Hearing aid replacement and/or clinical exception request form

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

Hearing aid replacements and/or clinical exception level hearing aids may be considered where appropriate. Visit our website for more information about hearing devices.

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

The WSIB may authorize replacement hearing aids within the five-year cycle if there has been a:

- Change in hearing of 20dBs or more at three frequencies in the 500 - 3,000Hz region
- Medical change in the ability to operate hearing aids
- Fitting issues
- Change in work duties and environment
- Bimodal use of hearing aid and other medical causes
- Repairs, if the number of manufacturer's accumulated repairs make the hearing aid(s) no longer viable

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

A hearing health care provider must complete this form and have it signed by their patient in person. For lost, stolen or damaged hearing device(s), the patient must submit the *Declaration of lost, stolen or damaged hearing devices form* (10570A) for us to consider replacement.

Patients should trial an entry to mid-level hearing aid from the other preferred manufacturers before requesting a clinical-exception level aid.

Clinical exceptions and prescriptions require an audiologist and/or physician signature with the *Hearing assessment form* (3275A). Please note the following considerations for requesting a clinical exception:

1. Hearing loss and medical conditions
2. Physical fit
3. Work duties and environment

For more information about the provision, replacement or repair of hearing devices, see our policy on hearing devices (policy #17-07-04). For more information on our hearing services program, visit wsib.ca/hearingservicesprogram.

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.

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

Patient information		
Last name	First name	Date of birth (dd/mmm/yyyy)
☐ Patient is retired ☐ Patient is employed	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:

Change in hearing (greater than 20dB)	☐ Right	☐ Left
Change in ability to operate hearing aid(s)	☐ Right	☐ Left
Fitting issues	☐ Right	☐ Left
Change in work duties and environment	☐ Right	☐ Left
Other:	☐ Right	☐ Left

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

	Ear	**Manufacturer**	**Model**	**Serial number**	**Original dispense date**
Current hearing aid(s):	**Right**				
	Left				
	Ear	**Manufacturer**	**Model**	**Service code**	**Price**
Requested replacement:	**Right**				
	Left				

Claim number

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

☐ I have included the manufacturer's invoice/report/supporting documentation with this form (i.e., manufacturer invoices and estimate of repair or manufacturer confirmation hearing aid(s) are damaged beyond repair).

Is the lost, stolen or damaged hearing aid(s) still within the manufacturer's lost and damaged warranty period? ☐ Yes ☐ No

Has the manufacturer warranty been used for a prior lost, stolen or damaged hearing aid?
If yes, please provide supporting documentation. ☐ Yes ☐ No

Has the manufacturer tested the hearing aid?
If yes, provide supporting documentation and the date of testing: ☐ 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*. ☐ Yes ☐ No

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

	Ear	Manufacturer	Model	Serial number	Original dispense date
Current hearing aid(s):	**Right**				
	Left				
	Ear	**Manufacturer**	**Model**	**Service code**	**Price**
Requested replacement:	**Right**				
	Left				

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

All of the following are required when submitting an exception level aid.

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

☐ I have attached the prescription. ☐ I have attached the manufacturer invoice for the mid-level hearing aid.

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

	Ear	Manufacturer	Model	Serial number	Original dispense date
Current hearing aid(s):	**Right**				
	Left				
	Ear	**Manufacturer**	**Model**	**Service code**	**Price**
Requested replacement:	**Right**				
	Left				

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Claim number

Section C: Clinical exception request (continued)

Have you trialled a mid-level aid with your patient? ☐ Yes ☐ No

If no, please provide the rationale.

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

Section D: Using the hearing aid (to be completed by the patient)

1. I need to wear my hearing aid(s) (check all that apply):

   ☐ At home ☐ At work ☐ For social/leisure ☐ Other

2. I need to connect my hearing aids to my (check all that apply):

   ☐ Corded home phone ☐ Cordless home phone ☐ Android smartphone ☐ iPhone

   ☐ Other

3. I require information on how the hearing aid(s) will operate with my hearing protection devices. ☐ Yes ☐ No ☐ N/A

4. I will have support with my hearing aid(s) needs from my (check all that apply):

   ☐ Family ☐ Friends ☐ Power of attorney (POA) ☐ Personal support worker

   ☐ Care/assistance living facility ☐ Other

Section E: 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 WSIB, and that I declare that all of the information provided above is true.

Audiologist name	Signature	Date (dd/mmm/yyyy)
Physician name	Signature	Date (dd/mmm/yyyy)
Hearing instrument specialist name	Signature	Date (dd/mmm/yyyy)

Section F: 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)