

**NF PETI Medical Necessity Certification Form  
Hearing Aid & Other Audiology Criteria**

Client name \_\_\_\_\_

Medicaid State ID number \_\_\_\_\_

**Medical Necessity (Shall be completed by the attending physician)**

**Circle appropriate items.**

1. Client needs to hear for communication and social interaction.
2. Audiometric exam confirms hearing aid or amplification device will significantly compensate for this client's degree and kind of hearing loss.
3. Client has previous history of successful hearing aid use.
4. Client's hearing aid(s) need repair.
5. Client requires hearing service such as wax removal.
6. Audiology examination will determine the type of hearing loss.
  - A. Individuals with conductive or mixed hearing loss shall be referred to an otolaryngologist for medical evaluation.
  - B. Individuals with sensorineural hearing loss may sign a medical waiver and be fitted with hearing aids based on the above criteria or may be referred to an otolaryngologist.
7. Client desires and has the physical and cognitive ability to wear and benefit from hearing aids or alternative amplification devices.

**Facility Instructions**

1. The primary care physician shall provide a written statement or write an order for a hearing evaluation.
2. Audiometric testing shall be performed by an ASHA certified audiologist.
3. Purchase of replacement hearing aid(s) shall include documentation explaining the reason for the replacement. The trade-in value for hearing aids or justification for the lack of value shall be documented in the request.
4. If two hearing aids are requested, submit a brief written statement as to why two are needed.
5. Include a copy of the most recent audiogram (no older than one year) performed by a licensed audiologist.
6. On-going expenses for maintenance and repair are part of the NF PETI program. Documentation shall accompany each NF PETI request and/or be maintained in the resident's file by the nursing facility.
7. Each NF PETI request shall include an itemized provider statement or treatment plan including procedure and diagnosis codes and itemized costs of each item included.

Requested NF PETI amount for this service: \_\_\_\_\_

Hearing Aid and Audiology Criteria for NF PETI  
Side 2

I certify that I consider the supplies and/or services included in this request to be medically necessary and that there are no medical or cognitive contraindications to providing these supplies and/or services.

Signature of Attending Physician \_\_\_\_\_ Date \_\_\_\_\_ License# \_\_\_\_\_

Signature of Audiologist \_\_\_\_\_ Date \_\_\_\_\_ License# \_\_\_\_\_

Signature of Otolaryngologist \_\_\_\_\_ Date \_\_\_\_\_ License# \_\_\_\_\_

I agree to the purchase of the supplies and/or equipment covered by this request. I understand that NF PETI may not cover the entire cost.

Signature of Client or Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_

**Incomplete forms shall be returned for completion.**