Workers' Compensation Board – Alberta

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C1265
HEARING LOSS SERVICES
Hearing Aid Replacement Information

WORKER DETAILS

		WCB Claim #
Worker's Surname	First Name and Initial	Date of Birth *(yyyy/mm/dd)*
Telephone Number	Assessment Date *(yyyy/mm/dd)*	Date of Accident *(yyyy/mm/dd)*
Retired ☐ Yes ☐ No If yes, when?		

Clinic information

Provider Name	Billing Number			Date *(yyyy/mm/dd)*
Address Street	City/Town	Province	Postal Code	Telephone Number
Audiologist / Registered Hearing Aid Practitioner Providing Service				Fax Number

***** Use this form if the hearing aid is less than 5 years old *****

Clause 4.09 "For replacement of hearing aids less than five (5) years old, the Contractors will submit the completed C1265 form to obtain pre-authorization from the Claim Owner prior to replacing the aid."

Description of current hearing aid(s)

A hearing aid is replaced only as required, regardless of its age; a rationale must be noted and supported with documentation. Additionally, if the present hearing aid is less than five years old, prior authorization from the ***WCB Hearing Loss Adjudicator*** is required before new hearing aid(s) may be dispensed.

Right Ear	Clinic Name	Date Fitted *(yyyy/mm/dd)*	Age of the Hearing Aid in years
Manufacture Model		Style	Serial Number
Left Ear	Clinic Name	Date Fitted *(yyyy/mm/dd)*	Age of the Hearing Aid in years
Manufacture Model		Style	Serial Number
Repair History:			

Request for authorization to replace hearing aid(s)

Please check appropriate boxes	**L**	**R**
The manufacturer will not repair the hearing aid(s) (Supporting document required)	☐	☐
Real ear measurements demonstrate that the hearing aid is no longer providing adequate gain for the worker *Supporting documents required:* • *Current audiogram (using form C662 Hearing Loss Assessment)* • *Real ear measurements (REM) of hearing aids requested to be replaced*	☐	☐

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Worker's *(Surname)* *(First Name and Initial)*	Claim Number

Electroacoustic analysis demonstrates that the hearing aid is no longer providing adequate gain for the worker *Supporting documents required: Electroacoustic analysis*	☐	☐
A change in hearing aid style is required due to a significant change in hearing (≥20dB) at three or more frequencies (500 – 4000Hz)	☐	☐
A change in hearing aid style is required due to a significant change in physical condition (i.e. stroke)	☐	☐
A change in hearing aid style is required due to improper fit resulting in feedback	☐	☐
Excessive repair history *(Three or more manufacturer repairs after warranty to a single hearing aid that is less than 5 years old).* *Please indicate cost of repair below, and provide details on the steps and solutions to resolve (below)* Cost of repairs in past year: $_____ and manufacturer's quote for repairs $_____	☐	☐

Please indicate steps taken to resolve issues and/or clinical rationale:

1.

2.

3.

Proposed Solutions (i.e. style, make, model):

1.

2.

3.

☐ Other reason for replacement (please provide explanation)

Signal Used:	Frequency Compression:
☐ Speech ☐ Simulated Speech	☐ Yes ☐ No

Simulated REMs used: ☐ Yes ☐ No

If yes, provide justification:

Is the hearing aid maxed out?	Is this a recent REM (within six months)?	Is the aid at user preference?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Client and Service Provider – please read before signing

I agree that my hearing aid(s) no longer meet my need(s) and that I meet the eligibility requirements for replacement as outlined above.

Signature of WCB Client:	**Signature of Provider:**

WCB Comments

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