are completing and submitting this form electronically. This represents your signature. You must fill out your name and the date above.