Saskatchewan Workers' Compensation Board

Health Care Services
200 – 1881 Scarth Street Regina SK
S4P 4L1

Phone: 306.787.4370
Toll-Free Phone: 1.800.667.7590
Fax: 306.787.4311
Toll-Free Fax: 1.888.844.7773

MCARE

Hearing loss – Request for funding

WCB claim number: _____

Workers' name: _____ **Provincial Health Number:** _____

Worker's address: _____ **Postal code:** _____ **Date of birth:**_____ (DD/MM/YY)

Clinic name: _____ **Clinic number:** _____ **Provider number:** _____

Clinic address: _____ **Postal code:** _____ **Phone:** _____ **Fax:** _____

Employer name: _____

PART I – REQUEST FOR FUNDING OF NEW OR REPLACEMENT HEARING AIDS

A. Hearing aid replacement request (to be completed if the worker has a current hearing aid)

Purchase date of current hearing aids: _____ (DD/MM/YY) Model/style: _____

Reasons to replace current hearing aid(s). Check appropriate boxes:

- ☐ L and/or ☐ R Improper amplification for hearing loss
- ☐ L and/or ☐ R Improper fit resulting in feedback
- ☐ L and/or ☐ R Significant change in hearing (20 dB at 3 or more frequencies (500 - 4,000 Hz)
- ☐ L and/or ☐ R Hearing aid style is inappropriate (e.g., dexterity)
- ☐ L and/or ☐ R Repair is no longer cost effective (manufacturer estimated cost of repair $ _____

Other (please explain):

B. Description of new hearing aid request

	Manufacturer/Model	Style	Warranty period (>3yrs)
Left ear			
Right ear			

Attach manufacturer's document stamped "not for payment" with invoice.

C. WCB invoicing

Code 202 - Manufacturer's price $_____ (not to exceed $954) + 10% handling fee + $556.50 for fitting, first-year visits, plus handling and shipping fees within the warranty period = $_____ per hearing aid.

Is the worker choosing to upgrade to a mid-range or premium model? Yes No

If yes, is the worker aware that the WCB will only pay the fee to a maximum of $1,605.90 and includes follow up and service fees for the first year as per the WCB fee schedule? Yes No

Care provider signature: _____ **Date:** _____

Worker signature: _____

Worker signature required if the worker upgrades hearing aid and agrees to pay any additional fees to the hearing instrument provider.

WCB claim number: _____

D. WCB Response

☐ Approved ☐ Denied

Date: _____ **Case manager:** _____ **Phone:** _____

PART 2 – REQUEST FOR REPAIRS OR HEARING AID SUPPLIES

A. Request for funding for repair (WCB fee code 205 – billable only after the warranty has expired)

Purchase date of current hearing aid(s): _____ (DD/MM/YY) Warranty expiry date: _____ (DD/MM/YY)

Authorization for repair requested for:

- ☐ Hearing aid three to four years old and repair exceeds $300
- ☐ Hearing aid greater than four years old
- ☐ Hearing aid between three and four years old and has been repaired within the last 12 months

Expected cost: $ _____

Repair history – List date(s) of repair, repair type and cost.

Date: _____ (DD/MM/YY) Repair type: _____ Cost: _____

Date: _____ (DD/MM/YY) Repair type: _____ Cost: _____

Date: _____ (DD/MM/YY) Repair type: _____ Cost: _____

Description of repairs for hearing aid(s):

Code 205 – Explain what needs to be repaired and the steps taken to resolve the issues (e.g., inadequate gain available or feedback/static).

B. Request for supplies for hearing aids

- ☐ Receiver is required after warranty expired
- ☐ Ear molds (WCB fee code 215) exceeding one mold per ear every two years

Expected cost: $ _____

C. Request for funding for servicing of hearing aid (WCB fee code 214 – only billable after the first year that the WCB prepaid.)

Authorization requested for a visit exceeding the prepaid two visits per year. This visit will be #____ this year.
Reason for additional service visit over two per year:

Care provider signature: _____ **Date:** _____

D. WCB response

☐ Approved ☐ Denied

Date: _____ **Case Manager:** _____ **Phone:** _____