UIC
UNIVERSITY
OF ILLINOIS
AT CHICAGO

**PHYSICIAN RECOMMENDATION FOR HEARING AIDS**

DIVISION OF SPECIALIZED CARE FOR CHILDREN

Child's Name ______________________________
Address ______________________________
______________________________
City/Zip ______________________________
Birthdate ______________________________
Diagnosis (with ICD Code) ______________________________
______________________________

I have reviewed the audiological/hearing aid evaluation report of ______________________________
The above named child was examined on (date) ______________________________

1. This patient:

| RIGHT EAR | LEFT EAR |
| --- | --- |
| ☐ Can use amplification<br>☐ Cannot use amplification | ☐ Can use amplification<br>☐ Cannot use amplification |

Reason for Denial ______________________________
Other tests recommended ______________________________

2. Audiologic evaluations should be completed:

☐ Annually ☐ As recommended by Audiologist

Other ______________________________

3. Medication needed ______________________________
4. Other services needed ______________________________
5. I would like to see this child again in ______________________________
6. Bill Attached ☐ Yes ☐ No EOB Attached ☐ Yes ☐ No

______________________________
Physician's Signature

______________________________
Address

______________________________
Physician's Printed Name

______________________________
City, State, Zip

______________________________
Phone

**Please return to:**