Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: HEARING AIDS

Identifying Information [This section may be completed by the provider.]

Individual	Prescriber *	Provider	Tester *
Name	Name *	Name	Name *
Medicaid ID number	Medicaid provider number *	Medicaid provider number	Credential *
Date of birth	NPI *	NPI	NPI (if not attached) *
	Telephone number *		Signature (if not attached) *

*** Certification [This section may be transcribed by the provider.] ***

Mark all items that apply.

Diagnosis code(s) *	Date of hearing test *	Pure-tone average hearing loss * _____ dB left ear _____ dB right ear

Hearing test *

The following procedures were performed:

- ☐ Testing of air-conducted stimuli at thresholds of 500 Hz, 1,000 Hz, 2,000 Hz, and 4,000 Hz
- ☐ Assessment of air-conducted speech awareness or speech reception threshold
- ☐ Establishment of most comfortable and most uncomfortable listening levels
- ☐ Pure-tone bone conduction audiometry (unless the individual's age or capability precluded such testing)
- ☐ Tympanometry (for an individual younger than 21)
- ☐ Acoustic reflex battery (for an individual younger than 21)
- ☐ Otoacoustic emissions testing (for an individual younger than 21)
- ☐ Other _____

☐ Bilateral testing was not performed. Explanation:

_____

_____

☐ A copy of the test results is attached.

Summary of test results *

☐ Documentation is attached.

Equipment prescribed

Technology: ☐ Digital ☐ Programmable digital ☐ Analog Placement: ☐ Left ear ☐ Right ear ☐ Both ears

Rationale for a programmable digital hearing aid or analog hearing aid:

_____

_____

_____

_____

☐ Documentation is attached.

*** Attestation [This section must be completed by the prescriber.]**

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber *	Date of signature *

False certification constitutes Medicaid fraud.

ODM 01915 (Rev. 7/2018) * - Filled out by Physician * - Filled out by testing clinician