American
Hearing Benefits
HAS CHANGED TO

START
HEARING

MEDICAL CLEARANCE FORM

Patient Name: ____ Date of Birth: _______________

Date of Examination: _________________

After thorough examination, I have determined that the above named patient is medically cleared for hearing aids.

If you need anything further from me, please contact me at the address or phone number listed below.

Examining Physician / Clinic Information:

Physician Signature: ____

Physician Printed Name: ____

Facility Name: ____

Address: ____

City, State, Zip: ____

Physician NPI Number: ____

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