Montana Medicaid Hearing Aid Certificate of Medical Necessity
Hearing Aid Evaluation

Medicaid Member Information			
Name:	**Medicaid ID:**		
Birth Date:	**Telephone Number:**		
Referring Provider Information			
Name:			
Address:	**City:**	**State:**	**Zip:**
Date of Evaluation/Referral:			
Date of Audiological Examination:			

Audiometric Test Results

	Right Ear	Left Ear
500 Hz		
1000 Hz		
2000 Hz		
3000 Hz		
Total Average		
PB Max Level		

The member has two-frequency at 1 KHz and 2 KHz:	Yes	No
greater than 40 decibels in both ears:	◯	◯
less than 90 decibels in both ears:	◯	◯
has an interaural difference of less than 15 decibels:	◯	◯
Word recognition or speech discrimination score is not greater than 20%:	◯	◯

Comments/Recommendations:

I certify that I am the audiologist completing the audiological evaluation for the patient identified in this form. I certify that the information contained in this document and its attachments are true, accurate, complete, and supported by clinical information in the patients record. I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

Audiologist Signature: **Date:**

Attachments: This form must be accompanied by copies of supporting documentation to include, but not limited to, the physician's referral for hearing aid services, and diagnostic and evaluation reports. Attachments are necessary for dispenser to request approval of the hearing aid(s) prior to the actual dispensing of the aid(s).