Saskatchewan Workers' Compensation Board

Health Care Services
200-1881 Scarth St.
Regina, SK S4P 4L1
wcbsask.com

Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

MCARE

Hearing loss – Request for funding

WCB claim number: ______________________

Worker's name: ________________________ **Provincial health number:** ____________________

Worker's address: ___________________________ **Postal code:** ______ **Date of birth:** _________ (DD/MM/YYYY)

Clinic name: ____________________ **Clinic number:** _____________ **Provider number:** _________

Clinic address: _______________________ **City/province:** _____________ **Postal code:** _______

Clinic phone: ___________ **Fax:** ____________ **Clinic email:** _______________________________

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/YYYY) 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 (such as dexterity)

☐ **L** and/or ☐ **R** Repair is no longer cost effective (manufacturer estimated cost of repair $ _______

☐ **L** and/or ☐ **R** Loss or damage

Other (please explain):

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

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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 $990 for initial purchase or $330 for replacement of lost or damaged hearing instrument) + 10% handling fee + Code 218 for manufacturer's shipping fee (not to exceed $20) + Code 213 ($577.50) 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 $1685.50 for initial purchase and includes follow up and service fees for the first year or $960.50 for replacement of lost or damaged hearing instrument as per the WCB fee schedule?

Yes No

Care provider signature: ________________________ **Date:** ____________________________________

Worker signature: ___________________________________

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/YYYY) Warranty expiry date: _______________ (DD/MM/YYYY)

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

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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: ____________ Repair type: ______________ Cost: ____________________
(DD/MM/YYYY)

Date: ____________ Repair type: ______________ Cost: ____________________
(DD/MM/YYYY)

Date: ____________ Repair type: ______________ Cost: ____________________
(DD/MM/YYYY)

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: $ __________________

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:** ___________________________

C. WCB response

☐ Approved ☐ Denied

Date: __________________ **Case manager:** _________________________ **Phone:** ________________

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