Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: HEARING AIDS

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber	Provider	Tester
Name	Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number	Credential
Date of birth	NPI	NPI	NPI (if not attached)
	Telephone number		Signature (if not attached)

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

Diagnosis code(s)	Date of hearing test	Pure-tone average hearing loss _____ dB left ear _____ dB right ear

Hearing test

The following procedures were performed:

- ☐ Testing of air-conducted stimuli at thresholds of 500 Hz, 1,000 Hz, 2,000 Hz, and 4,000 Hz
- ☐ Assessment of air-conducted speech awareness or speech reception threshold
- ☐ Establishment of most comfortable and most uncomfortable listening levels
- ☐ Pure-tone bone conduction audiometry (unless the individual's age or capability precluded such testing)
- ☐ Tympanometry (for an individual younger than 21)
- ☐ Acoustic reflex battery (for an individual younger than 21)
- ☐ Otoacoustic emissions testing (for an individual younger than 21)
- ☐ Other _____

☐ Bilateral testing was not performed. Explanation:

_____

_____

☐ A copy of the test results is attached.

Summary of test results

☐ Documentation is attached.

Equipment prescribed

Technology: ☐ Digital ☐ Programmable digital ☐ Analog Placement: ☐ Left ear ☐ Right ear ☐ Both ears

Rationale for a programmable digital hearing aid or analog hearing aid:

_____

_____

_____

_____

☐ Documentation is attached.

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.