

Hearing Aid Benefit Request

For Patients Aged 10 and Older



(Please contact GEMS directly for the process to follow if your patient is younger than 10 years.)

Section A: Patient Details

Membership No.	<input type="text"/>	ID No.	<input type="text"/>
Surname	<input type="text"/>		
Full name	<input type="text"/>		
Email	<input type="text"/>		
Tel Work	<input type="text"/>	Cellphone No.	<input type="text"/>
Dependant Code	<input type="text"/>	ID No.	<input type="text"/>
		Date of birth	<input type="text"/>
Surname	<input type="text"/>		
Full name	<input type="text"/>		
Email	<input type="text"/>		
Tel Work	<input type="text"/>	Cellphone No.	<input type="text"/>

Section B: Healthcare Provider Details

Details of the audiologist or acoustician who will be providing the hearing aid fitting and ongoing care

HPCSA No.	<input type="text"/>
Surname	<input type="text"/>
Full name	<input type="text"/>
Name of Practice	<input type="text"/>
Group Practice No.	<input type="text"/>
Personal practice no.	<input type="text"/>
Physical Address	<input type="text"/>
Email	<input type="text"/>
Contact No.	<input type="text"/>
Date of test	<input type="text"/>

Section C: Hearing aid information

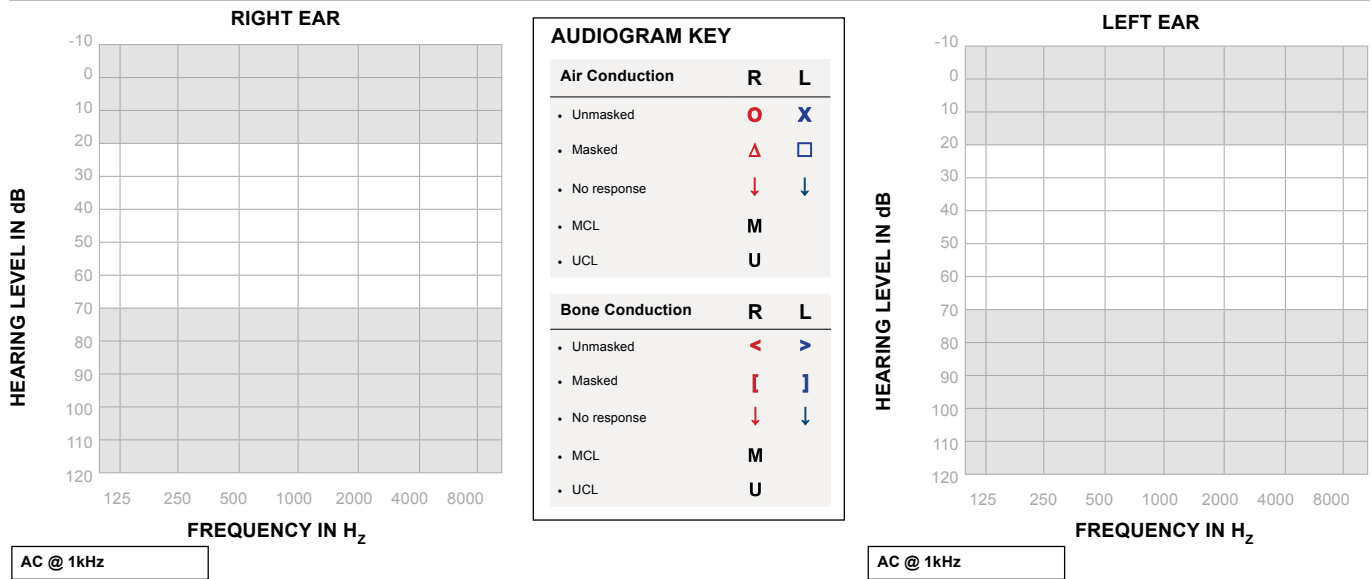
Right Ear			Left Ear		
Procedure code	<input type="text"/>	ICD10 code	<input type="text"/>	Procedure code	<input type="text"/>
NAPPI code	<input type="text"/>	Cost (VAT incl)	<input type="text"/>	NAPPI code	<input type="text"/>
Manufacturer	<input type="text"/>	Model	<input type="text"/>	Manufacturer	<input type="text"/>

Section D: Summary of motivation for hearing aids

Right Ear		Left Ear	
Type of hearing loss	<input type="text"/>	Type of hearing loss	<input type="text"/>
Degree of hearing loss	<input type="text"/>	Degree of hearing loss	<input type="text"/>
Previously worn hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Previously worn hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section E: Clinical Results

E1: Pure tone Audiogram (include UCL and MCL)



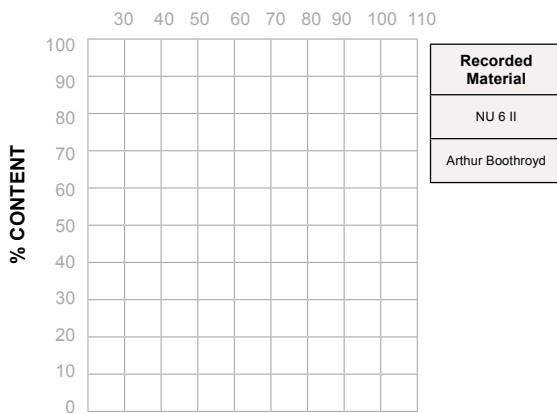
E2: Immittance

TYMPANOGRAM		
	R	L
Type		
Pressure		
Volume		
Compliance		

E3: Word recognition (please complete word and sentence tests in quiet and in noise)

	RIGHT	LEFT	Sound-field
PTA (Pure Tone Average)	dB	dB	dBs
Speech Reception Threshold	dB	dB	dBs
Max Word Recognition	%	%	%
SDT (Speech Detection Threshold)	dB	dB	dBs

Word Recognition Intensity (dBHL)



Recorded Speech Perception Tests

Test Materials	dB	Right/Left/Sound-Field/Binaural	SNR	% Correct

E4: Summary of results and/or additional motivation for hearing aid benefit:

Section F: Examiner Declaration

I hereby certify that I personally identified and examined the applicant named on this pre-authorization form and that this information, together with attached notes, embodies my hearing evaluation completely and correctly. I consent to provide Medscheme with additional information or evidence upon request. This may include further diagnostic assessment results as well as proof of equipment calibration certification.

Signature of practitioner _____ Signature of patient _____ Date