START HEARING

Justification Form

UMWA patients only

Patient Name: _____ Date of Birth: _____

'UM' Member ID: _____

Current hearing aids (Make/model): _____

Provider name: _____ Date of visit: _____

(Printed)

Please check all that apply:

- ☐ Patient has not worn hearing aids previously
- ☐ 15 dB drop in hearing from last exam-please specify:
  - ☐ Pure Tone Average
  - ☐ >15 dB decline at multiple frequencies
- ☐ Change in shape or size of ear canal
- ☐ Pinna deformity or external canal deformity
- ☐ Difficult audiometric configuration
- ☐ Unilateral deafness
- ☐ Acoustic feedback potential with fitting
- ☐ Other (CIC or IIC justification and / or technology level):

_____

_____

_____

- ☐ Very poor speech perception:
  - ☐ For replacement HA - Word discrimination decline of >20%
- ☐ Recruitment / Misophonia
- ☐ Hyperacusis
- ☐ Reduced manual dexterity
- ☐ Limited hand dexterity
- ☐ Reduced Vision or Blindness

- ☐ Current hearing aids no longer function*:
  - Provide all repair history
  - Provide all reprogramming attempts

*Repair Date:	Serial number:	Reason for Repair:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

***Reprogramming Date:** _____ **Outcome:** _____

***Reprogramming Date:** _____ **Outcome:** _____

Recommended Hearing Aid(s): _____

Provider signature: _____ **Date:** _____

☐ If a peer-to-peer review is required, I authorize a Kepro Representative to contact me.

Phone: _____ In office Days / Times: _____

